State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 2128

03/11/2021 Authored by Liebling, Schultz and Bernardy
The bill was read for the first time and referred to the Committee on Health Finance and Policy
04/12/2021 Adoption of Report: Amended and re-referred to the Committee on Ways and Means
04/16/2021 Adoption of Report: Placed on the General Register as Amended
Read for the Second Time
04/19/2021 By motion, re-referred to the Committee on Ways and Means

A bill for an act

relating to state government; modifying provisions governing health, health care, human services, human services licensing and background studies, health-related licensing boards, prescription drugs, health insurance, telehealth, children and family services, behavioral health, direct care and treatment, disability services and continuing care for older adults, community supports, and chemical and mental health services; establishing a budget for health and human services; making forecast adjustments; making technical and conforming changes; requiring reports; transferring money; appropriating money; amending Minnesota Statutes 2020, sections 62A.04, subdivision 2; 62A.10, by adding a subdivision; 62A.15, subdivision 4, by adding a subdivision; 62A.152, subdivision 3; 62A.3094, subdivision 1; 62A.65, subdivision 1, by adding a subdivision; 62C.01, by adding a subdivision; 62D.01, by adding a subdivision; 62D.095, subdivisions 2, 3, 4, 5; 62J.495, subdivisions 1, 2, 3, 4; 62J.497, subdivisions 1, 3; 62J.498; 62J.4981; 62J.4982; 62J.63, subdivisions 1, 2; 62Q.01, subdivision 2a; 62Q.02; 62Q.096; 62Q.46; 62Q.677, by adding a subdivision; 62Q.81; 62U.04, subdivisions 4, 5, 11; 62V.05, by adding a subdivision; 62W.11; 103H.201, subdivision 1; 119B.011, subdivision 15; 119B.025, subdivision 4; 119B.03, subdivisions 4, 6; 119B.09, subdivision 4; 119B.11, subdivision 2a; 119B.125, subdivision 1; 119B.13, subdivisions 1, 1a, 6, 7; 119B.25, subdivision 3; 122A.18, subdivision 8; 136A.128, subdivisions 2, 4; 144.0724, subdivisions 1, 2, 3a, 4, 5, 7, 8, 9, 12; 144.1205, subdivisions 2, 4, 8, 9, by adding a subdivision; 144.125, subdivision 1; 144.1481, subdivision 1; 144.1501, subdivisions 1, 2, 3; 144.1911, subdivision 6; 144.212, by adding a subdivision; 144.225, subdivisions 2, 7; 144.226, by adding subdivisions; 144.55, subdivisions 4, 6; 144.551, subdivision 1, by adding a subdivision; 144.555; 144.651, subdivision 2; 144.9501, subdivision 17; 144.9502, subdivision 3; 144.9504, subdivisions 2, 5; 144D.01, subdivision 4; 144G.08, subdivision 7, as amended; 144G.84; 145.893, subdivision 1; 145.894; 145.897; 145.899; 145.901, subdivisions 2, 4; 147.033; 148.90, subdivision 2; 148.911; 148B.30, subdivision 1; 148B.31; 148B.51; 148B.5301, subdivision 2; 148B.54, subdivision 2; 148E.010, by adding a subdivision; 148E.120, subdivision 2; 148E.130, subdivision 1, by adding a subdivision; 148F.11, subdivision 1; 151.01, by adding subdivisions; 151.071, subdivisions 1, 2; 151.37, subdivision 2; 151.555, subdivisions 1, 7, 11, by adding a subdivision; 152.01, subdivision 23; 152.02, subdivisions 2, 3; 152.11, subdivision 1a, by adding a subdivision; 152.12, by adding a subdivision; 152.125, subdivision 3; 152.22, subdivisions 6, 11, by adding subdivisions; 152.23; 152.25, by adding a subdivision; 152.26; 152.27, subdivisions 3, 4, 6; 152.28, subdivision 1; 152.29, subdivisions 1, 3, by adding subdivisions;

152.31; 152.32, subdivision 3; 156.12, subdivision 2; 171.07, by adding a subdivision; 174.30, subdivision 3; 245.462, subdivisions 1, 6, 8, 9, 14, 16, 17, 18, 21, 23, by adding a subdivision; 245.4661, subdivision 5; 245.4662, subdivision 1; 245.467, subdivisions 2, 3; 245.469, subdivisions 1, 2; 245.470, subdivision 1; 245.4712, subdivision 2; 245.472, subdivision 2; 245.4863; 245.4871, subdivisions 9a, 10, 11a, 17, 21, 26, 27, 29, 31, 32, 34, by adding a subdivision; 245.4876, subdivisions 2, 3; 245.4879, subdivision 1; 245.488, subdivision 1; 245.4882, subdivisions 1, 3; 245.4885, subdivision 1; 245.4889, subdivision 1; 245.4901, subdivision 2; 245.62, subdivision 2; 245.735, subdivisions 3, 5, by adding a subdivision; 245A.02, by adding subdivisions; 245A.03, subdivision 7; 245A.04, subdivision 5; 245A.041, by adding a subdivision; 245A.043, subdivision 3; 245A.05; 245A.07, subdivision 1; 245A.10, subdivision 4; 245A.14, subdivision 4; 245A.16, by adding a subdivision; 245A.50, subdivisions 7, 9; 245A.65, subdivision 2; 245C.02, subdivisions 4a, 5, by adding subdivisions; 245C.03; 245C.05, subdivisions 1, 2, 2a, 2b, 2c, 2d, 4; 245C.08, subdivision 3, by adding a subdivision; 245C.10, subdivision 15, by adding subdivisions; 245C.13, subdivision 2; 245C.14, subdivision 1, by adding a subdivision; 245C.15, by adding a subdivision; 245C.16, subdivisions 1, 2; 245C.17, subdivision 1, by adding a subdivision; 245C.18; 245C.24, subdivisions 2, 3, 4, by adding a subdivision; 245C.32, subdivision 1a; 245D.02, subdivision 20; 245F.04, subdivision 2; 245G.01, subdivisions 13, 26; 245G.03, subdivision 2; 245G.06, subdivision 1; 246.54, subdivision 1b; 254A.19, subdivision 5; 254B.01, subdivision 4a, by adding a subdivision; 254B.05, subdivision 5; 254B.12, by adding a subdivision; 256.01, subdivisions 14b, 28; 256.0112, subdivision 6; 256.041; 256.042, subdivisions 2, 4; 256.043, subdivision 3; 256.969, subdivisions 2b, 9, by adding a subdivision; 256.9695, subdivision 1; 256.9741, subdivision 1; 256.98, subdivision 1; 256.983; 256B.04, subdivisions 12, 14; 256B.055, subdivision 6; 256B.056, subdivision 10; 256B.057, subdivision 3; 256B.06, subdivision 4; 256B.0615, subdivisions 1, 5; 256B.0616, subdivisions 1, 3, 5; 256B.0621, subdivision 10; 256B.0622, subdivisions 1, 2, 3a, 4, 7, 7a, 7b, 7d; 256B.0623, subdivisions 1, 2, 3, 4, 5, 6, 9, 12; 256B.0624; 256B.0625, subdivisions 3b, 3c, 3d, 3e, 5, 5m, 9, 10, 13, 13c, 13d, 13e, 13h, 17, 17b, 18, 18b, 19c, 20, 20b, 28a, 30, 31, 42, 46, 48, 49, 52, 56a, 58, by adding subdivisions; 256B.0631, subdivision 1; 256B.0638, subdivisions 3, 5, 6; 256B.0659, subdivision 13; 256B.0757, subdivision 4c; 256B.0759, subdivisions 2, 4, by adding subdivisions; 256B.0911, subdivisions 1a, 3a, 3f, 4d; 256B.092, subdivisions 4, 5, 12; 256B.0924, subdivision 6; 256B.094, subdivision 6; 256B.0941, subdivision 1; 256B.0943, subdivisions 1, 2, 3, 4, 5, 5a, 6, 7, 9, 11; 256B.0946, subdivisions 1, 1a, 2, 3, 4, 6; 256B.0947, subdivisions 1, 2, 3, 3a, 5, 6, 7; 256B.0949, subdivisions 2, 4, 5a, by adding a subdivision; 256B.097, by adding subdivisions; 256B.196, subdivision 2; 256B.25, subdivision 3; 256B.439, by adding subdivisions; 256B.49, subdivisions 11, 11a, 14, 17, by adding a subdivision; 256B.4914, subdivisions 5, 6, 7, 8, 9, by adding a subdivision; 256B.69, subdivisions 5a, 6, 6d, by adding subdivisions; 256B.6928, subdivision 5; 256B.75; 256B.76, subdivisions 2, 4; 256B.761; 256B.763; 256B.79, subdivisions 1, 3; 256B.85, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 11b, 12, 12b, 13, 13a, 15, 17a, 18a, 20b, 23, 23a, by adding subdivisions; 256D.03, by adding a subdivision; 256D.051, by adding subdivisions; 256D.0515; 256D.0516, subdivision 2; 256E.34, subdivision 1; 256I.03, subdivision 13; 256I.04, subdivision 3; 256I.05, subdivisions 1a, 1c, 11; 256I.06, subdivisions 6, 8; 256J.08, subdivisions 15, 71, 79; 256J.09, subdivision 3; 256J.10; 256J.21, subdivisions 3, 4, 5; 256J.24, subdivision 5; 256J.30, subdivision 8; 256J.33, subdivisions 1, 2, 4; 256J.37, subdivisions 1, 1b, 3, 3a; 256J.45, subdivision 1; 256J.626, subdivision 1; 256J.95, subdivision 9; 256L.01, subdivision 5; 256L.03, subdivision 5; 256L.04, subdivision 7b; 256L.05, subdivision 3a; 256L.11, subdivisions 6a, 7; 256N.25, subdivisions 2, 3; 256N.26, subdivisions 11, 13; 256P.01, subdivisions 3, 6a, by adding a subdivision; 256P.04, subdivisions 4, 8; 256P.06, subdivisions 2, 3; 256P.07; 256S.05, subdivision 2; 256S.18, subdivision 7; 256S.20, subdivision 1; 260.761, subdivision 2; 260C.007, subdivisions 6, 14, 26c, 31; 260C.157, subdivision 3;

260C.212, subdivisions 1a, 13; 260C.215, subdivision 4; 260C.4412; 260C.452; 260C.704; 260C.706; 260C.708; 260C.71; 260C.712; 260C.714; 260D.01; 260D.05; 260D.06, subdivision 2; 260D.07; 260D.08; 260D.14; 260E.01; 260E.02, subdivision 1; 260E.03, subdivision 22, by adding subdivisions; 260E.06, subdivision 1; 260E.14, subdivisions 2, 5; 260E.17, subdivision 1; 260E.18; 260E.20, subdivision 2; 260E.24, subdivisions 2, 7; 260E.31, subdivision 1; 260E.33, subdivision 1, by adding a subdivision; 260E.35, subdivision 6; 260E.36, by adding a subdivision; 295.50, subdivision 9b; 295.53, subdivision 1; 325F.721, subdivision 1; 326.71, subdivision 4; 326.75, subdivisions 1, 2, 3; Laws 2019, First Special Session chapter 9, article 14, section 3, as amended; Laws 2020, First Special Session chapter 7, section 1, subdivision 2, as amended; Laws 2020, Fifth Special Session chapter 3, article 10, section 3; Laws 2020, Seventh Special Session chapter 1, article 6, section 12, subdivision 4; proposing coding for new law in Minnesota Statutes, chapters 62A; 62J; 62Q; 62W; 119B; 144; 145; 151; 245; 245A; 245C; 254B; 256B; 256P; 256S; proposing coding for new law as Minnesota Statutes, chapter 245I; repealing Minnesota Statutes 2020, sections 16A.724, subdivision 2; 62A.67; 62A.671; 62A.672; 62J.63, subdivision 3; 119B.04; 119B.125, subdivision 5; 144.0721, subdivision 1; 144.0722; 144.0724, subdivision 10; 144.693; 245.462, subdivision 4a; 245.4871, subdivision 32a; 245.4879, subdivision 2; 245.62, subdivisions 3, 4; 245.69, subdivision 2; 245.735, subdivisions 1, 2, 4; 245C.10, subdivisions 2, 2a, 3, 4, 5, 6, 7, 8, 9, 9a, 10, 11, 12, 13, 14, 16; 256B.0596; 256B.0615, subdivision 2; 256B.0616, subdivision 2; 256B.0622, subdivisions 3, 5a; 256B.0623, subdivisions 7, 8, 10, 11; 256B.0625, subdivisions 5l, 18c, 18d, 18e, 18h, 35a, 35b, 61, 62, 65; 256B.0916, subdivisions 2, 3, 4, 5, 8, 11, 12; 256B.0924, subdivision 4a; 256B.0943, subdivisions 8, 10; 256B.0944; 256B.0946, subdivision 5; 256B.097, subdivisions 1, 2, 3, 4, 5, 6; 256B.49, subdivisions 26, 27; 256D.051, subdivisions 1, 1a, 2, 2a, 3, 3a, 3b, 6b, 6c, 7, 8, 9, 18; 256D.052, subdivision 3; 256J.08, subdivisions 10, 53, 61, 62, 81, 83; 256J.21, subdivisions 1, 2; 256J.30, subdivisions 5, 7, 8; 256J.33, subdivisions 3, 4, 5; 256J.34, subdivisions 1, 2, 3, 4; 256J.37, subdivision 10; 256S.20, subdivision 2; Minnesota Rules, parts 9505.0275; 9505.0370; 9505.0371; 9505.0372; 9505.1693; 9505.1696, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22; 9505.1699; 9505.1701; 9505.1703; 9505.1706; 9505.1712; 9505.1715; 9505.1718; 9505.1724; 9505.1727; 9505.1730; 9505.1733; 9505.1736; 9505.1739; 9505.1742; 9505.1745; 9505.1748; 9520.0010; 9520.0020; 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090; 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160; 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; 9520.0230; 9520.0750; 9520.0760; 9520.0770; 9520.0780; 9520.0790; 9520.0800; 9520.0810; 9520.0820; 9520.0830; 9520.0840; 9520.0850; 9520.0860; 9520.0870; 9530.6800; 9530.6810.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

DEPARTMENT OF HUMAN SERVICES HEALTH CARE PROGRAMS

Section 1. **[62A.002] APPLICABILITY OF CHAPTER.**

Any benefit or coverage mandate included in this chapter does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L.

Sec. 2. Minnesota Statutes 2020, section 62C.01, is amended by adding a subdivision to read:

Subd. 4. **Applicability.** Any benefit or coverage mandate included in this chapter does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L.

Sec. 3. Minnesota Statutes 2020, section 62D.01, is amended by adding a subdivision to read:

Subd. 3. **Applicability.** Any benefit or coverage mandate included in this chapter does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L.

Sec. 4. **[62J.011] APPLICABILITY OF CHAPTER.**

Any benefit or coverage mandate included in this chapter does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L.

Sec. 5. Minnesota Statutes 2020, section 62Q.02, is amended to read:

62Q.02 APPLICABILITY OF CHAPTER.

(a) This chapter applies only to health plans, as defined in section 62Q.01, and not to other types of insurance issued or renewed by health plan companies, unless otherwise specified.

(b) This chapter applies to a health plan company only with respect to health plans, as defined in section 62Q.01, issued or renewed by the health plan company, unless otherwise specified.

(c) If a health plan company issues or renews health plans in other states, this chapter applies only to health plans issued or renewed in this state for Minnesota residents, or to cover a resident of the state, unless otherwise specified.

(d) Any benefit or coverage mandate included in this chapter does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L.

Sec. 6. Minnesota Statutes 2020, section 174.30, subdivision 3, is amended to read:

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

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

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

Sec. 7. Minnesota Statutes 2020, section 256.01, subdivision 28, is amended to read:

Subd. 28. **Statewide health information exchange.** (a) The commissioner has the authority to join and participate as a member in a legal entity developing and operating a statewide health information exchange or to develop and operate an encounter alerting service that shall meet the following criteria:

(1) the legal entity must meet all constitutional and statutory requirements to allow the commissioner to participate; and

(2) the commissioner or the commissioner's designated representative must have the right to participate in the governance of the legal entity under the same terms and conditions and subject to the same requirements as any other member in the legal entity and in that role shall act to advance state interests and lessen the burdens of government.

(b) Notwithstanding chapter 16C, the commissioner may pay the state's prorated share of development-related expenses of the legal entity retroactively from October 29, 2007, regardless of the date the commissioner joins the legal entity as a member.

Sec. 8. Minnesota Statutes 2020, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according to the following:

(1) critical access hospitals as defined by Medicare shall be paid using a cost-based methodology;

(2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology under subdivision 25;

(3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation distinct parts as defined by Medicare shall be paid according to the methodology under subdivision 12; and

(4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

(b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For rate setting periods after November 1, 2014, in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals.

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year or years for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

(3) trauma services as defined by the National Uniform Billing Committee;

(4) transplant services;

(5) obstetric services, newborn services, and behavioral health services provided by hospitals outside the seven-county metropolitan area;

(6) outlier admissions;

(7) low-volume providers; and

(8) services provided by small rural hospitals that are not critical access hospitals.

(f) Hospital payment rates established under paragraph (c) must incorporate the following:

(1) for hospitals paid under the DRG methodology, the base year payment rate per admission is standardized by the applicable Medicare wage index and adjusted by the hospital's disproportionate population adjustment;

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

(3) the cost and charge data used to establish hospital payment rates must only reflect inpatient services covered by medical assistance; and

(4) in determining hospital payment rates for discharges occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per discharge shall be based on the cost-finding methods and allowable costs of the Medicare

program in effect during the base year or years. In determining hospital payment rates for discharges in subsequent base years, the per discharge rates shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year or years and the next base year or years. In any year that inpatient claims volume falls below the threshold required to ensure a statically valid sample of claims, the commissioner may combine claims data from two consecutive years to serve as the base year. Years in which inpatient claims volume is reduced or altered due to a pandemic or other public health emergency shall not be used as a base year or part of a base year if the base year includes more than one year. Changes in costs between base years shall be measured using the lower of the hospital cost index defined in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per claim. The commissioner shall establish the base year for each rebasing period considering the most recent year or years for which filed Medicare cost reports are available. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and

after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

(1) hospitals that had payments at or below 80 percent of their costs in the base year shall have a rate set that equals 85 percent of their base year costs;

(2) hospitals that had payments that were above 80 percent, up to and including 90 percent of their costs in the base year shall have a rate set that equals 95 percent of their base year costs; and

(3) hospitals that had payments that were above 90 percent of their costs in the base year shall have a rate set that equals 100 percent of their base year costs.

(j) The commissioner may refine the payment tiers and criteria for critical access hospitals to coincide with the next rebasing under paragraph (h). The factors used to develop the new methodology may include, but are not limited to:

(1) the ratio between the hospital's costs for treating medical assistance patients and the hospital's charges to the medical assistance program;

(2) the ratio between the hospital's costs for treating medical assistance patients and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(3) the ratio between the hospital's charges to the medical assistance program and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

(5) the proportion of that hospital's costs that are administrative and trends in administrative costs; and

(6) geographic location.

Sec. 9. Minnesota Statutes 2020, section 256.969, is amended by adding a subdivision to read:

Subd. 2f. **Alternate inpatient payment rate.** Effective January 1, 2022, for a hospital eligible to receive disproportionate share hospital payments under subdivision 9, paragraph (d), clause (6), the commissioner shall reduce the amount calculated under subdivision 9, paragraph (d), clause (6), by 99 percent and compute an alternate inpatient payment rate.

The alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to what the hospital would have received for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance had the hospital received the entire amount calculated under subdivision 9, paragraph (d), clause (6).

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 10. Minnesota Statutes 2020, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) Certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

(c) Upon federal approval of the related state plan amendment, paragraph (b) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology using 2012 as the base year. Annual payments made under this paragraph shall equal the total amount of payments made for 2012. A licensed children's hospital shall receive only a single DSH factor for children's hospitals. Other DSH factors may be combined to arrive at a single factor for each hospital that is eligible for DSH payments. The new methodology shall make payments only to hospitals located in Minnesota and include the following factors:

(1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000 fee-for-service discharges in the base year shall receive a factor of 0.7880;

(2) a hospital that has in effect for the initial rate year a contract with the commissioner to provide extended psychiatric inpatient services under section 256.9693 shall receive a factor of 0.0160;

(3) a hospital that has received medical assistance payment ~~from the fee-for-service program~~ for at least 20 transplant services in the base year shall receive a factor of 0.0435;

(4) a hospital that has a medical assistance utilization rate in the base year between 20 percent up to one standard deviation above the statewide mean utilization rate shall receive a factor of 0.0468;

(5) a hospital that has a medical assistance utilization rate in the base year that is at least one standard deviation above the statewide mean utilization rate but is less than two and one-half standard deviations above the mean shall receive a factor of 0.2300; and

(6) a hospital that is a level one trauma center and that has a medical assistance utilization rate in the base year that is at least two and one-half standard deviations above the statewide mean utilization rate shall receive a factor of 0.3711.

(e) For the purposes of determining eligibility for the disproportionate share hospital factors in paragraph (d), clauses (1) to (6), the medical assistance utilization rate and discharge thresholds shall be measured using only one year when a two-year base period is used.

~~(e)~~ (f) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to

exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

~~(f)~~ (g) An additional payment adjustment shall be established by the commissioner under this subdivision for a hospital that provides high levels of administering high-cost drugs to enrollees in fee-for-service medical assistance. The commissioner shall consider factors including fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, or if the hospital qualifies for the alternative payment rate described in subdivision 2e, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed ~~$1,500,000~~ $9,000,000.

EFFECTIVE DATE. This section is effective July 1, 2021, except that the amendment to paragraph (g) is effective January 1, 2023.

Sec. 11. Minnesota Statutes 2020, section 256.9695, subdivision 1, is amended to read:

Subdivision 1. **Appeals.** A hospital may appeal a decision arising from the application of standards or methods under section 256.9685, 256.9686, or 256.969, if an appeal would result in a change to the hospital's payment rate or payments. Both overpayments and underpayments that result from the submission of appeals shall be implemented. Regardless of any appeal outcome, relative values, Medicare wage indexes, Medicare cost-to-charge ratios, and policy adjusters shall not be changed. The appeal shall be heard by an administrative law judge according to sections 14.57 to 14.62, or upon agreement by both parties, according to a modified appeals procedure established by the commissioner and the Office of Administrative Hearings. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

To appeal a payment rate or payment determination or a determination made from base year information, the hospital shall file a written appeal request to the commissioner within 60 days of the date the preliminary payment rate determination was mailed. The appeal request shall specify: (i) the disputed items; (ii) the authority in federal or state statute or rule upon which the hospital relies for each disputed item; and (iii) the name and address

of the person to contact regarding the appeal. Facts to be considered in any appeal of base year information are limited to those in existence ~~12~~ 18 months after the last day of the calendar year that is the base year for the payment rates in dispute.

Sec. 12. Minnesota Statutes 2020, section 256.983, is amended to read:

256.983 FRAUD PREVENTION INVESTIGATIONS.

Subdivision 1. **Programs established.** Within the limits of available appropriations, the commissioner of human services shall require the maintenance of budget neutral fraud prevention investigation programs in the counties or tribal agencies participating in the fraud prevention investigation project established under this section. If funds are sufficient, the commissioner may also extend fraud prevention investigation programs to other counties or tribal agencies provided the expansion is budget neutral to the state. Under any expansion, the commissioner has the final authority in decisions regarding the creation and realignment of individual county, tribal agency, or regional operations.

Subd. 2. **County and tribal agency proposals.** Each participating county and tribal agency shall develop and submit an annual staffing and funding proposal to the commissioner no later than April 30 of each year. Each proposal shall include, but not be limited to, the staffing and funding of the fraud prevention investigation program, a job description for investigators involved in the fraud prevention investigation program, and the organizational structure of the county or tribal agency unit, training programs for case workers, and the operational requirements which may be directed by the commissioner. The proposal shall be approved, to include any changes directed or negotiated by the commissioner, no later than June 30 of each year.

Subd. 3. **Department responsibilities.** The commissioner shall establish training programs which shall be attended by all investigative and supervisory staff of the involved county and tribal agencies. The commissioner shall also develop the necessary operational guidelines, forms, and reporting mechanisms, which shall be used by the involved county or tribal agencies. An individual's application or redetermination form for public assistance benefits, including child care assistance programs and medical care programs, must include an authorization for release by the individual to obtain documentation for any information on that form which is involved in a fraud prevention investigation. The authorization for release is effective for six months after public assistance benefits have ceased.

Subd. 4. **Funding.** (a) County and tribal agency reimbursement shall be made through the settlement provisions applicable to the Supplemental Nutrition Assistance Program

(SNAP), MFIP, child care assistance programs, the medical assistance program, and other federal and state-funded programs.

(b) The commissioner will maintain program compliance if for any three consecutive month period, a county or tribal agency fails to comply with fraud prevention investigation program guidelines, or fails to meet the cost-effectiveness standards developed by the commissioner. This result is contingent on the commissioner providing written notice, including an offer of technical assistance, within 30 days of the end of the third or subsequent month of noncompliance. The county or tribal agency shall be required to submit a corrective action plan to the commissioner within 30 days of receipt of a notice of noncompliance. Failure to submit a corrective action plan or, continued deviation from standards of more than ten percent after submission of a corrective action plan, will result in denial of funding for each subsequent month, or billing the county or tribal agency for fraud prevention investigation (FPI) service provided by the commissioner, or reallocation of program grant funds, or investigative resources, or both, to other counties or tribal agencies. The denial of funding shall apply to the general settlement received by the county or tribal agency on a quarterly basis and shall not reduce the grant amount applicable to the FPI project.

Subd. 5. **Child care providers; financial misconduct.** (a) A county or tribal agency may conduct investigations of financial misconduct by child care providers as described in chapter 245E. Prior to opening an investigation, a county or tribal agency must contact the commissioner to determine whether an investigation under this chapter may compromise an ongoing investigation.

(b) If, upon investigation, a preponderance of evidence shows a provider committed an intentional program violation, intentionally gave the county or tribe materially false information on the provider's billing forms, provided false attendance records to a county, tribe, or the commissioner, or committed financial misconduct as described in section 245E.01, subdivision 8, the county or tribal agency may suspend a provider's payment pursuant to chapter 245E, or deny or revoke a provider's authorization pursuant to section 119B.13, subdivision 6, paragraph (d), clause (2), prior to pursuing other available remedies. The county or tribe must send notice in accordance with the requirements of section 119B.161, subdivision 2. If a provider's payment is suspended under this section, the payment suspension shall remain in effect until: (1) the commissioner, county, tribe, or a law enforcement authority determines that there is insufficient evidence warranting the action and a county, tribe, or the commissioner does not pursue an additional administrative remedy under chapter 119B or 245E, or section 256.046 or 256.98; or (2) all criminal, civil, and

administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted.

(c) For the purposes of this section, an intentional program violation includes intentionally making false or misleading statements; intentionally misrepresenting, concealing, or withholding facts; and repeatedly and intentionally violating program regulations under chapters 119B and 245E.

(d) A provider has the right to administrative review under section 119B.161 if: (1) payment is suspended under chapter 245E; or (2) the provider's authorization was denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (2).

Sec. 13. **[256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

(a) Effective January 1, 2023, the commissioner shall contract with a dental administrator to administer dental services for all recipients of medical assistance and MinnesotaCare, including persons enrolled in managed care as described in section 256B.69.

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

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

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

(4) dental claims processing;

(5) coordination of dental care with other services;

(6) management of fraud and abuse;

(7) monitoring access to dental services;

(8) performance measurement;

(9) quality improvement and evaluation; and

(10) management of third-party liability requirements.

(c) Payments to contracted dental providers must be at the rates established under section 256B.76.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 14. Minnesota Statutes 2020, section 256B.04, subdivision 12, is amended to read:

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

~~The rules shall provide:~~

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

~~(2) reimbursement of public and private nonprofit providers serving the population with a disability generally at reasonable maximum rates that reflect the cost of providing the service regardless of the fare that might be charged by the provider for similar services to individuals other than those receiving medical assistance or medical care under this chapter.~~

~~(b) The commissioner shall encourage providers reimbursed under this chapter to coordinate their operation with similar services that are operating in the same community. To the extent practicable, the commissioner shall encourage eligible individuals to utilize less expensive providers capable of serving their needs.~~

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

Sec. 15. Minnesota Statutes 2020, section 256B.04, subdivision 14, is amended to read:

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

(1) eyeglasses;

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

(3) hearing aids and supplies; ~~and~~

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

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

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

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

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

(6) drugs.

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

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for ~~special transportation services or~~ incontinence products and related supplies.

Sec. 16. Minnesota Statutes 2020, section 256B.055, subdivision 6, is amended to read:

Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid for a pregnant woman who meets the other eligibility criteria of this section and whose unborn child would be eligible as a needy child under subdivision 10 if born and living with the woman. In accordance with Code of Federal Regulations, title 42, section 435.956, the commissioner must accept self-attestation of pregnancy unless the agency has information

that is not reasonably compatible with such attestation. For purposes of this subdivision, a woman is considered pregnant for ~~60 days~~ six months postpartum.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

Sec. 17. Minnesota Statutes 2020, section 256B.056, subdivision 10, is amended to read:

Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the ~~60-day~~ six-month postpartum period to update their income and asset information and to submit any required income or asset verification.

(b) The commissioner shall determine the eligibility of private-sector health care coverage for infants less than one year of age eligible under section 256B.055, subdivision 10, or 256B.057, subdivision 1, paragraph (c), and shall pay for private-sector coverage if this is determined to be cost-effective.

(c) The commissioner shall verify assets and income for all applicants, and for all recipients upon renewal.

(d) The commissioner shall utilize information obtained through the electronic service established by the secretary of the United States Department of Health and Human Services and other available electronic data sources in Code of Federal Regulations, title 42, sections 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish standards to define when information obtained electronically is reasonably compatible with information provided by applicants and enrollees, including use of self-attestation, to accomplish real-time eligibility determinations and maintain program integrity.

(e) Each person applying for or receiving medical assistance under section 256B.055, subdivision 7, and any other person whose resources are required by law to be disclosed to determine the applicant's or recipient's eligibility must authorize the commissioner to obtain information from financial institutions to identify unreported accounts as required in section 256.01, subdivision 18f. If a person refuses or revokes the authorization, the commissioner may determine that the applicant or recipient is ineligible for medical assistance. For purposes of this paragraph, an authorization to identify unreported accounts meets the requirements of the Right to Financial Privacy Act, United States Code, title 12, chapter 35, and need not be furnished to the financial institution.

(f) County and tribal agencies shall comply with the standards established by the commissioner for appropriate use of the asset verification system specified in section 256.01, subdivision 18f.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

Sec. 18. Minnesota Statutes 2020, section 256B.057, subdivision 3, is amended to read:

Subd. 3. **Qualified Medicare beneficiaries.** (a) A person ~~who is entitled to Part A Medicare benefits, whose income is equal to or less than 100 percent of the federal poverty guidelines, and whose assets are no more than $10,000 for a single individual and $18,000 for a married couple or family of two or more,~~ is eligible for medical assistance reimbursement of Medicare Part A and Part B premiums, Part A and Part B coinsurance and deductibles, and cost-effective premiums for enrollment with a health maintenance organization or a competitive medical plan under section 1876 of the Social Security Act~~.~~ if:

(1) the person is entitled to Medicare Part A benefits;

(2) the person's income is equal to or less than 100 percent of the federal poverty guidelines; and

(3) the person's assets are no more than (i) $10,000 for a single individual, or (ii) $18,000 for a married couple or family of two or more; or, when the resource limits for eligibility for the Medicare Part D extra help low income subsidy (LIS) exceed either amount in item (i) or (ii), the person's assets are no more than the LIS resource limit in United States Code, title 42, section 1396d, subsection (p).

(b) Reimbursement of the Medicare coinsurance and deductibles, when added to the amount paid by Medicare, must not exceed the total rate the provider would have received for the same service or services if the person were a medical assistance recipient with Medicare coverage. Increases in benefits under Title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

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

Sec. 19. Minnesota Statutes 2020, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other

persons residing lawfully in the United States. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(1) refugees admitted to the United States according to United States Code, title 8, section 1157;

(2) persons granted asylum according to United States Code, title 8, section 1158;

(3) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(4) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(5) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning July 1, 2010, children and pregnant women who are noncitizens described in paragraph (b) or who are lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation as provided by the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

(e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(f) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition.

(g) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment of an emergency medical condition are limited to the following:

(i) services delivered in an emergency room or by an ambulance service licensed under chapter 144E that are directly related to the treatment of an emergency medical condition;

(ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; and

(iii) follow-up services that are directly related to the original service provided to treat the emergency medical condition and are covered by the global payment made to the provider.

(2) Services for the treatment of emergency medical conditions do not include:

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ transplants, stem cell transplants, and related care;

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

(viii) rehabilitation services;

(ix) physical, occupational, or speech therapy;

(x) transportation services;

(xi) case management;

(xii) prosthetics, orthotics, durable medical equipment, or medical supplies;

(xiii) dental services;

(xiv) hospice care;

(xv) audiology services and hearing aids;

(xvi) podiatry services;

(xvii) chiropractic services;

(xviii) immunizations;

(xix) vision services and eyeglasses;

(xx) waiver services;

(xxi) individualized education programs; or

(xxii) chemical dependency treatment.

(i) Pregnant noncitizens who are ineligible for federally funded medical assistance because of immigration status, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and ~~60 days~~ six months postpartum~~, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program~~.

(j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance. The nonprofit center referenced under this paragraph may establish itself as a provider of mental health targeted case management services through a county contract under section 256.0112, subdivision 6. If the nonprofit center is unable to secure a contract with a lead county in its service area, then, notwithstanding the requirements of section 256B.0625, subdivision 20, the commissioner may negotiate a contract with the nonprofit center for provision of mental health targeted case management services. When serving clients who are not the financial responsibility of their contracted lead county, the nonprofit center must gain the concurrence of the county of financial responsibility prior to providing mental health targeted case management services for those clients.

(k) Notwithstanding paragraph (h), clause (2), the following services are covered as emergency medical conditions under paragraph (f) except where coverage is prohibited under federal law for services under clauses (1) and (2):

(1) dialysis services provided in a hospital or freestanding dialysis facility;

(2) surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission and requires surgery, chemotherapy, or radiation treatment; and

(3) kidney transplant if the person has been diagnosed with end stage renal disease, is currently receiving dialysis services, and is a potential candidate for a kidney transplant.

(l) Effective July 1, 2013, recipients of emergency medical assistance under this subdivision are eligible for coverage of the elderly waiver services provided under chapter

256S, and coverage of rehabilitative services provided in a nursing facility. The age limit for elderly waiver services does not apply. In order to qualify for coverage, a recipient of emergency medical assistance is subject to the assessment and reassessment requirements of section 256B.0911. Initial and continued enrollment under this paragraph is subject to the limits of available funding.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

Sec. 20. Minnesota Statutes 2020, section 256B.0625, subdivision 3c, is amended to read:

Subd. 3c. **Health Services ~~Policy Committee~~ Advisory Council.** (a) The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a ~~13-member~~ 14-member Health Services ~~Policy Committee~~ Advisory Council, which consists of ~~12~~ 13 voting members and one nonvoting member. The Health Services ~~Policy Committee~~ Advisory Council shall advise the commissioner regarding (1) health services pertaining to the administration of health care benefits covered under ~~the medical assistance and MinnesotaCare programs~~ Minnesota health care programs (MHCP); and (2) evidence-based decision-making and health care benefit and coverage policies for MHCP. The Health Services Advisory Council shall consider available evidence regarding quality, safety, and cost-effectiveness when advising the commissioner. The Health Services ~~Policy Committee~~ Advisory Council shall meet at least quarterly. The Health Services ~~Policy Committee~~ Advisory Council shall annually ~~elect~~ select a ~~physician~~ chair from among its members~~,~~ who shall work directly with the commissioner's medical director~~,~~ to establish the agenda for each meeting. The Health Services ~~Policy Committee shall also~~ Advisory Council may recommend criteria for verifying centers of excellence for specific aspects of medical care where a specific set of combined services, a volume of patients necessary to maintain a high level of competency, or a specific level of technical capacity is associated with improved health outcomes.

(b) The commissioner shall establish a dental ~~subcommittee~~ subcouncil to operate under the Health Services ~~Policy Committee~~ Advisory Council. The dental ~~subcommittee~~ subcouncil consists of general dentists, dental specialists, safety net providers, dental hygienists, health plan company and county and public health representatives, health researchers, consumers, and a designee of the commissioner of health. The dental ~~subcommittee~~ subcouncil shall advise the commissioner regarding:

(1) the critical access dental program under section 256B.76, subdivision 4, including but not limited to criteria for designating and terminating critical access dental providers;

(2) any changes to the critical access dental provider program necessary to comply with program expenditure limits;

(3) dental coverage policy based on evidence, quality, continuity of care, and best practices;

(4) the development of dental delivery models; and

(5) dental services to be added or eliminated from subdivision 9, paragraph (b).

~~(c) The Health Services Policy Committee shall study approaches to making provider reimbursement under the medical assistance and MinnesotaCare programs contingent on patient participation in a patient-centered decision-making process, and shall evaluate the impact of these approaches on health care quality, patient satisfaction, and health care costs. The committee shall present findings and recommendations to the commissioner and the legislative committees with jurisdiction over health care by January 15, 2010.~~

~~(d)~~ (c) The Health Services ~~Policy Committee shall~~ Advisory Council may monitor and track the practice patterns of ~~physicians providing services to medical assistance and MinnesotaCare enrollees~~ health care providers who serve MHCP recipients under fee-for-service, managed care, and county-based purchasing. The ~~committee~~ monitoring and tracking shall focus on services or specialties for which there is a high variation in utilization or quality across ~~physicians~~ providers, or which are associated with high medical costs. The commissioner, based upon the findings of the ~~committee~~ Health Services Advisory Council, ~~shall regularly~~ may notify ~~physicians~~ providers whose practice patterns indicate below average quality or higher than average utilization or costs. Managed care and county-based purchasing plans shall provide the commissioner with utilization and cost data necessary to implement this paragraph, and the commissioner shall make ~~this~~ these data available to the ~~committee~~ Health Services Advisory Council.

~~(e) The Health Services Policy Committee shall review caesarean section rates for the fee-for-service medical assistance population. The committee may develop best practices policies related to the minimization of caesarean sections, including but not limited to standards and guidelines for health care providers and health care facilities.~~

Sec. 21. Minnesota Statutes 2020, section 256B.0625, subdivision 3d, is amended to read:

Subd. 3d. **Health Services ~~Policy Committee~~ Advisory Council members.** (a) The Health Services ~~Policy Committee~~ Advisory Council consists of:

(1) ~~seven~~ six voting members who are licensed physicians actively engaged in the practice of medicine in Minnesota, ~~one of whom must be actively engaged in the treatment of persons with mental illness, and~~ three of whom must represent health plans currently under contract to serve ~~medical assistance~~ MHCP recipients;

(2) two voting members who are licensed physician specialists actively practicing their specialty in Minnesota;

(3) two voting members who are nonphysician health care professionals licensed or registered in their profession and actively engaged in their practice of their profession in Minnesota;

(4) one voting member who is a health care or mental health professional licensed or registered in the member's profession, actively engaged in the practice of the member's profession in Minnesota, and actively engaged in the treatment of persons with mental illness;

~~(4) one consumer~~ (5) two consumers who shall serve as ~~a~~ voting ~~member~~ members; and

~~(5)~~ (6) the commissioner's medical director who shall serve as a nonvoting member.

(b) Members of the Health Services ~~Policy Committee~~ Advisory Council shall not be employed by the ~~Department of Human Services~~ state of Minnesota, except for the medical director. A quorum shall comprise a simple majority of the voting members. Vacant seats shall not count toward a quorum.

Sec. 22. Minnesota Statutes 2020, section 256B.0625, subdivision 3e, is amended to read:

Subd. 3e. **Health Services ~~Policy Committee~~ Advisory Council terms and compensation.** ~~Committee~~ Members shall serve staggered three-year terms, with one-third of the voting members' terms expiring annually. Members may be reappointed by the commissioner. The commissioner may require more frequent Health Services ~~Policy Committee~~ Advisory Council meetings as needed. An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each ~~committee~~ council member in attendance except the medical director. The Health Services ~~Policy Committee~~ Advisory Council does not expire as provided in section 15.059, subdivision 6.

Sec. 23. Minnesota Statutes 2020, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services. The commissioner shall contract with a dental administrator for the administration of dental services. The

contract shall include the administration of dental services for persons enrolled in managed care as described in section 256B.69.

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; ~~and~~

(15) full-mouth debridement, limited to one every five years~~.~~; and

(16) nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

(e) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

(1) house calls or extended care facility calls for on-site delivery of covered services;

(2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

(f) The commissioner shall not require prior authorization for the services included in paragraph (e), clauses (1) to (3)~~, and shall prohibit managed care and county-based purchasing plans from requiring prior authorization for the services included in paragraph (e), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12~~.

EFFECTIVE DATE. This section is effective July 1, 2021, except that the amendments to paragraphs (a) and (f) are effective January 1, 2023.

Sec. 24. Minnesota Statutes 2020, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, a physician assistant, or an advanced practice registered nurse employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner~~.~~ or the drug appears on the 90-day supply list published by the commissioner. The 90-day supply list shall be published by the commissioner on the department's website. The commissioner may add to, delete from, and otherwise modify the 90-day supply list after providing public notice and the opportunity for a 15-day public comment period. The 90-day supply list may include cost-effective generic drugs and shall not include controlled substances.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the Formulary Committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine

necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies. By March 1 of each year, each 340B covered entity and ambulatory pharmacy under common ownership of the 340B covered entity must report to the commissioner its reimbursements for the previous calendar year from each managed care and county-based purchasing plan, or the pharmacy benefit manager contracted with the managed care or county-based purchasing plan. The report must include:

(1) the National Provider Identification (NPI) number for each 340B covered entity or ambulatory pharmacy under common ownership of the 340B covered entity;

(2) the name of each 340B covered entity;

(3) the servicing address of each 340B covered entity;

(4) the aggregate cost of drugs purchased during the prior calendar year through the 340B program;

(5) the aggregate cost of drugs purchased during the prior calendar year outside of the 340B program;

(6) the total reimbursement received by the 340B covered entity from all payers, including uninsured patients, for all drugs during the prior calendar year; and

(7) either: (i) the number of outpatient 340B pharmacy claims and reimbursement amounts from each managed care and county-based purchasing plan, or pharmacy benefit manager contracted with the managed care or county-based purchasing plan; or (ii) the number of

professional or facility 340B claim lines and reimbursement amounts during the prior calendar year from each managed care and county-based purchasing plan.

The commissioner shall submit a copy of the reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by April 1 of each year. Drugs acquired through the federal 340B Drug Pricing Program and dispensed by a 340B covered entity or ambulatory pharmacy under common ownership of the 340B covered entity are not eligible for coverage if the 340B covered entity or ambulatory pharmacy under common ownership of the 340B covered entity fails to submit a report to the commissioner containing the information required under clauses (1) to (7).

(g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 16.

Sec. 25. Minnesota Statutes 2020, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least twice per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid

to each committee member in attendance. ~~The Formulary Committee expires June 30, 2022.~~ Notwithstanding section 15.059, subdivision 6, the Formulary Committee does not expire.

Sec. 26. Minnesota Statutes 2020, section 256B.0625, subdivision 13d, is amended to read:

Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the Formulary Committee shall review and comment on the formulary contents.

(b) The formulary shall not include:

(1) drugs, active pharmaceutical ingredients, or products for which there is no federal funding;

(2) over-the-counter drugs, except as provided in subdivision 13;

~~(3) drugs or active pharmaceutical ingredients used for weight loss, except that medically necessary lipase inhibitors may be covered for a recipient with type II diabetes;~~

~~(4)~~ (3) drugs or active pharmaceutical ingredients when used for the treatment of impotence or erectile dysfunction;

~~(5)~~ (4) drugs or active pharmaceutical ingredients for which medical value has not been established;

~~(6)~~ (5) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act; and

~~(7)~~ (6) medical cannabis as defined in section 152.22, subdivision 6.

(c) If a single-source drug used by at least two percent of the fee-for-service medical assistance recipients is removed from the formulary due to the failure of the manufacturer to sign a rebate agreement with the Department of Health and Human Services, the commissioner shall notify prescribing practitioners within 30 days of receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was not signed.

Sec. 27. Minnesota Statutes 2020, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be ~~$10.48~~ $10.77 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be ~~$10.48~~ $10.77 per ~~bag~~ claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be ~~$10.48~~ $10.77 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable

cost of a multisource drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

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

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

(d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC of the generic product or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or

specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

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

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

(h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for specialty prescription drugs and a single statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the

department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement.

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

Sec. 28. Minnesota Statutes 2020, section 256B.0625, subdivision 17, is amended to read:

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

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

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

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

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

(4) public transit, as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers.

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly

operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

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

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

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

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

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

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

(1) adhere to the policies defined by the commissioner ~~in consultation with the Nonemergency Medical Transportation Advisory Committee~~;

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

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

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

~~(f) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).~~

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

facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the ~~local agency~~ administrator.

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

~~(h)~~ (g) The administrative agency shall use the level of service process established by the commissioner ~~in consultation with the Nonemergency Medical Transportation Advisory Committee~~ to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

~~(i)~~ (h) The covered modes of transportation are:

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

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

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

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

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

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

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

~~(j) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the commissioner has developed, made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government.~~

~~(k)~~ (i) The commissioner shall:

(1) ~~in consultation with the Nonemergency Medical Transportation Advisory Committee,~~ verify that the mode and use of nonemergency medical transportation is appropriate;

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

(3) investigate all complaints and appeals.

~~(l) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.~~

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

~~(1) $0.22 per mile for client reimbursement;~~

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

~~(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $11 for the base rate and $1.30 per mile when provided by a nonemergency medical transportation provider;~~

~~(4) $13 for the base rate and $1.30 per mile for assisted transport;~~

~~(5) $18 for the base rate and $1.55 per mile for lift-equipped/ramp transport;~~

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

~~(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary.~~

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

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

~~(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (m), clauses (1) to (7).~~

~~(o) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (m) and (n), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.~~

~~(p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.~~

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

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 29. Minnesota Statutes 2020, section 256B.0625, subdivision 17b, is amended to read:

Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency medical transportation providers must document each occurrence of a service provided to a recipient according to this subdivision. Providers must maintain odometer and other records

sufficient to distinguish individual trips with specific vehicles and drivers. The documentation may be collected and maintained using electronic systems or software or in paper form but must be made available and produced upon request. Program funds paid for transportation that is not documented according to this subdivision shall be recovered by the nonemergency medical transportation vendor or department.

(b) A nonemergency medical transportation provider must compile transportation records that meet the following requirements:

(1) the record must be in English and must be legible according to the standard of a reasonable person;

(2) the recipient's name must be on each page of the record; and

(3) each entry in the record must document:

(i) the date on which the entry is made;

(ii) the date or dates the service is provided;

(iii) the printed last name, first name, and middle initial of the driver;

(iv) the signature of the driver attesting to the following: "I certify that I have accurately reported in this record the trip miles I actually drove and the dates and times I actually drove them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings.";

(v) the signature of the recipient or authorized party attesting to the following: "I certify that I received the reported transportation service.", or the signature of the provider of medical services certifying that the recipient was delivered to the provider;

(vi) the address, or the description if the address is not available, of both the origin and destination, and the mileage for the most direct route from the origin to the destination;

(vii) the mode of transportation in which the service is provided;

(viii) the license plate number of the vehicle used to transport the recipient;

(ix) whether the service was ambulatory or nonambulatory;

(x) the time of the pickup and the time of the drop-off with "a.m." and "p.m." designations;

(xi) the name of the extra attendant when an extra attendant is used to provide special transportation service; and

(xii) the electronic source documentation used to calculate driving directions and mileage.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 30. Minnesota Statutes 2020, section 256B.0625, subdivision 18, is amended to read:

Subd. 18. **~~Bus~~ Public transit or taxicab transportation.** (a) To the extent authorized by rule of the state agency, medical assistance covers the most appropriate and cost-effective form of transportation incurred by any ambulatory eligible person for obtaining nonemergency medical care.

(b) The commissioner may provide a monthly public transit pass to recipients who are well-served by public transit for the recipient's nonemergency medical transportation needs. Any recipient who is eligible for one public transit trip for a medically necessary covered service may select to receive a transit pass for that month. Recipients who do not have any transportation needs for a medically necessary service in any given month or who have received a transit pass for that month through another program administered by a county or Tribe are not eligible for a transit pass that month. The commissioner shall not require recipients to select a monthly transit pass if the recipient's transportation needs cannot be served by public transit systems. Recipients who receive a monthly transit pass are not eligible for other modes of transportation, unless an unexpected need arises that cannot be accessed through public transit.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 31. Minnesota Statutes 2020, section 256B.0625, subdivision 18b, is amended to read:

Subd. 18b. **~~Broker dispatching prohibition~~ Administration of nonemergency medical transportation.** ~~Except for establishing level of service process, the commissioner shall not use a broker or coordinator for any purpose related to nonemergency medical transportation services under subdivision 18.~~ The commissioner shall contract either statewide or regionally for the administration of the nonemergency medical transportation program in compliance with the provisions of this chapter. The contract shall include the administration of all covered modes under the nonemergency medical transportation benefit for those enrolled in managed care as described in section 256B.69.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 32. Minnesota Statutes 2020, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and

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

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

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

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

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

(f) Effective January 1, 2001, through December 31, 2020, each FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United

States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l).

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

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

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

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

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

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

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

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

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

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

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

(k) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization in accordance with section 1905(b) of the Social Security Act for expenditures made to organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

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

(1) the commissioner shall establish a single medical and single dental organization encounter rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization encounter rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social services and administrative costs;

(ii) retail pharmacy;

(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fund-raising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year. Years in which organizational cost or claims volume is reduced or altered due to a pandemic, disease, or other public health

emergency shall not be used as part of a base year when the base year includes more than one year. The commissioner may use the Medicare cost reports of a year unaffected by a pandemic, disease, or other public health emergency, or previous two consecutive years, inflated to the base year as established under item (iv);

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization encounter rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization encounter rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate currently received by the FQHC or rural health clinic;

(10) for FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rate;

(13) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

(14) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

Sec. 33. Minnesota Statutes 2020, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions

and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications

that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in Code of Federal Regulations, title 42, part 440.70.

(h) Allergen-reducing products provided according to subdivision 67, paragraph (c) or (d), shall be considered durable medical equipment.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 34. Minnesota Statutes 2020, section 256B.0625, subdivision 58, is amended to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** (a) Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). In administering the EPSDT program, the commissioner shall, at a minimum:

(1) provide information to children and families, using the most effective mode identified, regarding:

(i) the benefits of preventative health care visits;

(ii) the services available as part of the EPSDT program; and

(iii) assistance finding a provider, transportation, or interpreter services;

(2) maintain an up-to-date periodicity schedule published in the department policy manual, taking into consideration the most up-to-date community standard of care; and

(3) maintain up-to-date policies for providers on the delivery of EPSDT services that are in the provider manual on the department website.

(b) The commissioner may contract for the administration of the outreach services as required within the EPSDT program.

(c) The commissioner may contract for the required EPSDT outreach services, including but not limited to children enrolled or attributed to an integrated health partnership demonstration project described in section 256B.0755. Integrated health partnerships that choose to include the EPSDT outreach services within the integrated health partnership's contracted responsibilities must receive compensation from the commissioner on a per-member per-month basis for each included child. Integrated health partnerships must accept responsibility for the effectiveness of outreach services it delivers. For children who

are not a part of the demonstration project, the commissioner may contract for the administration of the outreach services.

(d) The payment amount for a complete EPSDT screening shall not include charges for health care services and products that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

EFFECTIVE DATE. This section is effective July 1, 2021, except that paragraph (c) is effective January 1, 2022.

Sec. 35. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 67. **Enhanced asthma care services.** (a) Medical assistance covers enhanced asthma care services and related products to be provided in the children's homes for children with poorly controlled asthma. To be eligible for services and products under this subdivision, a child must:

(1) have poorly controlled asthma defined by having received health care for the child's asthma from a hospital emergency department at least one time in the past year or have been hospitalized for the treatment of asthma at least one time in the past year; and

(2) receive a referral for services and products under this subdivision from a treating health care provider.

(b) Covered services include home visits provided by a registered environmental health specialist or lead risk assessor currently credentialed by the Department of Health or a healthy homes specialist credentialed by the Building Performance Institute.

(c) Covered products include the following allergen-reducing products that are identified as needed and recommended for the child by a registered environmental health specialist, healthy homes specialist, lead risk assessor, certified asthma educator, public health nurse, or other health care professional providing asthma care for the child, and proven to reduce asthma triggers:

(1) allergen encasements for mattresses, box springs, and pillows;

(2) an allergen-rated vacuum cleaner, filters, and bags;

(3) a dehumidifier and filters;

(4) HEPA single-room air cleaners and filters;

(5) integrated pest management, including traps and starter packages of food storage containers;

(6) a damp mopping system;

(7) if the child does not have access to a bed, a waterproof hospital-grade mattress; and

(8) for homeowners only, furnace filters.

(d) The commissioner shall determine additional products that may be covered as new best practices for asthma care are identified.

(e) A home assessment is a home visit to identify asthma triggers in the home and to provide education on trigger-reducing products. A child is limited to two home assessments except that a child may receive an additional home assessment if the child moves to a new home; if a new asthma trigger, including tobacco smoke, enters the home; or if the child's health care provider identifies a new allergy for the child, including an allergy to mold, pests, pets, or dust mites. The commissioner shall determine the frequency with which a child may receive a product under paragraph (c) or (d) based on the reasonable expected lifetime of the product.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 36. Minnesota Statutes 2020, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness. No co-payments

shall apply to medications when used for the prevention or treatment of the human immunodeficiency virus (HIV);

(4) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; and

(5) total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

EFFECTIVE DATE. This section is effective January 1, 2022, subject to federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 37. Minnesota Statutes 2020, section 256B.0638, subdivision 3, is amended to read:

Subd. 3. **Opioid prescribing work group.** (a) The commissioner of human services, in consultation with the commissioner of health, shall appoint the following voting members to an opioid prescribing work group:

(1) two consumer members who have been impacted by an opioid abuse disorder or opioid dependence disorder, either personally or with family members;

(2) one member who is a licensed physician actively practicing in Minnesota and registered as a practitioner with the DEA;

(3) one member who is a licensed pharmacist actively practicing in Minnesota and registered as a practitioner with the DEA;

(4) one member who is a licensed nurse practitioner actively practicing in Minnesota and registered as a practitioner with the DEA;

(5) one member who is a licensed dentist actively practicing in Minnesota and registered as a practitioner with the DEA;

(6) two members who are nonphysician licensed health care professionals actively engaged in the practice of their profession in Minnesota, and their practice includes treating pain;

(7) one member who is a mental health professional who is licensed or registered in a mental health profession, who is actively engaged in the practice of that profession in Minnesota, and whose practice includes treating patients with chemical dependency or substance abuse;

(8) one member who is a medical examiner for a Minnesota county;

(9) one member of the Health Services Policy Committee established under section 256B.0625, subdivisions 3c to 3e;

(10) one member who is a medical director of a health plan company doing business in Minnesota;

(11) one member who is a pharmacy director of a health plan company doing business in Minnesota; ~~and~~

(12) one member representing Minnesota law enforcement~~.~~; and

(13) two consumer members who are Minnesota residents and who have used or are using opioids to manage chronic pain.

(b) In addition, the work group shall include the following nonvoting members:

(1) the medical director for the medical assistance program;

(2) a member representing the Department of Human Services pharmacy unit; ~~and~~

(3) the medical director for the Department of Labor and Industry~~.~~; and

(4) a member representing the Minnesota Department of Health.

(c) An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each voting member in attendance.

Sec. 38. Minnesota Statutes 2020, section 256B.0638, subdivision 5, is amended to read:

Subd. 5. **Program implementation.** (a) The commissioner shall implement the programs within the Minnesota health care program to improve the health of and quality of care provided to Minnesota health care program enrollees. The commissioner shall annually collect and report to provider groups the sentinel measures of data showing individual opioid ~~prescribers data showing the sentinel measures of their~~ prescribers' opioid prescribing patterns compared to their anonymized peers. Provider groups shall distribute data to their affiliated, contracted, or employed opioid prescribers.

(b) The commissioner shall notify an opioid prescriber and all provider groups with which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber and any provider group that receives a notice under this paragraph shall submit to the commissioner a quality improvement plan for review and approval by the commissioner with the goal of bringing the opioid prescriber's prescribing practices into alignment with community standards. A quality improvement plan must include:

(1) components of the program described in subdivision 4, paragraph (a);

(2) internal practice-based measures to review the prescribing practice of the opioid prescriber and, where appropriate, any other opioid prescribers employed by or affiliated with any of the provider groups with which the opioid prescriber is employed or affiliated; and

(3) appropriate use of the prescription monitoring program under section 152.126.

(c) If, after a year from the commissioner's notice under paragraph (b), the opioid prescriber's prescribing practices do not improve so that they are consistent with community standards, the commissioner shall take one or more of the following steps:

(1) monitor prescribing practices more frequently than annually;

(2) monitor more aspects of the opioid prescriber's prescribing practices than the sentinel measures; or

(3) require the opioid prescriber to participate in additional quality improvement efforts, including but not limited to mandatory use of the prescription monitoring program established under section 152.126.

(d) The commissioner shall terminate from Minnesota health care programs all opioid prescribers and provider groups whose prescribing practices fall within the applicable opioid disenrollment standards.

Sec. 39. Minnesota Statutes 2020, section 256B.0638, subdivision 6, is amended to read:

Subd. 6. **Data practices.** (a) Reports and data identifying an opioid prescriber are private data on individuals as defined under section 13.02, subdivision 12, until an opioid prescriber is subject to termination as a medical assistance provider under this section. Notwithstanding this data classification, the commissioner shall share with all of the provider groups with which an opioid prescriber is employed, contracted, or affiliated, ~~a report identifying an opioid prescriber who is subject to quality improvement activities~~ the data under subdivision 5, paragraph (a), (b), or (c).

(b) Reports and data identifying a provider group are nonpublic data as defined under section 13.02, subdivision 9, until the provider group is subject to termination as a medical assistance provider under this section.

(c) Upon termination under this section, reports and data identifying an opioid prescriber or provider group are public, except that any identifying information of Minnesota health care program enrollees must be redacted by the commissioner.

Sec. 40. Minnesota Statutes 2020, section 256B.0659, subdivision 13, is amended to read:

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must work for a personal care assistance provider agency, meet the definition of qualified professional under section 256B.0625, subdivision 19c, ~~and enroll with the department as a qualified professional after clearing~~ clear a background study, and meet provider training requirements. Before a qualified professional provides services, the personal care assistance provider agency must initiate a background study on the qualified professional under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional:

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

(2) is disqualified, but the qualified professional has received a set aside of the disqualification under section 245C.22.

(b) The qualified professional shall perform the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care assistance services. The qualified professional shall:

(1) develop and monitor with the recipient a personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) develop and monitor with the recipient a monthly plan for the use of personal care assistance services;

(3) review documentation of personal care assistance services provided;

(4) provide training and ensure competency for the personal care assistant in the individual needs of the recipient; and

(5) document all training, communication, evaluations, and needed actions to improve performance of the personal care assistants.

(c) ~~Effective July 1, 2011,~~ The qualified professional shall complete the provider training with basic information about the personal care assistance program approved by the commissioner. Newly hired qualified professionals must complete the training within six months of the date hired by a personal care assistance provider agency. Qualified professionals who have completed the required training as a worker from a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the last three years. The required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing to demonstrate an understanding of the content without attending in-person training. A qualified professional is allowed to be employed and is not subject to the training requirement until the training is offered online or through remote electronic connection. A qualified professional employed by a personal care assistance provider agency certified for participation in Medicare as a home health agency is exempt from the training required in this subdivision. When available, the qualified professional working for a Medicare-certified home health agency must successfully complete the competency test. The commissioner shall ensure there is a mechanism in place to verify the identity of persons completing the competency testing electronically.

Sec. 41. Minnesota Statutes 2020, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center

and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, ~~Hennepin County and~~ Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed ~~$12,000,000 per year from Hennepin County and~~ $6,000,000 per year ~~from Ramsey County~~. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to ~~Hennepin County Medical Center or~~ Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to ~~Hennepin County Medical Center and~~ Regions Hospital by those plans. For the purposes of this paragraph, "the base amount" means the total annual value of increased medical assistance capitation payments, including the voluntary intergovernmental transfers, under this paragraph in calendar year 2017. For managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance capitation payments under this paragraph by an amount equal to ten percent of the base amount, and by an additional ten percent of the base amount for each subsequent contract year until December 31, 2025. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to ~~Hennepin County Medical Center and~~ Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph. This paragraph expires January 1, 2026.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul, and ambulance services owned and operated by another governmental entity that chooses to participate by requesting the commissioner to determine an upper payment limit. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County, the city of St. Paul, and other participating governmental entities of the periodic

intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities. A tribal government that owns and operates an ambulance service is not eligible to participate under this subdivision.

(e) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform the University of Minnesota Medical School and University of Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians equal to the difference between the established medical assistance payment for physician, dentist, and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians.

(f) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (e), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

(g) The payments in paragraphs (a) to (e) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

(h) All of the data and funding transactions related to the payments in paragraphs (a) to (e) shall be between the commissioner and the governmental entities.

(i) For purposes of this subdivision, billing professionals are limited to physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants,

anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and dental therapists.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval of both this section and Minnesota Statutes, section 256B.1973, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 42. **[256B.1973] DIRECTED PAYMENT ARRANGEMENTS.**

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

(b) "Billing professionals" means physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, anesthesiologists, and certified registered anesthetists, and may include dentists, individually enrolled dental hygienists, and dental therapists.

(c) "Health plan" means a managed care or county-based purchasing plan that is under contract with the commissioner to deliver services to medical assistance enrollees under section 256B.69.

(d) "High medical assistance utilization" means a medical assistance utilization rate equal to the standard established in section 256.969, subdivision 9, paragraph (d), clause (6).

Subd. 2. **Federal approval required.** Each directed payment arrangement under this section is contingent on federal approval and must conform with the requirements for permissible directed managed care organization expenditures under section 256B.6928, subdivision 5.

Subd. 3. **Eligible providers.** Eligible providers under this section are nonstate government teaching hospitals with high medical assistance utilization and a level 1 trauma center and the hospital's affiliated billing professionals, ambulance services, and clinics.

Subd. 4. **Voluntary intergovernmental transfers.** A nonstate governmental entity that is eligible to perform intergovernmental transfers may make voluntary intergovernmental transfers to the commissioner. The commissioner shall inform the nonstate governmental entity of the intergovernmental transfers necessary to maximize the allowable directed payments.

Subd. 5. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment arrangement that is a state-directed fee schedule

requirement, the commissioner shall determine a uniform adjustment factor to be applied to each claim submitted by an eligible provider to a health plan. The uniform adjustment factor shall be determined using the average commercial payer rate or using another method acceptable to the Centers for Medicare and Medicaid Services if the average commercial payer rate is not approved, minus the amount necessary for the plan to satisfy tax liabilities under sections 256.9657 and 297I.05 attributable to the directed payment arrangement. The commissioner shall ensure that the application of the uniform adjustment factor maximizes the allowable directed payments and does not result in payments exceeding federal limits, and may use an annual settle-up process. The directed payment shall be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(b) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that the eligible provider receives the entire permissible value of the federally approved directed payment arrangement. If federal approval of a directed payment arrangement under this subdivision is retroactive, the commissioner shall make a onetime pro rata increase to the uniform adjustment factor and the initial payments in order to include claims submitted between the retroactive federal approval date and the period captured by the initial payments.

Subd. 6. **Health plan duties; submission of claims.** In accordance with its contract, each health plan shall submit to the commissioner payment information for each claim paid to an eligible provider for services provided to a medical assistance enrollee.

Subd. 7. **Health plan duties; directed payments.** In accordance with its contract, each health plan shall make directed payments to the eligible provider in an amount equal to the payment amounts the plan received from the commissioner.

Subd. 8. **State quality goals.** The directed payment arrangement and state-directed fee schedule requirement must align the state quality goals to Hennepin Healthcare medical assistance patients, including unstably housed individuals, those with higher levels of social and clinical risk, limited English proficiency (LEP) patients, adults with serious chronic conditions, and individuals of color. The directed payment arrangement must maintain quality and access to a full range of health care delivery mechanisms for these patients that may include behavioral health, emergent care, preventive care, hospitalization, transportation, interpreter services, and pharmaceutical services. The commissioner, in consultation with Hennepin Healthcare, shall submit to the Centers for Medicare and Medicaid Services a methodology to measure access to care and the achievement of state quality goals.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later, unless the federal approval provides for an effective date that is before the date the federal approval was issued, including a retroactive effective date, in which case this section is effective retroactively from the federally approved effective date. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 43. Minnesota Statutes 2020, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude ~~or modify~~ coverage for outpatient prescription drugs dispensed by a pharmacy to a member eligible for medical assistance under this chapter from the prepaid managed care contracts entered into under this section ~~in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates~~.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon completion of the Medicaid Management Information System pharmacy module modernization project, whichever is later. The commissioner shall notify the revisor of statutes when the project is completed.

Sec. 44. Minnesota Statutes 2020, section 256B.69, is amended by adding a subdivision to read:

Subd. 9f. **Annual report on provider reimbursement rates.** (a) The commissioner, by December 15 of each year, shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance a report on managed care and county-based purchasing plan provider reimbursement rates. The report must comply with sections 3.195 and 3.197.

(b) The report must include, for each managed care and county-based purchasing plan, the mean and median provider reimbursement rates by county for the calendar year preceding the reporting year, for the five most common billing codes statewide across all plans, in each of the following provider service categories:

(1) physician services - prenatal and preventive;

(2) physician services - nonprenatal and nonpreventive;

(3) dental services;

(4) inpatient hospital services;

(5) outpatient hospital services; and

(6) mental health services.

(c) The commissioner shall also include in the report:

(1) the mean and median reimbursement rates across all plans by county for the calendar year preceding the reporting year for the billing codes and provider service categories described in paragraph (b); and

(2) the mean and median fee-for-service reimbursement rates by county for the calendar year preceding the reporting year for the billing codes and provider service categories described in paragraph (b).

Sec. 45. Minnesota Statutes 2020, section 256B.69, is amended by adding a subdivision to read:

Subd. 9g. **Annual report on prepaid health plan reimbursement to 340B covered entities.** (a) By March 1 of each year, each managed care and county-based purchasing plan shall report to the commissioner its reimbursement to 340B covered entities for the previous calendar year. The report must include:

(1) the National Provider Identification (NPI) number for each 340B covered entity;

(2) the name of each 340B covered entity;

(3) the servicing address of each 340B covered entity; and

(4) either: (i) the number of outpatient 340B pharmacy claims and reimbursement amounts; or (ii) the number of professional or facility 340B claim lines and reimbursement amounts.

(b) The commissioner shall submit a copy of the reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by April 1 of each year.

Sec. 46. Minnesota Statutes 2020, section 256B.6928, subdivision 5, is amended to read:

Subd. 5. **Direction of managed care organization expenditures.** (a) The commissioner shall not direct managed care organizations expenditures under the managed care contract,

except ~~in~~ as permitted under Code of Federal Regulations, part 42, section 438.6(c). The exception under this paragraph includes the following situations:

(1) implementation of a value-based purchasing model for provider reimbursement, including pay-for-performance arrangements, bundled payments, or other service payments intended to recognize value or outcomes over volume of services;

(2) participation in a multipayer or medical assistance-specific delivery system reform or performance improvement initiative; or

(3) implementation of a minimum or maximum fee schedule, or a uniform dollar or percentage increase for network providers that provide a particular service. The maximum fee schedule must allow the managed care organization the ability to reasonably manage risk and provide discretion in accomplishing the goals of the contract.

(b) Any managed care contract that directs managed care organization expenditures as permitted under paragraph (a), clauses (1) to (3), must be developed in accordance with Code of Federal Regulations, part 42, sections 438.4 and 438.5; comply with actuarial soundness and generally accepted actuarial principles and practices; and have written approval from the Centers for Medicare and Medicaid Services before implementation. To obtain approval, the commissioner shall demonstrate in writing that the contract arrangement:

(1) is based on the utilization and delivery of services;

(2) directs expenditures equally, using the same terms of performance for a class of providers providing service under the contract;

(3) is intended to advance at least one of the goals and objectives in the commissioner's quality strategy;

(4) has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals in the commissioner's quality strategy;

(5) does not condition network provider participation on the network provider entering into or adhering to an intergovernmental transfer agreement; and

(6) is not renewed automatically.

(c) For contract arrangements identified in paragraph (a), clauses (1) and (2), the commissioner shall:

(1) make participation in the value-based purchasing model, special delivery system reform, or performance improvement initiative available, using the same terms of

performance, to a class of providers providing services under the contract related to the model, reform, or initiative; and

(2) use a common set of performance measures across all payers and providers.

(d) The commissioner shall not set the amount or frequency of the expenditures or recoup from the managed care organization any unspent funds allocated for these arrangements.

Sec. 47. Minnesota Statutes 2020, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) (1) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process

is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics.

(2) Effective for services provided on or after January 1, 2023, the rate described in clause (1) shall be increased for hospitals providing high levels of high-cost drugs or 340B drugs. The rate adjustment shall be based on each hospital's share of the total reimbursement for 340B drugs to all critical access hospitals, but shall not exceed three percentage points.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision. When implementing prospective payment methodologies, the commissioner shall use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified in this chapter.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

Sec. 48. Minnesota Statutes 2020, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, through December 31, 2022, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) Beginning October 1, 1999, through December 31, 2022, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, through December 31, 2022, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, through December 31, 2022, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall

receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

~~(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).~~

~~(j)~~ (i) Effective for services rendered on or after January 1, 2014, through December 31, 2022, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

~~(k) Effective for services rendered on or after July 1, 2015, through December 31, 2016, the commissioner shall increase payment rates for services furnished by dental providers located outside of the seven-county metropolitan area by the maximum percentage possible above the rates in effect on June 30, 2015, while remaining within the limits of funding appropriated for this purpose. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2016, through December 31, 2016, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph. The commissioner shall require managed care and county-based purchasing plans to pass on the full amount of the increase, in the form of higher payment rates to dental providers located outside of the seven-county metropolitan area.~~

~~(l)~~ (j) Effective for services provided on or after January 1, 2017, through December 31, 2022, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

~~(m)~~ (k) Effective for services provided on or after July 1, 2017, through December 31, 2022, the commissioner shall increase payment rates by 23.8 percent for dental services provided to enrollees under the age of 21. This rate increase does not apply to state-operated

dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers. This rate increase does not apply to managed care plans and county-based purchasing plans.

(l) Effective for services provided on or after January 1, 2023, payment for dental services shall be the lower of the submitted charge or the ..... percentile of 2018 submitted charges from claims paid by the commissioner. The commissioner shall increase this payment amount by 20 percent for providers designated as critical access dental providers under medical assistance and MinnesotaCare. The critical access dental provider payment add-on shall be calculated to be specific to each individual clinic location within a larger system. This paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

(m) Beginning January 1, 2026, and every four years thereafter, the commissioner shall rebase payment rates for dental services to the first percentile of submitted charges for the applicable base year using charge data from paid claims submitted by providers. The base year used for each rebasing shall be the calendar year that is two years prior to the effective date of the rebasing.

Sec. 49. Minnesota Statutes 2020, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) The commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2016, through December 31, 2022, the commissioner shall increase reimbursement by 37.5 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) For dental services rendered on or after July 1, 2016, through December 31, 2022, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (d), clause (4), and is owned and operated by a health maintenance organization licensed under chapter 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.

(c) Critical access dental payments made under paragraph (a) or (b) for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments

from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

(d) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

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

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) hospital-based dental clinics owned and operated by a city, county, or former state hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

(i) the dentist's office is located within the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; or

(ii) the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

Sec. 50. Minnesota Statutes 2020, section 256B.79, subdivision 1, is amended to read:

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

(b) "Adverse outcomes" means maternal opiate addiction, other reportable prenatal substance abuse, low birth weight, or preterm birth.

(c) "Qualified integrated perinatal care collaborative" or "collaborative" means a combination of (1) members of community-based organizations that represent communities within the identified targeted populations, and (2) local or tribally based service entities, including health care, public health, social services, mental health, chemical dependency treatment, and community-based providers, determined by the commissioner to meet the criteria for the provision of integrated care and enhanced services for enrollees within targeted populations.

(d) "Targeted populations" means pregnant medical assistance enrollees residing in ~~geographic areas~~ communities identified by the commissioner as being at above-average risk for adverse outcomes.

Sec. 51. Minnesota Statutes 2020, section 256B.79, subdivision 3, is amended to read:

Subd. 3. **Grant awards.** The commissioner shall award grants to qualifying applicants to support interdisciplinary, integrated perinatal care. Grant funds must be distributed through a request for proposals process to a designated lead agency within an entity that has been determined to be a qualified integrated perinatal care collaborative or within an entity in the process of meeting the qualifications to become a qualified integrated perinatal care collaborative~~, and priority shall be given to qualified integrated perinatal care collaboratives that received grants under this section prior to January 1, 2019~~. Grant awards must be used to support interdisciplinary, team-based needs assessments, planning, and implementation of integrated care and enhanced services for targeted populations. In determining grant award amounts, the commissioner shall consider the identified health and social risks linked to adverse outcomes and attributed to enrollees within the identified targeted population.

Sec. 52. Minnesota Statutes 2020, section 256L.01, subdivision 5, is amended to read:

Subd. 5. **Income.** "Income" has the meaning given for modified adjusted gross income, as defined in Code of Federal Regulations, title 26, section 1.36B-1, and means a household's ~~current income, or if income fluctuates month to month, the income for the 12-month eligibility period~~ projected annual income for the applicable tax year.

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

Sec. 53. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 ~~and~~, to American Indians as defined in Code of Federal Regulations, title 42, section 600.5, or to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

EFFECTIVE DATE. This section is effective January 1, 2022, subject to federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 54. Minnesota Statutes 2020, section 256L.04, subdivision 7b, is amended to read:

Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income limits under this section annually ~~each July 1~~ on January 1 as ~~described in section 256B.056, subdivision 1c~~ provided in Code of Federal Regulations, title 26, section 1.36B-1(h).

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

Sec. 55. Minnesota Statutes 2020, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Redetermination of eligibility.** (a) An enrollee's eligibility must be redetermined on an annual basis~~, in accordance with Code of Federal Regulations, title 42,~~

~~section 435.916 (a). The 12-month eligibility period begins the month of application. Beginning July 1, 2017, the commissioner shall adjust the eligibility period for enrollees to implement renewals throughout the year according to guidance from the Centers for Medicare and Medicaid Services~~. The period of eligibility is the entire calendar year following the year in which eligibility is redetermined. Eligibility redeterminations shall occur during the open enrollment period for qualified health plans as specified in Code of Federal Regulations, title 45, section 155.410(e)(3).

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. Coverage begins as provided in section 256L.06.

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

Sec. 56. Minnesota Statutes 2020, section 256L.11, subdivision 6a, is amended to read:

Subd. 6a. **Dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2018, through December 31, 2022, the commissioner shall increase payment rates to dental providers by 54 percent. Payments made to prepaid health plans under section 256L.12 shall reflect the payment increase described in this subdivision. The prepaid health plans under contract with the commissioner shall provide payments to dental providers that are at least equal to a rate that includes the payment rate specified in this subdivision, and if applicable to the provider, the rates described under subdivision 7.

Sec. 57. Minnesota Statutes 2020, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after July 1, 2017, through December 31, 2022, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 20 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

Sec. 58. Minnesota Statutes 2020, section 295.53, subdivision 1, is amended to read:

Subdivision 1. **Exclusions and exemptions.** (a) The following payments are excluded from the gross revenues subject to the hospital, surgical center, or health care provider taxes under sections 295.50 to 295.59:

(1) payments received by a health care provider or the wholly owned subsidiary of a health care provider for care provided outside Minnesota;

(2) government payments received by the commissioner of human services for state-operated services;

(3) payments received by a health care provider for hearing aids and related equipment or prescription eyewear delivered outside of Minnesota; and

(4) payments received by an educational institution from student tuition, student activity fees, health care service fees, government appropriations, donations, or grants, and for services identified in and provided under an individualized education program as defined in section 256B.0625 or Code of Federal Regulations, chapter 34, section 300.340(a). Fee for service payments and payments for extended coverage are taxable.

(b) The following payments are exempted from the gross revenues subject to hospital, surgical center, or health care provider taxes under sections 295.50 to 295.59:

(1) payments received for services provided under the Medicare program, including payments received from the government and organizations governed by sections 1833, 1853, and 1876 of title XVIII of the federal Social Security Act, United States Code, title 42, section 1395; and enrollee deductibles, co-insurance, and co-payments, whether paid by the Medicare enrollee, by Medicare supplemental coverage as described in section 62A.011, subdivision 3, clause (10), or by Medicaid payments under title XIX of the federal Social Security Act. Payments for services not covered by Medicare are taxable;

(2) payments received for home health care services;

(3) payments received from hospitals or surgical centers for goods and services on which liability for tax is imposed under section 295.52 or the source of funds for the payment is exempt under clause (1), (6), (9), (10), or (11);

(4) payments received from the health care providers for goods and services on which liability for tax is imposed under this chapter or the source of funds for the payment is exempt under clause (1), (6), (9), (10), or (11);

(5) amounts paid for legend drugs to a wholesale drug distributor who is subject to tax under section 295.52, subdivision 3, reduced by reimbursement received for legend drugs otherwise exempt under this chapter;

(6) payments received from the chemical dependency fund under chapter 254B;

(7) payments received in the nature of charitable donations that are not designated for providing patient services to a specific individual or group;

(8) payments received for providing patient services incurred through a formal program of health care research conducted in conformity with federal regulations governing research on human subjects. Payments received from patients or from other persons paying on behalf of the patients are subject to tax;

(9) payments received from any governmental agency for services benefiting the public, not including payments made by the government in its capacity as an employer or insurer or payments made by the government for services provided under the MinnesotaCare program or the medical assistance program governed by title XIX of the federal Social Security Act, United States Code, title 42, sections 1396 to 1396v;

(10) payments received under the federal Employees Health Benefits Act, United States Code, title 5, section 8909(f), as amended by the Omnibus Reconciliation Act of 1990. Enrollee deductibles, co-insurance, and co-payments are subject to tax;

(11) payments received under the federal Tricare program, Code of Federal Regulations, title 32, section 199.17(a)(7). Enrollee deductibles, co-insurance, and co-payments are subject to tax; and

(12) supplemental ~~or,~~ enhanced, or uniform adjustment factor payments authorized under section 256B.196 ~~or,~~ 256B.197, or 256B.1973.

(c) Payments received by wholesale drug distributors for legend drugs sold directly to veterinarians or veterinary bulk purchasing organizations are excluded from the gross revenues subject to the wholesale drug distributor tax under sections 295.50 to 295.59.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2021.

Sec. 59. **COURT RULING ON AFFORDABLE CARE ACT.**

In the event the United States Supreme Court reverses, in whole or in part, Public Law 111-148, as amended by Public Law 111-152, the commissioner of human services shall take all actions necessary to maintain the current policies of the medical assistance and MinnesotaCare programs, including but not limited to pursuing federal funds, or if federal funding is not available, operating programs with state funding for at least one year following the date of the Supreme Court decision or until the conclusion of the next regular legislative session, whichever is later. Nothing in this section prohibits the commissioner from making

changes necessary to comply with federal or state requirements for the medical assistance or MinnesotaCare programs that were not affected by the Supreme Court decision.

Sec. 60. **DELIVERY REFORM ANALYSIS REPORT.**

(a) The commissioner of human services shall present to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance, by January 15, 2023, a report comparing service delivery and payment system models for delivering services to Medical Assistance enrollees for whom income eligibility is determined using the modified adjusted gross income methodology under Minnesota Statutes, section 256B.056, subdivision 1a, paragraph (b), clause (1), and MinnesotaCare enrollees eligible under Minnesota Statutes, chapter 256L. The report must compare the current delivery model with at least two alternative models. The alternative models must include a state-based model in which the state holds the plan risk as the insurer and may contract with a third-party administrator for claims processing and plan administration. The alternative models may include but are not limited to:

(1) expanding the use of integrated health partnerships under Minnesota Statutes, section 256B.0755;

(2) delivering care under fee-for-service through a primary care case management system; and

(3) continuing to contract with managed care and county-based purchasing plans for some or all enrollees under modified contracts.

(b) The report must include:

(1) a description of how each model would address:

(i) racial and other inequities in the delivery of health care and health care outcomes;

(ii) geographic inequities in the delivery of health care;

(iii) the provision of incentives for preventive care and other best practices;

(iv) reimbursing providers for high-quality, value-based care at levels sufficient to sustain or increase enrollee access to care; and

(v) transparency and simplicity for enrollees, health care providers, and policymakers;

(2) a comparison of the projected cost of each model; and

(3) an implementation timeline for each model, that includes the earliest date by which each model could be implemented if authorized during the 2023 legislative session, and a discussion of barriers to implementation.

Sec. 61. **DENTAL HOME DEMONSTRATION PROJECT.**

(a) The Dental Services Advisory Committee, in collaboration with stakeholders, shall design a dental home demonstration project and present recommendations by February 1, 2022, to the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over health finance and policy.

(b) The Dental Services Advisory Committee, at a minimum, shall engage with the following stakeholders: the Minnesota Department of Health, the Minnesota Dental Association, the Minnesota Dental Hygienists' Association, the University of Minnesota School of Dentistry, dental programs operated by the Minnesota State Colleges and Universities system, and representatives of each of the following dental provider types serving medical assistance and MinnesotaCare enrollees:

(1) private practice dental clinics for which medical assistance and MinnesotaCare enrollees comprise more than 25 percent of the clinic's patient load;

(2) private practice dental clinics for which medical assistance and MinnesotaCare enrollees comprise 25 percent or less of the clinic's patient load;

(3) nonprofit dental clinics with a primary focus on serving Indigenous communities and other communities of color;

(4) nonprofit dental clinics with a primary focus on providing eldercare;

(5) nonprofit dental clinics with a primary focus on serving children;

(6) nonprofit dental clinics providing services within the seven-county metropolitan area;

(7) nonprofit dental clinics providing services outside of the seven-county metropolitan area; and

(8) multispecialty hospital-based dental clinics.

(c) The dental home demonstration project shall give incentives for qualified providers that provide high-quality, patient-centered, comprehensive, and coordinated oral health services. The demonstration project shall seek to increase the number of new dental providers serving medical assistance and MinnesotaCare enrollees and increase the capacity of existing

providers. The demonstration project must test payment methods that establish value-based incentives to:

(1) increase the extent to which current dental providers serve medical assistance and MinnesotaCare enrollees across their lifespan;

(2) develop service models that create equity and reduce disparities in access to dental services for high-risk and medically and socially complex enrollees;

(3) advance alternative delivery models of care within community settings using evidence-based approaches and innovative workforce teams; and

(4) improve the quality of dental care by meeting dental home goals.

Sec. 62. **DIRECTION TO COMMISSIONER; INCOME AND ASSET EXCLUSION FOR ST. PAUL GUARANTEED INCOME DEMONSTRATION PROJECT.**

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

(b) "Commissioner" means the commissioner of human services unless specified otherwise.

(c) "Guaranteed income demonstration project" means a demonstration project in St. Paul to evaluate how unconditional cash payments have a causal effect on income volatility, financial well-being, and early childhood development in infants and toddlers.

Subd. 2. **Commissioner; income and asset exclusion.** (a) During the duration of the guaranteed income demonstration project, the commissioner shall not count payments made to families by the guaranteed income demonstration project as income or assets for purposes of determining or redetermining eligibility for the following programs:

(1) child care assistance programs under Minnesota Statutes, chapter 119B; and

(2) the Minnesota family investment program, work benefit program, or diversionary work program under Minnesota Statutes, chapter 256J.

(b) During the duration of the guaranteed income demonstration project, the commissioner shall not count payments made to families by the guaranteed income demonstration project as income or assets for purposes of determining or redetermining eligibility for the following programs:

(1) medical assistance under Minnesota Statutes, chapter 256B; and

(2) MinnesotaCare under Minnesota Statutes, chapter 256L.

Subd. 3. **Report.** The city of St. Paul shall provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance by February 15, 2023, with information on the progress and outcomes of the guaranteed income demonstration project under this section.

Subd. 4. **Expiration.** This section expires June 30, 2023.

EFFECTIVE DATE. This section is effective July 1, 2021, except for subdivision 2, paragraph (b), which is effective July 1, 2021, or upon federal approval, whichever is later.

Sec. 63. **EXPANSION OF OUTPATIENT DRUG CARVE OUT; PRESCRIPTION DRUG PURCHASING PROGRAM.**

The commissioner of human services, in consultation with the commissioners of commerce and health, shall assess the feasibility of, and develop recommendations for: (1) expanding the outpatient prescription drug carve out under Minnesota Statutes, section 256B.69, subdivision 6d, to include MinnesotaCare enrollees; and (2) establishing a prescription drug purchasing program to serve nonpublic program enrollees of health plan companies. The recommendations must address the process and terms by which the commissioner would contract with health plan companies to administer prescription drug benefits for the companies' enrollees and develop and manage a formulary. The commissioner shall present recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services policy and finance by December 15, 2023.

Sec. 64. **FEDERAL APPROVAL; EXTENSION OF POSTPARTUM COVERAGE.**

The commissioner of human services shall seek all federal waivers and approvals necessary to extend medical assistance postpartum coverage, as provided in Minnesota Statutes, section 256B.055, subdivision 6.

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

Sec. 65. **PROPOSAL FOR A PUBLIC OPTION.**

(a) The commissioner of human services shall consult with the Centers for Medicare and Medicaid Services, the Internal Revenue Service, and other relevant federal agencies to develop a proposal for a public option program. The proposal may consider multiple public option structures, at least one of which must be through expanded enrollment into MinnesotaCare. Each option must:

(1) allow individuals with incomes above the maximum income eligibility limit under Minnesota Statutes, section 256L.04, subdivision 1 or 7, the option of purchasing coverage through the public option;

(2) allow undocumented noncitizens, and individuals with access to subsidized employer health coverage who are subject to the family glitch, the option of purchasing through the public option;

(3) establish a small employer public option that allows employers with 50 or fewer employees to offer the public option to the employer's employees and contribute to the employees' premiums;

(4) allow the state to:

(i) receive the maximum pass through of federal dollars that would otherwise be used to provide coverage for eligible public option enrollees if the enrollees were instead covered through qualified health plans with premium tax credits, emergency medical assistance, or other relevant programs; and

(ii) continue to receive basic health program payments for eligible MinnesotaCare enrollees; and

(5) be administered in coordination with the existing MinnesotaCare program to maximize efficiency and improve continuity of care, consistent with the requirements of Minnesota Statutes, sections 256L.06, 256L.10, and 256L.11.

(b) Each public option proposal must include:

(1) a premium scale for public option enrollees that at least meets the Affordable Care Act affordability standard for each income level;

(2) an analysis of the impact of the public option on MNsure enrollment and the consumer assistance program and, if necessary, a proposal to ensure that the public option has an adequate enrollment infrastructure and consumer assistance capacity;

(3) actuarial and financial analyses necessary to project program enrollment and costs; and

(4) an analysis of the cost of implementing the public option using current eligibility and enrollment technology systems, and at the option of the commissioner, an analysis of alternative eligibility and enrollment systems that may reduce initial and ongoing costs and improve functionality and accessibility.

(c) The commissioner shall incorporate into the design of the public option mechanisms to ensure the long-term financial sustainability of MinnesotaCare and mitigate any adverse financial impacts to MNsure. These mechanisms must minimize: (i) adverse selection; (ii) state financial risk and expenditures; and (iii) potential impacts on premiums in the individual and group insurance markets.

(d) The commissioner shall present the proposal to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by December 15, 2021. The proposal must include recommendations on any legislative changes necessary to implement the public option. Any implementation of the proposal that requires a state financial contribution must be contingent on legislative approval.

Sec. 66. **RESPONSE TO COVID-19 PUBLIC HEALTH EMERGENCY.**

(a) Notwithstanding Minnesota Statutes, section 256B.057, subdivision 9, 256L.06, subdivision 3, or any other provision to the contrary, the commissioner shall not collect any unpaid premium for a coverage month that occurred during the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

(b) Notwithstanding any provision to the contrary, periodic data matching under Minnesota Statutes, section 256B.0561, subdivision 2, may be suspended for up to six months following the last day of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

(c) Notwithstanding any provision to the contrary, the requirement for the commissioner of human services to issue an annual report on periodic data matching under Minnesota Statutes, section 256B.0561, is suspended for one year following the last day of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

EFFECTIVE DATE. This section is effective the day following final enactment, except paragraph (a) related to MinnesotaCare premiums is effective upon federal approval. The commissioner shall notify the revisor of statutes when federal approval is received.

Sec. 67. **REVISOR INSTRUCTION.**

The revisor of statutes must change the term "Health Services Policy Committee" to "Health Services Advisory Council" wherever the term appears in Minnesota Statutes and may make any necessary changes to grammar or sentence structure to preserve the meaning of the text.

Sec. 68. **REPEALER.**

(a) Minnesota Rules, parts 9505.0275; 9505.1693; 9505.1696, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, and 22; 9505.1699; 9505.1701; 9505.1703; 9505.1706; 9505.1712; 9505.1715; 9505.1718; 9505.1724; 9505.1727; 9505.1730; 9505.1733; 9505.1736; 9505.1739; 9505.1742; 9505.1745; and 9505.1748, are repealed.

(b) Minnesota Statutes 2020, section 256B.0625, subdivisions 18c, 18d, 18e, and 18h, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective July 1, 2021, and paragraph (b) is effective January 1, 2023.

ARTICLE 2

DEPARTMENT OF HUMAN SERVICES LICENSING AND BACKGROUND STUDIES

Section 1. Minnesota Statutes 2020, section 62V.05, is amended by adding a subdivision to read:

Subd. 4a. **Background study required.** (a) The board must initiate background studies under section 245C.031 of:

(1) each navigator;

(2) each in-person assister; and

(3) each certified application counselor.

(b) The board may initiate the background studies required by paragraph (a) using the online NETStudy 2.0 system operated by the commissioner of human services.

(c) The board shall not permit any individual to provide any service or function listed in paragraph (a) until the board has received notification from the commissioner of human services indicating that the individual:

(1) is not disqualified under chapter 245C; or

(2) is disqualified, but has received a set aside from the board of that disqualification according to sections 245C.22 and 245C.23.

(d) The board or its delegate shall review a reconsideration request of an individual in paragraph (a), including granting a set aside, according to the procedures and criteria in chapter 245C. The board shall notify the individual and the Department of Human Services of the board's decision.

Sec. 2. Minnesota Statutes 2020, section 122A.18, subdivision 8, is amended to read:

Subd. 8. **Background ~~checks~~ studies.** (a) The Professional Educator Licensing and Standards Board and the Board of School Administrators must ~~obtain a~~ initiate criminal history background ~~check on~~ studies of all first-time ~~teaching~~ applicants for educator licenses under their jurisdiction. Applicants must include with their licensure applications:

(1) an executed criminal history consent form, including fingerprints; and

(2) payment to conduct the background ~~check~~ study. The Professional Educator Licensing and Standards Board must deposit payments received under this subdivision in an account in the special revenue fund. Amounts in the account are annually appropriated to the Professional Educator Licensing and Standards Board to pay for the costs of background ~~checks~~ studies on applicants for licensure.

(b) The background ~~check~~ study for all first-time teaching applicants for licenses must include a review of information from the Bureau of Criminal Apprehension, including criminal history data as defined in section 13.87, and must also include a review of the national criminal records repository. The superintendent of the Bureau of Criminal Apprehension is authorized to exchange fingerprints with the Federal Bureau of Investigation for purposes of the criminal history check. ~~The superintendent shall recover the cost to the bureau of a background check through the fee charged to the applicant under paragraph (a).~~

(c) The Professional Educator Licensing and Standards Board ~~must contract with~~ may initiate criminal history background studies through the commissioner of human services according to section 245C.031 to ~~conduct background checks and~~ obtain background ~~check~~ study data required under this chapter.

Sec. 3. **[245.975] OMBUDSPERSON FOR FAMILY CHILD CARE PROVIDERS.**

Subdivision 1. **Appointment.** The governor shall appoint an ombudsperson in the classified service to assist family child care providers with licensing, compliance, and other issues facing family child care providers. The ombudsperson must be selected without regard to the person's political affiliation.

Subd. 2. **Duties.** (a) The ombudsperson's duties shall include:

(1) advocating on behalf of a family child care provider to address all areas of concern related to the provision of child care services, including licensing monitoring activities, licensing actions, and other interactions with state and county licensing staff;

(2) providing recommendations for family child care improvement or family child care provider education;

(3) operating a telephone line to answer questions, receive complaints, and discuss agency actions when a family child care provider believes their rights or program may have been adversely affected; and

(4) assisting family child care license applicants with navigating the application process.

(b) The ombudsperson must report annually by December 31 to the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over child care on the services provided by the ombudsperson to child care providers, including the number and locations of child care providers served, and the activities of the ombudsperson in carrying out the duties under this section. The commissioner shall determine the form of the report and may specify additional reporting requirements.

Subd. 3. **Staff.** The ombudsperson may appoint and compensate out of available funds a deputy, confidential secretary, and other employees in the unclassified service as authorized by law. The ombudsperson and the full-time staff are members of the Minnesota State Retirement Association. The ombudsperson may delegate to members of the staff any authority or duties of the office except the duty to provide reports to the governor, commissioner, or the legislature.

Subd. 4. **Access to records.** (a) The ombudsperson or designee, excluding volunteers, has access to data of a state agency necessary for the discharge of the ombudsperson's duties, including records classified as confidential data on individuals or private data on individuals under chapter 13 or any other law. The ombudsperson's data request must relate to a specific case and is subject to section 13.03, subdivision 4. If the data concerns an individual, the ombudsperson or designee shall first obtain the individual's consent. If the individual cannot consent and has no parent or legal guardian, then access to the data is authorized by this section.

(b) The ombudsperson and designees must adhere to the Minnesota Government Data Practices Act and must not disseminate any private or confidential data on individuals unless specifically authorized by state, local, or federal law or pursuant to a court order.

(c) The commissioner and county agency must provide the ombudsperson copies of all fix-it tickets, correction orders, and licensing actions issued to family child care providers.

Subd. 5. **Independence of action.** In carrying out the duties under this section, the ombudsperson may act independently of the department to provide testimony to the

legislature, make periodic reports to the legislature, and address areas of concern to child care providers.

Subd. 6. **Civil actions.** The ombudsperson or designee is not civilly liable for any action taken under this section if the action was taken in good faith, was within the scope of the ombudsperson's authority, and did not constitute willful or reckless misconduct.

Subd. 7. **Qualifications.** The ombudsperson must be a person who has knowledge and experience concerning the provision of family child care. The ombudsperson must be experienced in dealing with governmental entities, interpretation of laws and regulations, investigations, record keeping, report writing, public speaking, and management. A person is not eligible to serve as the ombudsperson while holding public office or while holding a family child care license.

Subd. 8. **Office support.** The commissioner shall provide the ombudsperson with the necessary office space, supplies, equipment, and clerical support to effectively perform the duties under this section.

Subd. 9. **Posting.** (a) The commissioner shall post on the department's website the mailing address, e-mail address, and telephone number for the office of the ombudsperson. The commissioner shall provide family child care providers with the mailing address, e-mail address, and telephone number of the office on the family child care licensing website and upon request from a family child care applicant or provider. Counties must provide family child care applicants and providers with the name, mailing address, e-mail address, and telephone number of the office upon request.

(b) The ombudsperson must approve all postings and notices required by the department and counties under this subdivision.

Sec. 4. Minnesota Statutes 2020, section 245A.043, subdivision 3, is amended to read:

Subd. 3. **Change of ownership process.** (a) When a change in ownership is proposed and the party intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service, the license holder must provide the commissioner with written notice of the proposed change on a form provided by the commissioner at least 60 days before the anticipated date of the change in ownership. For purposes of this subdivision and subdivision 4, "party" means the party that intends to operate the service or program.

(b) The party must submit a license application under this chapter on the form and in the manner prescribed by the commissioner at least 30 days before the change in ownership

is complete, and must include documentation to support the upcoming change. The party must comply with background study requirements under chapter 245C and shall pay the application fee required under section 245A.10. ~~A party that intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service is exempt from the requirements of Minnesota Rules, part 9530.6800.~~

(c) The commissioner may streamline application procedures when the party is an existing license holder under this chapter and is acquiring a program licensed under this chapter or service in the same service class as one or more licensed programs or services the party operates and those licenses are in substantial compliance. For purposes of this subdivision, "substantial compliance" means within the previous 12 months the commissioner did not (1) issue a sanction under section 245A.07 against a license held by the party, or (2) make a license held by the party conditional according to section 245A.06.

(d) Except when a temporary change in ownership license is issued pursuant to subdivision 4, the existing license holder is solely responsible for operating the program according to applicable laws and rules until a license under this chapter is issued to the party.

(e) If a licensing inspection of the program or service was conducted within the previous 12 months and the existing license holder's license record demonstrates substantial compliance with the applicable licensing requirements, the commissioner may waive the party's inspection required by section 245A.04, subdivision 4. The party must submit to the commissioner (1) proof that the premises was inspected by a fire marshal or that the fire marshal deemed that an inspection was not warranted, and (2) proof that the premises was inspected for compliance with the building code or that no inspection was deemed warranted.

(f) If the party is seeking a license for a program or service that has an outstanding action under section 245A.06 or 245A.07, the party must submit a letter as part of the application process identifying how the party has or will come into full compliance with the licensing requirements.

(g) The commissioner shall evaluate the party's application according to section 245A.04, subdivision 6. If the commissioner determines that the party has remedied or demonstrates the ability to remedy the outstanding actions under section 245A.06 or 245A.07 and has determined that the program otherwise complies with all applicable laws and rules, the commissioner shall issue a license or conditional license under this chapter. The conditional license remains in effect until the commissioner determines that the grounds for the action are corrected or no longer exist.

(h) The commissioner may deny an application as provided in section 245A.05. An applicant whose application was denied by the commissioner may appeal the denial according to section 245A.05.

(i) This subdivision does not apply to a licensed program or service located in a home where the license holder resides.

Sec. 5. Minnesota Statutes 2020, section 245A.05, is amended to read:

245A.05 DENIAL OF APPLICATION.

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

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

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

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

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

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

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

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

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

(9) has a history of noncompliance as a license holder or controlling individual with applicable laws or rules, including but not limited to this chapter and chapters 119B and 245C; ~~or~~

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

(11) for a family foster setting, has nondisqualifying background study information, as described in section 245C.05, subdivision 4, that reflects on the individual's ability to safely provide care to foster children.

(b) An applicant whose application has been denied by the commissioner must be given notice of the denial, which must state the reasons for the denial in plain language. Notice must be given by certified mail or personal service. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an appeal request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the notice of denial. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 6. Minnesota Statutes 2020, section 245A.07, subdivision 1, is amended to read:

Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional under section 245A.06, the commissioner may suspend or revoke the license, impose a fine, or secure an injunction against the continuing operation of the program of a license holder who does not comply with applicable law or rule, or who has nondisqualifying background study information, as described in section 245C.05, subdivision 4, that reflects on the license holder's ability to safely provide care to foster children. When applying sanctions authorized under this section, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

(b) If a license holder appeals the suspension or revocation of a license and the license holder continues to operate the program pending a final order on the appeal, the commissioner shall issue the license holder a temporary provisional license. Unless otherwise specified by the commissioner, variances in effect on the date of the license sanction under appeal continue under the temporary provisional license. If a license holder fails to comply with applicable law or rule while operating under a temporary provisional license, the commissioner may impose additional sanctions under this section and section 245A.06, and may terminate any prior variance. If a temporary provisional license is set to expire, a new temporary provisional license shall be issued to the license holder upon payment of any fee

required under section 245A.10. The temporary provisional license shall expire on the date the final order is issued. If the license holder prevails on the appeal, a new nonprovisional license shall be issued for the remainder of the current license period.

(c) If a license holder is under investigation and the license issued under this chapter is due to expire before completion of the investigation, the program shall be issued a new license upon completion of the reapplication requirements and payment of any applicable license fee. Upon completion of the investigation, a licensing sanction may be imposed against the new license under this section, section 245A.06, or 245A.08.

(d) Failure to reapply or closure of a license issued under this chapter by the license holder prior to the completion of any investigation shall not preclude the commissioner from issuing a licensing sanction under this section or section 245A.06 at the conclusion of the investigation.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 7. Minnesota Statutes 2020, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600
125 to 149 persons	$700
150 to 174 persons	$800
175 to 199 persons	$900
200 to 224 persons	$1,000
225 or more persons	$1,100

(b)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee based on revenues derived from the provision of services that would require licensure under chapter 245D during the calendar year immediately preceding the year in which the license fee is paid, according to the following schedule:

License Holder Annual Revenue	License Fee
less than or equal to $10,000	$200
greater than $10,000 but less than or equal to $25,000	$300
greater than $25,000 but less than or equal to $50,000	$400
greater than $50,000 but less than or equal to $100,000	$500
greater than $100,000 but less than or equal to $150,000	$600
greater than $150,000 but less than or equal to $200,000	$800
greater than $200,000 but less than or equal to $250,000	$1,000
greater than $250,000 but less than or equal to $300,000	$1,200
greater than $300,000 but less than or equal to $350,000	$1,400
greater than $350,000 but less than or equal to $400,000	$1,600
greater than $400,000 but less than or equal to $450,000	$1,800
greater than $450,000 but less than or equal to $500,000	$2,000
greater than $500,000 but less than or equal to $600,000	$2,250
greater than $600,000 but less than or equal to $700,000	$2,500
greater than $700,000 but less than or equal to $800,000	$2,750
greater than $800,000 but less than or equal to $900,000	$3,000
greater than $900,000 but less than or equal to $1,000,000	$3,250
greater than $1,000,000 but less than or equal to $1,250,000	$3,500
greater than $1,250,000 but less than or equal to $1,500,000	$3,750
greater than $1,500,000 but less than or equal to $1,750,000	$4,000
greater than $1,750,000 but less than or equal to $2,000,000	$4,250
greater than $2,000,000 but less than or equal to $2,500,000	$4,500

greater than $2,500,000 but less than or equal to $3,000,000	$4,750
greater than $3,000,000 but less than or equal to $3,500,000	$5,000
greater than $3,500,000 but less than or equal to $4,000,000	$5,500
greater than $4,000,000 but less than or equal to $4,500,000	$6,000
greater than $4,500,000 but less than or equal to $5,000,000	$6,500
greater than $5,000,000 but less than or equal to $7,500,000	$7,000
greater than $7,500,000 but less than or equal to $10,000,000	$8,500
greater than $10,000,000 but less than or equal to $12,500,000	$10,000
greater than $12,500,000 but less than or equal to $15,000,000	$14,000
greater than $15,000,000	$18,000

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(5) Notwithstanding clause (1), a license holder providing services under one or more licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license holder for all licenses held under chapter 245B for calendar year 2013. For calendar year 2017 and thereafter, the license holder shall pay an annual license fee according to clause (1).

(c) A chemical dependency treatment program licensed under chapter 245G, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600

25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

(d) A ~~chemical dependency~~ detoxification program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, ~~to provide detoxification services~~ or a withdrawal management program licensed under chapter 245F shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

A detoxification program that also operates a withdrawal management program at the same location shall only pay one fee based upon the licensed capacity of the program with the higher overall capacity.

(e) Except for child foster care, a residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

(f) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

(g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(h) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of $1,500.

(i) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

(j) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900
75 to 99 persons	$1,100
100 or more persons	$1,300

(k) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(l) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of $1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

Sec. 8. Minnesota Statutes 2020, section 245A.14, subdivision 4, is amended to read:

Subd. 4. **Special family ~~day~~ child care homes.** Nonresidential child care programs serving 14 or fewer children that are conducted at a location other than the license holder's own residence shall be licensed under this section and the rules governing family ~~day~~ child care or group family ~~day~~ child care if:

(a) the license holder is the primary provider of care and the nonresidential child care program is conducted in a dwelling that is located on a residential lot;

(b) the license holder is an employer who may or may not be the primary provider of care, and the purpose for the child care program is to provide child care services to children of the license holder's employees;

(c) the license holder is a church or religious organization;

(d) the license holder is a community collaborative child care provider. For purposes of this subdivision, a community collaborative child care provider is a provider participating in a cooperative agreement with a community action agency as defined in section 256E.31;

(e) the license holder is a not-for-profit agency that provides child care in a dwelling located on a residential lot and the license holder maintains two or more contracts with community employers or other community organizations to provide child care services. The county licensing agency may grant a capacity variance to a license holder licensed under this paragraph to exceed the licensed capacity of 14 children by no more than five children during transition periods related to the work schedules of parents, if the license holder meets the following requirements:

(1) the program does not exceed a capacity of 14 children more than a cumulative total of four hours per day;

(2) the program meets a one to seven staff-to-child ratio during the variance period;

(3) all employees receive at least an extra four hours of training per year than required in the rules governing family child care each year;

(4) the facility has square footage required per child under Minnesota Rules, part 9502.0425;

(5) the program is in compliance with local zoning regulations;

(6) the program is in compliance with the applicable fire code as follows:

(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2015, Section 202; or

(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code 2015, Section 202, unless the rooms in which the children are cared for are located on a level of

exit discharge and each of these child care rooms has an exit door directly to the exterior, then the applicable fire code is Group E occupancies, as provided in the Minnesota State Fire Code 2015, Section 202; and

(7) any age and capacity limitations required by the fire code inspection and square footage determinations shall be printed on the license; or

(f) the license holder is the primary provider of care and has located the licensed child care program in a commercial space, if the license holder meets the following requirements:

(1) the program is in compliance with local zoning regulations;

(2) the program is in compliance with the applicable fire code as follows:

(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2015, Section 202; or

(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire Code 2015, Section 202;

(3) any age and capacity limitations required by the fire code inspection and square footage determinations are printed on the license; and

(4) the license holder prominently displays the license issued by the commissioner which contains the statement "This special family child care provider is not licensed as a child care center."

(g) ~~The commissioner may approve two or more licenses under paragraphs (a) to (f) to be issued at the same location or under one contiguous roof, if each license holder is able to demonstrate compliance with all applicable rules and laws. Each license holder must operate the license holder's respective licensed program as a distinct program and within the capacity, age, and ratio distributions of each license.~~ Notwithstanding Minnesota Rules, part 9502.0335, subpart 12, the commissioner may issue up to four licenses to an organization licensed under paragraphs (b), (c), or (e). Each license must have its own primary provider of care as required under paragraph (i). Each license must operate as a distinct and separate program in compliance with all applicable laws and regulations.

(h) ~~The commissioner may grant variances to this section to allow a primary provider of care, a not-for-profit organization, a church or religious organization, an employer, or a community collaborative to be licensed to provide child care under paragraphs (e) and (f)~~

~~if the license holder meets the other requirements of the statute.~~ For licenses issued under paragraphs (b), (c), (d), (e), or (f), the commissioner may approve up to four licenses at the same location or under one contiguous roof if each license holder is able to demonstrate compliance with all applicable rules and laws. Each licensed program must operate as a distinct program and within the capacity, age, and ratio distributions of each license.

(i) For a license issued under paragraphs (b), (c), or (e), the license holder must designate a person to be the primary provider of care at the licensed location on a form and in a manner prescribed by the commissioner. The license holder shall notify the commissioner in writing before there is a change of the person designated to be the primary provider of care. The primary provider of care:

(1) must be the person who will be the provider of care at the program and present during the hours of operation;

(2) must operate the program in compliance with applicable laws and regulations under chapter 245A and Minnesota Rules, chapter 9502;

(3) is considered a child care background study subject as defined in section 245C.02, subdivision 6a, and must comply with background study requirements in chapter 245C; and

(4) must complete the training that is required of license holders in section 245A.50.

(j) For any license issued under this subdivision, the license holder must ensure that any other caregiver, substitute, or helper who assists in the care of children meets the training requirements in section 245A.50 and background study requirements under chapter 245C.

Sec. 9. Minnesota Statutes 2020, section 245A.16, is amended by adding a subdivision to read:

Subd. 9. **Licensed family foster settings.** (a) Before recommending to grant a license, deny a license under section 245A.05, or revoke a license under section 245A.07 for nondisqualifying background study information received under section 245C.05, subdivision 4, paragraph (a), clause (3), for a licensed family foster setting, a county agency or private agency that has been designated or licensed by the commissioner must review the following:

(1) the type of offenses;

(2) the number of offenses;

(3) the nature of the offenses;

(4) the age of the individual at the time of the offenses;

(5) the length of time that has elapsed since the last offense;

(6) the relationship of the offenses and the capacity to care for a child;

(7) evidence of rehabilitation;

(8) information or knowledge from community members regarding the individual's capacity to provide foster care;

(9) any available information regarding child maltreatment reports or child in need of protection or services petitions, or related cases, in which the individual has been involved or implicated, and documentation that the individual has remedied issues or conditions identified in child protection or court records that are relevant to safely caring for a child;

(10) a statement from the study subject;

(11) a statement from the license holder; and

(12) other aggravating and mitigating factors.

(b) For purposes of this section, "evidence of rehabilitation" includes but is not limited to the following:

(1) maintaining a safe and stable residence;

(2) continuous, regular, or stable employment;

(3) successful participation in an education or job training program;

(4) positive involvement with the community or extended family;

(5) compliance with the terms and conditions of probation or parole following the individual's most recent conviction;

(6) if the individual has had a substance use disorder, successful completion of a substance use disorder assessment, substance use disorder treatment, and recommended continuing care, if applicable, demonstrated abstinence from controlled substances, as defined in section 152.01, subdivision 4, or the establishment of a sober network;

(7) if the individual has had a mental illness or documented mental health issues, demonstrated completion of a mental health evaluation, participation in therapy or other recommended mental health treatment, or appropriate medication management, if applicable;

(8) if the individual's offense or conduct involved domestic violence, demonstrated completion of a domestic violence or anger management program, and the absence of any orders for protection or harassment restraining orders against the individual since the previous offense or conduct;

(9) written letters of support from individuals of good repute, including but not limited to employers, members of the clergy, probation or parole officers, volunteer supervisors, or social services workers;

(10) demonstrated remorse for convictions or conduct, or demonstrated positive behavior changes; and

(11) absence of convictions or arrests since the previous offense or conduct, including any convictions that were expunged or pardoned.

(c) An applicant for a family foster setting license must sign all releases of information requested by the county or private licensing agency.

(d) When licensing a relative for a family foster setting, the commissioner shall also consider the importance of maintaining the child's relationship with relatives as an additional significant factor in determining whether an application will be denied.

(e) When recommending that the commissioner deny or revoke a license, the county or private licensing agency must send a summary of the review completed according to paragraph (a), on a form developed by the commissioner, to the commissioner and include any recommendation for licensing action.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 10. Minnesota Statutes 2020, section 245A.50, subdivision 7, is amended to read:

Subd. 7. **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 2 to 8 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).

Sec. 11. Minnesota Statutes 2020, section 245A.50, subdivision 9, is amended to read:

Subd. 9. **Supervising for safety; training requirement.** (a) Courses required by this subdivision must include the following health and safety topics:

(1) preventing and controlling infectious diseases;

(2) administering medication;

(3) preventing and responding to allergies;

(4) ensuring building and physical premises safety;

(5) handling and storing biological contaminants;

(6) preventing and reporting child abuse and maltreatment; and

(7) emergency preparedness.

(b) Before initial licensure and before caring for a child, all family child care license holders and each second adult caregiver shall complete and document the completion of the six-hour Supervising for Safety for Family Child Care course developed by the commissioner.

(c) The license holder must ensure and document that, before caring for a child, all substitutes have completed the four-hour Basics of Licensed Family Child Care for Substitutes course developed by the commissioner, which must include health and safety topics as well as child development and learning.

(d) The family child care license holder and each second adult caregiver shall complete and document:

(1) the annual completion of either:

(i) a two-hour active supervision course developed by the commissioner; or

(ii) any courses in the ensuring safety competency area under the health, safety, and nutrition standard of the Knowledge and Competency Framework that the commissioner has identified as an active supervision training course; and

(2) the completion at least once every five years of the two-hour courses Health and Safety I and Health and Safety II. When the training is due for the first time or expires, it must be taken no later than the day before the anniversary of the license holder's license effective date. A license holder's or second adult caregiver's completion of either training in a given year meets the annual active supervision training requirement in clause (1).

(e) At least once every three years, license holders must ensure and document that substitutes have completed the four-hour Basics of Licensed Family Child Care for Substitutes course. When the training expires, it must be retaken no later than the day before the anniversary of the license holder's license effective date.

Sec. 12. Minnesota Statutes 2020, section 245C.02, subdivision 4a, is amended to read:

Subd. 4a. **Authorized fingerprint collection vendor.** "Authorized fingerprint collection vendor" means a qualified organization under a written contract with the commissioner to provide services in accordance with section 245C.05, subdivision 5, paragraph (b). The commissioner may retain the services of more than one authorized fingerprint collection vendor.

Sec. 13. Minnesota Statutes 2020, section 245C.02, subdivision 5, is amended to read:

Subd. 5. **Background study.** "Background study" means:

(1) the collection and processing of a background study subject's fingerprints, including the process of obtaining a background study subject's classifiable fingerprints and photograph as required by section 245C.05, subdivision 5, paragraph (b); and

(2) the review of records conducted by the commissioner to determine whether a subject is disqualified from direct contact with persons served by a program and, where specifically provided in statutes, whether a subject is disqualified from having access to persons served by a program and from working in a children's residential facility or foster residence setting.

Sec. 14. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision to read:

Subd. 5b. **Alternative background study.** "Alternative background study" means:

(1) the collection and processing of a background study subject's fingerprints, including the process of obtaining a background study subject's classifiable fingerprints and photograph as required by section 245C.05, subdivision 5, paragraph (b); and

(2) a review of records conducted by the commissioner pursuant to section 245C.08 in order to forward the background study investigating information to the entity that submitted the alternative background study request under section 245C.031, subdivision 2. The commissioner shall not make any eligibility determinations on background studies conducted under section 245C.031.

Sec. 15. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision to read:

Subd. 11c. **Entity.** "Entity" means any program, organization, or agency initiating a background study.

Sec. 16. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision to read:

Subd. 16a. **Results.** "Results" means a determination that a study subject is eligible, disqualified, set aside, granted a variance, or that more time is needed to complete the background study.

Sec. 17. Minnesota Statutes 2020, section 245C.03, is amended to read:

245C.03 BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study on:

(1) the person or persons applying for a license;

(2) an individual age 13 and over living in the household where the licensed program will be provided who is not receiving licensed services from the program;

(3) current or prospective employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program, when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(7) all controlling individuals as defined in section 245A.02, subdivision 5a;

(8) notwithstanding the other requirements in this subdivision, child care background study subjects as defined in section 245C.02, subdivision 6a; and

(9) notwithstanding clause (3), for children's residential facilities and foster residence settings, any adult working in the facility, whether or not the individual will have direct contact with persons served by the facility.

(b) For child foster care when the license holder resides in the home where foster care services are provided, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

(c) This subdivision applies to the following programs that must be licensed under chapter 245A:

(1) adult foster care;

(2) child foster care;

(3) children's residential facilities;

(4) family child care;

(5) licensed child care centers;

(6) licensed home and community-based services under chapter 245D;

(7) residential mental health programs for adults;

(8) substance use disorder treatment programs under chapter 245G;

(9) withdrawal management programs under chapter 245F;

(10) programs that provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons;

(11) adult day care centers;

(12) family adult day services;

(13) independent living assistance for youth;

(14) detoxification programs;

(15) community residential settings; and

(16) intensive residential treatment services and residential crisis stabilization under chapter 245I.

Subd. 1a. **Procedure.** (a) Individuals and organizations that are required under this section to have or initiate background studies shall comply with the requirements of this chapter.

(b) All studies conducted under this section shall be conducted according to sections 299C.60 to 299C.64. This requirement does not apply to subdivisions 1, paragraph (c), clauses (2) to (5), and 6a.

Subd. 2. **Personal care provider organizations.** The commissioner shall conduct background studies on any individual required under sections 256B.0651 to 256B.0654 and 256B.0659 to have a background study completed under this chapter.

Subd. 3. **Supplemental nursing services agencies.** The commissioner shall conduct all background studies required under this chapter and initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1.

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

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

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

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

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

Subd. 3b. **Exception to personal care assistant; requirements.** The personal care assistant for a recipient may be allowed to enroll with a different personal care assistance provider agency upon initiation of a new background study according to this chapter if:

(1) the commissioner determines that a change in enrollment or affiliation of the personal care assistant is needed in order to ensure continuity of services and protect the health and safety of the recipient;

(2) the chosen agency has been continuously enrolled as a personal care assistance provider agency for at least two years;

(3) the recipient chooses to transfer to the personal care assistance provider agency;

(4) the personal care assistant has been continuously enrolled with the former personal care assistance provider agency since the last background study was completed; and

(5) the personal care assistant continues to meet requirements of section 256B.0659, subdivision 11, notwithstanding paragraph (a), clause (3).

Subd. 4. **Personnel agencies; educational programs; professional services agencies.** The commissioner also may conduct studies on individuals specified in subdivision 1, paragraph (a), clauses (3) and (4), when the studies are initiated by:

(1) personnel pool agencies;

(2) temporary personnel agencies;

(3) educational programs that train individuals by providing direct contact services in licensed programs; and

(4) professional services agencies that are not licensed and which contract with licensed programs to provide direct contact services or individuals who provide direct contact services.

Subd. 5. **Other state agencies.** The commissioner shall conduct background studies on applicants and license holders under the jurisdiction of other state agencies who are required in other statutory sections to initiate background studies under this chapter, including the applicant's or license holder's employees, contractors, and volunteers when required under other statutory sections.

Subd. 5a. **Facilities serving children or adults licensed or regulated by the Department of Health.** (a) The commissioner shall conduct background studies of:

(1) individuals providing services who have direct contact, as defined under section 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; assisted living facilities and assisted living facilities with dementia care licensed under chapter 144G; and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17;

(2) individuals specified in subdivision 2 who provide direct contact services in a nursing home or a home care agency licensed under chapter 144A; an assisted living facility or assisted living facility with dementia care licensed under chapter 144G; or a boarding care home licensed under sections 144.50 to 144.58. If the individual undergoing a study resides outside of Minnesota, the study must include a check for substantiated findings of maltreatment of adults and children in the individual's state of residence when the state makes the information available;

(3) all other employees in assisted living facilities or assisted living facilities with dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact with or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as

defined in section 245C.02, subdivision 8, when the employee's employment responsibilities do not include providing direct contact services;

(4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

(5) controlling persons of a supplemental nursing services agency, as defined by section 144A.70.

(b) If a facility or program is licensed by the Department of Human Services and the Department of Health and is subject to the background study provisions of this chapter, the Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed program.

(c) The commissioner of health shall review and make decisions regarding reconsideration requests, including whether to grant variances, according to the procedures and criteria in this chapter. The commissioner of health shall inform the requesting individual and the Department of Human Services of the commissioner of health's decision regarding the reconsideration. The commissioner of health's decision to grant or deny a reconsideration of a disqualification is a final administrative agency action.

Subd. 5b. **Facilities serving children or youth licensed by the Department of Corrections.** (a) The commissioner shall conduct background studies of individuals working in secure and nonsecure children's residential facilities, juvenile detention facilities, and foster residence settings, whether or not the individual will have direct contact, as defined under section 245C.02, subdivision 11, with persons served in the facilities or settings.

(b) A clerk or administrator of any court, the Bureau of Criminal Apprehension, a prosecuting attorney, a county sheriff, or a chief of a local police department shall assist in conducting background studies by providing the commissioner of human services or the commissioner's representative all criminal conviction data available from local and state criminal history record repositories related to applicants, operators, all persons living in a household, and all staff of any facility subject to background studies under this subdivision.

(c) For the purpose of this subdivision, the term "secure and nonsecure residential facility and detention facility" includes programs licensed or certified under section 241.021, subdivision 2.

(d) If an individual is disqualified, the Department of Human Services shall notify the disqualified individual and the facility in which the disqualified individual provides services of the disqualification and shall inform the disqualified individual of the right to request a

reconsideration of the disqualification by submitting the request to the Department of Corrections.

(e) The commissioner of corrections shall review and make decisions regarding reconsideration requests, including whether to grant variances, according to the procedures and criteria in this chapter. The commissioner of corrections shall inform the requesting individual and the Department of Human Services of the commissioner of corrections' decision regarding the reconsideration. The commissioner of corrections' decision to grant or deny a reconsideration of a disqualification is the final administrative agency action.

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** (a) The commissioner shall conduct background studies ~~on~~ of any individual ~~required under section 256B.4912 to have a background study completed under this chapter~~ who provides direct contact, as defined in section 245C.02, subdivision 11, for services specified in the federally approved home and community-based waiver plans under section 256B.4912. The individual studied must meet the requirements of this chapter prior to providing waiver services and as part of ongoing enrollment.

(b) The requirements in paragraph (a) apply to consumer-directed community supports under section 256B.4911.

Subd. 6a. **Legal nonlicensed and certified child care programs.** The commissioner shall conduct background studies ~~on an individual~~ of the following individuals as required ~~under~~ by sections 119B.125 and 245H.10 ~~to complete a background study under this chapter.~~:

(1) every individual who applies for certification;

(2) every member of a provider's household who is age 13 and older and lives in the household where nonlicensed child care is provided; and

(3) an individual who is at least ten years of age and under 13 years of age and lives in the household where the nonlicensed child care will be provided when the county has reasonable cause as defined under section 245C.02, subdivision 15.

Subd. 7. **Children's therapeutic services and supports providers.** The commissioner shall conduct background studies ~~according to this chapter when initiated by a children's therapeutic services and supports provider~~ of all direct service providers and volunteers for children's therapeutic services and supports providers under section 256B.0943.

~~Subd. 8. **Self-initiated background studies.** Upon implementation of NETStudy 2.0, the commissioner shall conduct background studies according to this chapter when initiated~~

~~by an individual who is not on the master roster. A subject under this subdivision who is not disqualified must be placed on the inactive roster.~~

Subd. 9. **Community first services and supports and financial management services organizations.** ~~The commissioner shall conduct background studies on any individual required under section 256B.85 to have a background study completed under this chapter.~~ Individuals affiliated with Community First Services and Supports (CFSS) agency-providers and Financial Management Services (FMS) providers enrolled to provide CFSS services under the medical assistance program must meet the following requirements:

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

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

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

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

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

Subd. 9a. **Exception to support worker requirements for continuity of services.** The support worker for a participant may enroll with a different Community First Services and Supports (CFSS) agency-provider or Financial Management Services (FMS) provider upon initiation, rather than completion, of a new background study according to this chapter if:

(1) the commissioner determines that the support worker's change in enrollment or affiliation is necessary to ensure continuity of services and to protect the health and safety of the participant;

(2) the chosen agency-provider or FMS provider has been continuously enrolled as a CFSS agency-provider or FMS provider for at least two years or since the inception of the CFSS program, whichever is shorter;

(3) the participant served by the support worker chooses to transfer to the CFSS agency-provider or the FMS provider to which the support worker is transferring;

(4) the support worker has been continuously enrolled with the former CFSS agency-provider or FMS provider since the support worker's last background study was completed; and

(5) the support worker continues to meet the requirements of section 256B.85, subdivision 16, notwithstanding paragraph (a), clause (1).

Subd. 10. **Providers of group residential housing or supplementary services.** (a) The commissioner shall conduct background studies ~~on any individual required under section 256I.04 to have a background study completed under this chapter.~~ of the following individuals who provide services under section 256I.04:

(1) controlling individuals as defined in section 245A.02;

(2) managerial officials as defined in section 245A.02; and

(3) all employees and volunteers of the establishment who have direct contact with recipients or who have unsupervised access to recipients, recipients' personal property, or recipients' private data.

(b) The provider of housing support must comply with all requirements for entities initiating background studies under this chapter.

(c) A provider of housing support must demonstrate that all individuals who are required to have a background study according to paragraph (a) have a notice stating that:

(1) the individual is not disqualified under section 245C.14; or

(2) the individual is disqualified and the individual has been issued a set aside of the disqualification for the setting under section 245C.22.

~~Subd. 11. **Child protection workers or social services staff having responsibility for child protective duties.** (a) The commissioner must complete background studies, according to paragraph (b) and section 245C.04, subdivision 10, when initiated by a county social services agency or by a local welfare agency according to section 626.559, subdivision 1b.~~

~~(b) For background studies completed by the commissioner under this subdivision, the commissioner shall not make a disqualification decision, but shall provide the background study information received to the county that initiated the study.~~

Subd. 12. **Providers of special transportation service.** (a) The commissioner shall conduct background studies ~~on any individual required under section 174.30 to have a~~

~~background study completed under this chapter.~~ of the following individuals who provide special transportation services under section 174.30:

(1) each person with a direct or indirect ownership interest of five percent or higher in a transportation service provider;

(2) each controlling individual as defined under section 245A.02;

(3) a managerial official as defined in section 245A.02;

(4) each driver employed by the transportation service provider;

(5) each individual employed by the transportation service provider to assist a passenger during transport; and

(6) each employee of the transportation service agency who provides administrative support, including an employee who:

(i) may have face-to-face contact with or access to passengers, passengers' personal property, or passengers' private data;

(ii) performs any scheduling or dispatching tasks; or

(iii) performs any billing activities.

(b) When a local or contracted agency is authorizing a ride under section 256B.0625, subdivision 17, by a volunteer driver, and the agency authorizing the ride has a reason to believe that the volunteer driver has a history that would disqualify the volunteer driver or that may pose a risk to the health or safety of passengers, the agency may initiate a background study that shall be completed according to this chapter using the commissioner of human services' online NETStudy system, or by contacting the Department of Human Services background study division for assistance. The agency that initiates the background study under this paragraph shall be responsible for providing the volunteer driver with the privacy notice required by section 245C.05, subdivision 2c, and with the payment for the background study required by section 245C.10 before the background study is completed.

Subd. 13. **Providers of housing support services.** The commissioner shall conduct background studies ~~on~~ of any ~~individual~~ provider of housing support services required ~~under~~ by section 256B.051 to have a background study completed under this chapter.

Subd. 14. **Tribal nursing facilities.** For completed background studies to comply with a Tribal organization's licensing requirements for individuals affiliated with a tribally licensed nursing facility, the commissioner shall obtain state and national criminal history data.

Subd. 15. **Early intensive developmental and behavioral intervention providers.** The commissioner shall conduct background studies according to this chapter when initiated by an early intensive developmental and behavioral intervention provider under section 256B.0949.

EFFECTIVE DATE. This section is effective July 1, 2021, except subdivision 6, paragraph (b), is effective upon federal approval and subdivision 15 is effective the day following final enactment. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 18. **[245C.031] BACKGROUND STUDY; ALTERNATIVE BACKGROUND STUDIES.**

Subdivision 1. **Alternative background studies.** (a) The commissioner shall conduct an alternative background study of individuals listed in this section.

(b) Notwithstanding other sections of this chapter, all alternative background studies except subdivision 12 shall be conducted according to this section and with section 299C.60 to 299C.64.

(c) All terms in this section shall have the definitions provided in section 245C.02.

(d) The entity that submits an alternative background study request under this section shall submit the request to the commissioner according to section 245C.05.

(e) The commissioner shall comply with the destruction requirements in section 245C.051.

(f) Background studies conducted under this section are subject to the provisions of section 245C.32.

(g) The commissioner shall forward all information that the commissioner receives under section 245C.08 to the entity that submitted the alternative background study request under subdivision 2. The commissioner shall not make any eligibility determinations regarding background studies conducted under this section.

Subd. 2. **Access to information.** Each entity that submits an alternative background study request shall enter into an agreement with the commissioner before submitting requests for alternative background studies under this section. As a part of the agreement, the entity must agree to comply with state and federal law.

Subd. 3. **Child protection workers or social services staff having responsibility for child protective duties.** The commissioner shall conduct an alternative background study of any person who has responsibility for child protection duties when the background study

is initiated by a county social services agency or by a local welfare agency according to section 260E.36, subdivision 3.

Subd. 4. **Applicants, licensees, and other occupations regulated by the commissioner of health.** The commissioner shall conduct an alternative background study, including a check of state data, and a national criminal history records check of the following individuals. For studies under this section, the following persons shall complete a consent form:

(1) an applicant for initial licensure, temporary licensure, or relicensure after a lapse in licensure as an audiologist or speech-language pathologist or an applicant for initial certification as a hearing instrument dispenser who must submit to a background study under section 144.0572.

(2) an applicant for a renewal license or certificate as an audiologist, speech-language pathologist, or hearing instrument dispenser who was licensed or obtained a certificate before January 1, 2018.

Subd. 5. **Guardians and conservators.** (a) The commissioner shall conduct an alternative background study of:

(1) every court-appointed guardian and conservator, unless a background study has been completed of the person under this section within the previous five years. The alternative background study shall be completed prior to the appointment of the guardian or conservator, unless a court determines that it would be in the best interests of the ward or protected person to appoint a guardian or conservator before the alternative background study can be completed. If the court appoints the guardian or conservator while the alternative background study is pending, the alternative background study must be completed as soon as reasonably possible after the guardian or conservator's appointment and no later than 30 days after the guardian or conservator's appointment; and

(2) a guardian and a conservator once every five years after the guardian or conservator's appointment if the person continues to serve as a guardian or conservator.

(b) An alternative background study is not required if the guardian or conservator is:

(1) a state agency or county;

(2) a parent or guardian of a proposed ward or protected person who has a developmental disability if the parent or guardian has raised the proposed ward or protected person in the family home until the time that the petition is filed, unless counsel appointed for the proposed ward or protected person under section 524.5-205, paragraph (d); 524.5-304, paragraph (b);

524.5-405, paragraph (a); or 524.5-406, paragraph (b), recommends a background study; or

(3) a bank with trust powers, a bank and trust company, or a trust company, organized under the laws of any state or of the United States and regulated by the commissioner of commerce or a federal regulator.

Subd. 6. **Guardians and conservators; required checks.** (a) An alternative background study for a guardian or conservator pursuant to subdivision 5 shall include:

(1) criminal history data from the Bureau of Criminal Apprehension and other criminal history data obtained by the commissioner of human services;

(2) data regarding whether the person has been a perpetrator of substantiated maltreatment of a vulnerable adult under section 626.557 or a minor under chapter 260E. If the subject of the study has been the perpetrator of substantiated maltreatment of a vulnerable adult or a minor, the commissioner must include a copy of the public portion of the investigation memorandum under section 626.557, subdivision 12b, or the public portion of the investigation memorandum under section 260E.30. The commissioner shall provide the court with information from a review of information according to subdivision 7 if the study subject provided information that the study subject has a current or prior affiliation with a state licensing agency;

(3) criminal history data from a national criminal history record check as defined in section 245C.02, subdivision 13c; and

(4) state licensing agency data if a search of the database or databases of the agencies listed in subdivision 7 shows that the proposed guardian or conservator has held a professional license directly related to the responsibilities of a professional fiduciary from an agency listed in subdivision 7 that was conditioned, suspended, revoked, or canceled.

(b) If the guardian or conservator is not an individual, the background study must be completed of all individuals who are currently employed by the proposed guardian or conservator who are responsible for exercising powers and duties under the guardianship or conservatorship.

Subd. 7. **Guardians and conservators; state licensing data.** (a) Within 25 working days of receiving the request for an alternative background study of a guardian or conservator, the commissioner shall provide the court with licensing agency data for licenses directly related to the responsibilities of a guardian or conservator if the study subject has a current or prior affiliation with the:

(1) Lawyers Responsibility Board;

(2) State Board of Accountancy;

(3) Board of Social Work;

(4) Board of Psychology;

(5) Board or Nursing;

(6) Board of Medical Practice;

(7) Department of Education;

(8) Department of Commerce;

(9) Board of Chiropractic Examiners;

(10) Board of Dentistry;

(11) Board of Marriage and Family Therapy;

(12) Department of Human Services;

(13) Peace Officer Standards and Training (POST) Board; and

(14) Professional Educator Licensing and Standards Board.

(b) The commissioner and each of the agencies listed above, except for the Department of Human Services, shall enter into a written agreement to provide the commissioner with electronic access to the relevant licensing data and to provide the commissioner with a quarterly list of new sanctions issued by the agency.

(c) The commissioner shall provide to the court the electronically available data maintained in the agency's database, including whether the proposed guardian or conservator is or has been licensed by the agency and whether a disciplinary action or a sanction against the individual's license, including a condition, suspension, revocation, or cancellation, is in the licensing agency's database.

(d) If the proposed guardian or conservator has resided in a state other than Minnesota during the previous ten years, licensing agency data under this section shall also include licensing agency data from any other state where the proposed guardian or conservator reported to have resided during the previous ten years if the study subject has a current or prior affiliation to the licensing agency. If the proposed guardian or conservator has or has had a professional license in another state that is directly related to the responsibilities of a guardian or conservator from one of the agencies listed under paragraph (a), state licensing agency data shall also include data from the relevant licensing agency of the other state.

(e) The commissioner is not required to repeat a search for Minnesota or out-of-state licensing data on an individual if the commissioner has provided this information to the court within the prior five years.

(f) The commissioner shall review the information in paragraph (c) at least once every four months to determine whether an individual who has been studied within the previous five years:

(1) has any new disciplinary action or sanction against the individual's license; or

(2) did not disclose a prior or current affiliation with a Minnesota licensing agency.

(g) If the commissioner's review in paragraph (f) identifies new information, the commissioner shall provide any new information to the court.

Subd. 8. **Guardians ad litem.** The commissioner shall conduct an alternative background study of:

(1) a guardian ad litem appointed under section 518.165 if a background study of the guardian ad litem has not been completed within the past three years. The background study of the guardian ad litem must be completed before the court appoints the guardian ad litem, unless the court determines that it is in the best interests of the child to appoint the guardian ad litem before a background study is completed by the commissioner.

(2) a guardian ad litem once every three years after the guardian has been appointed, as long as the individual continues to serve as a guardian ad litem.

Subd. 9. **Guardians ad litem; required checks.** (a) An alternative background study for a guardian ad litem under subdivision 8 must include:

(1) criminal history data from the Bureau of Criminal Apprehension and other criminal history data obtained by the commissioner of human services; and

(2) data regarding whether the person has been a perpetrator of substantiated maltreatment of a minor or a vulnerable adult. If the study subject has been determined by the Department of Human Services or the Department of Health to be the perpetrator of substantiated maltreatment of a minor or a vulnerable adult in a licensed facility, the response must include a copy of the public portion of the investigation memorandum under section 260E.30 or the public portion of the investigation memorandum under section 626.557, subdivision 12b. When the background study shows that the subject has been determined by a county adult protection or child protection agency to have been responsible for maltreatment, the court shall be informed of the county, the date of the finding, and the nature of the maltreatment that was substantiated.

(b) For checks of records under paragraph (a), clauses (1) and (2), the commissioner shall provide the records within 15 working days of receiving the request. The information obtained under sections 245C.05 and 245C.08 from a national criminal history records check shall be provided within three working days of the commissioner's receipt of the data.

(c) Notwithstanding section 260E.30 or 626.557, subdivision 12b, if the commissioner or county lead agency or lead investigative agency has information that a person of whom a background study was previously completed under this section has been determined to be a perpetrator of maltreatment of a minor or vulnerable adult, the commissioner or the county may provide this information to the court that requested the background study.

Subd. 10. **First-time applicants for educator licenses with the Professional Educator Licensing and Standards Board.** The Professional Educator Licensing and Standards Board shall make all eligibility determinations for alternative background studies conducted under this section for the Professional Educator Licensing and Standards Board. The commissioner may conduct an alternative background study of all first-time applicants for educator licenses pursuant to section 122A.18, subdivision 8. The alternative background study for all first-time applicants for educator licenses must include a review of information from the Bureau of Criminal Apprehension, including criminal history data as defined in section 13.87, and must also include a review of the national criminal records repository.

Subd. 11. **First-time applicants for administrator licenses with the Board of School Administrators.** The Board of School Administrators shall make all eligibility determinations for alternative background studies conducted under this section for the Board of School Administrators. The commissioner may conduct an alternative background study of all first-time applicants for administrator licenses pursuant to section 122A.18, subdivision 8. The alternative background study for all first-time applicants for administrator licenses must include a review of information from the Bureau of Criminal Apprehension, including criminal history data as defined in section 13.87, and must also include a review of the national criminal records repository.

Subd. 12. **Occupations regulated by MNsure.** (a) The commissioner shall conduct a background study of any individual required under section 62V.05 to have a background study completed under this chapter. Notwithstanding subdivision 1, paragraph (g), the commissioner shall conduct a background study only based on Minnesota criminal records of:

(1) each navigator;

(2) each in-person assister; and

(3) each certified application counselor.

(b) The MNsure board of directors may initiate background studies required by paragraph (a) using the online NETStudy 2.0 system operated by the commissioner.

(c) The commissioner shall review information that the commissioner receives to determine if the study subject has potentially disqualifying offenses. The commissioner shall send a letter to the subject indicating any of the subject's potential disqualifications as well as any relevant records. The commissioner shall send a copy of the letter indicating any of the subject's potential disqualifications to the MNsure board.

(d) The MNsure board or its delegate shall review a reconsideration request of an individual in paragraph (a), including granting a set aside, according to the procedures and criteria in chapter 245C. The board shall notify the individual and the Department of Human Services of the board's decision.

Sec. 19. Minnesota Statutes 2020, section 245C.05, subdivision 1, is amended to read:

Subdivision 1. **Individual studied.** (a) The individual who is the subject of the background study must provide the applicant, license holder, or other entity under section 245C.04 with sufficient information to ensure an accurate study, including:

(1) the individual's first, middle, and last name and all other names by which the individual has been known;

(2) current home address, city, and state of residence;

(3) current zip code;

(4) sex;

(5) date of birth;

(6) driver's license number or state identification number; and

(7) upon implementation of NETStudy 2.0, the home address, city, county, and state of residence for the past five years.

(b) Every subject of a background study conducted or initiated by counties or private agencies under this chapter must also provide the home address, city, county, and state of residence for the past five years.

(c) Every subject of a background study related to private agency adoptions or related to child foster care licensed through a private agency, who is 18 years of age or older, shall also provide the commissioner a signed consent for the release of any information received

from national crime information databases to the private agency that initiated the background study.

(d) The subject of a background study shall provide fingerprints and a photograph as required in subdivision 5.

(e) The subject of a background study shall submit a completed criminal and maltreatment history records check consent form for applicable national and state level record checks.

Sec. 20. Minnesota Statutes 2020, section 245C.05, subdivision 2, is amended to read:

Subd. 2. **Applicant, license holder, or other entity.** (a) The applicant, license holder, or other ~~entities~~ entity initiating the background study as provided in this chapter shall verify that the information collected under subdivision 1 about an individual who is the subject of the background study is correct and must provide the information on forms or in a format prescribed by the commissioner.

(b) The information collected under subdivision 1 about an individual who is the subject of a completed background study may only be viewable by an entity that initiates a subsequent background study on that individual under NETStudy 2.0 after the entity has paid the applicable fee for the study and has provided the individual with the privacy notice in subdivision 2c.

Sec. 21. Minnesota Statutes 2020, section 245C.05, subdivision 2a, is amended to read:

Subd. 2a. **County or private agency.** For background studies related to child foster care when the applicant or license holder resides in the home where child foster care services are provided, county and private agencies initiating the background study must collect the information under subdivision 1 and forward it to the commissioner.

Sec. 22. Minnesota Statutes 2020, section 245C.05, subdivision 2b, is amended to read:

Subd. 2b. **County agency to collect and forward information to commissioner.** (a) For background studies related to all family adult day services and to adult foster care when the adult foster care license holder resides in the adult foster care residence, the county agency or private agency initiating the background study must collect the information required under subdivision 1 and forward it to the commissioner.

(b) Upon implementation of NETStudy 2.0, for background studies related to family child care and legal nonlicensed child care authorized under chapter 119B, the county agency

initiating the background study must collect the information required under subdivision 1 and provide the information to the commissioner.

Sec. 23. Minnesota Statutes 2020, section 245C.05, subdivision 2c, is amended to read:

Subd. 2c. **Privacy notice to background study subject.** (a) Prior to initiating each background study, the entity initiating the study must provide the commissioner's privacy notice to the background study subject required under section 13.04, subdivision 2. The notice must be available through the commissioner's electronic NETStudy and NETStudy 2.0 systems and shall include the information in paragraphs (b) and (c).

(b) The background study subject shall be informed that any previous background studies that received a set-aside will be reviewed, and without further contact with the background study subject, the commissioner may notify the agency that initiated the subsequent background study:

(1) that the individual has a disqualification that has been set aside for the program or agency that initiated the study;

(2) the reason for the disqualification; and

(3) that information about the decision to set aside the disqualification will be available to the license holder upon request without the consent of the background study subject.

(c) The background study subject must also be informed that:

(1) the subject's fingerprints collected for purposes of completing the background study under this chapter must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or by the commissioner. The Federal Bureau of Investigation will ~~only retain fingerprints of subjects with a criminal history~~ not retain background study subjects' fingerprints;

(2) effective upon implementation of NETStudy 2.0, the subject's photographic image will be retained by the commissioner, and if the subject has provided the subject's Social Security number for purposes of the background study, the photographic image will be available to prospective employers and agencies initiating background studies under this chapter to verify the identity of the subject of the background study;

(3) the commissioner's authorized fingerprint collection vendor or vendors shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from

NETStudy 2.0. The authorized fingerprint collection vendor or vendors shall retain no more than the subject's name and the date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities;

(4) the commissioner shall provide the subject notice, as required in section 245C.17, subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

(5) the subject may request in writing a report listing the entities that initiated a background study on the individual as provided in section 245C.17, subdivision 1, paragraph (b);

(6) the subject may request in writing that information used to complete the individual's background study in NETStudy 2.0 be destroyed if the requirements of section 245C.051, paragraph (a), are met; and

(7) notwithstanding clause (6), the commissioner shall destroy:

(i) the subject's photograph after a period of two years when the requirements of section 245C.051, paragraph (c), are met; and

(ii) any data collected on a subject under this chapter after a period of two years following the individual's death as provided in section 245C.051, paragraph (d).

Sec. 24. Minnesota Statutes 2020, section 245C.05, subdivision 2d, is amended to read:

Subd. 2d. **Fingerprint data notification.** The commissioner of human services shall notify all background study subjects under this chapter that the Department of Human Services, Department of Public Safety, and the Bureau of Criminal Apprehension do not retain fingerprint data after a background study is completed, and that the Federal Bureau of Investigation ~~only retains the fingerprints of subjects who have a criminal history~~ does not retain background study subjects' fingerprints.

Sec. 25. Minnesota Statutes 2020, section 245C.05, subdivision 4, is amended to read:

Subd. 4. **Electronic transmission.** (a) For background studies conducted by the Department of Human Services, the commissioner shall implement a secure system for the electronic transmission of:

(1) background study information to the commissioner;

(2) background study results to the license holder;

(3) background study ~~results~~ information obtained under this section and section 245C.08 to counties and private agencies for background studies conducted by the commissioner for

child foster care, including a summary of nondisqualifying results, except as prohibited by law; and

(4) background study results to county agencies for background studies conducted by the commissioner for adult foster care and family adult day services and, upon implementation of NETStudy 2.0, family child care and legal nonlicensed child care authorized under chapter 119B.

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as NETStudy or NETStudy 2.0 to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

(d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 26. Minnesota Statutes 2020, section 245C.08, subdivision 3, is amended to read:

Subd. 3. **Arrest and investigative information.** (a) For any background study completed under this section, if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual, the commissioner also may review arrest and investigative information from:

(1) the Bureau of Criminal Apprehension;

(2) the commissioners of health and human services;

(3) a county attorney;

(4) a county sheriff;

(5) a county agency;

(6) a local chief of police;

(7) other states;

(8) the courts;

(9) the Federal Bureau of Investigation;

(10) the National Criminal Records Repository; and

(11) criminal records from other states.

(b) Except when specifically required by law, the commissioner is not required to conduct more than one review of a subject's records from the Federal Bureau of Investigation if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the entity that initiated the background study.

(c) If the commissioner conducts a national criminal history record check when required by law and uses the information from the national criminal history record check to make a disqualification determination, the data obtained is private data and cannot be shared with ~~county agencies,~~ private agencies~~,~~ or prospective employers of the background study subject.

(d) If the commissioner conducts a national criminal history record check when required by law and uses the information from the national criminal history record check to make a disqualification determination, the license holder or entity that submitted the study is not required to obtain a copy of the background study subject's disqualification letter under section 245C.17, subdivision 3.

Sec. 27. Minnesota Statutes 2020, section 245C.08, is amended by adding a subdivision to read:

Subd. 5. **Authorization.** The commissioner of human services shall be authorized to receive information under this chapter.

Sec. 28. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 1b. **Background study fees.** (a) The commissioner shall recover the cost of background studies. Except as otherwise provided in subdivisions 1c and 1d, the fees collected under this section shall be appropriated to the commissioner for the purpose of conducting background studies under this chapter. Fees under this section are charges under section 16A.1283, paragraph (b), clause (3).

(b) Background study fees may include:

(1) a fee to compensate the commissioner's authorized fingerprint collection vendor or vendors for obtaining and processing a background study subject's classifiable fingerprints and photograph pursuant to subdivision 1c; and

(2) a separate fee under subdivision 1c to complete a review of background-study-related records as authorized under this chapter.

(c) Fees charged under paragraph (b) may be paid in whole or part when authorized by law by a state agency or board; by state court administration; by a service provider, employer, license holder, or other organization that initiates the background study; by the commissioner or other organization with duly appropriated funds; by a background study subject; or by some combination of these sources.

Sec. 29. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 1c. **Fingerprint and photograph processing fees.** The commissioner shall enter into a contract with a qualified vendor or vendors to obtain and process a background study subject's classifiable fingerprints and photograph as required by section 245C.05. The commissioner may, at their discretion, directly collect fees and reimburse the commissioner's authorized fingerprint collection vendor for the vendor's services or require the vendor to collect the fees. The authorized vendor is responsible for reimbursing the vendor's subcontractors at a rate specified in the contract with the commissioner.

Sec. 30. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 1d. **Background studies fee schedule.** (a) By March 1 each year, the commissioner shall publish a schedule of fees sufficient to administer and conduct background studies under this chapter. The published schedule of fees shall be effective on July 1 each year.

(b) Fees shall be based on the actual costs of administering and conducting background studies, including payments to external agencies, department indirect cost payments under section 16A.127, processing fees, and costs related to due process.

(c) The commissioner shall publish a notice of fees by posting fee amounts on the department website. The notice shall specify the actual costs that comprise the fees including the categories described in paragraph (b).

(d) The published schedule of fees shall remain in effect from July 1 to June 30 each year.

(e) The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies, alternative background studies, and criminal background checks.

EFFECTIVE DATE. This section is effective July 1, 2021. The commissioner of human services shall publish the initial fee schedule on the Department of Human Services website on July 1, 2021, and the initial fee schedule is effective September 1, 2021.

Sec. 31. Minnesota Statutes 2020, section 245C.10, subdivision 15, is amended to read:

Subd. 15. **Guardians and conservators.** The ~~commissioner shall recover the cost of conducting background studies for guardians and conservators under section 524.5-118 through a fee of no more than $110 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.~~ fee for conducting an alternative background study for appointment of a professional guardian or conservator must be paid by the guardian or conservator. In other cases, the fee must be paid as follows:

(1) if the matter is proceeding in forma pauperis, the fee must be paid as an expense for purposes of section 524.5-502, paragraph (a);

(2) if there is an estate of the ward or protected person, the fee must be paid from the estate; or

(3) in the case of a guardianship or conservatorship of a person that is not proceeding in forma pauperis, the fee must be paid by the guardian, conservator, or the court.

Sec. 32. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 17. **Early intensive developmental and behavioral intervention providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 15, for the purposes of early intensive developmental and behavioral intervention under section 256B.0949, through a fee of no more than $20 per study charged to the enrolled agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

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

Sec. 33. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 18. **Applicants, licensees, and other occupations regulated by commissioner of health.** The applicant or license holder is responsible for paying to the Department of

Human Services all fees associated with the preparation of the fingerprints, the criminal records check consent form, and the criminal background check.

Sec. 34. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 19. **Occupations regulated by MNsure.** The commissioner shall set fees to recover the cost of background studies and criminal background checks initiated by MNsure under sections 62V.05 and 245C.031. The fee amount shall be established through interagency agreement between the commissioner and the board of MNsure or its designee. The fees collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks.

Sec. 35. Minnesota Statutes 2020, section 245C.13, subdivision 2, is amended to read:

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

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

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

(i) the individual is not disqualified; or

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

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

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

(b) For a background study affiliated with a licensed child care center or certified license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii), must require the individual to be under continuous direct supervision prior to completion of the background study except as permitted in subdivision 3.

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

(1) being issued a license;

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

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

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

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

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

(7) for background studies affiliated with a personal care provider organization, except as provided in section 245C.03, subdivision 3b, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study of the personal care assistant under this chapter and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

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

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

Sec. 36. Minnesota Statutes 2020, section 245C.14, subdivision 1, is amended to read:

Subdivision 1. **Disqualification from direct contact.** (a) The commissioner shall disqualify an individual who is the subject of a background study from any position allowing direct contact with persons receiving services from the license holder or entity identified in section 245C.03, upon receipt of information showing, or when a background study completed under this chapter shows any of the following:

(1) a conviction of, admission to, or Alford plea to one or more crimes listed in section 245C.15, regardless of whether the conviction or admission is a felony, gross misdemeanor, or misdemeanor level crime;

(2) a preponderance of the evidence indicates the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, regardless of whether the preponderance of the evidence is for a felony, gross misdemeanor, or misdemeanor level crime; or

(3) an investigation results in an administrative determination listed under section 245C.15, subdivision 4, paragraph (b).

(b) No individual who is disqualified following a background study under section 245C.03, subdivisions 1 and 2, may be retained in a position involving direct contact with persons served by a program or entity identified in section 245C.03, unless the commissioner has provided written notice under section 245C.17 stating that:

(1) the individual may remain in direct contact during the period in which the individual may request reconsideration as provided in section 245C.21, subdivision 2;

(2) the commissioner has set aside the individual's disqualification for that program or entity identified in section 245C.03, as provided in section 245C.22, subdivision 4; or

(3) the license holder has been granted a variance for the disqualified individual under section 245C.30.

(c) Notwithstanding paragraph (a), for the purposes of a background study affiliated with a licensed family foster setting, the commissioner shall disqualify an individual who is the subject of a background study from any position allowing direct contact with persons receiving services from the license holder or entity identified in section 245C.03, upon receipt of information showing or when a background study completed under this chapter shows reason for disqualification under section 245C.15, subdivision 4a.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 37. Minnesota Statutes 2020, section 245C.14, is amended by adding a subdivision to read:

Subd. 4. **Disqualification from working in licensed child care centers or certified license-exempt child care centers.** (a) For a background study affiliated with a licensed child care center or certified license-exempt child care center, if an individual is disqualified from direct contact under subdivision 1, the commissioner must also disqualify the individual

from working in any position regardless of whether the individual would have direct contact with or access to children served in the licensed child care center or certified license-exempt child care center and from having access to a person receiving services from the center.

(b) Notwithstanding any other requirement of this chapter, for a background study affiliated with a licensed child care center or a certified license-exempt child care center, if an individual is disqualified, the individual may not work in the child care center until the commissioner has issued a notice stating that:

(1) the individual is not disqualified;

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

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

Sec. 38. Minnesota Statutes 2020, section 245C.15, is amended by adding a subdivision to read:

Subd. 4a. **Licensed family foster setting disqualifications.** (a) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting, regardless of how much time has passed, an individual is disqualified under section 245C.14 if the individual committed an act that resulted in a felony-level conviction for sections: 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.2112 (criminal vehicular homicide); 609.221 (assault in the first degree); 609.223, subdivision 2 (assault in the third degree, past pattern of child abuse); 609.223, subdivision 3 (assault in the third degree, victim under four); a felony offense under sections 609.2242 and 609.2243 (domestic assault, spousal abuse, child abuse or neglect, or a crime against children); 609.2247 (domestic assault by strangulation); 609.2325 (criminal abuse of a vulnerable adult resulting in the death of a vulnerable adult); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.255 (false imprisonment); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.322, subdivision 1 (solicitation, inducement, and promotion of prostitution; sex trafficking in the first degree); 609.324, subdivision 1 (other prohibited acts; engaging in, hiring, or agreeing to hire minor to engage in prostitution); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second

degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory conduct); 609.352 (solicitation of children to engage in sexual conduct); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.561 (arson in the first degree); 609.582, subdivision 1 (burglary in the first degree); 609.746 (interference with privacy); 617.23 (indecent exposure); 617.246 (use of minors in sexual performance prohibited); or 617.247 (possession of pictorial representations of minors).

(b) Notwithstanding subdivisions 1 to 4, for the purposes of a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14, regardless of how much time has passed, if the individual:

(1) committed an action under paragraph (d) that resulted in death or involved sexual abuse, as defined in section 260E.03, subdivision 20;

(2) committed an act that resulted in a gross misdemeanor-level conviction for section 609.3451 (criminal sexual conduct in the fifth degree);

(3) committed an act against or involving a minor that resulted in a felony-level conviction for: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree); or 609.224 (assault in the fifth degree); or

(4) committed an act that resulted in a misdemeanor or gross misdemeanor-level conviction for section 617.293 (dissemination and display of harmful materials to minors).

(c) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14 if less than 20 years have passed since the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or if the individual consented to a termination of parental rights under section 260C.301, subdivision 1, paragraph (a), to settle a petition to involuntarily terminate parental rights. An individual is disqualified under section 245C.14 if less than 20 years have passed since the termination of the individual's parental rights in any other state or country, where the conditions for the individual's termination of parental rights are substantially similar to the conditions in section 260C.301, subdivision 1, paragraph (b).

(d) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14 if less than five years have passed since a felony-level violation for sections: 152.021 (controlled substance

crime in the first degree); 152.022 (controlled substance crime in the second degree); 152.023 (controlled substance crime in the third degree); 152.024 (controlled substance crime in the fourth degree); 152.025 (controlled substance crime in the fifth degree); 152.0261 (importing controlled substances across state borders); 152.0262, subdivision 1, paragraph (b) (possession of substance with intent to manufacture methamphetamine); 152.027, subdivision 6, paragraph (c) (sale or possession of synthetic cannabinoids); 152.096 (conspiracies prohibited); 152.097 (simulated controlled substances); 152.136 (anhydrous ammonia; prohibited conduct; criminal penalties; civil liabilities); 152.137 (methamphetamine-related crimes involving children or vulnerable adults); 169A.24 (felony first-degree driving while impaired); 243.166 (violation of predatory offender registration requirements); 609.2113 (criminal vehicular operation; bodily harm); 609.2114 (criminal vehicular operation; unborn child); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult not resulting in the death of a vulnerable adult); 609.233 (criminal neglect); 609.235 (use of drugs to injure or facilitate a crime); 609.24 (simple robbery); 609.322, subdivision 1a (solicitation, inducement, and promotion of prostitution; sex trafficking in the second degree); 609.498, subdivision 1 (tampering with a witness in the first degree); 609.498, subdivision 1b (aggravated first-degree witness tampering); 609.562 (arson in the second degree); 609.563 (arson in the third degree); 609.582, subdivision 2 (burglary in the second degree); 609.66 (felony dangerous weapons); 609.687 (adulteration); 609.713 (terroristic threats); 609.749, subdivision 3, 4, or 5 (felony-level harassment or stalking); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); or 624.713 (certain people not to possess firearms).

(e) Notwithstanding subdivisions 1 to 4, except as provided in paragraph (a), for a background study affiliated with a licensed family child foster care license, an individual is disqualified under section 245C.14 if less than five years have passed since:

(1) a felony-level violation for an act not against or involving a minor that constitutes: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the fifth degree);

(2) a violation of an order for protection under section 518B.01, subdivision 14;

(3) a determination or disposition of the individual's failure to make required reports under section 260E.06 or 626.557, subdivision 3, for incidents in which the final disposition under chapter 260E or section 626.557 was substantiated maltreatment and the maltreatment was recurring or serious;

(4) a determination or disposition of the individual's substantiated serious or recurring maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under chapter 260E or section 626.557 and meet the definition of serious maltreatment or recurring maltreatment;

(5) a gross misdemeanor-level violation for sections: 609.224, subdivision 2 (assault in the fifth degree); 609.2242 and 609.2243 (domestic assault); 609.233 (criminal neglect); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.746 (interference with privacy); 609.749 (stalking); or 617.23 (indecent exposure); or

(6) committing an act against or involving a minor that resulted in a misdemeanor-level violation of section 609.224, subdivision 1 (assault in the fifth degree).

(f) For purposes of this subdivision, the disqualification begins from:

(1) the date of the alleged violation, if the individual was not convicted;

(2) the date of conviction, if the individual was convicted of the violation but not committed to the custody of the commissioner of corrections; or

(3) the date of release from prison, if the individual was convicted of the violation and committed to the custody of the commissioner of corrections.

Notwithstanding clause (3), if the individual is subsequently reincarcerated for a violation of the individual's supervised release, the disqualification begins from the date of release from the subsequent incarceration.

(g) An individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota Statutes, permanently disqualifies the individual under section 245C.14. An individual is disqualified under section 245C.14 if less than five years have passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (d) and (e).

(h) An individual's offense in any other state or country, where the elements of the offense are substantially similar to any of the offenses listed in paragraphs (a) and (b), permanently disqualifies the individual under section 245C.14. An individual is disqualified under section 245C.14 if less than five years has passed since an offense in any other state or country, the elements of which are substantially similar to the elements of any offense listed in paragraphs (d) and (e).

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 39. Minnesota Statutes 2020, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people receiving services.

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

(1) the recency of the disqualifying characteristic;

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

(3) the number of disqualifying characteristics;

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

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

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

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

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

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

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

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

(e) Except for paragraph (f), this section does not apply to a background study that is also subject to the requirements under section 256B.0659, subdivisions 11 and 13, for a personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1.

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

Sec. 40. Minnesota Statutes 2020, section 245C.16, subdivision 2, is amended to read:

Subd. 2. **Findings.** (a) After evaluating the information immediately available under subdivision 1, the commissioner may have reason to believe one of the following:

(1) the individual poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact or access to persons served by the program or where the individual studied will work;

(2) the individual poses a risk of harm requiring continuous, direct supervision while providing direct contact services during the period in which the subject may request a reconsideration; or

(3) the individual does not pose an imminent risk of harm or a risk of harm requiring continuous, direct supervision while providing direct contact services during the period in which the subject may request a reconsideration.

(b) After determining an individual's risk of harm under this section, the commissioner must notify the subject of the background study and the applicant or license holder as required under section 245C.17.

(c) For Title IV-E eligible children's residential facilities and foster residence settings, the commissioner is prohibited from making the findings in paragraph (a), clause (2) or (3).

(d) For licensed child care centers or certified license-exempt child care centers, the commissioner is prohibited from making the findings in paragraph (a), clause (2) or (3).

Sec. 41. Minnesota Statutes 2020, section 245C.17, subdivision 1, is amended to read:

Subdivision 1. **Time frame for notice of study results and auditing system access.** (a) Within three working days after the commissioner's receipt of a request for a background study submitted through the commissioner's NETStudy or NETStudy 2.0 system, the commissioner shall notify the background study subject and the license holder or other entity as provided in this chapter in writing or by electronic transmission of the results of the study or that more time is needed to complete the study. The notice to the individual shall include the identity of the entity that initiated the background study.

(b) Before being provided access to NETStudy 2.0, the license holder or other entity under section 245C.04 shall sign an acknowledgment of responsibilities form developed by the commissioner that includes identifying the sensitive background study information person, who must be an employee of the license holder or entity. All queries to NETStudy 2.0 are electronically recorded and subject to audit by the commissioner. The electronic record shall identify the specific user. A background study subject may request in writing to the commissioner a report listing the entities that initiated a background study on the individual.

(c) When the commissioner has completed a prior background study on an individual that resulted in an order for immediate removal and more time is necessary to complete a subsequent study, the notice that more time is needed that is issued under paragraph (a) shall include an order for immediate removal of the individual from any position allowing direct contact with or access to people receiving services and from working in a children's residential facility ~~or~~, foster residence setting, child care center, or certified license-exempt child care center pending completion of the background study.

Sec. 42. Minnesota Statutes 2020, section 245C.17, is amended by adding a subdivision to read:

Subd. 8. **Disqualification notice to child care centers and certified license-exempt child care centers.** (a) For child care centers and certified license-exempt child care centers, all notices under this section that order the license holder to immediately remove the individual studied from any position allowing direct contact with, or access to a person served by the center, must also order the license holder to immediately remove the individual

studied from working in any position regardless of whether the individual would have direct contact with or access to children served in the center.

(b) For child care centers and certified license-exempt child care centers, notices under this section must not allow an individual to work in the center.

Sec. 43. Minnesota Statutes 2020, section 245C.18, is amended to read:

245C.18 OBLIGATION TO REMOVE DISQUALIFIED INDIVIDUAL FROM DIRECT CONTACT AND FROM WORKING IN A PROGRAM, FACILITY, ~~OR~~ SETTING, OR CENTER.

(a) Upon receipt of notice from the commissioner, the license holder must remove a disqualified individual from direct contact with persons served by the licensed program if:

(1) the individual does not request reconsideration under section 245C.21 within the prescribed time;

(2) the individual submits a timely request for reconsideration, the commissioner does not set aside the disqualification under section 245C.22, subdivision 4, and the individual does not submit a timely request for a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14; or

(3) the individual submits a timely request for a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14, and the commissioner does not set aside or rescind the disqualification under section 245A.08, subdivision 5, or 256.045.

(b) For children's residential facility and foster residence setting license holders, upon receipt of notice from the commissioner under paragraph (a), the license holder must also remove the disqualified individual from working in the program, facility, or setting and from access to persons served by the licensed program.

(c) For Title IV-E eligible children's residential facility and foster residence setting license holders, upon receipt of notice from the commissioner under paragraph (a), the license holder must also remove the disqualified individual from working in the program and from access to persons served by the program and must not allow the individual to work in the facility or setting until the commissioner has issued a notice stating that:

(1) the individual is not disqualified;

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

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

(d) For licensed child care center and certified license-exempt child care center license holders, upon receipt of notice from the commissioner under paragraph (a), the license holder must remove the disqualified individual from working in any position regardless of whether the individual would have direct contact with or access to children served in the center and from having access to persons served by the center and must not allow the individual to work in the center until the commissioner has issued a notice stating that:

(1) the individual is not disqualified;

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

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

Sec. 44. Minnesota Statutes 2020, section 245C.24, subdivision 2, is amended to read:

Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in paragraphs (b) to ~~(e)~~ (f), the commissioner may not set aside the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 1.

(b) For an individual in the chemical dependency or corrections field who was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose disqualification was set aside prior to July 1, 2005, the commissioner must consider granting a variance pursuant to section 245C.30 for the license holder for a program dealing primarily with adults. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the license holder that was subject to the prior set-aside decision addressing the individual's quality of care to children or vulnerable adults and the circumstances of the individual's departure from that service.

(c) If an individual who requires a background study for nonemergency medical transportation services under section 245C.03, subdivision 12, was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and if more than 40 years have passed since the discharge of the sentence imposed, the commissioner may consider granting a set-aside pursuant to section 245C.22. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the employer. This paragraph does not apply to a person disqualified based on a violation of sections 243.166; 609.185 to 609.205; 609.25; 609.342 to 609.3453; 609.352; 617.23, subdivision 2, clause (1), or 3, clause (1); 617.246; or 617.247.

(d) When a licensed foster care provider adopts an individual who had received foster care services from the provider for over six months, and the adopted individual is required to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30 to permit the adopted individual with a permanent disqualification to remain affiliated with the license holder under the conditions of the variance when the variance is recommended by the county of responsibility for each of the remaining individuals in placement in the home and the licensing agency for the home.

(e) For an individual 18 years of age or older affiliated with a licensed family foster setting, the commissioner must not set aside or grant a variance for the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 4a, paragraphs (a) and (b).

(f) In connection with a family foster setting license, the commissioner may grant a variance to the disqualification for an individual who is under 18 years of age at the time the background study is submitted.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 45. Minnesota Statutes 2020, section 245C.24, subdivision 3, is amended to read:

Subd. 3. **Ten-year bar to set aside disqualification.** (a) The commissioner may not set aside the disqualification of an individual in connection with a license to provide family child care for children~~, foster care for children in the provider's home,~~ or foster care or day care services for adults in the provider's home if: (1) less than ten years has passed since the discharge of the sentence imposed, if any, for the offense; or (2) when disqualified based on a preponderance of evidence determination under section 245C.14, subdivision 1, paragraph (a), clause (2), or an admission under section 245C.14, subdivision 1, paragraph (a), clause (1), and less than ten years has passed since the individual committed the act or admitted to committing the act, whichever is later; and (3) the individual has committed a violation of any of the following offenses: sections 609.165 (felon ineligible to possess firearm); criminal vehicular homicide or criminal vehicular operation causing death under 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (aiding suicide or aiding attempted suicide); felony violations under 609.223 or 609.2231 (assault in the third or fourth degree); 609.229 (crimes committed for benefit of a gang); 609.713 (terroristic threats); 609.235 (use of drugs to injure or to facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.562 (arson in the second degree); 609.71 (riot);

609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a witness); burglary in the first or second degree under 609.582 (burglary); 609.66 (dangerous weapon); 609.665 (spring guns); 609.67 (machine guns and short-barreled shotguns); 609.749, subdivision 2 (gross misdemeanor harassment); 152.021 or 152.022 (controlled substance crime in the first or second degree); 152.023, subdivision 1, clause (3) or (4) or subdivision 2, clause (4) (controlled substance crime in the third degree); 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree); 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report); 609.265 (abduction); 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree); 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree); 609.268 (injury or death of an unborn child in the commission of a crime); repeat offenses under 617.23 (indecent exposure); 617.293 (disseminating or displaying harmful material to minors); a felony-level conviction involving alcohol or drug use, a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts); a gross misdemeanor offense under 609.378 (neglect or endangerment of a child); a gross misdemeanor offense under 609.377 (malicious punishment of a child); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or 624.713 (certain persons not to possess firearms); or Minnesota Statutes 2012, section 609.21.

(b) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a) as each of these offenses is defined in Minnesota Statutes.

(c) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraph (a).

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 46. Minnesota Statutes 2020, section 245C.24, subdivision 4, is amended to read:

Subd. 4. **Seven-year bar to set aside disqualification.** The commissioner may not set aside the disqualification of an individual in connection with a license to provide family

child care for children~~, foster care for children in the provider's home,~~ or foster care or day care services for adults in the provider's home if within seven years preceding the study:

(1) the individual committed an act that constitutes maltreatment of a child under sections 260E.24, subdivisions 1, 2, and 3, and 260E.30, subdivisions 1, 2, and 4, and the maltreatment resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence; or

(2) the individual was determined under section 626.557 to be the perpetrator of a substantiated incident of maltreatment of a vulnerable adult that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 47. Minnesota Statutes 2020, section 245C.24, is amended by adding a subdivision to read:

Subd. 6. **Five-year bar to set aside disqualification; family foster setting.** (a) The commissioner shall not set aside or grant a variance for the disqualification of an individual 18 years of age or older in connection with a foster family setting license if within five years preceding the study the individual is convicted of a felony in section 245C.15, subdivision 4a, paragraph (d).

(b) In connection with a foster family setting license, the commissioner may set aside or grant a variance to the disqualification for an individual who is under 18 years of age at the time the background study is submitted.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 48. Minnesota Statutes 2020, section 245C.32, subdivision 1a, is amended to read:

Subd. 1a. **NETStudy 2.0 system.** (a) The commissioner shall design, develop, and test the NETStudy 2.0 system and implement it no later than September 1, 2015.

(b) The NETStudy 2.0 system developed and implemented by the commissioner shall incorporate and meet all applicable data security standards and policies required by the Federal Bureau of Investigation (FBI), Department of Public Safety, Bureau of Criminal Apprehension, and the Office of MN.IT Services. The system shall meet all required standards for encryption of data at the database level as well as encryption of data that travels electronically among agencies initiating background studies, the commissioner's

authorized fingerprint collection vendor or vendors, the commissioner, the Bureau of Criminal Apprehension, and in cases involving national criminal record checks, the FBI.

(c) The data system developed and implemented by the commissioner shall incorporate a system of data security that allows the commissioner to control access to the data field level by the commissioner's employees. The commissioner shall establish that employees have access to the minimum amount of private data on any individual as is necessary to perform their duties under this chapter.

(d) The commissioner shall oversee regular quality and compliance audits of the authorized fingerprint collection vendor or vendors.

Sec. 49. Minnesota Statutes 2020, section 245F.04, subdivision 2, is amended to read:

Subd. 2. **Contents of application.** Prior to the issuance of a license, an applicant must submit, on forms provided by the commissioner, documentation demonstrating the following:

(1) compliance with this section;

(2) compliance with applicable building, fire, and safety codes; health rules; zoning ordinances; and other applicable rules and regulations or documentation that a waiver has been granted. The granting of a waiver does not constitute modification of any requirement of this section; and

~~(3) completion of an assessment of need for a new or expanded program as required by Minnesota Rules, part 9530.6800; and~~

~~(4)~~ (3) insurance coverage, including bonding, sufficient to cover all patient funds, property, and interests.

Sec. 50. Minnesota Statutes 2020, section 245G.03, subdivision 2, is amended to read:

Subd. 2. **Application.** (a) Before the commissioner issues a license, an applicant must submit, on forms provided by the commissioner, any documents the commissioner requires.

(b) At least 60 days prior to submitting an application for licensure under this chapter, the applicant must notify the county human services director in writing of the applicant's intent to open a new treatment program. The written notification must include, at a minimum:

(1) a description of the proposed treatment program;

(2) a description of the target population to be served by the treatment program; and

(3) a copy of the program's abuse prevention plan, as required under section 245A.65, subdivision 2.

(c) The county human services director may submit a written statement to the commissioner regarding the county's support of or opposition to the opening of the new treatment program. The written statement must include documentation of the rationale for the county's determination. The commissioner shall consider the county's written statement when determining whether to issue a license for the treatment program. If the county does not submit a written statement, the commissioner shall confirm with the county that the county received the notification required by paragraph (b).

Sec. 51. Minnesota Statutes 2020, section 256B.0949, is amended by adding a subdivision to read:

Subd. 16a. **Background studies.** The requirements for background studies under this section shall be met by an early intensive developmental and behavioral intervention services agency through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 15, and 245C.10, subdivision 17.

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

Sec. 52. Minnesota Statutes 2020, section 260C.215, subdivision 4, is amended to read:

Subd. 4. **Duties of commissioner.** The commissioner of human services shall:

(1) provide practice guidance to responsible social services agencies and licensed child-placing agencies that reflect federal and state laws and policy direction on placement of children;

(2) develop criteria for determining whether a prospective adoptive or foster family has the ability to understand and validate the child's cultural background;

(3) provide a standardized training curriculum for adoption and foster care workers and administrators who work with children. Training must address the following objectives:

(i) developing and maintaining sensitivity to all cultures;

(ii) assessing values and their cultural implications;

(iii) making individualized placement decisions that advance the best interests of a particular child under section 260C.212, subdivision 2; and

(iv) issues related to cross-cultural placement;

(4) provide a training curriculum for all prospective adoptive and foster families that prepares them to care for the needs of adoptive and foster children taking into consideration the needs of children outlined in section 260C.212, subdivision 2, paragraph (b), and, as necessary, preparation is continued after placement of the child and includes the knowledge and skills related to reasonable and prudent parenting standards for the participation of the child in age or developmentally appropriate activities, according to section 260C.212, subdivision 14;

(5) develop and provide to responsible social services agencies and licensed child-placing agencies a home study format to assess the capacities and needs of prospective adoptive and foster families. The format must address problem-solving skills; parenting skills; evaluate the degree to which the prospective family has the ability to understand and validate the child's cultural background, and other issues needed to provide sufficient information for agencies to make an individualized placement decision consistent with section 260C.212, subdivision 2. For a study of a prospective foster parent, the format must also address the capacity of the prospective foster parent to provide a safe, healthy, smoke-free home environment. If a prospective adoptive parent has also been a foster parent, any update necessary to a home study for the purpose of adoption may be completed by the licensing authority responsible for the foster parent's license. If a prospective adoptive parent with an approved adoptive home study also applies for a foster care license, the license application may be made with the same agency which provided the adoptive home study; ~~and~~

(6) consult with representatives reflecting diverse populations from the councils established under sections 3.922 and 15.0145, and other state, local, and community organizations~~.~~; and

(7) establish family foster setting licensing guidelines for county agencies and private agencies designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04. Guidelines that the commissioner establishes under this clause shall be considered directives of the commissioner under section 245A.16.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 53. Laws 2020, First Special Session chapter 7, section 1, as amended by Laws 2020, Third Special Session chapter 1, section 3, is amended by adding a subdivision to read:

Subd. 5. **Waivers and modifications; extension for 180 days.** When the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, waiver CV23: modifying background study requirements, issued by the commissioner of human services pursuant to Executive

Orders 20-11 and 20-12, including any amendments to the modification issued before the peacetime emergency expires, shall remain in effect for 180 days after the peacetime emergency ends.

EFFECTIVE DATE. This section is effective the day following final enactment or retroactively from the date the peacetime emergency declared by the governor in response to the COVID-19 outbreak ends, whichever is earlier.

Sec. 54. **CHILD CARE CENTER REGULATION MODERNIZATION.**

(a) The commissioner of human services shall contract with an experienced and independent organization or individual consultant to conduct the work outlined in this section. If practicable, the commissioner must contract with the National Association for Regulatory Administration.

(b) The consultant must develop a proposal for revised licensing standards that includes a risk-based model for monitoring compliance with child care center licensing standards, grounded in national regulatory best practices. Violations in the new model must be weighted to reflect the potential risk that the violations pose to children's health and safety, and licensing sanctions must be tied to the potential risk. The proposed new model must protect the health and safety of children in child care centers and be child-centered, family-friendly, and fair to providers.

(c) The consultant shall develop and implement a stakeholder engagement process that solicits input from parents, licensed child care centers, staff of the Department of Human Services, and experts in child development about appropriate licensing standards, appropriate tiers for violations of the standards based on the potential risk of harm that each violation poses, and appropriate licensing sanctions for each tier.

(d) The consultant shall solicit input from parents, licensed child care centers, and staff of the Department of Human Services about which child care centers should be eligible for abbreviated inspections that predict compliance with other licensing standards for licensed child care centers using key indicators previously identified by an empirically based statistical methodology developed by the National Association for Regulatory Administration and the Research Institute for Key Indicators.

(e) No later than February 1, 2024, the commissioner shall submit a report and proposed legislation required to implement the new licensing model to the chairs and ranking minority members of the legislative committees with jurisdiction over child care regulation.

Sec. 55. **CHILD FOSTER CARE LICENSING GUIDELINES.**

By July 1, 2023, the commissioner of human services shall, in consultation with stakeholders with expertise in child protection and children's behavioral health, develop family foster setting licensing guidelines for county agencies and private agencies that perform licensing functions. Stakeholders include but are not limited to child advocates, representatives from community organizations, representatives of the state ethnic councils, the ombudsperson for families, family foster setting providers, youth who have experienced family foster setting placements, county child protection staff, and representatives of county and private licensing agencies.

Sec. 56. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; FAMILY CHILD CARE ONE-STOP ASSISTANCE NETWORK.**

By January 1, 2022, the commissioner of human services shall, in consultation with county agencies, providers, and other relevant stakeholders, develop a proposal to create, advertise, and implement a one-stop regional assistance network comprised of individuals who have experience starting a licensed family or group family child care program or technical expertise regarding the applicable licensing statutes and procedures, in order to assist individuals with matters relating to starting or sustaining a licensed family or group family child care program. The proposal shall include an estimated timeline for implementation of the assistance network, an estimated budget of the cost of the assistance network, and any necessary legislative proposals to implement the assistance network. The proposal shall also include a plan to raise awareness and distribute contact information for the assistance network to all licensed family or group family child care providers.

Sec. 57. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; RECOMMENDED FAMILY CHILD CARE ORIENTATION TRAINING.**

(a) By July 1, 2022, the commissioner of human services shall develop, in consultation with licensed family child care providers and representatives from counties, recommended orientation training for family child care license applicants to ensure that all family child care license applicants have access to information about Minnesota Statutes, chapters 245A and 245C, and Minnesota Rules, chapter 9502.

(b) The orientation training is voluntary and completion of the orientation is not required to receive or maintain a family child care license.

Sec. 58. **FAMILY CHILD CARE REGULATION MODERNIZATION.**

(a) The commissioner of human services shall contract with an experienced and independent organization or individual consultant to conduct the work outlined in this section. If practicable, the commissioner must contract with the National Association for Regulatory Administration.

(b) The consultant must develop a proposal for updated family child care licensing standards and solicit input from stakeholders as described in paragraph (d).

(c) The consultant must develop a proposal for a risk-based model for monitoring compliance with family child care licensing standards, grounded in national regulatory best practices. Violations in the new model must be weighted to reflect the potential risk they pose to children's health and safety, and licensing sanctions must be tied to the potential risk. The proposed new model must protect the health and safety of children in family child care programs and be child-centered, family-friendly, and fair to providers.

(d) The consultant shall develop and implement a stakeholder engagement process that solicits input from parents, licensed family child care providers, county licensors, staff of the Department of Human Services, and experts in child development about licensing standards, tiers for violations of the standards based on the potential risk of harm that each violation poses, and licensing sanctions for each tier.

(e) The consultant shall solicit input from parents, licensed family child care providers, county licensors, and staff of the Department of Human Services about which family child care providers should be eligible for abbreviated inspections that predict compliance with other licensing standards for licensed family child care providers using key indicators previously identified by an empirically based statistical methodology developed by the National Association for Regulatory Administration and the Research Institute for Key Indicators.

(f) No later than February 1, 2024, the commissioner shall submit a report and proposed legislation required to implement the new licensing model and the new licensing standards to the chairs and ranking minority members of the legislative committees with jurisdiction over child care regulation.

Sec. 59. **FAMILY CHILD CARE TRAINING ADVISORY COMMITTEE.**

Subdivision 1. **Formation; duties.** (a) The Family Child Care Training Advisory Committee shall advise the commissioner of human services on the training requirements for licensed family and group family child care providers. Beginning January 1, 2022, the

advisory committee shall meet at least twice per year. The advisory committee shall annually elect a chair from among its members who shall establish the agenda for each meeting. The commissioner or commissioner's designee shall attend all advisory committee meetings.

(b) The Family Child Care Training Advisory Committee shall advise and make recommendations to the commissioner of human services and the contractors working on the family child care licensing modernization project on:

(1) updates to the rules and statutes governing family child care training, including technical updates to facilitate providers' understanding of training requirements;

(2) difficulties facing family child care providers in completing training requirements, including proposed solutions to provider difficulties; and

(3) other ideas for improving access to and quality of training for family child care providers.

(c) The Family Child Care Training Advisory Committee shall expire December 1, 2025.

Subd. 2. **Advisory committee members.** (a) The Family Child Care Training Advisory Committee consists of:

(1) four members representing family child care providers from greater Minnesota, including two appointed by the speaker of the house and two appointed by the senate majority leader;

(2) two members representing family child care providers from the seven-county metropolitan area as defined in Minnesota Statutes, section 473.121, subdivision 2, including one appointed by the speaker of the house and one appointed by the senate majority leader;

(3) one member appointed by the Minnesota Association of Child Care Professionals;

(4) one member appointed by the Minnesota Child Care Provider Information Network;

(5) two members appointed by the Association of Minnesota Child Care Licensors, including one from greater Minnesota and one from the seven-county metropolitan area, as defined in Minnesota Statutes, section 473.121, subdivision 2; and

(6) five members with experience in child development, instructional design, and training delivery, with:

(i) one member appointed by Child Care Aware of Minnesota;

(ii) one member appointed by the Minnesota Initiative Foundations;

(iii) one member appointed by the Center for Inclusive Child Care;

(iv) one member appointed by the Greater Minnesota Partnership; and

(v) one member appointed by Achieve, the Minnesota Center for Professional Development.

(b) Advisory committee members shall not be employed by the Department of Human Services. Advisory committee members shall receive no compensation for their participation in the advisory committee.

(c) Advisory committee members must include representatives of diverse cultural communities.

(d) Advisory committee members shall serve two-year terms. Initial appointments to the advisory committee must be made by December 1, 2021. Subsequent appointments to the advisory committee must be made by December 1 of the year in which the member's term expires.

Subd. 3. **Commissioner report.** The commissioner of human services shall report annually by November 1 to the chairs and ranking minority members of the legislative committees with jurisdiction over early care and education programs on any recommendations from the Family Child Care Training Advisory Committee.

Sec. 60. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 245C.02, so that the subdivisions are alphabetical. The revisor shall correct any cross-references that arise as a result of the renumbering.

Sec. 61. **REPEALER.**

(a) Minnesota Statutes 2020, section 245C.10, subdivisions 2, 2a, 3, 4, 5, 6, 7, 8, 9, 9a, 10, 11, 12, 13, 14, and 16, are repealed.

(b) Minnesota Rules, parts 9530.6800; and 9530.6810, are repealed.

EFFECTIVE DATE. Paragraph (b) is effective the day following final enactment.

ARTICLE 3
HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2020, section 62J.495, subdivision 1, is amended to read:

Subdivision 1. **Implementation.** The commissioner of health, in consultation with the e-Health Advisory Committee, shall develop uniform standards to be used for the

interoperable electronic health records system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, and updated on an ongoing basis. ~~The commissioner shall include an update on standards development as part of an annual report to the legislature.~~ Individual health care providers in private practice with no other providers and health care providers that do not accept reimbursement from a group purchaser, as defined in section 62J.03, subdivision 6, are excluded from the requirements of this section.

Sec. 2. Minnesota Statutes 2020, section 62J.495, subdivision 2, is amended to read:

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

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

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

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

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

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

(c) ~~The commissioner shall prepare and issue an annual report not later than January 30 of each year outlining progress to date in implementing a statewide health information infrastructure and recommending action on policy and necessary resources to continue the promotion of adoption and effective use of health information technology.~~

~~(d)~~ This subdivision expires June 30, ~~2021~~ 2031.

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

Sec. 3. Minnesota Statutes 2020, section 62J.495, subdivision 3, is amended to read:

Subd. 3. **Interoperable electronic health record requirements.** (a) Hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(b) The electronic health record must be a qualified electronic health record.

(c) The electronic health record must be certified by the Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(d) The electronic health record must meet the standards established according to section 3004 of the HITECH Act as applicable.

(e) The electronic health record must have the ability to generate information on clinical quality measures and other measures reported under sections 4101, 4102, and 4201 of the HITECH Act.

(f) The electronic health record system must be connected to a state-certified health information organization either directly or through a connection facilitated by a ~~state-certified~~ health data intermediary as defined in section 62J.498.

(g) A health care provider who is a prescriber or dispenser of legend drugs must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 4. Minnesota Statutes 2020, section 62J.495, subdivision 4, is amended to read:

Subd. 4. **Coordination with national HIT activities.** (a) The commissioner, in consultation with the e-Health Advisory Committee, shall update the statewide

implementation plan required under subdivision 2 and released June 2008, to be consistent with the updated federal ~~HIT Strategic Plan released by the Office of the National Coordinator in accordance with section 3001 of the HITECH Act. The statewide plan shall meet the requirements for a plan required under section 3013 of the HITECH Act~~ plans.

(b) The commissioner, in consultation with the e-Health Advisory Committee, shall work to ensure coordination between state, regional, and national efforts to support and accelerate efforts to effectively use health information technology to improve the quality and coordination of health care and the continuity of patient care among health care providers, to reduce medical errors, to improve population health, to reduce health disparities, and to reduce chronic disease. The commissioner's coordination efforts shall include but not be limited to:

~~(1) assisting in the development and support of health information technology regional extension centers established under section 3012(c) of the HITECH Act to provide technical assistance and disseminate best practices;~~

~~(2) providing supplemental information to the best practices gathered by regional centers to ensure that the information is relayed in a meaningful way to the Minnesota health care community;~~

~~(3)~~ (1) providing financial and technical support to Minnesota health care providers to encourage implementation of admission, discharge and transfer alerts, and care summary document exchange transactions and to evaluate the impact of health information technology on cost and quality of care. Communications about available financial and technical support shall include clear information about the interoperable health record requirements in subdivision 1, including a separate statement in bold-face type clarifying the exceptions to those requirements;

~~(4)~~ (2) providing educational resources and technical assistance to health care providers and patients related to state and national privacy, security, and consent laws governing clinical health information, including the requirements in sections 144.291 to 144.298. In carrying out these activities, the commissioner's technical assistance does not constitute legal advice;

~~(5)~~ (3) assessing Minnesota's legal, financial, and regulatory framework for health information exchange, including the requirements in sections 144.291 to 144.298, and making recommendations for modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable; and

~~(6)~~ (4) seeking public input on both patient impact and costs associated with requirements related to patient consent for release of health records for the purposes of treatment, payment, and health care operations, as required in section 144.293, subdivision 2. The commissioner shall provide a report to the legislature on the findings of this public input process no later than February 1, 2017.

(c) The commissioner, in consultation with the e-Health Advisory Committee, shall monitor national activity related to health information technology and shall coordinate statewide input on policy development. The commissioner shall coordinate statewide responses to proposed federal health information technology regulations in order to ensure that the needs of the Minnesota health care community are adequately and efficiently addressed in the proposed regulations. The commissioner's responses may include, but are not limited to:

(1) reviewing and evaluating any standard, implementation specification, or certification criteria proposed by the national HIT standards ~~committee~~ committees;

(2) reviewing and evaluating policy proposed by ~~the~~ national HIT policy ~~committee~~ committees relating to the implementation of a nationwide health information technology infrastructure; and

(3) ~~monitoring and responding to activity related to the development of quality measures and other measures as required by section 4101 of the HITECH Act. Any response related to quality measures shall consider and address the quality efforts required under chapter 62U; and~~

~~(4)~~ monitoring and responding to national activity related to privacy, security, and data stewardship of electronic health information and individually identifiable health information.

(d) To the extent that the state is either required or allowed to apply, or designate an entity to apply for or carry out activities and programs ~~under section 3013 of the HITECH Act~~, the commissioner of health, in consultation with the e-Health Advisory Committee and the commissioner of human services, shall be the lead applicant or sole designating authority. The commissioner shall make such designations consistent with the goals and objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

(e) The commissioner of human services shall apply for funding necessary to administer the incentive payments to providers authorized under title IV of the American Recovery and Reinvestment Act.

~~(f) The commissioner shall include in the report to the legislature information on the activities of this subdivision and provide recommendations on any relevant policy changes that should be considered in Minnesota.~~

Sec. 5. Minnesota Statutes 2020, section 62J.497, subdivision 1, is amended to read:

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

~~(b) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.~~

~~(c)~~ (b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

~~(d)~~ (c) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

~~(e)~~ (d) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

~~(f)~~ (e) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

~~(g)~~ (f) "Electronic prescription drug program" means a program that provides for e-prescribing.

~~(h)~~ (g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

~~(i)~~ (h) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

~~(j)~~ (i) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

~~(k)~~ (j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

~~(l)~~ (k) "NCPDP Formulary and Benefits Standard" means the most recent version of the National Council for Prescription Drug Programs Formulary and Benefits Standard~~,~~ ~~Implementation Guide, Version 1, Release 0, October 2005~~ or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance.

~~(m)~~ (l) "NCPDP SCRIPT Standard" means the most recent version of the National Council for Prescription Drug Programs ~~Prescriber/Pharmacist Interface~~ SCRIPT Standard, ~~Implementation Guide Version 8, Release 1 (Version 8.1), October 2005,~~ or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. ~~Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.~~

~~(n)~~ (m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

~~(o)~~ (n) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

~~(p)~~ (o) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

~~(q)~~ (p) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Sec. 6. Minnesota Statutes 2020, section 62J.497, subdivision 3, is amended to read:

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. ~~The NCPDP SCRIPT Standard shall be used to conduct the following transactions:~~

~~(1) get message transaction;~~

~~(2) status response transaction;~~

~~(3) error response transaction;~~

~~(4) new prescription transaction;~~

~~(5) prescription change request transaction;~~

~~(6) prescription change response transaction;~~

~~(7) refill prescription request transaction;~~

~~(8) refill prescription response transaction;~~

~~(9) verification transaction;~~

~~(10) password change transaction;~~

~~(11) cancel prescription request transaction; and~~

~~(12) cancel prescription response transaction.~~

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

Sec. 7. Minnesota Statutes 2020, section 62J.498, is amended to read:

62J.498 HEALTH INFORMATION EXCHANGE.

Subdivision 1. **Definitions.** (a) The following definitions apply to sections 62J.498 to 62J.4982:

(b) "Clinical data repository" means a real time database that consolidates data from a variety of clinical sources to present a unified view of a single patient and is used by a ~~state-certified~~ health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include clinical data that are

submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

(c) "Clinical transaction" means any meaningful use transaction or other health information exchange transaction that is not covered by section 62J.536.

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

(e) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(f) "Health data intermediary" means an entity that provides the technical capabilities or related products and services to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This includes but is not limited to health information service providers (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries as defined in section 62J.495.

(g) "Health information exchange" means the electronic transmission of health-related information between organizations according to nationally recognized standards.

(h) "Health information exchange service provider" means a health data intermediary or health information organization.

(i) "Health information organization" means an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k), to improve coordination of patient care and the efficiency of health care delivery.

~~(j) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act as defined in section 62J.495.~~

~~(k)~~ (j) "Major participating entity" means:

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health information exchange service provider;

(2) a participating entity providing administrative, financial, or management services to the health information organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health information organization; and

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors or equivalent governing body of the health information organization.

~~(l)~~ (k) "Master patient index" means an electronic database that holds unique identifiers of patients registered at a care facility and is used by a ~~state-certified~~ health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

~~(m) "Meaningful use" means use of certified electronic health record technology to improve quality, safety, and efficiency and reduce health disparities; engage patients and families; improve care coordination and population and public health; and maintain privacy and security of patient health information as established by the Centers for Medicare and Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

~~(n) "Meaningful use transaction" means an electronic transaction that a health care provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

~~(o)~~ (l) "Participating entity" means any of the following persons, health care providers, companies, or other organizations with which a health information organization ~~or health data intermediary~~ has contracts or other agreements for the provision of health information exchange services:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

~~(p)~~ (m) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of clinical transactions.

~~(q) "State-certified health data intermediary" means a health data intermediary that has been issued a certificate of authority to operate in Minnesota.~~

~~(r)~~ (n) "State-certified health information organization" means a health information organization that has been issued a certificate of authority to operate in Minnesota.

Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from ~~health data intermediaries and~~ health information organizations for certificates of authority to operate in Minnesota;

(2) require information to be provided as needed from health information exchange service providers in order to meet requirements established under sections 62J.498 to 62J.4982;

~~(2)~~ (3) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

~~(3)~~ (4) respond to public complaints related to health information exchange services;

~~(4)~~ (5) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

~~(5)~~ (6) provide a biennial report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences; and

~~(6)~~ (7) other duties necessary to protect the public interest.

(b) As part of the application review process for certification under paragraph (a), prior to issuing a certificate of authority, the commissioner shall:

(1) make all portions of the application classified as public data available to the public for at least ten days while an application is under consideration. At the request of the commissioner, the applicant shall participate in a public hearing by presenting an overview of their application and responding to questions from interested parties; and

(2) consult with hospitals, physicians, and other providers prior to issuing a certificate of authority.

(c) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(d) The commissioner may disclose data classified as protected nonpublic or confidential under paragraph (c) if disclosing the data will protect the health or safety of patients.

(e) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

Sec. 8. Minnesota Statutes 2020, section 62J.4981, is amended to read:

62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.

Subdivision 1. **Authority to require organizations to apply.** The commissioner shall require ~~a health data intermediary or~~ a health information organization to apply for a certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is considered a health information exchange service provider whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

~~Subd. 2. **Certificate of authority for health data intermediaries.** (a) A health data intermediary must be certified by the state and comply with requirements established in this section.~~

~~(b) Notwithstanding any law to the contrary, any corporation organized to do so may apply to the commissioner for a certificate of authority to establish and operate as a health data intermediary in compliance with this section. No person shall establish or operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health data intermediary contract unless the organization has a certificate of authority or has an application under active consideration under this section.~~

~~(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:~~

~~(1) hold reciprocal agreements with at least one state-certified health information organization to access patient data, and for the transmission and receipt of clinical transactions. Reciprocal agreements must meet the requirements established in subdivision 5; and~~

~~(2) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability between state-certified health information organizations and state-certified health data intermediaries.~~

Subd. 3. **Certificate of authority for health information organizations.** (a) A health information organization must obtain a certificate of authority from the commissioner and demonstrate compliance with the criteria in paragraph (c).

(b) Notwithstanding any law to the contrary, an organization may apply for a certificate of authority to establish and operate a health information organization under this section. No person shall establish or operate a health information organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health information organization or health information contract unless the organization has a certificate of authority under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

(1) the entity is a legally established organization;

(2) appropriate insurance, including liability insurance, for the operation of the health information organization is in place and sufficient to protect the interest of the public and participating entities;

(3) strategic and operational plans address governance, technical infrastructure, legal and policy issues, finance, and business operations in regard to how the organization will expand to support providers in achieving health information exchange goals over time;

(4) the entity addresses the parameters to be used with participating entities and other health information exchange service providers for clinical transactions, compliance with Minnesota law, and interstate health information exchange trust agreements;

(5) the entity's board of directors or equivalent governing body is composed of members that broadly represent the health information organization's participating entities and consumers;

(6) the entity maintains a professional staff responsible to the board of directors or equivalent governing body with the capacity to ensure accountability to the organization's mission;

(7) the organization is compliant with national certification and accreditation programs designated by the commissioner;

(8) the entity maintains the capability to query for patient information based on national standards. The query capability may utilize a master patient index, clinical data repository, or record locator service as defined in section 144.291, subdivision 2, paragraph (j). The entity must be compliant with the requirements of section 144.293, subdivision 8, when conducting clinical transactions;

(9) the organization demonstrates interoperability with all other state-certified health information organizations using nationally recognized standards;

(10) the organization demonstrates compliance with all privacy and security requirements required by state and federal law; and

(11) the organization uses financial policies and procedures consistent with generally accepted accounting principles and has an independent audit of the organization's financials on an annual basis.

(d) Health information organizations that have obtained a certificate of authority must:

(1) meet the requirements established for connecting to the National eHealth Exchange;

(2) annually submit strategic and operational plans for review by the commissioner that address:

(i) progress in achieving objectives included in previously submitted strategic and operational plans across the following domains: business and technical operations, technical infrastructure, legal and policy issues, finance, and organizational governance;

(ii) plans for ensuring the necessary capacity to support clinical transactions;

(iii) approach for attaining financial sustainability, including public and private financing strategies, and rate structures;

(iv) rates of adoption, utilization, and transaction volume, and mechanisms to support health information exchange; and

(v) an explanation of methods employed to address the needs of community clinics, critical access hospitals, and free clinics in accessing health information exchange services;

(3) enter into reciprocal agreements with all other state-certified health information organizations ~~and state-certified health data intermediaries~~ to enable access to patient data, and for the transmission and receipt of clinical transactions. Reciprocal agreements must meet the requirements in subdivision 5;

(4) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability ~~between state-certified health information organizations and state-certified health data intermediaries~~; and

(5) comply with additional requirements for the certification or recertification of health information organizations that may be established by the commissioner.

Subd. 4. **Application for certificate of authority for health information ~~exchange service providers~~ organizations.** (a) Each application for a certificate of authority shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant. Each application shall include the following in addition to information described in the criteria in ~~subdivisions 2 and~~ subdivision 3:

(1) ~~for health information organizations only,~~ a copy of the basic organizational document, if any, of the applicant and of each major participating entity, such as the articles of incorporation, or other applicable documents, and all amendments to it;

(2) ~~for health information organizations only,~~ a list of the names, addresses, and official positions of the following:

(i) all members of the board of directors or equivalent governing body, and the principal officers and, if applicable, shareholders of the applicant organization; and

(ii) all members of the board of directors or equivalent governing body, and the principal officers of each major participating entity and, if applicable, each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

(3) ~~for health information organizations only,~~ the name and address of each participating entity and the agreed-upon duration of each contract or agreement if applicable;

(4) a copy of each standard agreement or contract intended to bind the participating entities and the health information ~~exchange service provider~~ organization. Contractual provisions shall be consistent with the purposes of this section, in regard to the services to be performed under the standard agreement or contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health information organization, and contractual termination provisions;

(5) a statement generally describing the health information ~~exchange service provider~~ organization, its health information exchange contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide participants with comprehensive health information exchange services;

(6) a statement reasonably describing the geographic area or areas to be served and the type or types of participants to be served;

(7) a description of the complaint procedures to be used as required under this section;

(8) a description of the mechanism by which participating entities will have an opportunity to participate in matters of policy and operation;

(9) a copy of any pertinent agreements between the health information organization and insurers, including liability insurers, demonstrating coverage is in place;

(10) a copy of the conflict of interest policy that applies to all members of the board of directors or equivalent governing body and the principal officers of the health information organization; and

(11) other information as the commissioner may reasonably require to be provided.

(b) Within 45 days after the receipt of the application for a certificate of authority, the commissioner shall determine whether or not the application submitted meets the requirements for completion in paragraph (a), and notify the applicant of any further information required for the application to be processed.

(c) Within 90 days after the receipt of a complete application for a certificate of authority, the commissioner shall issue a certificate of authority to the applicant if the commissioner

determines that the applicant meets the minimum criteria requirements of ~~subdivision 2 for health data intermediaries or~~ subdivision 3 ~~for health information organizations~~. If the commissioner determines that the applicant is not qualified, the commissioner shall notify the applicant and specify the reasons for disqualification.

(d) Upon being granted a certificate of authority to operate as a state-certified health information organization ~~or state-certified health data intermediary~~, the organization must operate in compliance with the provisions of this section. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority according to section 62J.4982.

Subd. 5. **Reciprocal agreements between health information ~~exchange entities~~ organizations.** (a) Reciprocal agreements between two health information organizations ~~or between a health information organization and a health data intermediary~~ must include a fair and equitable model for charges between the entities that:

(1) does not impede the secure transmission of clinical transactions;

(2) does not charge a fee for the exchange of ~~meaningful use~~ transactions transmitted according to nationally recognized standards where no additional value-added service is rendered to the sending or receiving health information organization ~~or health data intermediary~~ either directly or on behalf of the client;

(3) is consistent with fair market value and proportionately reflects the value-added services accessed as a result of the agreement; and

(4) prevents health care stakeholders from being charged multiple times for the same service.

(b) Reciprocal agreements must include comparable quality of service standards that ensure equitable levels of services.

(c) Reciprocal agreements are subject to review and approval by the commissioner.

(d) Nothing in this section precludes a state-certified health information organization ~~or state-certified health data intermediary~~ from entering into contractual agreements for the provision of value-added services ~~beyond meaningful use transactions~~.

Sec. 9. Minnesota Statutes 2020, section 62J.4982, is amended to read:

62J.4982 ENFORCEMENT AUTHORITY; COMPLIANCE.

Subdivision 1. **Penalties and enforcement.** (a) The commissioner may, for any violation of statute or rule applicable to a health information ~~exchange service provider~~ organization,

levy an administrative penalty in an amount up to $25,000 for each violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of participating entities affected by the violation;

(2) the effect of the violation on participating entities' access to health information exchange services;

(3) if only one participating entity is affected, the effect of the violation on the patients of that entity;

(4) whether the violation is an isolated incident or part of a pattern of violations;

(5) the economic benefits derived by the health information organization ~~or a health data intermediary~~ by virtue of the violation;

(6) whether the violation hindered or facilitated an individual's ability to obtain health care;

(7) whether the violation was intentional;

(8) whether the violation was beyond the direct control of the health information ~~exchange service provider~~ organization;

(9) any history of prior compliance with the provisions of this section, including violations;

(10) whether and to what extent the health information ~~exchange service provider~~ organization attempted to correct previous violations;

(11) how the health information ~~exchange service provider~~ organization responded to technical assistance from the commissioner provided in the context of a compliance effort; and

(12) the financial condition of the health information ~~exchange service provider~~ organization including~~,~~ but not limited to~~,~~ whether the health information ~~exchange service provider~~ organization had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information ~~exchange service provider~~ organization to continue to deliver health information exchange services.

The commissioner shall give reasonable notice in writing to the health information ~~exchange service provider~~ organization of the intent to levy the penalty and the reasons for it. A health information ~~exchange service provider~~ organization may have 15 days within which to contest whether the facts found constitute a violation of sections 62J.4981 and

62J.4982, according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(b) If the commissioner has reason to believe that a violation of section 62J.4981 or 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved before commencing action under subdivision 2. The commissioner may notify the health information ~~exchange service provider~~ organization and the representatives, or other persons who appear to be involved in the suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives. The purpose of the conference is to attempt to learn the facts about the suspected violation and, if it appears that a violation has occurred or is threatened, to find a way to correct or prevent it. The conference is not governed by any formal procedural requirements, and may be conducted as the commissioner considers appropriate.

(c) The commissioner may issue an order directing a health information ~~exchange service provider~~ organization or a representative of a health information ~~exchange service provider~~ organization to cease and desist from engaging in any act or practice in violation of sections 62J.4981 and 62J.4982.

(d) Within 20 days after service of the order to cease and desist, a health information ~~exchange service provider~~ organization may contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(e) In the event of noncompliance with a cease and desist order issued under this subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey County District Court.

Subd. 2. **Suspension or revocation of certificates of authority.** (a) The commissioner may suspend or revoke a certificate of authority issued to a ~~health data intermediary or~~ health information organization under section 62J.4981 if the commissioner finds that:

(1) the health information ~~exchange service provider~~ organization is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62J.4981, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the health information ~~exchange service provider~~ organization is unable to fulfill its obligations to furnish comprehensive health information exchange services as required under its health information exchange contract;

(3) the health information ~~exchange service provider~~ organization is no longer financially solvent or may not reasonably be expected to meet its obligations to participating entities;

(4) the health information ~~exchange service provider~~ organization has failed to implement the complaint system in a manner designed to reasonably resolve valid complaints;

(5) the health information ~~exchange service provider~~ organization, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misleading, deceptive, or unfair manner;

(6) the continued operation of the health information ~~exchange service provider~~ organization would be hazardous to its participating entities or the patients served by the participating entities; or

(7) the health information ~~exchange service provider~~ organization has otherwise failed to substantially comply with section 62J.4981 or with any other statute or administrative rule applicable to health information exchange service providers, or has submitted false information in any report required under sections 62J.498 to 62J.4982.

(b) A certificate of authority shall be suspended or revoked only after meeting the requirements of subdivision 3.

(c) If the certificate of authority of a health information ~~exchange service provider~~ organization is suspended, the health information ~~exchange service provider~~ organization shall not, during the period of suspension, enroll any additional participating entities, and shall not engage in any advertising or solicitation.

(d) If the certificate of authority of a health information ~~exchange service provider~~ organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may, by written order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the greatest practical opportunity to access continuing health information exchange services.

Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a) When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, the commissioner shall notify the health information

~~exchange service provider~~ organization in writing stating the grounds for denial, suspension, or revocation and setting a time within 20 days for a hearing on the matter.

(b) After a hearing before the commissioner at which the health information ~~exchange service provider~~ organization may respond to the grounds for denial, suspension, or revocation, or upon the failure of the health information ~~exchange service provider~~ organization to appear at the hearing, the commissioner shall take action as deemed necessary and shall issue written findings and mail them to the health information ~~exchange service provider~~ organization.

(c) If suspension, revocation, or administrative penalty is proposed according to this section, the commissioner must deliver, or send by certified mail with return receipt requested, to the health information ~~exchange service provider~~ organization written notice of the commissioner's intent to impose a penalty. This notice of proposed determination must include:

(1) a reference to the statutory basis for the penalty;

(2) a description of the findings of fact regarding the violations with respect to which the penalty is proposed;

(3) the nature and amount of the proposed penalty;

(4) any circumstances described in subdivision 1, paragraph (a), that were considered in determining the amount of the proposed penalty;

(5) instructions for responding to the notice, including a statement of the health information ~~exchange service provider's~~ organization's right to a contested case proceeding and a statement that failure to request a contested case proceeding within 30 calendar days permits the imposition of the proposed penalty; and

(6) the address to which the contested case proceeding request must be sent.

Subd. 4. **Coordination.** The commissioner shall, to the extent possible, seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the certification and recertification of health information ~~exchange service providers~~ organizations when implementing sections 62J.498 to 62J.4982.

Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every health information ~~exchange service provider~~ organization subject to sections 62J.4981 and 62J.4982 as follows:

(1) filing an application for certificate of authority to operate as a health information organization, $7,000; and

(2) ~~filing an application for certificate of authority to operate as a health data intermediary, $7,000;~~

~~(3)~~ annual health information organization certificate fee, $7,000~~; and~~.

~~(4) annual health data intermediary certificate fee, $7,000.~~

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

(c) Administrative monetary penalties imposed under this subdivision shall be credited to an account in the special revenue fund and are appropriated to the commissioner for the purposes of sections 62J.498 to 62J.4982.

Sec. 10. Minnesota Statutes 2020, section 62J.63, subdivision 1, is amended to read:

Subdivision 1. ~~**Establishment; administration**~~ **Support for state health care purchasing and performance measurement.** The commissioner of health shall ~~establish and administer the Center for Health Care Purchasing Improvement as an administrative unit within the Department of Health. The Center for Health Care Purchasing Improvement shall~~ support the state in its efforts to be a more prudent and efficient purchaser of quality health care services~~. The center shall~~, aid the state in developing and using more common strategies and approaches for health care performance measurement and health care purchasing~~. The common strategies and approaches shall~~, promote greater transparency of health care costs and quality~~,~~ and greater accountability for health care results and improvement~~. The center shall also~~, and identify barriers to more efficient, effective, quality health care and options for overcoming the barriers.

Sec. 11. Minnesota Statutes 2020, section 62J.63, subdivision 2, is amended to read:

Subd. 2. ~~**Staffing;** **Duties; scope.** (a)~~ The commissioner of health may ~~appoint a director, and up to three additional senior-level staff or codirectors, and other staff as needed who are under the direction of the commissioner. The staff of the center are in the unclassified service.~~:

~~(b) With the authorization of the commissioner of health, and in consultation or interagency agreement with the appropriate commissioners of state agencies, the director, or codirectors, may:~~

~~(1) initiate projects to develop plan designs for state health care purchasing;~~

~~(2)~~ (1) require reports or surveys to evaluate the performance of current health care purchasing or administrative simplification strategies;

~~(3)~~ (2) calculate fiscal impacts, including net savings and return on investment, of health care purchasing strategies and initiatives;

~~(4) conduct policy audits of state programs to measure conformity to state statute or other purchasing initiatives or objectives;~~

~~(5)~~ (3) support the Administrative Uniformity Committee under ~~section~~ sections 62J.50 and 62J.536 and other relevant groups or activities to advance agreement on health care administrative process streamlining;

~~(6) consult with the Health Economics Unit of the Department of Health regarding reports and assessments of the health care marketplace;~~

~~(7) consult with the Department of Commerce regarding health care regulatory issues and legislative initiatives;~~

~~(8) work with appropriate Department of Human Services staff and the Centers for Medicare and Medicaid Services to address federal requirements and conformity issues for health care purchasing;~~

~~(9) assist the Minnesota Comprehensive Health Association in health care purchasing strategies;~~

~~(10) convene medical directors of agencies engaged in health care purchasing for advice, collaboration, and exploring possible synergies;~~

~~(11)~~ (4) contact and participate with other relevant health care task forces, study activities, and similar efforts with regard to health care performance measurement and performance-based purchasing; and

~~(12)~~ (5) assist in seeking external funding through appropriate grants or other funding opportunities and may administer grants and externally funded projects.

Sec. 12. **[62J.826] MEDICAL PRACTICES; CURRENT STANDARD CHARGES; COMPARISON TOOL.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Chargemaster" means the list of all individual items and services maintained by a medical practice for which the medical practice has established a charge.

(c) "Diagnostic laboratory testing" means a service charged using a CPT code within the CPT code range of 80047 to 89398.

(d) "Diagnostic radiology service" means a service charged using a CPT code within the CPT code range of 70010 to 7999 and includes the provision of x-rays, computed tomography scans, positron emission tomography scans, magnetic resonance imaging scans, and mammographies.

(e) "Hospital" means an acute care institution licensed under sections 144.50 to 144.58, but does not include a health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination.

(f) "Medical practice" means a business that:

(1) earns revenue by providing medical care to the public;

(2) issues payment claims to health plan companies and other payers; and

(3) may be identified by its federal tax identification number.

(g) "Outpatient surgical center" means a health care facility other than a hospital offering elective outpatient surgery under a license issued under sections 144.50 to 144.58.

Subd. 2. **Requirement; current standard charges.** The following medical practices must make available to the public a list of the medical practice's current standard charges, as reflected in the medical practice's chargemaster, for all items and services provided by the medical practice:

(1) hospitals;

(2) outpatient surgical centers; and

(3) any other medical practice that has revenue of greater than $50,000,000 per year and that derives the majority of the medical practice's revenue by providing one or more of the following services:

(i) diagnostic radiology services;

(ii) diagnostic laboratory testing;

(iii) orthopedic surgical procedures, including joint arthroplasty procedures within the CPT code range of 26990 to 27899;

(iv) ophthalmologic surgical procedures, including cataract surgery coded using CPT code 66982 or 66984, or refractive correction surgery to improve visual acuity;

(v) anesthesia services commonly provided as an ancillary to services provided at a hospital, outpatient surgical center, or medical practice that provides orthopedic surgical procedures or ophthalmologic surgical procedures; or

(vi) oncology services, including radiation oncology treatments within the CPT code range of 77261 to 77799 and drug infusions.

Subd. 3. **Required file format and data attributes.** (a) A medical practice required to post the medical practice's current standard charges must post the following data attributes in the listed order:

(1) federal tax identification number for the medical practice;

(2) name of the medical practice, defined as the provider name that the medical practice enters on the CMS claim form 1500 or a successor form when the medical practice submits health care claims to a payer organization;

(3) internal chargemaster record identification, defined as the internal record identifier for this chargemaster line item in the medical practice's billing system;

(4) service billing code system, defined as a code signifying the HIPAA-compliant billing code system from which the service billing code was drawn;

(5) service billing code, defined as a specific billing code drawn from the service billing code system denoted by the value in the service billing code type field;

(6) service description, defined as the shortest, nonabbreviated official description associated with the service billing code in the applicable service billing code system;

(7) revenue code, defined as the National Uniform Billing Committee revenue code denoting the patient's location within the medical practice where the patient will receive the item or service subject to this charge. This value is required only if the charge amount is dependent on the location within the medical practice where the item or service is provided;

(8) revenue code description, defined as the description provided by the National Uniform Billing Committee for the revenue code. This value is required only if the charge amount is dependent on the location within the medical practice where the item or service is provided;

(9) national drug code, defined as the national drug code for a drug that is administered as part of the service subject to this charge. This field is required only when the charge amount is dependent on which, if any, drug is being administered as part of this service;

(10) national drug code description, defined as the official description associated with the national drug code for a drug that is administered as part of the service subject to this

charge. This field is required only when the charge amount is dependent on which, if any, drug is being administered as part of this service;

(11) inpatient gross charge, defined as the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts as defined in Code of Federal Regulations, title 45, section 180.20, for an item or service provided on an inpatient basis;

(12) outpatient gross charge, defined as the charge for an individual item or service that is reflected on a chargemaster, absent any discounts as defined in Code of Federal Regulations, title 45, section 180.20, for an item or service provided on an outpatient basis;

(13) inpatient discounted cash price, defined as the charge that applies to an individual who pays cash or a cash equivalent for an item or service being reported under this section and provided on an inpatient basis;

(14) outpatient discounted cash price, defined as the charge that applies to an individual who pays cash or a cash equivalent for an item or service being reported under this section and provided on an outpatient basis;

(15) charge unit, defined as the unit cost basis for the charge;

(16) effective date of the charge; and

(17) payer-specific negotiated charges, as defined in Code of Federal Regulations, title 45, section 180.20. There must be a separate field for each payer's rate and the payers must be listed in alphabetical order.

(b) The data attributes specified in paragraph (a) must be posted in the form of a comma-separated values file, with all text values quoted and all leading and trailing white spaces trimmed before and after data attribute values.

(c) The data attributes specified in paragraph (a) must be posted on a web page labeled "Cost of Care at [Name of Medical Practice]" which members of the public can access via a direct, clearly labeled link on the medical practice's main billing web page, and which is searchable by entering the words "cost of care at [name of medical practice]" into an Internet search engine. The consumer-friendly list of standard charges for a limited set of shoppable services required under Code of Federal Regulations, title 45, section 180.60, must be presented on the same web page.

(d) The file must be named according to the following convention: <ein>_<hospital-name>_standardcharges.csv as required by Code of Federal Regulations, title 45, section 180.50.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 13. Minnesota Statutes 2020, section 62U.04, subdivision 4, is amended to read:

Subd. 4. **Encounter data.** (a) ~~Beginning July 1, 2009, and every six months thereafter,~~ All health plan companies and third-party administrators shall submit encounter data on a monthly basis to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home and, for claims incurred on or after January 1, 2019, data deemed necessary by the commissioner to uniquely identify claims in the individual health insurance market; and

(3) except for the identifier described in clause (2), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under section 62J.536.

(b) The commissioner or the commissioner's designee shall only use the data submitted under paragraph (a) to carry out the commissioner's responsibilities in this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the data classifications in this paragraph, data on providers collected under this subdivision may be released or published as authorized in subdivision 11. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner or the commissioner's designee shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commissioner or the commissioner's designee shall not publish analyses or reports that identify, or could potentially identify, individual patients.

(e) The commissioner shall compile summary information on the data submitted under this subdivision. The commissioner shall work with its vendors to assess the data submitted

in terms of compliance with the data submission requirements and the completeness of the data submitted by comparing the data with summary information compiled by the commissioner and with established and emerging data quality standards to ensure data quality.

Sec. 14. Minnesota Statutes 2020, section 62U.04, subdivision 5, is amended to read:

Subd. 5. **Pricing data.** (a) Beginning July 1, 2009, and annually on January 1 thereafter, all health plan companies and third-party administrators shall submit data on their contracted prices with health care providers to a private entity designated by the commissioner of health for the purposes of performing the analyses required under this subdivision. The data shall be submitted in the form and manner specified by the commissioner of health.

(b) The commissioner or the commissioner's designee shall only use the data submitted under this subdivision to carry out the commissioner's responsibilities under this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data collected under this subdivision are nonpublic data as defined in section 13.02. Notwithstanding the data classification in this paragraph, data collected under this subdivision may be released or published as authorized in subdivision 11. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

Sec. 15. Minnesota Statutes 2020, section 62U.04, subdivision 11, is amended to read:

Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's designee shall only use the data submitted under subdivisions 4 and 5 for the following purposes:

(1) to evaluate the performance of the health care home program as authorized under section 62U.03, subdivision 7;

(2) to study, in collaboration with the reducing avoidable readmissions effectively (RARE) campaign, hospital readmission trends and rates;

(3) to analyze variations in health care costs, quality, utilization, and illness burden based on geographical areas or populations;

(4) to evaluate the state innovation model (SIM) testing grant received by the Departments of Health and Human Services, including the analysis of health care cost, quality, and utilization baseline and trend information for targeted populations and communities; and

(5) to compile one or more public use files of summary data or tables that must:

(i) be available to the public for no or minimal cost by March 1, 2016, and available by web-based electronic data download by June 30, 2019;

(ii) not identify individual patients~~,~~ or payers~~, or providers~~ but that may identify the rendering or billing hospital, clinic, or medical practice;

(iii) be updated by the commissioner, at least annually, with the most current data available;

(iv) contain clear and conspicuous explanations of the characteristics of the data, such as the dates of the data contained in the files, the absence of costs of care for uninsured patients or nonresidents, and other disclaimers that provide appropriate context; and

(v) not lead to the collection of additional data elements beyond what is authorized under this section as of June 30, 2015.

(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) ~~so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned~~. The data published under this paragraph may identify hospitals, clinics, and medical practices so long as no individual health professionals are identified and the commissioner finds the data to be accurate, valid, and suitable for publication for such use.

(c) Nothing in this subdivision shall be construed to prohibit the commissioner from using the data collected under subdivision 4 to complete the state-based risk adjustment system assessment due to the legislature on October 1, 2015.

(d) The commissioner or the commissioner's designee may use the data submitted under subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1, 2023.

(e) The commissioner shall consult with the all-payer claims database work group established under subdivision 12 regarding the technical considerations necessary to create the public use files of summary data described in paragraph (a), clause (5).

Sec. 16. Minnesota Statutes 2020, section 103H.201, subdivision 1, is amended to read:

Subdivision 1. **Procedure.** (a) If groundwater quality monitoring results show that there is a degradation of groundwater, the commissioner of health may promulgate health risk limits under subdivision 2 for substances degrading the groundwater.

(b) Health risk limits shall be determined by two methods depending on their toxicological end point.

(c) For systemic toxicants that are not carcinogens, the adopted health risk limits shall be derived using United States Environmental Protection Agency risk assessment methods using a reference dose, a drinking water equivalent, and a relative source contribution factor.

(d) For toxicants that are known or probable carcinogens, the adopted health risk limits shall be derived from a quantitative estimate of the chemical's carcinogenic potency published by the United States Environmental Protection Agency ~~and~~ or determined by the commissioner to have undergone thorough scientific review.

Sec. 17. **[144.066] DISTRIBUTION OF COVID-19 VACCINES.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section and sections 144.0661 to 144.0663.

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

(c) "COVID-19 vaccine" means a vaccine against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

(d) "Department" means the Department of Health.

(e) "Disproportionately impacted community" means a community or population that has been disproportionately and negatively impacted by the COVID-19 pandemic.

(f) "Local health department" has the meaning given in section 145A.02, subdivision 8b.

(g) "Mobile vaccination vehicle" means a vehicle-mounted unit that is either motorized or trailered, that is readily movable without disassembling, and at which vaccines are provided in more than one geographic location.

Subd. 2. **Distribution.** The commissioner shall establish and maintain partnerships or agreements with local health departments; local health care providers, including community health centers and primary care providers; and local pharmacies to administer COVID-19

vaccines throughout the state. COVID-19 vaccines may also be administered via mobile vaccination vehicles authorized under section 144.0662.

Subd. 3. **Second dose or booster.** For all COVID-19 vaccines for which a second dose or booster is required, during the first vaccine appointment the registered vaccine provider should be directed by the department during the vaccine provider registration process to assist vaccine recipients with scheduling an appointment for the second dose or booster. This assistance may be provided during the observation period following vaccine administration.

Subd. 4. **Nondiscrimination.** Nothing in sections 144.066 to 144.0663 shall be construed to allow or require the denial of any benefit or opportunity on the basis of race, color, creed, marital status, status with regard to public assistance, disability, genetic information, sexual orientation, age, religion, national origin, sex, or membership in a local human rights commission.

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

Sec. 18. **[144.0661] EQUITABLE COVID-19 VACCINE DISTRIBUTION.**

Subdivision 1. **COVID-19 vaccination equity and outreach.** The commissioner shall establish positions to continue the department's COVID-19 vaccination equity and outreach activities and to plan and implement actions and programs to overcome disparities in COVID-19 vaccination rates that are rooted in historic and current racism; biases based on ethnicity, income, primary language, immigration status, or disability; geography; or transportation access, language access, or Internet access. This work shall be managed by a director who shall serve in a leadership role in the department's COVID-19 response.

Subd. 2. **Vaccine education and outreach campaign; direct delivery of information.** (a) The commissioner shall administer a COVID-19 vaccine education and outreach campaign that engages in direct delivery of information to members of disproportionately impacted communities. In this campaign, the commissioner shall contract with community-based organizations including community faith-based organizations, tribal governments, local health departments, and local health care providers, including community health centers and primary care providers, to deliver the following information in a culturally relevant and linguistically appropriate manner:

(1) medically and scientifically accurate information on the safety, efficacy, science, and benefits of vaccines generally and COVID-19 vaccines in particular;

(2) information on how members of disproportionately impacted communities may obtain a COVID-19 vaccine including, if applicable, obtaining a vaccine from a mobile vaccination vehicle; and

(3) measures to prevent transmission of COVID-19, including adequate indoor ventilation, wearing face coverings, and physical distancing from individuals outside the household.

(b) This information must be delivered directly by methods that include phone calls, text messages, physically distanced door-to-door and street canvassing, and digital event-based communication involving live and interactive messengers. For purposes of this subdivision, direct delivery shall not include delivery by television, radio, newspaper, or other forms of mass media.

Subd. 3. **Vaccine education and outreach campaign; mass media.** The commissioner shall administer a mass media campaign to provide COVID-19 vaccine education and outreach to members of disproportionately impacted communities. In this campaign, the commissioner shall contract with media vendors to provide the following information to members of disproportionately impacted communities in a manner that is culturally relevant and linguistically appropriate:

(1) medically and scientifically accurate information on the safety, efficacy, science, and benefits of COVID-19 vaccines; and

(2) information on how members of disproportionately impacted communities may obtain a COVID-19 vaccine.

Subd. 4. **Community assistance.** The commissioner shall administer a program to help members of disproportionately impacted communities arrange for and prepare to obtain a COVID-19 vaccine and to support transportation-limited members of these communities with transportation to vaccination appointments or otherwise arrange for vaccine providers to reach members of these communities.

Subd. 5. **Equitable distribution of COVID-19 vaccines.** The commissioner shall establish a set of metrics to measure the equitable distribution of COVID-19 vaccines in the state, and shall set and periodically update goals for COVID-19 vaccine distribution in the state that are focused on equity.

Subd. 6. **Expiration of programs.** The vaccine education and outreach programs in subdivisions 2 and 3 and the community assistance program in subdivision 4 shall operate until a sufficient percentage of individuals in each county or census tract have received the

full series of COVID-19 vaccines to protect individuals in each county or census tract from COVID-19.

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

Sec. 19. **[144.0662] MOBILE VACCINATION PROGRAM.**

Subdivision 1. **Administration.** The commissioner, in partnership with local health departments and the regional health care coalitions, shall administer a mobile vaccination program in which mobile vaccination vehicles are deployed to communities around the state to provide COVID-19 vaccines to individuals. The commissioner shall deploy mobile vaccination vehicles to communities to improve access to vaccines based on factors that include but are not limited to vulnerability, likelihood of exposure, limits to transportation access, rate of vaccine uptake, and limited access to vaccines or barriers to obtaining vaccines.

Subd. 2. **Eligibility.** Notwithstanding the phases and priorities of the state's COVID-19 allocation and prioritization plan or guidance, all individuals in a community to which a mobile vaccination vehicle is deployed shall be eligible to receive COVID-19 vaccines from the vehicle.

Subd. 3. **Staffing.** Each mobile vaccination vehicle must be staffed in accordance with Centers for Disease Control and Prevention guidelines and may be staffed with additional support staff based on needs determined by local request. Additional support staff may include but are not limited to community partners and translators.

Subd. 4. **Second doses.** For vaccine recipients who receive a first dose of a COVID-19 vaccine from a mobile vaccination vehicle, vehicle staff shall provide assistance in scheduling an appointment with a mobile vaccination vehicle or with another vaccine provider for any needed second dose or booster. The commissioner shall, to the extent possible, deploy mobile vaccination vehicles in a manner that allows vaccine recipients to receive second doses or boosters from a mobile vaccination vehicle.

Subd. 5. **Expiration.** The commissioner shall administer the mobile vaccination vehicle program until a sufficient percentage of individuals in each county or census tract have received the full series of COVID-19 vaccines to protect individuals in each county or census tract from the spread of COVID-19.

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

Sec. 20. **[144.0663] COVID-19 VACCINATION PLAN AND DATA; REPORTS.**

Subdivision 1. **COVID-19 vaccination plan; implementation protocols.** The commissioner shall:

(1) publish the set of metrics and goals for equitable COVID-19 vaccine distribution established by the commissioner under section 144.0661, subdivision 5; and

(2) publish implementation protocols to address the disparities in COVID-19 vaccination rates in certain communities and ensure that members of disproportionately impacted communities are given adequate access to COVID-19 vaccines.

Subd. 2. **Data on COVID-19 vaccines.** On at least a weekly basis, the commissioner shall publish on the department website:

(1) data measuring compliance with the set of metrics and goals for equitable COVID-19 vaccine distribution established by the commissioner under section 144.0661, subdivision 5; and

(2) summary data on individuals who have received one or two doses of a COVID-19 vaccine, broken out by race, gender, ethnicity, age within an age range, and zip code.

Subd. 3. **Quarterly reports.** On a quarterly basis while funds are available, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over finance, ways and means, and health care:

(1) funds distributed to local health departments for COVID-19 activities and the sources of the funds; and

(2) funds expended to implement sections 144.066 to 144.0663.

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

Sec. 21. Minnesota Statutes 2020, section 144.0724, subdivision 1, is amended to read:

Subdivision 1. **Resident reimbursement case mix classifications.** The commissioner of health shall establish resident reimbursement case mix classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under this section and according to section 256R.17.

Sec. 22. Minnesota Statutes 2020, section 144.0724, subdivision 2, is amended to read:

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

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

(b) "Case mix index" means the weighting factors assigned to the RUG-IV classifications.

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

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

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

(f) "Resource utilization groups" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by the facility's Minimum Data Set.

(g) "Activities of daily living" ~~means grooming,~~ includes personal hygiene, dressing, bathing, transferring, bed mobility, ~~positioning,~~ locomotion, eating, and toileting.

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

(1) nursing facility services under section 256B.434 or chapter 256R;

(2) elderly waiver services under chapter 256S;

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

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

Sec. 23. Minnesota Statutes 2020, section 144.0724, subdivision 3a, is amended to read:

Subd. 3a. **Resident reimbursement case mix classifications beginning January 1, 2012.** (a) Beginning January 1, 2012, resident reimbursement case mix classifications shall be based on the Minimum Data Set, version 3.0 assessment instrument, or its successor

version mandated by the Centers for Medicare and Medicaid Services that nursing facilities are required to complete for all residents. The commissioner of health shall establish resident classifications according to the RUG-IV, 48 group, resource utilization groups. Resident classification must be established based on the individual items on the Minimum Data Set, which must be completed according to the Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 or its successor issued by the Centers for Medicare and Medicaid Services.

(b) Each resident must be classified based on the information from the Minimum Data Set according to general categories ~~as defined in the Case Mix Classification Manual for Nursing Facilities~~ issued by the Minnesota Department of Health.

Sec. 24. Minnesota Statutes 2020, section 144.0724, subdivision 5, is amended to read:

Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an admission assessment for all residents who stay in the facility 14 days or less~~.~~, unless the resident is admitted and discharged from the facility on the same day, in which case the admission assessment is not required. When an admission assessment is not submitted, the case mix classification shall be the rate with a case mix index of 1.0.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make this election annually.

(c) Nursing facilities must elect one of the options described in paragraphs (a) and (b) by reporting to the commissioner of health, as prescribed by the commissioner. The election is effective on July 1 each year.

Sec. 25. Minnesota Statutes 2020, section 144.0724, subdivision 7, is amended to read:

Subd. 7. **Notice of resident reimbursement case mix classification.** (a) The commissioner of health shall provide to a nursing facility a notice for each resident of the ~~reimbursement~~ classification established under subdivision 1. The notice must inform the resident of the case mix classification ~~that was~~ assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification and the address and telephone number of the Office of Ombudsman for Long-Term Care. The commissioner must transmit the notice of resident classification by electronic means to the nursing facility. ~~A~~ The nursing facility is responsible for the distribution of the notice to

each resident~~, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident~~ or the resident's representative. This notice must be distributed within three ~~working~~ business days after the facility's receipt ~~of the electronic file of notice of case mix classifications from the commissioner of health~~.

(b) If a facility submits a ~~modification to the most recent assessment used to establish a case mix classification conducted under subdivision 3 that results~~ modifying assessment resulting in a change in the case mix classification, the facility ~~shall give~~ must provide a written notice to the resident or the resident's representative ~~about~~ regarding the item or items that ~~was~~ were modified and the reason for the ~~modification~~ modifications. The notice ~~of modified assessment may~~ must be provided ~~at the same time that the resident or resident's representative is provided the resident's modified notice of classification~~ within three business days after distribution of the resident case mix classification notice.

Sec. 26. Minnesota Statutes 2020, section 144.0724, subdivision 8, is amended to read:

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement case mix classification and any item or items changed during the audit process. The request for reconsideration must be submitted in writing to the commissioner ~~within 30 days of the day the resident or the resident's representative receives the resident classification notice~~ of health.

(b) For reconsideration requests initiated by the resident or the resident's representative:

(1) The resident or the resident's representative must submit in writing a reconsideration request to the facility administrator within 30 days of receipt of the resident classification notice. The written request ~~for reconsideration~~ must include the ~~name of the resident, the name and address of the facility in which the resident resides, the~~ reasons for the reconsideration~~, and documentation supporting the~~ request. ~~The documentation accompanying the reconsideration request is limited to a copy of the MDS that determined the classification and other documents that would support or change the MDS findings.~~

(2) Within three business days of receiving the reconsideration request, the nursing facility must submit to the commissioner of health a completed reconsideration request form, a copy of the resident's or resident's representative's written request, and all supporting documentation used to complete the assessment being considered. If the facility fails to provide the required information, the reconsideration will be completed with the information submitted and the facility cannot make further reconsideration requests on this classification.

~~(b)~~ (3) Upon written request and within three business days, the nursing facility must give the resident or the resident's representative a copy of the assessment ~~form~~ being reconsidered and ~~the other~~ all supporting documentation ~~that was given to the commissioner of health~~ used to ~~support~~ complete the assessment ~~findings~~. ~~The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information.~~ Notwithstanding any law to the contrary, the facility may not charge a fee for providing copies of the requested documentation. If a facility fails to provide the ~~material~~ required documents within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information, and ~~that~~ as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) ~~in addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and~~ ~~(iii)~~ For reconsideration requests initiated by the facility:

(1) The facility is required to inform the resident or the resident's representative in writing that a reconsideration of the resident's case mix classification is being requested. The notice must inform the resident or the resident's representative:

(i) of the date and reason for the reconsideration request;

(ii) of the potential for a classification and subsequent rate change;

(iii) of the extent of the potential rate change;

(iv) that copies of the request and supporting documentation are available for review; and

(v) that the resident or the resident's representative has the right to request a reconsideration.

(2) Within 30 days of receipt of the audit exit report or resident classification notice, the facility must submit to the commissioner of health a completed reconsideration request

form, all supporting documentation used to complete the assessment being reconsidered, and a copy of ~~a~~ the notice ~~sent to~~ informing the resident or ~~to~~ the resident's representative~~.~~ ~~This notice must inform the resident or the resident's representative~~ that a reconsideration of the resident's classification is being requested~~, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration~~.

(3) If the facility fails to provide the required information ~~listed in item (iii) with the reconsideration request, the commissioner may request that the facility provide the information within 14 calendar days.~~, the reconsideration request ~~must~~ may be denied ~~if the information is then not provided,~~ and the facility may not make further reconsideration requests on ~~that specific reimbursement~~ this classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the assessment that determined the classification and upon the information provided to the commissioner of health under paragraphs (a) ~~and (b)~~ to (c). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 ~~working~~ business days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect characteristics of the resident at the time of the assessment. ~~The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made.~~ The commissioner must transmit the reconsideration classification notice by electronic means to the nursing facility. The nursing facility is responsible for the distribution of the notice to the resident or the resident's representative. The notice must be distributed by the nursing facility within three business days after receipt. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The ~~resident~~ case mix classification established by the commissioner shall be the classification ~~that~~ which applies to the resident while the request for reconsideration is pending. If a request for reconsideration applies to an assessment used to determine nursing facility level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing facility level of care while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Sec. 27. Minnesota Statutes 2020, section 144.0724, subdivision 9, is amended to read:

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

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

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

(d) The commissioner shall consider documentation under the time frames for coding items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment Instrument User's Manual published by the Centers for Medicare and Medicaid Services.

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

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

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

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

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

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

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

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

(v) a criminal indictment alleging provider fraud;

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

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

(viii) nonsubmission of assessments;

(ix) late submission of assessments; or

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

(f) ~~Within 15 working days of completing the audit process, the commissioner shall make available electronically the results of the audit to the facility. If the results of the audit reflect a change in the resident's case mix classification, a case mix classification notice will be made available electronically to the facility, using the procedure in subdivision 7, paragraph (a). The notice must contain the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility of their right to review the commissioner's documents supporting the classification and to request a reconsideration of the classification. This notice must also include the address and telephone number of the Office of Ombudsman for Long-Term Care.~~ If the audit results in a case mix classification change, the commissioner must transmit the audit classification notice by electronic means to the nursing facility within 15 business days of completing an audit. The nursing facility is responsible for distribution of the notice to each resident or the resident's representative. This notice must be distributed by the nursing facility within three business days after receipt. The notice must inform the resident of the case mix classification assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, the opportunity to request a reconsideration of the classification, and the address and telephone number of the Office of Ombudsman for Long-Term Care.

Sec. 28. Minnesota Statutes 2020, section 144.0724, subdivision 12, is amended to read:

Subd. 12. **Appeal of nursing facility level of care determination.** (a) A resident or prospective resident whose level of care determination results in a denial of long-term care services can appeal the determination as outlined in section 256B.0911, subdivision 3a, paragraph (h), clause (9).

(b) The commissioner of human services shall ensure that notice of changes in eligibility due to a nursing facility level of care determination is provided to each affected recipient or the recipient's guardian at least 30 days before the effective date of the change. The notice shall include the following information:

(1) how to obtain further information on the changes;

(2) how to receive assistance in obtaining other services;

(3) a list of community resources; and

(4) appeal rights.

~~A recipient who meets the criteria in section 256B.0922, subdivision 2, paragraph (a), clauses (1) and (2), may request continued services pending appeal within the time period allowed to request an appeal under section 256.045, subdivision 3, paragraph (i). This paragraph is in effect for appeals filed between January 1, 2015, and December 31, 2016.~~

Sec. 29. Minnesota Statutes 2020, section 144.1205, subdivision 2, is amended to read:

Subd. 2. **Initial and annual fee.** (a) A licensee must pay an initial fee that is equivalent to the annual fee upon issuance of the initial license.

(b) A licensee must pay an annual fee at least 60 days before the anniversary date of the issuance of the license. The annual fee is as follows:

TYPE	~~ANNUAL~~ LICENSE FEE
	~~$19,920~~
Academic broad scope - type A, B, or C	$25,896
~~Academic broad scope - type B~~	~~19,920~~
~~Academic broad scope - type C~~	~~19,920~~
Academic broad scope - type A, B, or C (4-8 locations)	$31,075
Academic broad scope - type A, B, or C (9 or more locations)	$36,254
	~~19,920~~
Medical broad scope - type A	$25,896
Medical broad scope- type A (4-8 locations)	$31,075
Medical broad scope- type A (9 or more locations)	$36,254
~~Medical institution - diagnostic and therapeutic~~	~~3,680~~
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$4,784
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (4-8 locations)	$5,740

Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (9 or more locations)	$6,697
~~Medical institution - diagnostic (no written directives)~~	~~3,680~~
~~Medical private practice - diagnostic and therapeutic~~	~~3,680~~
~~Medical private practice - diagnostic (no written directives)~~	~~3,680~~
~~Eye applicators~~	~~3,680~~
~~Nuclear medical vans~~	~~3,680~~
~~High dose rate afterloader~~	~~3,680~~
~~Mobile high dose rate afterloader~~	~~3,680~~
~~Medical therapy - other emerging technology~~	~~3,680~~
Teletherapy	~~8,960~~ $11,648
Gamma knife	~~8,960~~ $11,648
Veterinary medicine	~~2,000~~ $2,600
In vitro testing lab	~~2,000~~ $2,600
Nuclear pharmacy	~~8,800~~ $11,440
Nuclear pharmacy (5 or more locations)	$13,728
Radiopharmaceutical distribution (10 CFR 32.72)	~~3,840~~ $4,992
Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~8,800~~ $11,440
Radiopharmaceutical processing and distribution (10 CFR 32.72) (5 or more locations)	$13,728
Medical sealed sources - distribution (10 CFR 32.74)	~~3,840~~ $4,992
Medical sealed sources - processing and distribution (10 CFR 32.74)	~~8,800~~ $11,440
Medical sealed sources - processing and distribution (10 CFR 32.74) (5 or more locations)	$13,728
Well logging - sealed sources	~~3,760~~ $4,888
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~2,000~~ $2,600
~~Measuring systems - portable gauge~~	~~2,000~~
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (4-8 locations)	$3,120
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (9 or more locations)	$3,640
X-ray fluorescent analyzer	~~1,520~~ $1,976
~~Measuring systems - gas chromatograph~~	~~2,000~~
~~Measuring systems - other~~	~~2,000~~

~~Broad scope~~ Manufacturing and distribution - type A broad scope	~~19,920~~ $25,896
Manufacturing and distribution - type A broad scope (4-8 locations)	$31,075
Manufacturing and distribution - type A broad scope (9 or more locations)	$36,254
~~Broad scope~~ Manufacturing and distribution - type B or C broad scope	~~17,600~~ $22,880
~~Broad scope Manufacturing and distribution - type C~~	~~17,600~~
Manufacturing and distribution - type B or C broad scope (4-8 locations)	$27,456
Manufacturing and distribution - type B or C broad scope (9 or more locations)	$32,032
Manufacturing and distribution - other	~~5,280~~ $6,864
Manufacturing and distribution - other (4-8 locations)	$8,236
Manufacturing and distribution - other (9 or more locations)	$9,609
Nuclear laundry	~~18,640~~ $24,232
Decontamination services	~~4,960~~ $6,448
Leak test services only	~~2,000~~ $2,600
Instrument calibration service only~~, less than 100 curies~~	~~2,000~~ $2,600
~~Instrument calibration service only, 100 curies or more~~	~~2,000~~
Service, maintenance, installation, source changes, etc.	~~4,960~~ $6,448
Waste disposal service, prepackaged only	~~6,000~~ $7,800
Waste disposal	~~8,320~~ $10,816
Distribution - general licensed devices (sealed sources)	~~1,760~~ $2,288
Distribution - general licensed material (unsealed sources)	~~1,120~~ $1,456
Industrial radiography - fixed or temporary location	~~9,840~~ $12,792
~~Industrial radiography - temporary job sites~~	~~9,840~~
Industrial radiography - fixed or temporary location (5 or more locations)	$16,629
Irradiators, self-shielding~~, less than 10,000 curies~~	~~2,880~~ $3,744
Irradiators, other, less than 10,000 curies	~~5,360~~ $6,968
~~Irradiators, self-shielding, 10,000 curies or more~~	~~2,880~~
Research and development - type A, B, or C broad scope	~~9,520~~ $12,376
~~Research and development - type B broad scope~~	~~9,520~~
~~Research and development - type C broad scope~~	~~9,520~~
Research and development - type A, B, or C broad scope (4-8 locations)	$14,851

Research and development - type A, B, or C broad scope (9 or more locations)	$17,326
Research and development - other	~~4,480~~ $5,824
Storage - no operations	~~2,000~~ $2,600
Source material - shielding	~~584~~ $759
Special nuclear material plutonium - neutron source in device	~~3,680~~ $4,784
Pacemaker by-product and/or special nuclear material - medical (institution)	~~3,680~~ $4,784
Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~5,280~~ $6,864
Accelerator-produced radioactive material	~~3,840~~ $4,992
Nonprofit educational institutions	~~300~~ $500
~~General license registration~~	~~150~~

Sec. 30. Minnesota Statutes 2020, section 144.1205, subdivision 4, is amended to read:

Subd. 4. **Initial and renewal application fee.** A licensee must pay an initial and a renewal application fee ~~as follows:~~ according to this subdivision.

TYPE	APPLICATION FEE
	~~$ 5,920~~
Academic broad scope - type A, B, or C	$6,808
~~Academic broad scope - type B~~	~~5,920~~
~~Academic broad scope - type C~~	~~5,920~~
Medical broad scope - type A	~~3,920~~ $4,508
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$1,748
~~Medical institution - diagnostic and therapeutic~~	~~1,520~~
~~Medical institution - diagnostic (no written directives)~~	~~1,520~~
~~Medical private practice - diagnostic and therapeutic~~	~~1,520~~
~~Medical private practice - diagnostic (no written directives)~~	~~1,520~~
~~Eye applicators~~	~~1,520~~
~~Nuclear medical vans~~	~~1,520~~
~~High dose rate afterloader~~	~~1,520~~
~~Mobile high dose rate afterloader~~	~~1,520~~
~~Medical therapy - other emerging technology~~	~~1,520~~
Teletherapy	~~5,520~~ $6,348
Gamma knife	~~5,520~~ $6,348
Veterinary medicine	~~960~~ $1,104
In vitro testing lab	~~960~~ $1,104

Nuclear pharmacy	~~4,880~~ $5,612
Radiopharmaceutical distribution (10 CFR 32.72)	~~2,160~~ $2,484
Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~4,880~~ $5,612
Medical sealed sources - distribution (10 CFR 32.74)	~~2,160~~ $2,484
Medical sealed sources - processing and distribution (10 CFR 32.74)	~~4,880~~ $5,612
Well logging - sealed sources	~~1,600~~ $1,840
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~960~~ $1,104
~~Measuring systems - portable gauge~~	~~960~~
X-ray fluorescent analyzer	~~584~~ $671
~~Measuring systems - gas chromatograph~~	~~960~~
~~Measuring systems - other~~	~~960~~
~~Broad scope~~ Manufacturing and distribution - type A, B, and C broad scope	~~5,920~~ $6,854
~~Broad scope manufacturing and distribution - type B~~	~~5,920~~
~~Broad scope manufacturing and distribution - type C~~	~~5,920~~
Manufacturing and distribution - other	~~2,320~~ $2,668
Nuclear laundry	~~10,080~~ $11,592
Decontamination services	~~2,640~~ $3,036
Leak test services only	~~960~~ $1,104
Instrument calibration service only~~, less than 100 curies~~	~~960~~ $1,104
~~Instrument calibration service only, 100 curies or more~~	~~960~~
Service, maintenance, installation, source changes, etc.	~~2,640~~ $3,036
Waste disposal service, prepackaged only	~~2,240~~ $2,576
Waste disposal	~~1,520~~ $1,748
Distribution - general licensed devices (sealed sources)	~~880~~ $1,012
Distribution - general licensed material (unsealed sources)	~~520~~ $598
Industrial radiography - fixed or temporary location	~~2,640~~ $3,036
~~Industrial radiography - temporary job sites~~	~~2,640~~
Irradiators, self-shielding~~, less than 10,000 curies~~	~~1,440~~ $1,656
Irradiators, other, less than 10,000 curies	~~2,960~~ $3,404
~~Irradiators, self-shielding, 10,000 curies or more~~	~~1,440~~
Research and development - type A, B, or C broad scope	~~4,960~~ $5,704
~~Research and development - type B broad scope~~	~~4,960~~
~~Research and development - type C broad scope~~	~~4,960~~
Research and development - other	~~2,400~~ $2,760
Storage - no operations	~~960~~ $1,104

Source material - shielding	~~136~~ $156
Special nuclear material plutonium - neutron source in device	~~1,200~~ $1,380
Pacemaker by-product and/or special nuclear material - medical (institution)	~~1,200~~ $1,380
Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~2,320~~ $2,668
Accelerator-produced radioactive material	~~4,100~~ $4,715
Nonprofit educational institutions	~~300~~ $345
~~General license registration~~	~~0~~
~~Industrial radiographer certification~~	~~150~~

Sec. 31. Minnesota Statutes 2020, section 144.1205, subdivision 8, is amended to read:

Subd. 8. **Reciprocity fee.** A licensee submitting an application for reciprocal recognition of a materials license issued by another agreement state or the United States Nuclear Regulatory Commission for a period of 180 days or less during a calendar year must pay ~~$1,200~~ $2,400. For a period of 181 days or more, the licensee must obtain a license under subdivision 4.

Sec. 32. Minnesota Statutes 2020, section 144.1205, subdivision 9, is amended to read:

Subd. 9. **Fees for license amendments.** A licensee must pay a fee of ~~$300~~ $600 to amend a license as follows:

(1) to amend a license requiring review including, but not limited to, addition of isotopes, procedure changes, new authorized users, or a new radiation safety officer; ~~and~~ or

(2) to amend a license requiring review and a site visit including, but not limited to, facility move or addition of processes.

Sec. 33. Minnesota Statutes 2020, section 144.1205, is amended by adding a subdivision to read:

Subd. 10. **Fees for general license registrations.** A person required to register generally licensed devices according to Minnesota Rules, part 4731.3215, must pay an annual registration fee of $450.

Sec. 34. Minnesota Statutes 2020, section 144.125, subdivision 1, is amended to read:

Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a

child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health.

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

(c) The fee to support the newborn screening program, including tests administered under this section and section 144.966, shall be ~~$135~~ $177 per specimen. This fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

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

Sec. 35. **[144.1461] DIGNITY IN PREGNANCY AND CHILDBIRTH.**

Subdivision 1. **Citation.** This section may be cited as the "Dignity in Pregnancy and Childbirth Act."

Subd. 2. **Continuing education requirement.** (a) Hospitals with obstetric care and birth centers must provide continuing education on anti-racism training and implicit bias. The continuing education must be evidence-based and must include at a minimum the following criteria:

(1) education aimed at identifying personal, interpersonal, institutional, structural, and cultural barriers to inclusion;

(2) identifying and implementing corrective measures to promote anti-racism practices and decrease implicit bias at the interpersonal and institutional levels, including the institution's ongoing policies and practices;

(3) providing information on the ongoing effects of historical and contemporary exclusion and oppression of Black and Indigenous communities with the greatest health disparities related to maternal and infant mortality and morbidity;

(4) providing information and discussion of health disparities in the perinatal health care field including how systemic racism and implicit bias have different impacts on health outcomes for different racial and ethnic communities; and

(5) soliciting perspectives of diverse, local constituency groups and experts on racial, identity, cultural, and provider-community relationship issues.

(b) In addition to the initial continuing educational requirement in paragraph (a), hospitals with obstetric care and birth centers must provide an annual refresher course that reflects current trends on race, culture, identity, and anti-racism principles and institutional implicit bias.

(c) Hospitals with obstetric care and birth centers must develop continuing education materials on anti-racism and implicit bias that must be provided and updated annually for direct care employees and contractors who routinely care for patients who are pregnant or postpartum.

(d) Hospitals with obstetric care and birth centers shall coordinate with health-related licensing boards to obtain continuing education credits for the trainings and materials required in this section. The commissioner of health shall monitor compliance with this section. Initial training for the continuing education requirements in this subdivision must be completed by December 31, 2022. The commissioner may inspect the training records or require reports on the continuing education materials in this section from hospitals with obstetric care and birth centers.

(e) A facility described in paragraph (d) must provide a certificate of training completion to another facility or a training attendee upon request. A facility may accept the training certificate from another facility for a health care provider that works in more than one facility.

Sec. 36. Minnesota Statutes 2020, section 144.1481, subdivision 1, is amended to read:

Subdivision 1. **Establishment; membership.** The commissioner of health shall establish a ~~15-member~~ 16-member Rural Health Advisory Committee. The committee shall consist of the following members, all of whom must reside outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2:

(1) two members from the house of representatives of the state of Minnesota, one from the majority party and one from the minority party;

(2) two members from the senate of the state of Minnesota, one from the majority party and one from the minority party;

(3) a volunteer member of an ambulance service based outside the seven-county metropolitan area;

(4) a representative of a hospital located outside the seven-county metropolitan area;

(5) a representative of a nursing home located outside the seven-county metropolitan area;

(6) a medical doctor or doctor of osteopathic medicine licensed under chapter 147;

(7) a dentist licensed under chapter 150A;

(8) a midlevel practitioner;

~~(8)~~ (9) a registered nurse or licensed practical nurse;

~~(9)~~ (10) a licensed health care professional from an occupation not otherwise represented on the committee;

~~(10)~~ (11) a representative of an institution of higher education located outside the seven-county metropolitan area that provides training for rural health care providers; and

~~(11)~~ (12) three consumers, at least one of whom must be an advocate for persons who are mentally ill or developmentally disabled.

The commissioner will make recommendations for committee membership. Committee members will be appointed by the governor. In making appointments, the governor shall ensure that appointments provide geographic balance among those areas of the state outside the seven-county metropolitan area. The chair of the committee shall be elected by the members. The advisory committee is governed by section 15.059, except that the members do not receive per diem compensation.

Sec. 37. Minnesota Statutes 2020, section 144.1501, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Advanced dental therapist" means an individual who is licensed as a dental therapist under section 150A.06, and who is certified as an advanced dental therapist under section 150A.106.

(c) "Alcohol and drug counselor" means an individual who is licensed as an alcohol and drug counselor under chapter 148F.

~~(c)~~ (d) "Dental therapist" means an individual who is licensed as a dental therapist under section 150A.06.

~~(d)~~ (e) "Dentist" means an individual who is licensed to practice dentistry.

~~(e)~~ (f) "Designated rural area" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

~~(f)~~ (g) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

~~(g)~~ (h) "Mental health professional" means an individual providing clinical services in the treatment of mental illness who is qualified in at least one of the ways specified in section 245.462, subdivision 18.

~~(h)~~ (i) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(i)~~ (j) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

~~(j)~~ (k) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

~~(k)~~ (l) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

~~(l)~~ (m) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners.

~~(m)~~ (n) "Pharmacist" means an individual with a valid license issued under chapter 151.

~~(n)~~ (o) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(o)~~ (p) "Physician assistant" means a person licensed under chapter 147A.

~~(p)~~ (q) "Public health nurse" means a registered nurse licensed in Minnesota who has obtained a registration certificate as a public health nurse from the Board of Nursing in accordance with Minnesota Rules, chapter 6316.

~~(q)~~ (r) "Qualified educational loan" means a government, commercial, or foundation loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

~~(r)~~ (s) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations

(MUPs) maintained and updated by the United States Department of Health and Human Services.

Sec. 38. Minnesota Statutes 2020, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents ~~and~~, mental health professionals, and alcohol and drug counselors agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care facility for persons with developmental disability; a hospital if the hospital owns and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home; a housing with services establishment as defined in section 144D.01, subdivision 4; or for a home care provider as defined in section 144A.43, subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(4) for other health care technicians agreeing to teach at least 12 credit hours, or 720 hours per year in their designated field in a postsecondary program at the undergraduate level or the equivalent at the graduate level. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses who agree to practice in designated rural areas; and

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 39. Minnesota Statutes 2020, section 144.1501, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an individual must:

(1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training or education program to become a dentist, dental therapist, advanced dental therapist, mental health professional, alcohol and drug counselor, pharmacist, public health nurse, midlevel practitioner, registered nurse, or a licensed practical nurse. The commissioner may also consider applications submitted by graduates in eligible professions who are licensed and in practice; and

(2) submit an application to the commissioner of health.

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training, with the exception of a nurse, who must agree to serve a minimum two-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training.

Sec. 40. Minnesota Statutes 2020, section 144.1911, subdivision 6, is amended to read:

Subd. 6. **International medical graduate primary care residency grant program and revolving account.** (a) The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. No grant shall exceed $150,000 per residency position per year. Eligible primary care residency grant recipients include accredited family medicine, general surgery, internal medicine, obstetrics and gynecology, psychiatry, and pediatric residency programs. Eligible primary care residency programs shall apply to the commissioner. Applications must include the number of anticipated residents to be funded using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires. Before any funds are distributed, a grant recipient shall provide the commissioner with the following:

(1) a copy of the signed contract between the primary care residency program and the participating international medical graduate;

(2) certification that the participating international medical graduate has lived in Minnesota for at least two years and is certified by the Educational Commission on Foreign Medical Graduates. Residency programs may also require that participating international medical graduates hold a Minnesota certificate of clinical readiness for residency, once the certificates become available; and

(3) verification that the participating international medical graduate has executed a participant agreement pursuant to paragraph (b).

(b) Upon acceptance by a participating residency program, international medical graduates shall enter into an agreement with the commissioner to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of postresidency employment. Participants shall pay $15,000 or ten percent of their annual compensation each year, whichever is less.

(c) A revolving international medical graduate residency account is established as an account in the special revenue fund in the state treasury. The commissioner of management and budget shall credit to the account appropriations, payments, and transfers to the account. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the account. Funds in the account are appropriated annually to the commissioner to award grants and administer the grant program established in paragraph (a). Notwithstanding any law to the contrary, any funds deposited in the account do not expire. The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any grant issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the account, as well as the amount of the contribution provided; and

(3) a contributing entity may not specify that the recipient or recipients of any funds use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

Sec. 41. Minnesota Statutes 2020, section 144.212, is amended by adding a subdivision to read:

Subd. 12. **Homeless youth.** "Homeless youth" has the meaning given in section 256K.45, subdivision 1a.

Sec. 42. Minnesota Statutes 2020, section 144.225, subdivision 2, is amended to read:

Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data pertaining to the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, including the original record of birth and the certified vital record, are confidential data. At the time of the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, the mother may designate demographic data pertaining to the birth as public. Notwithstanding the designation of the data as confidential, it may be disclosed:

(1) to a parent or guardian of the child;

(2) to the child when the child is 16 years of age or older, except as provided in clause (3);

(3) to the child if the child is a homeless youth;

~~(3)~~ (4) under paragraph (b), (e), ~~or~~ (f), or (g); or

~~(4)~~ (5) pursuant to a court order. For purposes of this section, a subpoena does not constitute a court order.

(b) Unless the child is adopted, data pertaining to the birth of a child that are not accessible to the public become public data if 100 years have elapsed since the birth of the child who is the subject of the data, or as provided under section 13.10, whichever occurs first.

(c) If a child is adopted, data pertaining to the child's birth are governed by the provisions relating to adoption records, including sections 13.10, subdivision 5; 144.218, subdivision 1; 144.2252; and 259.89.

(d) The name and address of a mother under paragraph (a) and the child's date of birth may be disclosed to the county social services, tribal health department, or public health member of a family services collaborative for purposes of providing services under section 124D.23.

(e) The commissioner of human services shall have access to birth records for:

(1) the purposes of administering medical assistance and the MinnesotaCare program;

(2) child support enforcement purposes; and

(3) other public health purposes as determined by the commissioner of health.

(f) Tribal child support programs shall have access to birth records for child support enforcement purposes.

(g) An entity administering a children's savings program that starts at birth shall have access to birth records for the purpose of opening an account in the program for the child as a beneficiary. For purposes of this paragraph, "children's savings program" means a long-term savings or investment program that helps children and their families build savings for the future.

Sec. 43. Minnesota Statutes 2020, section 144.225, subdivision 7, is amended to read:

Subd. 7. **Certified birth or death record.** (a) The state registrar or local issuance office shall issue a certified birth or death record or a statement of no vital record found to an individual upon the individual's proper completion of an attestation provided by the commissioner and, except as provided in section 144.2255, payment of the required fee:

(1) to a person who ~~has a tangible interest in the requested vital record. A person who has a tangible interest~~ is:

(i) the subject of the vital record;

(ii) a child of the subject;

(iii) the spouse of the subject;

(iv) a parent of the subject;

(v) the grandparent or grandchild of the subject;

(vi) if the requested record is a death record, a sibling of the subject;

~~(vii) the party responsible for filing the vital record;~~

~~(viii)~~ (vii) the legal custodian, guardian or conservator, or health care agent of the subject;

~~(ix)~~ (viii) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

~~(x)~~ (ix) a successor of the subject, as defined in section 524.1-201, if the subject is deceased, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

~~(xi)~~ (x) if the requested record is a death record, a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust;

~~(xii)~~ (xi) a person or entity who demonstrates that a certified vital record is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner; or

~~(xiii)~~ (xii) an adoption agency in order to complete confidential postadoption searches as required by section 259.83;

(2) to any local, state, tribal, or federal governmental agency upon request if the certified vital record is necessary for the governmental agency to perform its authorized duties;

(3) to an attorney representing the subject of the vital record or another person listed in clause (1), upon evidence of the attorney's license;

(4) pursuant to a court order issued by a court of competent jurisdiction. For purposes of this section, a subpoena does not constitute a court order; or

(5) to a representative authorized by a person under clauses (1) to (4).

(b) The state registrar or local issuance office shall also issue a certified death record to an individual described in paragraph (a), clause (1), items (ii) to ~~(viii)~~ (xi), if, on behalf of the individual, a licensed mortician furnishes the registrar with a properly completed attestation in the form provided by the commissioner within 180 days of the time of death of the subject of the death record. This paragraph is not subject to the requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

Sec. 44. **[144.2255] CERTIFIED BIRTH RECORD FOR HOMELESS YOUTH.**

Subdivision 1. **Application; certified birth record.** A subject of a birth record who is a homeless youth in Minnesota or another state may apply to the state registrar or a local issuance office for a certified birth record according to this section. The state registrar or local issuance office shall issue a certified birth record or statement of no vital record found to a subject of a birth record who submits:

(1) a completed application signed by the subject of the birth record;

(2) a statement that the subject of the birth record is a homeless youth, signed by the subject of the birth record; and

(3) one of the following:

(i) a document of identity listed in Minnesota Rules, part 4601.2600, subpart 8, or, at the discretion of the state registrar or local issuance office, Minnesota Rules, part 4601.2600, subpart 9;

(ii) a statement that complies with Minnesota Rules, part 4601.2600, subparts 6 and 7; or

(iii) a statement verifying that the subject of the birth record is a homeless youth that complies with the requirements in subdivision 2 and is from an employee of a human services agency that receives public funding to provide services to homeless youth, runaway youth, youth with mental illness, or youth with substance use disorders; a school staff person who provides services to homeless youth; or a school social worker.

Subd. 2. **Statement verifying subject is a homeless youth.** A statement verifying that a subject of a birth record is a homeless youth must include:

(1) the following information regarding the individual providing the statement: first name, middle name, if any, and last name; home or business address; telephone number, if any; and e-mail address, if any;

(2) the first name, middle name, if any, and last name of the subject of the birth record; and

(3) a statement specifying the relationship of the individual providing the statement to the subject of the birth record and verifying that the subject of the birth record is a homeless youth.

The individual providing the statement must also provide a copy of the individual's employment identification.

Subd. 3. **Expiration; reissuance.** If a subject of a birth record obtains a certified birth record under this section using the statement specified in subdivision 1, clause (3), item (iii), the certified birth record issued shall expire six months after the date of issuance. Upon expiration of the certified birth record, the subject of the birth record may surrender the expired birth record to the state registrar or a local issuance office and obtain another birth record. Each certified birth record obtained under this subdivision shall expire six months after the date of issuance. If the subject of the birth record does not surrender the expired birth record, the subject may apply for a certified birth record using the process in subdivision 1.

Subd. 4. **Fees waived.** The state registrar or local issuance office shall not charge any fee for issuance of a certified birth record or statement of no vital record found under this section.

Subd. 5. **Data practices.** Data listed under subdivision 1, clauses (2) and (3), item (iii), are private data on individuals.

EFFECTIVE DATE. This section is effective the day following final enactment for applications for and the issuance of certified birth records on or after January 1, 2022.

Sec. 45. Minnesota Statutes 2020, section 144.226, is amended by adding a subdivision to read:

Subd. 7. **Transaction fees.** The state registrar may charge and permit agents to charge a convenience fee and a transaction fee for electronic transactions and transactions by telephone or Internet, as well as the fees established under subdivisions 1 to 4. The convenience fee may not exceed three percent of the cost of the charges for payment. The state registrar may permit agents to charge and retain a transaction fee as payment agreed upon under contract. When an electronic convenience fee or transaction fee is charged, the agent charging the fee is required to post information on their web page informing individuals of the fee. The information must be near the point of payment, clearly visible, include the amount of the fee, and state: "This contracted agent is allowed by state law to charge a convenience fee and transaction fee for this electronic transaction."

Sec. 46. Minnesota Statutes 2020, section 144.226, is amended by adding a subdivision to read:

Subd. 8. **Birth record fees waived for homeless youth.** A subject of a birth record who is a homeless youth shall not be charged any of the fees specified in this section for a certified birth record or statement of no vital record found under section 144.2255.

EFFECTIVE DATE. This section is effective the day following final enactment for applications for and the issuance of certified birth records on or after January 1, 2022.

Sec. 47. Minnesota Statutes 2020, section 144.55, subdivision 4, is amended to read:

Subd. 4. **Routine inspections; presumption.** Any hospital surveyed and accredited under the standards of the hospital accreditation program of an approved accrediting organization that submits to the commissioner within a reasonable time copies of (a) its currently valid accreditation certificate and accreditation letter, together with accompanying recommendations and comments and (b) any further recommendations, progress reports

and correspondence directly related to the accreditation is presumed to comply with application requirements of subdivision 1 and the standards requirements of subdivision 3 and no further routine inspections or accreditation information shall be required by the commissioner to determine compliance. Notwithstanding the provisions of sections 144.54 and 144.653, subdivisions 2 and 4, hospitals shall be inspected only as provided in this section. The provisions of section 144.653 relating to the assessment and collection of fines shall not apply to any hospital. The commissioner of health shall annually conduct, with notice, validation inspections of a selected sample of the number of hospitals accredited by an approved accrediting organization, not to exceed ten percent of accredited hospitals, for the purpose of determining compliance with the provisions of subdivision 3. If a validation survey discloses a failure to comply with subdivision 3, the provisions of section 144.653 relating to correction orders, reinspections, and notices of noncompliance shall apply. The commissioner shall also conduct any inspection necessary to determine whether hospital construction, addition, or remodeling projects comply with standards for construction promulgated in rules pursuant to subdivision 3. The commissioner shall also conduct any inspections necessary to determine whether a hospital or hospital corporate system continues to satisfy the conditions on which a hospital construction moratorium exception was granted under section 144.551. Pursuant to section 144.653, the commissioner shall inspect any hospital that does not have a currently valid hospital accreditation certificate from an approved accrediting organization. Nothing in this subdivision shall be construed to limit the investigative powers of the Office of Health Facility Complaints as established in sections 144A.51 to 144A.54.

Sec. 48. Minnesota Statutes 2020, section 144.55, subdivision 6, is amended to read:

Subd. 6. **Suspension, revocation, and refusal to renew.** (a) The commissioner may refuse to grant or renew, or may suspend or revoke, a license on any of the following grounds:

(1) violation of any of the provisions of sections 144.50 to 144.56 or the rules or standards issued pursuant thereto, or Minnesota Rules, chapters 4650 and 4675;

(2) permitting, aiding, or abetting the commission of any illegal act in the institution;

(3) conduct or practices detrimental to the welfare of the patient; or

(4) obtaining or attempting to obtain a license by fraud or misrepresentation; or

(5) with respect to hospitals and outpatient surgical centers, if the commissioner determines that there is a pattern of conduct that one or more physicians or advanced practice registered nurses who have a "financial or economic interest," as defined in section 144.6521,

subdivision 3, in the hospital or outpatient surgical center, have not provided the notice and disclosure of the financial or economic interest required by section 144.6521.

(b) The commissioner shall not renew a license for a boarding care bed in a resident room with more than four beds.

(c) The commissioner shall not renew licenses for hospital beds issued to a hospital or hospital corporate system pursuant to a hospital construction moratorium exception under section 144.551 if the commissioner determines the hospital or hospital corporate system is not satisfying the conditions on which the exception was granted.

EFFECTIVE DATE. This section is effective for license renewals occurring on or after July 1, 2021.

Sec. 49. Minnesota Statutes 2020, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; ~~and~~ (iv) the relocation or redistribution does not involve the construction of a new hospital building; and (v) the transferred beds are used first to replace within the hospital corporate system the total number of beds previously used in the closed facility site or complex for mental health services and substance use disorder services. Only after the hospital corporate system has fulfilled the requirements of this item may the remainder of the available capacity of the closed facility site or complex be transferred for any other purpose;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds in an existing hospital in Carver County serving the southwest suburban metropolitan area;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

(19) a critical access hospital established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law;

(20) notwithstanding section 144.552, a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

(i) the project, including each hospital or health system that will own or control the entity that will hold the new hospital license, is approved by a resolution of the Maple Grove City Council as of March 1, 2006;

(ii) the entity that will hold the new hospital license will be owned or controlled by one or more not-for-profit hospitals or health systems that have previously submitted a plan or plans for a project in Maple Grove as required under section 144.552, and the plan or plans have been found to be in the public interest by the commissioner of health as of April 1, 2005;

(iii) the new hospital's initial inpatient services must include, but are not limited to, medical and surgical services, obstetrical and gynecological services, intensive care services, orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health services, and emergency room services;

(iv) the new hospital:

(A) will have the ability to provide and staff sufficient new beds to meet the growing needs of the Maple Grove service area and the surrounding communities currently being served by the hospital or health system that will own or control the entity that will hold the new hospital license;

(B) will provide uncompensated care;

(C) will provide mental health services, including inpatient beds;

(D) will be a site for workforce development for a broad spectrum of health-care-related occupations and have a commitment to providing clinical training programs for physicians and other health care providers;

(E) will demonstrate a commitment to quality care and patient safety;

(F) will have an electronic medical records system, including physician order entry;

(G) will provide a broad range of senior services;

(H) will provide emergency medical services that will coordinate care with regional providers of trauma services and licensed emergency ambulance services in order to enhance the continuity of care for emergency medical patients; and

(I) will be completed by December 31, 2009, unless delayed by circumstances beyond the control of the entity holding the new hospital license; and

(v) as of 30 days following submission of a written plan, the commissioner of health has not determined that the hospitals or health systems that will own or control the entity that will hold the new hospital license are unable to meet the criteria of this clause;

(21) a project approved under section 144.553;

(22) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board;

(23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility;

(24) notwithstanding section 144.552, a project for the construction and expansion of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients who are under 21 years of age on the date of admission. The commissioner conducted a public interest review of the mental health needs of Minnesota and the Twin Cities metropolitan area in 2008. No further public interest review shall be conducted for the construction or expansion project under this clause;

(25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city of Maple Grove, exclusively for patients who are under 21 years of age on the date of admission, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(ii) this project shall serve patients in the continuing care benefit program under section 256.9693. The project may also serve patients not in the continuing care benefit program; and

(iii) if the project ceases to participate in the continuing care benefit program, the commissioner must complete a subsequent public interest review under section 144.552. If the project is found not to be in the public interest, the license must be terminated six months from the date of that finding. If the commissioner of human services terminates the contract without cause or reduces per diem payment rates for patients under the continuing care benefit program below the rates in effect for services provided on December 31, 2015, the

project may cease to participate in the continuing care benefit program and continue to operate without a subsequent public interest review;

(27) a project involving the addition of 21 new beds in an existing psychiatric hospital in Hennepin County that is exclusively for patients who are under 21 years of age on the date of admission; ~~or~~

(28) a project to add 55 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which 15 beds are to be used for inpatient mental health and 40 are to be used for other services. In addition, five unlicensed observation mental health beds shall be added~~.~~;

(29) notwithstanding section 144.552, a project to add 45 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5. The commissioner conducted a public interest review of the construction and expansion of this hospital in 2018. No further public interest review shall be conducted for the project under this clause; or

(30) the addition of licensed beds in a hospital or hospital corporate system to primarily provide mental health services or substance use disorder services. In order to add beds under this clause, a hospital must have an emergency department and must not be a hospital that solely provides treatment to adults for mental illnesses or substance use disorders. Beds added under this clause must be available to serve medical assistance and MinnesotaCare enrollees. Notwithstanding section 144.552, public interest review shall not be required for an addition of beds under this clause.

EFFECTIVE DATE. (a) Paragraph (b), clause (29), is effective the day following final enactment, contingent upon:

(1) the addition of the 15 inpatient mental health beds specified in paragraph (b), clause (28), to the Ramsey County level I trauma center's bed capacity;

(2) five of the 45 additional beds authorized in paragraph (b), clause (29), being designated for use for inpatient mental health and added to the hospital's bed capacity before the remaining 40 beds authorized under that clause are added; and

(3) the Ramsey County level I trauma center's agreement to not participate in the Revenue Recapture Act under Minnesota Statutes, chapter 270, and Minnesota Statutes, section 270C.41.

(b) The amendment to paragraph (b), clause (8), and paragraph (b), clause (30), are effective the day following final enactment.

Sec. 50. Minnesota Statutes 2020, section 144.551, is amended by adding a subdivision to read:

Subd. 5. **Monitoring.** The commissioner shall monitor the implementation of exceptions under this section. Each hospital or hospital corporate system granted an exception under this section shall submit to the commissioner each year a report on how the hospital or hospital corporate system continues to satisfy the conditions on which the exception was granted.

Sec. 51. Minnesota Statutes 2020, section 144.555, is amended to read:

144.555 ~~HOSPITAL~~ FACILITY OR CAMPUS CLOSINGS, RELOCATING SERVICES, OR CEASING TO OFFER CERTAIN SERVICES; PATIENT RELOCATIONS.

Subdivision 1. **Notice of closing or curtailing ~~service~~ operations; facilities other than hospitals.** If a facility licensed under sections 144.50 to 144.56, other than a hospital, voluntarily plans to cease operations or to curtail operations to the extent that patients or residents must be relocated, the controlling persons of the facility must notify the commissioner of health at least 90 days before the scheduled cessation or curtailment. The commissioner shall cooperate with the controlling persons and advise them about relocating the patients or residents.

Subd. 1a. **Notice of closing, curtailing operations, relocating services, or ceasing to offer certain services; hospitals.** (a) The controlling persons of a hospital licensed under sections 144.50 to 144.56 or a hospital campus must notify the commissioner of health at least nine months before a scheduled action if the hospital or hospital campus voluntarily plans to:

(1) cease operations;

(2) curtail operations to the extent that patients must be relocated;

(3) relocate the provision of health services to another hospital or another hospital campus; or

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

(b) The commissioner shall cooperate with the controlling persons and advise them about relocating the patients. The controlling persons of the hospital or hospital campus must comply with section 144.556.

Subd. 1b. **Public hearing.** Upon receiving notice under subdivision 1a, the commissioner shall conduct a public hearing on the scheduled cessation of operations, curtailment of operations, relocation of health services, or cessation in offering health services. The commissioner must provide adequate public notice of the hearing in a time and manner determined by the commissioner. The public hearing must be held in the community where the hospital or hospital campus is located at least six months before the scheduled cessation or curtailment of operations, relocation of health services, or cessation in offering health services. The controlling persons of the hospital or hospital campus must participate in the public hearing. The public hearing must include:

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

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

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

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

Subd. 2. **Penalty.** Failure to notify the commissioner under subdivision 1 or 1a or failure to participate in a public hearing under subdivision 1b may result in issuance of a correction order under section 144.653, subdivision 5.

Sec. 52. **[144.556] RIGHT OF FIRST REFUSAL FOR HOSPITAL OR HOSPITAL CAMPUS.**

Subdivision 1. **Prerequisite before sale, conveyance, or ceasing operations of hospital or hospital campus.** The controlling persons of a hospital licensed under sections 144.50 to 144.56 shall not sell or convey the hospital or a campus of the hospital, offer to sell or convey the hospital or hospital campus, or voluntarily cease operations of the hospital or hospital campus unless the controlling persons have first made a good faith offer to sell or convey the hospital or hospital campus to the home rule charter or statutory city, county, town, or hospital district in which the hospital or hospital campus is located.

Subd. 2. **Offer.** The offer to sell or convey the hospital or hospital campus must be at a price that does not exceed the current fair market value of the hospital or hospital campus. A party to whom an offer is made under subdivision 1 must accept or decline the offer within 60 days after receipt. If the party fails to respond within 60 days after receipt, the offer is deemed declined.

Sec. 53. Minnesota Statutes 2020, section 144.9501, subdivision 17, is amended to read:

Subd. 17. **Lead hazard reduction.** "Lead hazard reduction" means abatement or interim controls undertaken to make a residence, child care facility, school, ~~or~~ playground, or other location where lead hazards are identified lead-safe by complying with the lead standards and methods adopted under section 144.9508.

Sec. 54. Minnesota Statutes 2020, section 144.9502, subdivision 3, is amended to read:

Subd. 3. **Reports of blood lead analysis required.** (a) Every hospital, medical clinic, medical laboratory, other facility, or individual performing blood lead analysis shall report the results after the analysis of each specimen analyzed, for both capillary and venous specimens, and epidemiologic information required in this section to the commissioner of health, within the time frames set forth in clauses (1) and (2):

(1) within two working days by telephone, fax, or electronic transmission as prescribed by the commissioner, with written or electronic confirmation within one month as prescribed by the commissioner, for a venous blood lead level equal to or greater than 15 micrograms of lead per deciliter of whole blood; or

(2) within one month in writing or by electronic transmission as prescribed by the commissioner, for any capillary result or for a venous blood lead level less than 15 micrograms of lead per deciliter of whole blood.

(b) If a blood lead analysis is performed outside of Minnesota and the facility performing the analysis does not report the blood lead analysis results and epidemiological information required in this section to the commissioner, the provider who collected the blood specimen must satisfy the reporting requirements of this section. For purposes of this section, "provider" has the meaning given in section 62D.02, subdivision 9.

(c) The commissioner shall coordinate with hospitals, medical clinics, medical laboratories, and other facilities performing blood lead analysis to develop a universal reporting form and mechanism.

Sec. 55. Minnesota Statutes 2020, section 144.9504, subdivision 2, is amended to read:

Subd. 2. **Lead risk assessment.** (a) Notwithstanding section 144.9501, subdivision 6a, for purposes of this subdivision, "child" means an individual under 18 years of age.

(b) An assessing agency shall conduct a lead risk assessment of a residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected according to the venous blood lead level and time frame set forth in clauses (1) to (4) for purposes of secondary prevention:

(1) within 48 hours of a child or pregnant female in the residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected being identified to the agency as having a venous blood lead level equal to or greater than 60 micrograms of lead per deciliter of whole blood;

(2) within five working days of a child or pregnant female in the residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected being identified to the agency as having a venous blood lead level equal to or greater than 45 micrograms of lead per deciliter of whole blood;

~~(3) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level equal to or greater than 15 micrograms of lead per deciliter of whole blood; or~~

~~(4)~~ (3) within ten working days of a child or pregnant female in the residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected being identified to the agency as having a venous blood lead level equal to or greater than ten micrograms of lead per deciliter of whole blood~~.~~; or

(4) within 20 working days of a child or pregnant female in the residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected being identified to the agency as having a venous blood lead level equal to or greater than five micrograms per deciliter of whole blood.

An assessing agency may refer investigations at sites other than the child's or pregnant female's residence to the commissioner.

~~(b)~~ (c) Within the limits of available local, state, and federal appropriations, an assessing agency may also conduct a lead risk assessment for children with any elevated blood lead level.

~~(c)~~ (d) In a building with two or more dwelling units, an assessing agency shall assess the individual unit in which the conditions of this section are met and shall inspect all

common areas accessible to a child. If a child visits one or more other sites such as another residence, or a residential or commercial child care facility, playground, or school, the assessing agency shall also inspect the other sites. The assessing agency shall have one additional day added to the time frame set forth in this subdivision to complete the lead risk assessment for each additional site.

~~(d)~~ (e) Within the limits of appropriations, the assessing agency shall identify the known addresses for the previous 12 months of the child or pregnant female with venous blood lead levels of at least 15 micrograms per deciliter for the child or at least ten micrograms per deciliter for the pregnant female; notify the property owners, landlords, and tenants at those addresses that an elevated blood lead level was found in a person who resided at the property; and give them primary prevention information. Within the limits of appropriations, the assessing agency may perform a risk assessment and issue corrective orders in the properties, if it is likely that the previous address contributed to the child's or pregnant female's blood lead level. The assessing agency shall provide the notice required by this subdivision without identifying the child or pregnant female with the elevated blood lead level. The assessing agency is not required to obtain the consent of the child's parent or guardian or the consent of the pregnant female for purposes of this subdivision. This information shall be classified as private data on individuals as defined under section 13.02, subdivision 12.

~~(e)~~ (f) The assessing agency shall conduct the lead risk assessment according to rules adopted by the commissioner under section 144.9508. An assessing agency shall have lead risk assessments performed by lead risk assessors licensed by the commissioner according to rules adopted under section 144.9508. If a property owner refuses to allow a lead risk assessment, the assessing agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead risk assessment set forth in this subdivision no longer applies. A lead risk assessor or assessing agency may observe the performance of lead hazard reduction in progress and shall enforce the provisions of this section under section 144.9509. Deteriorated painted surfaces, bare soil, and dust must be tested with appropriate analytical equipment to determine the lead content, except that deteriorated painted surfaces or bare soil need not be tested if the property owner agrees to engage in lead hazard reduction on those surfaces. The lead content of drinking water must be measured if another probable source of lead exposure is not identified. Within a standard metropolitan statistical area, an assessing agency may order lead hazard reduction of bare soil without measuring the lead content of the bare soil if the property is in a census tract in which soil sampling has been performed according to rules established by the commissioner and at

least 25 percent of the soil samples contain lead concentrations above the standard in section 144.9508.

~~(f)~~ (g) Each assessing agency shall establish an administrative appeal procedure which allows a property owner to contest the nature and conditions of any lead order issued by the assessing agency. Assessing agencies must consider appeals that propose lower cost methods that make the residence lead safe. The commissioner shall use the authority and appeal procedure granted under sections 144.989 to 144.993.

~~(g)~~ (h) Sections 144.9501 to 144.9512 neither authorize nor prohibit an assessing agency from charging a property owner for the cost of a lead risk assessment.

Sec. 56. Minnesota Statutes 2020, section 144.9504, subdivision 5, is amended to read:

Subd. 5. **Lead orders.** (a) An assessing agency, after conducting a lead risk assessment, shall order a property owner to perform lead hazard reduction on all lead sources that exceed a standard adopted according to section 144.9508. If lead risk assessments and lead orders are conducted at times when weather or soil conditions do not permit the lead risk assessment or lead hazard reduction, external surfaces and soil lead shall be assessed, and lead orders complied with, if necessary, at the first opportunity that weather and soil conditions allow.

(b) If, after conducting a lead risk assessment, an assessing agency determines that the property owner's lead hazard originated from another source location, the assessing agency may order the responsible person of the source location to:

(1) perform lead hazard reduction at the site where the assessing agency conducted the lead risk assessment; and

(2) remediate the conditions at the source location that allowed the lead hazard, pollutant, or contaminant to migrate from the source location.

(c) For purposes of this subdivision, "pollutant or contaminant" has the meaning given in section 115B.02, subdivision 13, and "responsible person" has the meaning given in section 115B.03.

~~(b)~~ (d) If the paint standard under section 144.9508 is violated, but the paint is intact, the assessing agency shall not order the paint to be removed unless the intact paint is a known source of actual lead exposure to a specific person. Before the assessing agency may order the intact paint to be removed, a reasonable effort must be made to protect the child and preserve the intact paint by the use of guards or other protective devices and methods.

~~(c)~~ (e) Whenever windows and doors or other components covered with deteriorated lead-based paint have sound substrate or are not rotting, those components should be repaired, sent out for stripping or planed down to remove deteriorated lead-based paint, or covered with protective guards instead of being replaced, provided that such an activity is the least cost method. However, a property owner who has been ordered to perform lead hazard reduction may choose any method to address deteriorated lead-based paint on windows, doors, or other components, provided that the method is approved in rules adopted under section 144.9508 and that it is appropriate to the specific property.

~~(d)~~ (f) Lead orders must require that any source of damage, such as leaking roofs, plumbing, and windows, be repaired or replaced, as needed, to prevent damage to lead-containing interior surfaces.

~~(e)~~ (g) The assessing agency is not required to pay for lead hazard reduction. The assessing agency shall enforce the lead orders issued to a property owner under this section.

Sec. 57. Minnesota Statutes 2020, section 144G.08, subdivision 7, as amended by Laws 2020, Seventh Special Session chapter 1, article 6, section 5, is amended to read:

Subd. 7. **Assisted living facility.** "Assisted living facility" means ~~a facility that~~ an establishment where an operating person or legal entity, either directly or through contract, business relationship, or common ownership with another person or entity, provides sleeping accommodations and assisted living services to one or more adults in the facility. Assisted living facility includes assisted living facility with dementia care, and does not include:

(1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361;

(2) a nursing home licensed under chapter 144A;

(3) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56;

(4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D or 245G;

(5) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D;

(6) a private home in which the residents are related by kinship, law, or affinity with the provider of services;

(7) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593;

(9) a setting offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing;

(10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services;

(11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q;

(12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56;

(13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011;

~~(14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b);~~ or

~~(15)~~ (14) any establishment that exclusively or primarily serves as a shelter or temporary shelter for victims of domestic or any other form of violence.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 58. Minnesota Statutes 2020, section 144G.84, is amended to read:

144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA.

(a) In addition to the minimum services required in section 144G.41, an assisted living facility with dementia care must also provide the following services:

(1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities;

(2) nonpharmacological practices that are person-centered and evidence-informed;

(3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings; and

(4) services that provide residents with choices for meaningful engagement with other facility residents and the broader community.

(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:

(1) past and current interests;

(2) current abilities and skills;

(3) emotional and social needs and patterns;

(4) physical abilities and limitations;

(5) adaptations necessary for the resident to participate; and

(6) identification of activities for behavioral interventions.

(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.

(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:

(1) occupation or chore related tasks;

(2) scheduled and planned events such as entertainment or outings;

(3) spontaneous activities for enjoyment or those that may help defuse a behavior;

(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;

(5) spiritual, creative, and intellectual activities;

(6) sensory stimulation activities;

(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and

(8) a resident's individualized activity plan for regular outdoor ~~activities~~ activity.

(e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated.

(f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly.

(g) ~~Access to secured outdoor space and walkways that allow residents to enter and return without staff assistance must be provided.~~ Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 59. **[145.87] HOME VISITING FOR PREGNANT WOMEN AND FAMILIES WITH YOUNG CHILDREN.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section and have the meanings given them.

(b) "Evidence-based home visiting program" means a program that:

(1) is based on a clear, consistent program or model that is research-based and grounded in relevant, empirically based knowledge;

(2) is linked to program-determined outcomes and is associated with a national organization, institution of higher education, or national or state public health institute;

(3) has comprehensive home visitation standards that ensure high-quality service delivery and continuous quality improvement;

(4) has demonstrated significant, sustained positive outcomes; and

(5) either:

(i) has been evaluated using rigorous randomized controlled research designs and the evaluation results have been published in a peer-reviewed journal; or

(ii) is based on quasi-experimental research using two or more separate, comparable client samples.

(c) "Evidence-informed home visiting program" means a program that:

(1) has data or evidence demonstrating effectiveness at achieving positive outcomes for pregnant women and young children; and

(2) either:

(i) has an active evaluation of the program; or

(ii) has a plan and timeline for an active evaluation of the program to be conducted.

(d) "Health equity" means every individual has a fair opportunity to attain the individual's full health potential and no individual is disadvantaged from achieving this potential.

(e) "Promising practice home visiting program" means a program that has shown improvement toward achieving positive outcomes for pregnant women or young children.

Subd. 2. **Grants for home visiting programs.** (a) The commissioner of health shall award grants to community health boards, nonprofit organizations, and tribal nations to start up or expand voluntary home visiting programs serving pregnant women and families with young children. Home visiting programs supported under this section shall provide voluntary home visits by early childhood professionals or health professionals, including but not limited to nurses, social workers, early childhood educators, and trained paraprofessionals. Grant money shall be used to:

(1) establish or expand evidence-based, evidence-informed, or promising practice home visiting programs that address health equity and utilize community-driven health strategies;

(2) serve families with young children or pregnant women who have high needs or are high-risk, including but not limited to a family with low income, a parent or pregnant woman with a mental illness or a substance use disorder, or a parent or pregnant woman experiencing housing instability or domestic abuse; and

(3) improve program outcomes in two or more of the following areas:

(i) maternal and newborn health;

(ii) school readiness and achievement;

(iii) family economic self-sufficiency;

(iv) coordination and referral for other community resources and supports;

(v) reduction in child injuries, abuse, or neglect; or

(vi) reduction in crime or domestic violence.

(b) Grants awarded to evidence-informed and promising practice home visiting programs must include money to evaluate program outcomes for up to four of the areas listed in paragraph (a), clause (3).

Subd. 3. **Grant prioritization.** (a) In awarding grants, the commissioner shall give priority to community health boards, nonprofit organizations, and tribal nations seeking to expand home visiting services with community or regional partnerships.

(b) The commissioner shall allocate at least 75 percent of the grant money awarded each grant cycle to evidence-based home visiting programs that address health equity and up to 25 percent of the grant money awarded each grant cycle to evidence-informed or promising practice home visiting programs that address health equity and utilize community-driven health strategies.

Subd. 4. **Administrative costs.** The commissioner may use up to seven percent of the annual appropriation under this section to provide training and technical assistance and to administer and evaluate the program. The commissioner may contract for training, capacity-building support for grantees or potential grantees, technical assistance, and evaluation support.

Subd. 5. **Use of state general fund appropriations.** Appropriations dedicated to establishing or expanding evidence-based home visiting programs shall, for grants awarded on or after July 1, 2021, be awarded according to this section. This section shall not govern grant awards of federal funds for home visiting programs and shall not govern grant awards using state general fund appropriations dedicated to establishing or expanding nurse-family partnership home visiting programs.

Sec. 60. Minnesota Statutes 2020, section 145.893, subdivision 1, is amended to read:

Subdivision 1. ~~**Vouchers**~~ **Food benefits.** An eligible individual shall receive ~~vouchers~~ food benefits for the purchase of specified nutritional supplements in type and quantity approved by the commissioner. Alternate forms of delivery may be developed by the commissioner in appropriate cases.

Sec. 61. Minnesota Statutes 2020, section 145.894, is amended to read:

145.894 STATE COMMISSIONER OF HEALTH; DUTIES, RESPONSIBILITIES.

The commissioner of health shall:

(1) develop a comprehensive state plan for the delivery of nutritional supplements to pregnant and lactating women, infants, and children;

(2) contract with existing local public or private nonprofit organizations for the administration of the nutritional supplement program;

(3) develop and implement a public education program promoting the provisions of sections 145.891 to 145.897, and provide for the delivery of individual and family nutrition education and counseling at project sites. The education programs must include a campaign to promote breast feeding;

(4) develop in cooperation with other agencies and vendors a uniform state ~~voucher~~ food benefit system for the delivery of nutritional supplements;

(5) authorize local health agencies to issue ~~vouchers bimonthly~~ food benefits trimonthly to some or all eligible individuals served by the agency, provided the agency demonstrates that the federal minimum requirements for providing nutrition education will continue to be met and that the quality of nutrition education and health services provided by the agency will not be adversely impacted;

(6) investigate and implement a system to reduce the cost of nutritional supplements and maintain ongoing negotiations with nonparticipating manufacturers and suppliers to maximize cost savings;

(7) develop, analyze, and evaluate the health aspects of the nutritional supplement program and establish nutritional guidelines for the program;

(8) apply for, administer, and annually expend at least 99 percent of available federal or private funds;

(9) aggressively market services to eligible individuals by conducting ongoing outreach activities and by coordinating with and providing marketing materials and technical assistance to local human services and community service agencies and nonprofit service providers;

(10) determine, on July 1 of each year, the number of pregnant women participating in each special supplemental food program for women, infants, and children (WIC) ~~and, in 1986, 1987, and 1988, at the commissioner's discretion, designate a different food program~~

~~deliverer if the current deliverer fails to increase the participation of pregnant women in the program by at least ten percent over the previous year's participation rate~~;

(11) promulgate all rules necessary to carry out the provisions of sections 145.891 to 145.897; and

(12) ensure that any state appropriation to supplement the federal program is spent consistent with federal requirements.

Sec. 62. Minnesota Statutes 2020, section 145.897, is amended to read:

145.897 ~~VOUCHERS~~ FOOD BENEFITS.

~~Vouchers~~ Food benefits issued pursuant to sections 145.891 to 145.897 shall be only for the purchase of those foods determined by the ~~commissioner~~ United States Department of Agriculture to be desirable nutritional supplements for pregnant and lactating women, infants and children. ~~These foods shall include, but not be limited to, iron fortified infant formula, vegetable or fruit juices, cereal, milk, cheese, and eggs.~~

Sec. 63. Minnesota Statutes 2020, section 145.899, is amended to read:

145.899 WIC ~~VOUCHERS~~ FOOD BENEFITS FOR ORGANICS.

~~Vouchers~~ Food benefits for the special supplemental nutrition program for women, infants, and children (WIC) may be used to purchase cost-neutral organic WIC allowable food. The commissioner of health shall regularly evaluate the list of WIC allowable food in accordance with federal requirements and shall add to the list any organic WIC allowable foods determined to be cost-neutral.

Sec. 64. Minnesota Statutes 2020, section 145.901, subdivision 2, is amended to read:

Subd. 2. **Access to data.** (a) The commissioner of health has access to medical data as defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined in section 13.83, subdivision 1, and health records created, maintained, or stored by providers ~~as defined in section 144.291, subdivision 2, paragraph (i),~~ without the consent of the subject of the data, and without the consent of the parent, spouse, other guardian, or legal representative of the subject of the data, when the subject of the data is a woman who died during a pregnancy or within 12 months of a fetal death, a live birth, or other termination of a pregnancy.

The commissioner has access only to medical data and health records related to deaths that occur on or after July 1, 2000, including the names of the providers, clinics, or other

health services such as family home visiting programs; the women, infants, and children (WIC) program; prescription monitoring programs; and behavioral health services, where care was received before, during, or related to the pregnancy or death. The commissioner has access to records maintained by a medical examiner, a coroner, or hospitals or to hospital discharge data, for the purpose of providing the name and location of any pre-pregnancy, prenatal, or other care received by the subject of the data up to one year after the end of the pregnancy.

(b) The provider or responsible authority that creates, maintains, or stores the data shall furnish the data upon the request of the commissioner. The provider or responsible authority may charge a fee for providing the data, not to exceed the actual cost of retrieving and duplicating the data.

(c) The commissioner shall make a good faith reasonable effort to notify the parent, spouse, other guardian, or legal representative of the subject of the data before collecting data on the subject. For purposes of this paragraph, "reasonable effort" means one notice is sent by certified mail to the last known address of the parent, spouse, guardian, or legal representative informing the recipient of the data collection and offering a public health nurse support visit if desired.

(d) The commissioner does not have access to coroner or medical examiner data that are part of an active investigation as described in section 13.83.

(e) The commissioner may request and receive from a coroner or medical examiner the name of the health care provider that provided prenatal, postpartum, or other health services to the subject of the data.

(f) The commissioner may access Department of Human Services data to identify sources of care and services to assist with the evaluation of welfare systems, including housing, to reduce preventable maternal deaths.

(g) The commissioner may request and receive law enforcement reports or incident reports related to the subject of the data.

Sec. 65. Minnesota Statutes 2020, section 145.901, subdivision 4, is amended to read:

Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source records under subdivision 2, including identifying information on individual providers, data subjects, or their children, and data derived by the commissioner under subdivision 3 for the purpose of carrying out maternal death studies, are classified as confidential data on

individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3, and 13.10, subdivision 1, paragraph (a).

(b) Information classified under paragraph (a) shall not be subject to discovery or introduction into evidence in any administrative, civil, or criminal proceeding. Such information otherwise available from an original source shall not be immune from discovery or barred from introduction into evidence merely because it was utilized by the commissioner in carrying out maternal death studies.

(c) Summary data on maternal death studies created by the commissioner, which does not identify individual data subjects or individual providers, shall be public in accordance with section 13.05, subdivision 7.

(d) Data provided by the commissioner of human services to the commissioner of health under this section retain the same classification the data held when retained by the commissioner of human services, as required under section 13.03, subdivision 4, paragraph (c).

Sec. 66. **[145.9013] SEVERE MATERNAL MORBIDITY STUDIES.**

Subdivision 1. **Purpose.** (a) The commissioner of health may conduct maternal morbidity studies to assist the planning, implementation, and evaluation of medical, health, and welfare service systems and to reduce the numbers of preventable adverse maternal outcomes in Minnesota.

(b) For purposes of this section, "maternal morbidity" has the meaning given to severe maternal morbidity by the Centers for Disease Control and Prevention and includes an unexpected outcome of labor or delivery that results in significant short- or long-term consequences to a woman's health.

Subd. 2. **Access to data.** (a) The commissioner has access to medical data as defined in section 13.384, subdivision 1, paragraph (b), and health records created, maintained, or stored by providers when the subject of the data experienced one or more maternal morbidities during a pregnancy or within 12 months of the end of a pregnancy. The commissioner has access only to medical data and health records related to maternal morbidities that occur on or after January 1, 2015, including the names of providers and clinics where care was received before, during, or related to the pregnancy. The commissioner has access to records maintained by family home visiting programs; the women, infants, and children (WIC) program; prescription monitoring programs; behavioral health services programs; substance use disorder treatment facilities; and hospitals for the purpose of

providing the name and location of any pre-pregnancy, prenatal, or other care received by the subject of the data up to one year following the end of the pregnancy.

(b) The provider or responsible authority that creates, maintains, or stores the data under paragraph (a) shall provide the commissioner with access to information on each maternal morbidity case in the manner and at times that the commissioner designates. The provider or responsible authority may charge a fee for providing the data, not to exceed the actual cost of retrieving and duplicating the data.

(c) Once the commissioner has determined that the subject of the data meets the criteria in paragraph (a) for a maternal morbidity review, the commissioner must inform the subject of the data about the collection of the subject's data under this section. At any time during the maternal morbidity review process, the subject of the data may request in writing, using a form prescribed by the commissioner, that the commissioner remove the subject of the data's personal identifying information from data obtained by the commissioner under this section. The commissioner must comply with such requests. For purposes of this paragraph, "inform the subject of the data about the collection of the subject's data" means one notice sent by certified mail to the last known address of the subject of the data.

(d) The subject of the data may voluntarily participate in an informant interview with staff on behalf of the commissioner related to the maternal experience. If the subject of the data agrees to the interview, the commissioner may compensate the subject of the data for time and other expenses related to the interview.

(e) The commissioner may access Department of Human Services data to identify sources of care and services to assist with the evaluation of welfare systems to reduce preventable maternal morbidities.

Subd. 3. **Management of records.** After the commissioner has collected all data about a subject of a maternal morbidity study needed to perform the study, the data from source records obtained under subdivision 2, other than data identifying the subject, must be transferred to separate records to be maintained by the commissioner. Notwithstanding section 138.17, after the data has been transferred, all source records obtained under subdivision 2 possessed by the commissioner must be destroyed.

Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source records under subdivision 2, including identifying information on individual providers, data subjects, or their children, and data derived by the commissioner under subdivision 3 for the purpose of carrying out maternal morbidity studies, are classified as confidential data

on individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3, and 13.10, subdivision 1, paragraph (a).

(b) Information classified under paragraph (a) shall not be subject to discovery or introduction into evidence in any administrative, civil, or criminal proceeding. Such information otherwise available from an original source shall not be immune from discovery or barred from introduction into evidence merely because the information was utilized by the commissioner in carrying out maternal morbidity studies.

(c) Summary data on maternal morbidity studies created by the commissioner, which does not identify individual data subjects or individual providers, shall be public in accordance with section 13.05, subdivision 7.

(d) Data provided by the commissioner of human services to the commissioner of health under this section retains the same classification the data held when retained by the commissioner of human services, as required under section 13.03, subdivision 4, paragraph (c).

Sec. 67. Minnesota Statutes 2020, section 152.01, subdivision 23, is amended to read:

Subd. 23. **Analog.** (a) Except as provided in paragraph (b), "analog" means a substance, the chemical structure of which is substantially similar to the chemical structure of a controlled substance in Schedule I or II:

(1) that has a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance in Schedule I or II; or

(2) with respect to a particular person, if the person represents or intends that the substance have a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance in Schedule I or II.

(b) "Analog" does not include:

(1) a controlled substance;

(2) any substance for which there is an approved new drug application under the Federal Food, Drug, and Cosmetic Act; ~~or~~

(3) with respect to a particular person, any substance, if an exemption is in effect for investigational use, for that person, as provided by United States Code, title 21, section 355, and the person is registered as a controlled substance researcher as required under section

152.12, subdivision 3, to the extent conduct with respect to the substance is pursuant to the exemption and registration; or

(4) marijuana or tetrahydrocannabinols naturally contained in a plant of the genus cannabis or in the resinous extractives of the plant.

EFFECTIVE DATE. This section is effective August 1, 2021, and applies to crimes committed on or after that date.

Sec. 68. Minnesota Statutes 2020, section 152.02, subdivision 2, is amended to read:

Subd. 2. **Schedule I.** (a) Schedule I consists of the substances listed in this subdivision.

(b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the following substances, including their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the analogs, isomers, esters, ethers, and salts is possible:

(1) acetylmethadol;

(2) allylprodine;

(3) alphacetylmethadol (except levo-alphacetylmethadol, also known as levomethadyl acetate);

(4) alphameprodine;

(5) alphamethadol;

(6) alpha-methylfentanyl benzethidine;

(7) betacetylmethadol;

(8) betameprodine;

(9) betamethadol;

(10) betaprodine;

(11) clonitazene;

(12) dextromoramide;

(13) diampromide;

(14) diethyliambutene;

(15) difenoxin;

(16) dimenoxadol;

(17) dimepheptanol;

(18) dimethyliambutene;

(19) dioxaphetyl butyrate;

(20) dipipanone;

(21) ethylmethylthiambutene;

(22) etonitazene;

(23) etoxeridine;

(24) furethidine;

(25) hydroxypethidine;

(26) ketobemidone;

(27) levomoramide;

(28) levophenacylmorphan;

(29) 3-methylfentanyl;

(30) acetyl-alpha-methylfentanyl;

(31) alpha-methylthiofentanyl;

(32) benzylfentanyl beta-hydroxyfentanyl;

(33) beta-hydroxy-3-methylfentanyl;

(34) 3-methylthiofentanyl;

(35) thenylfentanyl;

(36) thiofentanyl;

(37) para-fluorofentanyl;

(38) morpheridine;

(39) 1-methyl-4-phenyl-4-propionoxypiperidine;

(40) noracymethadol;

(41) norlevorphanol;

(42) normethadone;

(43) norpipanone;

(44) 1-(2-phenylethyl)-4-phenyl-4-acetoxypiperidine (PEPAP);

(45) phenadoxone;

(46) phenampromide;

(47) phenomorphan;

(48) phenoperidine;

(49) piritramide;

(50) proheptazine;

(51) properidine;

(52) propiram;

(53) racemoramide;

(54) tilidine;

(55) trimeperidine;

(56) N-(1-Phenethylpiperidin-4-yl)-N-phenylacetamide (acetyl fentanyl);

(57) 3,4-dichloro-N-[(1R,2R)-2-(dimethylamino)cyclohexyl]-N-methylbenzamide(U47700);

(58) N-phenyl-N-[1-(2-phenylethyl)piperidin-4-yl]furan-2-carboxamide(furanylfentanyl);

(59) 4-(4-bromophenyl)-4-dimethylamino-1-phenethylcyclohexanol (bromadol);

(60) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide (Cyclopropryl fentanyl);

(61) N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide) (butyryl fentanyl);

(62) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine) (MT-45);

(63) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide (cyclopentyl fentanyl);

(64) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide (isobutyryl fentanyl);

(65) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide (valeryl fentanyl);

(66) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (para-chloroisobutyryl fentanyl);

(67) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-fluorobutyryl fentanyl);

(68) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-methoxybutyryl fentanyl);

(69) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide (ocfentanil);

(70) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (4-fluoroisobutyryl fentanyl or para-fluoroisobutyryl fentanyl);

(71) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide (acryl fentanyl or acryloylfentanyl);

(72) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide (methoxyacetyl fentanyl);

(73) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide (ortho-fluorofentanyl or 2-fluorofentanyl);

(74) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide (tetrahydrofuranyl fentanyl); and

(75) Fentanyl-related substances, their isomers, esters, ethers, salts and salts of isomers, esters and ethers, meaning any substance not otherwise listed under another federal Administration Controlled Substance Code Number or not otherwise listed in this section, and for which no exemption or approval is in effect under section 505 of the Federal Food, Drug, and Cosmetic Act, United States Code , title 21, section 355, that is structurally related to fentanyl by one or more of the following modifications:

(i) replacement of the phenyl portion of the phenethyl group by any monocycle, whether or not further substituted in or on the monocycle;

(ii) substitution in or on the phenethyl group with alkyl, alkenyl, alkoxyl, hydroxyl, halo, haloalkyl, amino, or nitro groups;

(iii) substitution in or on the piperidine ring with alkyl, alkenyl, alkoxyl, ester, ether, hydroxyl, halo, haloalkyl, amino, or nitro groups;

(iv) replacement of the aniline ring with any aromatic monocycle whether or not further substituted in or on the aromatic monocycle; or

(v) replacement of the N-propionyl group by another acyl group.

(c) Opium derivatives. Any of the following substances, their analogs, salts, isomers, and salts of isomers, unless specifically excepted or unless listed in another schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) acetorphine;

(2) acetyldihydrocodeine;

(3) benzylmorphine;

(4) codeine methylbromide;

(5) codeine-n-oxide;

(6) cyprenorphine;

(7) desomorphine;

(8) dihydromorphine;

(9) drotebanol;

(10) etorphine;

(11) heroin;

(12) hydromorphinol;

(13) methyldesorphine;

(14) methyldihydromorphine;

(15) morphine methylbromide;

(16) morphine methylsulfonate;

(17) morphine-n-oxide;

(18) myrophine;

(19) nicocodeine;

(20) nicomorphine;

(21) normorphine;

(22) pholcodine; and

(23) thebacon.

(d) Hallucinogens. Any material, compound, mixture or preparation which contains any quantity of the following substances, their analogs, salts, isomers (whether optical, positional,

or geometric), and salts of isomers, unless specifically excepted or unless listed in another schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) methylenedioxy amphetamine;

(2) methylenedioxymethamphetamine;

(3) methylenedioxy-N-ethylamphetamine (MDEA);

(4) n-hydroxy-methylenedioxyamphetamine;

(5) 4-bromo-2,5-dimethoxyamphetamine (DOB);

(6) 2,5-dimethoxyamphetamine (2,5-DMA);

(7) 4-methoxyamphetamine;

(8) 5-methoxy-3, 4-methylenedioxyamphetamine;

(9) alpha-ethyltryptamine;

(10) bufotenine;

(11) diethyltryptamine;

(12) dimethyltryptamine;

(13) 3,4,5-trimethoxyamphetamine;

(14) 4-methyl-2, 5-dimethoxyamphetamine (DOM);

(15) ibogaine;

(16) lysergic acid diethylamide (LSD);

(17) mescaline;

(18) parahexyl;

(19) N-ethyl-3-piperidyl benzilate;

(20) N-methyl-3-piperidyl benzilate;

(21) psilocybin;

(22) psilocyn;

(23) tenocyclidine (TPCP or TCP);

(24) N-ethyl-1-phenyl-cyclohexylamine (PCE);

(25) 1-(1-phenylcyclohexyl) pyrrolidine (PCPy);

(26) 1-[1-(2-thienyl)cyclohexyl]-pyrrolidine (TCPy);

(27) 4-chloro-2,5-dimethoxyamphetamine (DOC);

(28) 4-ethyl-2,5-dimethoxyamphetamine (DOET);

(29) 4-iodo-2,5-dimethoxyamphetamine (DOI);

(30) 4-bromo-2,5-dimethoxyphenethylamine (2C-B);

(31) 4-chloro-2,5-dimethoxyphenethylamine (2C-C);

(32) 4-methyl-2,5-dimethoxyphenethylamine (2C-D);

(33) 4-ethyl-2,5-dimethoxyphenethylamine (2C-E);

(34) 4-iodo-2,5-dimethoxyphenethylamine (2C-I);

(35) 4-propyl-2,5-dimethoxyphenethylamine (2C-P);

(36) 4-isopropylthio-2,5-dimethoxyphenethylamine (2C-T-4);

(37) 4-propylthio-2,5-dimethoxyphenethylamine (2C-T-7);

(38) 2-(8-bromo-2,3,6,7-tetrahydrofuro [2,3-f][1]benzofuran-4-yl)ethanamine (2-CB-FLY);

(39) bromo-benzodifuranyl-isopropylamine (Bromo-DragonFLY);

(40) alpha-methyltryptamine (AMT);

(41) N,N-diisopropyltryptamine (DiPT);

(42) 4-acetoxy-N,N-dimethyltryptamine (4-AcO-DMT);

(43) 4-acetoxy-N,N-diethyltryptamine (4-AcO-DET);

(44) 4-hydroxy-N-methyl-N-propyltryptamine (4-HO-MPT);

(45) 4-hydroxy-N,N-dipropyltryptamine (4-HO-DPT);

(46) 4-hydroxy-N,N-diallyltryptamine (4-HO-DALT);

(47) 4-hydroxy-N,N-diisopropyltryptamine (4-HO-DiPT);

(48) 5-methoxy-N,N-diisopropyltryptamine (5-MeO-DiPT);

(49) 5-methoxy-α-methyltryptamine (5-MeO-AMT);

(50) 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT);

(51) 5-methylthio-N,N-dimethyltryptamine (5-MeS-DMT);

(52) 5-methoxy-N-methyl-N-isopropyltryptamine (5-MeO-MiPT);

(53) 5-methoxy-α-ethyltryptamine (5-MeO-AET);

(54) 5-methoxy-N,N-dipropyltryptamine (5-MeO-DPT);

(55) 5-methoxy-N,N-diethyltryptamine (5-MeO-DET);

(56) 5-methoxy-N,N-diallyltryptamine (5-MeO-DALT);

(57) methoxetamine (MXE);

(58) 5-iodo-2-aminoindane (5-IAI);

(59) 5,6-methylenedioxy-2-aminoindane (MDAI);

(60) 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe);

(61) 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe);

(62) 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe);

(63) 2-(2,5-Dimethoxyphenyl)ethanamine (2C-H);

(64) 2-(4-Ethylthio-2,5-dimethoxyphenyl)ethanamine (2C-T-2);

(65) N,N-Dipropyltryptamine (DPT);

(66) 3-[1-(Piperidin-1-yl)cyclohexyl]phenol (3-HO-PCP);

(67) N-ethyl-1-(3-methoxyphenyl)cyclohexanamine (3-MeO-PCE);

(68) 4-[1-(3-methoxyphenyl)cyclohexyl]morpholine (3-MeO-PCMo);

(69) 1-[1-(4-methoxyphenyl)cyclohexyl]-piperidine (methoxydine, 4-MeO-PCP);

(70) 2-(2-Chlorophenyl)-2-(ethylamino)cyclohexan-1-one (N-Ethylnorketamine, ethketamine, NENK);

(71) methylenedioxy-N,N-dimethylamphetamine (MDDMA);

(72) 3-(2-Ethyl(methyl)aminoethyl)-1H-indol-4-yl (4-AcO-MET); and

(73) 2-Phenyl-2-(methylamino)cyclohexanone (deschloroketamine).

(e) Peyote. All parts of the plant presently classified botanically as Lophophora williamsii Lemaire, whether growing or not, the seeds thereof, any extract from any part of the plant, and every compound, manufacture, salts, derivative, mixture, or preparation of the plant, its seeds or extracts. The listing of peyote as a controlled substance in Schedule I does not apply to the nondrug use of peyote in bona fide religious ceremonies of the American Indian Church, and members of the American Indian Church are exempt from registration. Any

person who manufactures peyote for or distributes peyote to the American Indian Church, however, is required to obtain federal registration annually and to comply with all other requirements of law.

(f) Central nervous system depressants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) mecloqualone;

(2) methaqualone;

(3) gamma-hydroxybutyric acid (GHB), including its esters and ethers;

(4) flunitrazepam;

(5) 2-(2-Methoxyphenyl)-2-(methylamino)cyclohexanone (2-MeO-2-deschloroketamine, methoxyketamine);

(6) tianeptine;

(7) clonazolam;

(8) etizolam;

(9) flubromazolam; and

(10) flubromazepam.

(g) Stimulants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) aminorex;

(2) cathinone;

(3) fenethylline;

(4) methcathinone;

(5) methylaminorex;

(6) N,N-dimethylamphetamine;

(7) N-benzylpiperazine (BZP);

(8) methylmethcathinone (mephedrone);

(9) 3,4-methylenedioxy-N-methylcathinone (methylone);

(10) methoxymethcathinone (methedrone);

(11) methylenedioxypyrovalerone (MDPV);

(12) 3-fluoro-N-methylcathinone (3-FMC);

(13) methylethcathinone (MEC);

(14) 1-benzofuran-6-ylpropan-2-amine (6-APB);

(15) dimethylmethcathinone (DMMC);

(16) fluoroamphetamine;

(17) fluoromethamphetamine;

(18) α-methylaminobutyrophenone (MABP or buphedrone);

(19) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one (butylone);

(20) 2-(methylamino)-1-(4-methylphenyl)butan-1-one (4-MEMABP or BZ-6378);

(21) 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl) pentan-1-one (naphthylpyrovalerone or naphyrone);

(22) (alpha-pyrrolidinopentiophenone (alpha-PVP);

(23) (RS)-1-(4-methylphenyl)-2-(1-pyrrolidinyl)-1-hexanone (4-Me-PHP or MPHP);

(24) 2-(1-pyrrolidinyl)-hexanophenone (Alpha-PHP);

(25) 4-methyl-N-ethylcathinone (4-MEC);

(26) 4-methyl-alpha-pyrrolidinopropiophenone (4-MePPP);

(27) 2-(methylamino)-1-phenylpentan-1-one (pentedrone);

(28) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one (pentylone);

(29) 4-fluoro-N-methylcathinone (4-FMC);

(30) 3,4-methylenedioxy-N-ethylcathinone (ethylone);

(31) alpha-pyrrolidinobutiophenone (α-PBP);

(32) 5-(2-Aminopropyl)-2,3-dihydrobenzofuran (5-APDB);

(33) 1-phenyl-2-(1-pyrrolidinyl)-1-heptanone (PV8);

(34) 6-(2-Aminopropyl)-2,3-dihydrobenzofuran (6-APDB);

(35) 4-methyl-alpha-ethylaminopentiophenone (4-MEAPP);

(36) 4'-chloro-alpha-pyrrolidinopropiophenone (4'-chloro-PPP);

(37) 1-(1,3-Benzodioxol-5-yl)-2-(dimethylamino)butan-1-one (dibutylone, bk-DMBDB);

(38) 1-(3-chlorophenyl) piperazine (meta-chlorophenylpiperazine or mCPP);

(39) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one (N-ethylpentylone, ephylone); and

(40) any other substance, except bupropion or compounds listed under a different schedule, that is structurally derived from 2-aminopropan-1-one by substitution at the 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the compound is further modified in any of the following ways:

(i) by substitution in the ring system to any extent with alkyl, alkylenedioxy, alkoxy, haloalkyl, hydroxyl, or halide substituents, whether or not further substituted in the ring system by one or more other univalent substituents;

(ii) by substitution at the 3-position with an acyclic alkyl substituent;

(iii) by substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or methoxybenzyl groups; or

(iv) by inclusion of the 2-amino nitrogen atom in a cyclic structure.

(h) ~~Marijuana,~~ Synthetic tetrahydrocannabinols~~,~~ and synthetic cannabinoids. Unless specifically excepted or unless listed in another schedule, any ~~natural or~~ synthetic material, compound, mixture, or preparation that contains any quantity of the following substances, their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the isomers, esters, ethers, or salts is possible:

~~(1) marijuana;~~

~~(2)~~ (1) synthetic tetrahydrocannabinols ~~naturally contained in a plant of the genus Cannabis,~~ that are the synthetic equivalents of the substances contained in the cannabis plant or in the resinous extractives of the plant, or synthetic substances with similar chemical structure and pharmacological activity to those substances contained in the plant or resinous extract, including, but not limited to, 1 cis or trans tetrahydrocannabinol, 6 cis or trans tetrahydrocannabinol, and 3,4 cis or trans tetrahydrocannabinol;

~~(3)~~ (2) synthetic cannabinoids, including the following substances:

(i) Naphthoylindoles, which are any compounds containing a 3-(1-napthoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of naphthoylindoles include, but are not limited to:

(A) 1-Pentyl-3-(1-naphthoyl)indole (JWH-018 and AM-678);

(B) 1-Butyl-3-(1-naphthoyl)indole (JWH-073);

(C) 1-Pentyl-3-(4-methoxy-1-naphthoyl)indole (JWH-081);

(D) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole (JWH-200);

(E) 1-Propyl-2-methyl-3-(1-naphthoyl)indole (JWH-015);

(F) 1-Hexyl-3-(1-naphthoyl)indole (JWH-019);

(G) 1-Pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);

(H) 1-Pentyl-3-(4-ethyl-1-naphthoyl)indole (JWH-210);

(I) 1-Pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);

(J) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM-2201).

(ii) Napthylmethylindoles, which are any compounds containing a 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of naphthylmethylindoles include, but are not limited to:

(A) 1-Pentyl-1H-indol-3-yl-(1-naphthyl)methane (JWH-175);

(B) 1-Pentyl-1H-indol-3-yl-(4-methyl-1-naphthyl)methane (JWH-184).

(iii) Naphthoylpyrroles, which are any compounds containing a 3-(1-naphthoyl)pyrrole structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the pyrrole ring to any extent, whether or not substituted in the naphthyl ring to any extent. Examples of naphthoylpyrroles include, but are not limited to, (5-(2-fluorophenyl)-1-pentylpyrrol-3-yl)-naphthalen-1-ylmethanone (JWH-307).

(iv) Naphthylmethylindenes, which are any compounds containing a naphthylideneindene structure with substitution at the 3-position of the indene ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indene ring to any extent, whether or not substituted in the naphthyl ring to any extent. Examples of naphthylemethylindenes include, but are not limited to, E-1-[1-(1-naphthalenylmethylene)-1H-inden-3-yl]pentane (JWH-176).

(v) Phenylacetylindoles, which are any compounds containing a 3-phenylacetylindole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent, whether or not substituted in the phenyl ring to any extent. Examples of phenylacetylindoles include, but are not limited to:

(A) 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole (RCS-8);

(B) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);

(C) 1-pentyl-3-(2-methylphenylacetyl)indole (JWH-251);

(D) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).

(vi) Cyclohexylphenols, which are compounds containing a 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not substituted in the cyclohexyl ring to any extent. Examples of cyclohexylphenols include, but are not limited to:

(A) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP 47,497);

(B) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (Cannabicyclohexanol or CP 47,497 C8 homologue);

(C) 5-(1,1-dimethylheptyl)-2-[(1R,2R)-5-hydroxy-2-(3-hydroxypropyl)cyclohexyl] -phenol (CP 55,940).

(vii) Benzoylindoles, which are any compounds containing a 3-(benzoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any

extent and whether or not substituted in the phenyl ring to any extent. Examples of benzoylindoles include, but are not limited to:

(A) 1-Pentyl-3-(4-methoxybenzoyl)indole (RCS-4);

(B) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM-694);

(C) (4-methoxyphenyl-[2-methyl-1-(2-(4-morpholinyl)ethyl)indol-3-yl]methanone (WIN 48,098 or Pravadoline).

(viii) Others specifically named:

(A) (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl) -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (HU-210);

(B) (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl) -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (Dexanabinol or HU-211);

(C) 2,3-dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de] -1,4-benzoxazin-6-yl-1-naphthalenylmethanone (WIN 55,212-2);

(D) (1-pentylindol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone (UR-144);

(E) (1-(5-fluoropentyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone (XLR-11);

(F) 1-pentyl-N-tricyclo[3.3.1.13,7]dec-1-yl-1H-indazole-3-carboxamide (AKB-48(APINACA));

(G) N-((3s,5s,7s)-adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide (5-Fluoro-AKB-48);

(H) 1-pentyl-8-quinolinyl ester-1H-indole-3-carboxylic acid (PB-22);

(I) 8-quinolinyl ester-1-(5-fluoropentyl)-1H-indole-3-carboxylic acid (5-Fluoro PB-22);

(J) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-pentyl-1H-indazole- 3-carboxamide (AB-PINACA);

(K) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(4-fluorophenyl)methyl]- 1H-indazole-3-carboxamide (AB-FUBINACA);

(L) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-(cyclohexylmethyl)-1H- indazole-3-carboxamide(AB-CHMINACA);

(M) (S)-methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3- methylbutanoate (5-fluoro-AMB);

(N) [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl) methanone (THJ-2201);

(O) (1-(5-fluoropentyl)-1H-benzo[d]imidazol-2-yl)(naphthalen-1-yl)methanone) (FUBIMINA);

(P) (7-methoxy-1-(2-morpholinoethyl)-N-((1S,2S,4R)-1,3,3-trimethylbicyclo [2.2.1]heptan-2-yl)-1H-indole-3-carboxamide (MN-25 or UR-12);

(Q) (S)-N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl) -1H-indole-3-carboxamide (5-fluoro-ABICA);

(R) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl) -1H-indole-3-carboxamide;

(S) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl) -1H-indazole-3-carboxamide;

(T) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido) -3,3-dimethylbutanoate;

(U) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1(cyclohexylmethyl)-1 H-indazole-3-carboxamide (MAB-CHMINACA);

(V) N-(1-Amino-3,3-dimethyl-1-oxo-2-butanyl)-1-pentyl-1H-indazole-3-carboxamide (ADB-PINACA);

(W) methyl (1-(4-fluorobenzyl)-1H-indazole-3-carbonyl)-L-valinate (FUB-AMB);

(X) N-[(1S)-2-amino-2-oxo-1-(phenylmethyl)ethyl]-1-(cyclohexylmethyl)-1H-Indazole-3-carboxamide. (APP-CHMINACA);

(Y) quinolin-8-yl 1-(4-fluorobenzyl)-1H-indole-3-carboxylate (FUB-PB-22); and

(Z) methyl N-[1-(cyclohexylmethyl)-1H-indole-3-carbonyl]valinate (MMB-CHMICA).

(ix) Additional substances specifically named:

(A) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1 H-pyrrolo[2,3-B]pyridine-3-carboxamide (5F-CUMYL-P7AICA);

(B) 1-(4-cyanobutyl)-N-(2- phenylpropan-2-yl)-1 H-indazole-3-carboxamide (4-CN-Cumyl-Butinaca);

(C) naphthalen-1-yl-1-(5-fluoropentyl)-1-H-indole-3-carboxylate (NM2201; CBL2201);

(D) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1 H-indazole-3-carboxamide (5F-ABPINACA);

(E) methyl-2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate (MDMB CHMICA);

(F) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate (5F-ADB; 5F-MDMB-PINACA); and

(G) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl) 1H-indazole-3-carboxamide (ADB-FUBINACA).

(i) A controlled substance analog, to the extent that it is implicitly or explicitly intended for human consumption.

EFFECTIVE DATE. This section is effective August 1, 2021, and applies to crimes committed on or after that date.

Sec. 69. Minnesota Statutes 2020, section 152.02, subdivision 3, is amended to read:

Subd. 3. **Schedule II.** (a) Schedule II consists of the substances listed in this subdivision.

(b) Unless specifically excepted or unless listed in another schedule, any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate.

(i) Excluding:

(A) apomorphine;

(B) thebaine-derived butorphanol;

(C) dextrophan;

(D) nalbuphine;

(E) nalmefene;

(F) naloxegol;

(G) naloxone;

(H) naltrexone; and

(I) their respective salts;

(ii) but including the following:

(A) opium, in all forms and extracts;

(B) codeine;

(C) dihydroetorphine;

(D) ethylmorphine;

(E) etorphine hydrochloride;

(F) hydrocodone;

(G) hydromorphone;

(H) metopon;

(I) morphine;

(J) oxycodone;

(K) oxymorphone;

(L) thebaine;

(M) oripavine;

(2) any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in clause (1), except that these substances shall not include the isoquinoline alkaloids of opium;

(3) opium poppy and poppy straw;

(4) coca leaves and any salt, cocaine compound, derivative, or preparation of coca leaves (including cocaine and ecgonine and their salts, isomers, derivatives, and salts of isomers and derivatives), and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine;

(5) concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid, or powder form which contains the phenanthrene alkaloids of the opium poppy).

(c) Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters and ethers, unless specifically excepted, or unless listed in another schedule, whenever the existence of such isomers, esters, ethers and salts is possible within the specific chemical designation:

(1) alfentanil;

(2) alphaprodine;

(3) anileridine;

(4) bezitramide;

(5) bulk dextropropoxyphene (nondosage forms);

(6) carfentanil;

(7) dihydrocodeine;

(8) dihydromorphinone;

(9) diphenoxylate;

(10) fentanyl;

(11) isomethadone;

(12) levo-alpha-acetylmethadol (LAAM);

(13) levomethorphan;

(14) levorphanol;

(15) metazocine;

(16) methadone;

(17) methadone - intermediate, 4-cyano-2-dimethylamino-4, 4-diphenylbutane;

(18) moramide - intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic acid;

(19) pethidine;

(20) pethidine - intermediate - a, 4-cyano-1-methyl-4-phenylpiperidine;

(21) pethidine - intermediate - b, ethyl-4-phenylpiperidine-4-carboxylate;

(22) pethidine - intermediate - c, 1-methyl-4-phenylpiperidine-4-carboxylic acid;

(23) phenazocine;

(24) piminodine;

(25) racemethorphan;

(26) racemorphan;

(27) remifentanil;

(28) sufentanil;

(29) tapentadol;

(30) 4-Anilino-N-phenethylpiperidine.

(d) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

(1) amphetamine, its salts, optical isomers, and salts of its optical isomers;

(2) methamphetamine, its salts, isomers, and salts of its isomers;

(3) phenmetrazine and its salts;

(4) methylphenidate;

(5) lisdexamfetamine.

(e) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) amobarbital;

(2) glutethimide;

(3) secobarbital;

(4) pentobarbital;

(5) phencyclidine;

(6) phencyclidine immediate precursors:

(i) 1-phenylcyclohexylamine;

(ii) 1-piperidinocyclohexanecarbonitrile;

(7) phenylacetone.

(f) Cannabis and cannabinoids:

(1) nabilone;

(2) unless specifically excepted or unless listed in another schedule, any natural material, compound, mixture, or preparation that contains any quantity of the following substances,

their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the isomers, esters, ethers, or salts is possible:

(i) marijuana; and

(ii) tetrahydrocannabinols naturally contained in a plant of the genus cannabis or in the resinous extractives of the plant; and

~~(2)~~ (3) dronabinol [(-)-delta-9-trans-tetrahydrocannabinol (delta-9-THC)] in an oral solution in a drug product approved for marketing by the United States Food and Drug Administration.

EFFECTIVE DATE. This section is effective August 1, 2021, and applies to crimes committed on or after that date.

Sec. 70. Minnesota Statutes 2020, section 152.11, subdivision 1a, is amended to read:

Subd. 1a. **Prescription requirements for Schedule II controlled substances.** Except as allowed under section 152.29, no person may dispense a controlled substance included in Schedule II of section 152.02 without a prescription issued by a doctor of medicine, a doctor of osteopathic medicine licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a doctor of podiatry, or a doctor of veterinary medicine, lawfully licensed to prescribe in this state or by a practitioner licensed to prescribe controlled substances by the state in which the prescription is issued, and having a current federal Drug Enforcement Administration registration number. The prescription must either be printed or written in ink and contain the handwritten signature of the prescriber or be transmitted electronically or by facsimile as permitted under subdivision 1. Provided that in emergency situations, as authorized by federal law, such drug may be dispensed upon oral prescription reduced promptly to writing and filed by the pharmacist. Such prescriptions shall be retained in conformity with section 152.101. No prescription for a Schedule II substance may be refilled.

Sec. 71. Minnesota Statutes 2020, section 152.11, is amended by adding a subdivision to read:

Subd. 5. **Exception.** References in this section to Schedule II controlled substances do not extend to marijuana or tetrahydrocannabinols.

Sec. 72. Minnesota Statutes 2020, section 152.12, is amended by adding a subdivision to read:

Subd. 6. **Exception.** References in this section to Schedule II controlled substances do not extend to marijuana or tetrahydrocannabinols.

Sec. 73. Minnesota Statutes 2020, section 152.125, subdivision 3, is amended to read:

Subd. 3. **Limits on applicability.** This section does not apply to:

(1) a physician's treatment of an individual for chemical dependency resulting from the use of controlled substances in Schedules II to V of section 152.02;

(2) the prescription or administration of controlled substances in Schedules II to V of section 152.02 to an individual whom the physician knows to be using the controlled substances for nontherapeutic purposes;

(3) the prescription or administration of controlled substances in Schedules II to V of section 152.02 for the purpose of terminating the life of an individual having intractable pain; ~~or~~

(4) the prescription or administration of a controlled substance in Schedules II to V of section 152.02 that is not a controlled substance approved by the United States Food and Drug Administration for pain relief; or

(5) the administration of medical cannabis under sections 152.22 to 152.37.

Sec. 74. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 5c. **Hemp processor.** "Hemp processor" means a person or business licensed by the commissioner of agriculture under chapter 18K to convert raw hemp into a product.

Sec. 75. Minnesota Statutes 2020, section 152.22, subdivision 6, is amended to read:

Subd. 6. **Medical cannabis.** (a) "Medical cannabis" means any species of the genus cannabis plant, or any mixture or preparation of them, including whole plant extracts and resins, and is delivered in the form of:

(1) liquid, including, but not limited to, oil;

(2) pill;

(3) vaporized delivery method with use of liquid or oil ~~but which does not require the use of dried leaves or plant form; or~~;

(4) combustion with use of dried raw cannabis; or

~~(4)~~ (5) any other method~~, excluding smoking,~~ approved by the commissioner.

(b) This definition includes any part of the genus cannabis plant prior to being processed into a form allowed under paragraph (a), that is possessed by a person while that person is engaged in employment duties necessary to carry out a requirement under sections 152.22 to 152.37 for a registered manufacturer or a laboratory under contract with a registered manufacturer. This definition also includes any hemp acquired by a manufacturer by a hemp grower as permitted under section 152.29, subdivision 1, paragraph (b).

EFFECTIVE DATE. This section is effective the earlier of (1) March 1, 2022, or (2) a date, as determined by the commissioner of health, by which (i) the rules adopted or amended under Minnesota Statutes, section 152.26, paragraph (b), are in effect and (ii) the independent laboratories under contract with the manufacturers have the necessary procedures and equipment in place to perform the required testing of dried raw cannabis. If this section is effective before March 1, 2022, the commissioner shall provide notice of that effective date to the public.

Sec. 76. Minnesota Statutes 2020, section 152.22, subdivision 11, is amended to read:

Subd. 11. **Registered designated caregiver.** "Registered designated caregiver" means a person who:

(1) is at least 18 years old;

(2) does not have a conviction for a disqualifying felony offense;

(3) has been approved by the commissioner to assist a patient who ~~has been identified by a health care practitioner as developmentally or physically disabled and therefore~~ requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility ~~due to the disability~~; and

(4) is authorized by the commissioner to assist the patient with the use of medical cannabis.

Sec. 77. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 13a. **Tribal medical cannabis program.** "Tribal medical cannabis program" means a medical cannabis program operated by a federally recognized Indian Tribe located

within the state that has been recognized by the commissioner of health in accordance with section 152.25, subdivision 5.

Sec. 78. Minnesota Statutes 2020, section 152.23, is amended to read:

152.23 LIMITATIONS.

(a) Nothing in sections 152.22 to 152.37 permits any person to engage in and does not prevent the imposition of any civil, criminal, or other penalties for:

(1) undertaking any task under the influence of medical cannabis that would constitute negligence or professional malpractice;

(2) possessing or engaging in the use of medical cannabis:

(i) on a school bus or van;

(ii) on the grounds of any preschool or primary or secondary school;

(iii) in any correctional facility; or

(iv) on the grounds of any child care facility or home day care;

(3) vaporizing or combusting medical cannabis pursuant to section 152.22, subdivision 6:

(i) on any form of public transportation;

(ii) where the vapor would be inhaled by a nonpatient minor child or where the smoke would be inhaled by a minor child; or

(iii) in any public place, including any indoor or outdoor area used by or open to the general public or a place of employment as defined under section 144.413, subdivision 1b; and

(4) operating, navigating, or being in actual physical control of any motor vehicle, aircraft, train, or motorboat, or working on transportation property, equipment, or facilities while under the influence of medical cannabis.

(b) Nothing in sections 152.22 to 152.37 require the medical assistance and MinnesotaCare programs to reimburse an enrollee or a provider for costs associated with the medical use of cannabis. Medical assistance and MinnesotaCare shall continue to provide coverage for all services related to treatment of an enrollee's qualifying medical condition if the service is covered under chapter 256B or 256L.

Sec. 79. Minnesota Statutes 2020, section 152.25, is amended by adding a subdivision to read:

Subd. 5. **Tribal medical cannabis programs.** Upon the request of an Indian Tribe operating a Tribal medical cannabis program, the commissioner shall determine if the standards for the Tribal medical cannabis program meet or exceed the standards required under sections 152.22 to 152.37 in terms of qualifying for the medical cannabis program, allowable forms of medical cannabis, production and distribution requirements, product safety and testing, and security measures. If the commissioner determines that the Tribal medical cannabis program meets or exceeds the standards in sections 152.22 to 152.37, the commissioner shall recognize the Tribal medical cannabis program and shall post the Tribal medical cannabis programs that have been recognized by the commissioner on the Department of Health's website.

Sec. 80. Minnesota Statutes 2020, section 152.26, is amended to read:

152.26 RULEMAKING.

(a) The commissioner may adopt rules to implement sections 152.22 to 152.37. Rules for which notice is published in the State Register before January 1, 2015, may be adopted using the process in section 14.389.

(b) The commissioner may adopt or amend rules, using the procedure in section 14.386, paragraph (a), to implement the addition of dried raw cannabis as an allowable form of medical cannabis under section 152.22, subdivision 6, paragraph (a), clause (4). Section 14.386, paragraph (b), does not apply to these rules.

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

Sec. 81. Minnesota Statutes 2020, section 152.27, subdivision 3, is amended to read:

Subd. 3. **Patient application.** (a) The commissioner shall develop a patient application for enrollment into the registry program. The application shall be available to the patient and given to health care practitioners in the state who are eligible to serve as health care practitioners. The application must include:

(1) the name, mailing address, and date of birth of the patient;

(2) the name, mailing address, and telephone number of the patient's health care practitioner;

(3) the name, mailing address, and date of birth of the patient's designated caregiver, if any, or the patient's parent, legal guardian, or spouse if the parent, legal guardian, or spouse will be acting as a caregiver;

(4) a copy of the certification from the patient's health care practitioner that is dated within 90 days prior to submitting the application ~~which~~ that certifies that the patient has been diagnosed with a qualifying medical condition ~~and, if applicable, that, in the health care practitioner's medical opinion, the patient is developmentally or physically disabled and, as a result of that disability, the patient requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility~~; and

(5) all other signed affidavits and enrollment forms required by the commissioner under sections 152.22 to 152.37, including, but not limited to, the disclosure form required under paragraph (c).

(b) The commissioner shall require a patient to resubmit a copy of the certification from the patient's health care practitioner on a yearly basis and shall require that the recertification be dated within 90 days of submission.

(c) The commissioner shall develop a disclosure form and require, as a condition of enrollment, all patients to sign a copy of the disclosure. The disclosure must include:

(1) a statement that, notwithstanding any law to the contrary, the commissioner, or an employee of any state agency, may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37; and

(2) the patient's acknowledgment that enrollment in the patient registry program is conditional on the patient's agreement to meet all of the requirements of sections 152.22 to 152.37.

Sec. 82. Minnesota Statutes 2020, section 152.27, subdivision 4, is amended to read:

Subd. 4. **Registered designated caregiver.** (a) The commissioner shall register a designated caregiver for a patient if ~~the patient's health care practitioner has certified that the patient, in the health care practitioner's medical opinion, is developmentally or physically disabled and, as a result of that disability,~~ the patient requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility and the caregiver has agreed, in writing, to be the patient's designated caregiver. As a condition of registration as a designated caregiver, the commissioner shall require the person to:

(1) be at least 18 years of age;

(2) agree to only possess the patient's medical cannabis for purposes of assisting the patient; and

(3) agree that if the application is approved, the person will not be a registered designated caregiver for more than ~~one patient, unless the~~ six registered patients at one time. Patients who reside in the same residence shall count as one patient.

(b) The commissioner shall conduct a criminal background check on the designated caregiver prior to registration to ensure that the person does not have a conviction for a disqualifying felony offense. Any cost of the background check shall be paid by the person seeking registration as a designated caregiver. A designated caregiver must have the criminal background check renewed every two years.

(c) Nothing in sections 152.22 to 152.37 shall be construed to prevent a person registered as a designated caregiver from also being enrolled in the registry program as a patient and possessing and using medical cannabis as a patient.

Sec. 83. Minnesota Statutes 2020, section 152.27, subdivision 6, is amended to read:

Subd. 6. **Patient enrollment.** (a) After receipt of a patient's application, application fees, and signed disclosure, the commissioner shall enroll the patient in the registry program and issue the patient and patient's registered designated caregiver or parent, legal guardian, or spouse, if applicable, a registry verification. The commissioner shall approve or deny a patient's application for participation in the registry program within 30 days after the commissioner receives the patient's application and application fee. ~~The commissioner may approve applications up to 60 days after the receipt of a patient's application and application fees until January 1, 2016.~~ A patient's enrollment in the registry program shall only be denied if the patient:

(1) does not have certification from a health care practitioner that the patient has been diagnosed with a qualifying medical condition;

(2) has not signed and returned the disclosure form required under subdivision 3, paragraph (c), to the commissioner;

(3) does not provide the information required; or

~~(4) has previously been removed from the registry program for violations of section 152.30 or 152.33; or~~

~~(5)~~ (4) provides false information.

(b) The commissioner shall give written notice to a patient of the reason for denying enrollment in the registry program.

(c) Denial of enrollment into the registry program is considered a final decision of the commissioner and is subject to judicial review under the Administrative Procedure Act pursuant to chapter 14.

(d) A patient's enrollment in the registry program may only be revoked upon the death of the patient or if a patient violates a requirement under section 152.30 or 152.33. If a patient's enrollment in the registry program has been revoked due to a violation of section 152.30 or 152.33, the patient may reapply for enrollment 12 months from the date the patient's enrollment was revoked. The commissioner shall process the application in accordance with this section.

(e) The commissioner shall develop a registry verification to provide to the patient, the health care practitioner identified in the patient's application, and to the manufacturer. The registry verification shall include:

(1) the patient's name and date of birth;

(2) the patient registry number assigned to the patient; and

(3) the name and date of birth of the patient's registered designated caregiver, if any, or the name of the patient's parent, legal guardian, or spouse if the parent, legal guardian, or spouse will be acting as a caregiver.

(f) The commissioner shall not deny a patient's application for participation in the registry program or revoke a patient's enrollment in the registry program solely because the patient is also enrolled in a Tribal medical cannabis program.

Sec. 84. Minnesota Statutes 2020, section 152.28, subdivision 1, is amended to read:

Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in the registry program, a health care practitioner shall:

(1) determine, in the health care practitioner's medical judgment, whether a patient suffers from a qualifying medical condition, and, if so determined, provide the patient with a certification of that diagnosis;

(2) ~~determine whether a patient is developmentally or physically disabled and, as a result of that disability, the patient requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility, and, if so determined, include that determination on the patient's certification of diagnosis;~~

~~(3)~~ advise patients, registered designated caregivers, and parents, legal guardians, or spouses who are acting as caregivers of the existence of any nonprofit patient support groups or organizations;

~~(4)~~ (3) provide explanatory information from the commissioner to patients with qualifying medical conditions, including disclosure to all patients about the experimental nature of therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the proposed treatment; the application and other materials from the commissioner; and provide patients with the Tennessen warning as required by section 13.04, subdivision 2; and

~~(5)~~ (4) agree to continue treatment of the patient's qualifying medical condition and report medical findings to the commissioner.

(b) Upon notification from the commissioner of the patient's enrollment in the registry program, the health care practitioner shall:

(1) participate in the patient registry reporting system under the guidance and supervision of the commissioner;

(2) report health records of the patient throughout the ongoing treatment of the patient to the commissioner in a manner determined by the commissioner and in accordance with subdivision 2;

(3) determine, on a yearly basis, if the patient continues to suffer from a qualifying medical condition and, if so, issue the patient a new certification of that diagnosis; and

(4) otherwise comply with all requirements developed by the commissioner.

(c) A health care practitioner may conduct a patient assessment to issue a recertification as required under paragraph (b), clause (3), via telemedicine as defined under section 62A.671, subdivision 9.

(d) Nothing in this section requires a health care practitioner to participate in the registry program.

Sec. 85. Minnesota Statutes 2020, section 152.29, subdivision 1, is amended to read:

Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer may operate eight distribution facilities, which may include the manufacturer's single location for cultivation, harvesting, manufacturing, packaging, and processing but is not required to include that location. The commissioner shall designate the geographical service areas to be served by each manufacturer based on geographical need throughout the state to improve patient access. A manufacturer shall not have more than two distribution facilities in each

geographical service area assigned to the manufacturer by the commissioner. A manufacturer shall operate only one location where all cultivation, harvesting, manufacturing, packaging, and processing of medical cannabis shall be conducted. This location may be one of the manufacturer's distribution facility sites. The additional distribution facilities may dispense medical cannabis and medical cannabis products but may not contain any medical cannabis in a form other than those forms allowed under section 152.22, subdivision 6, and the manufacturer shall not conduct any cultivation, harvesting, manufacturing, packaging, or processing at the other distribution facility sites. Any distribution facility operated by the manufacturer is subject to all of the requirements applying to the manufacturer under sections 152.22 to 152.37, including, but not limited to, security and distribution requirements.

(b) A manufacturer may acquire hemp grown in this state from a hemp grower, and may acquire hemp products produced by a hemp processor. A manufacturer may manufacture or process hemp and hemp products into an allowable form of medical cannabis under section 152.22, subdivision 6. Hemp and hemp products acquired by a manufacturer under this paragraph ~~is~~ are subject to the same quality control program, security and testing requirements, and other requirements that apply to medical cannabis under sections 152.22 to 152.37 and Minnesota Rules, chapter 4770.

(c) A medical cannabis manufacturer shall contract with a laboratory approved by the commissioner, subject to any additional requirements set by the commissioner, for purposes of testing medical cannabis manufactured or hemp or hemp products acquired by the medical cannabis manufacturer as to content, contamination, and consistency to verify the medical cannabis meets the requirements of section 152.22, subdivision 6. The cost of laboratory testing shall be paid by the manufacturer.

(d) The operating documents of a manufacturer must include:

(1) procedures for the oversight of the manufacturer and procedures to ensure accurate record keeping;

(2) procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabis and unauthorized entrance into areas containing medical cannabis; and

(3) procedures for the delivery and transportation of hemp between hemp growers and manufacturers and for the delivery and transportation of hemp products between hemp processors and manufacturers.

(e) A manufacturer shall implement security requirements, including requirements for the delivery and transportation of hemp and hemp products, protection of each location by

a fully operational security alarm system, facility access controls, perimeter intrusion detection systems, and a personnel identification system.

(f) A manufacturer shall not share office space with, refer patients to a health care practitioner, or have any financial relationship with a health care practitioner.

(g) A manufacturer shall not permit any person to consume medical cannabis on the property of the manufacturer.

(h) A manufacturer is subject to reasonable inspection by the commissioner.

(i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is not subject to the Board of Pharmacy licensure or regulatory requirements under chapter 151.

(j) A medical cannabis manufacturer may not employ any person who is under 21 years of age or who has been convicted of a disqualifying felony offense. An employee of a medical cannabis manufacturer must submit a completed criminal history records check consent form, a full set of classifiable fingerprints, and the required fees for submission to the Bureau of Criminal Apprehension before an employee may begin working with the manufacturer. The bureau must conduct a Minnesota criminal history records check and the superintendent is authorized to exchange the fingerprints with the Federal Bureau of Investigation to obtain the applicant's national criminal history record information. The bureau shall return the results of the Minnesota and federal criminal history records checks to the commissioner.

(k) A manufacturer may not operate in any location, whether for distribution or cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a public or private school existing before the date of the manufacturer's registration with the commissioner.

(l) A manufacturer shall comply with reasonable restrictions set by the commissioner relating to signage, marketing, display, and advertising of medical cannabis.

(m) Before a manufacturer acquires hemp from a hemp grower or hemp products from a hemp processor, the manufacturer must verify that the hemp grower or hemp processor has a valid license issued by the commissioner of agriculture under chapter 18K.

(n) Until a state-centralized, seed-to-sale system is implemented that can track a specific medical cannabis plant from cultivation through testing and point of sale, the commissioner shall conduct at least one unannounced inspection per year of each manufacturer that includes inspection of:

(1) business operations;

(2) physical locations of the manufacturer's manufacturing facility and distribution facilities;

(3) financial information and inventory documentation, including laboratory testing results; and

(4) physical and electronic security alarm systems.

Sec. 86. Minnesota Statutes 2020, section 152.29, subdivision 3, is amended to read:

Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval for the distribution of medical cannabis to a patient. A manufacturer may transport medical cannabis or medical cannabis products that have been cultivated, harvested, manufactured, packaged, and processed by that manufacturer to another registered manufacturer for the other manufacturer to distribute.

(b) A manufacturer may distribute medical cannabis products, whether or not the products have been manufactured by that manufacturer.

(c) Prior to distribution of any medical cannabis, the manufacturer shall:

(1) verify that the manufacturer has received the registry verification from the commissioner for that individual patient;

(2) verify that the person requesting the distribution of medical cannabis is the patient, the patient's registered designated caregiver, or the patient's parent, legal guardian, or spouse listed in the registry verification using the procedures described in section 152.11, subdivision 2d;

(3) assign a tracking number to any medical cannabis distributed from the manufacturer;

(4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to chapter 151 has consulted with the patient to determine the proper dosage for the individual patient after reviewing the ranges of chemical compositions of the medical cannabis and the ranges of proper dosages reported by the commissioner. For purposes of this clause, a consultation may be conducted remotely ~~using a~~ by secure videoconference, telephone, or other remote means, so long as the employee providing the consultation is able to confirm the identity of the patient~~, the consultation occurs while the patient is at a distribution facility,~~ and the consultation adheres to patient privacy requirements that apply to health care services delivered through telemedicine. A pharmacist consultation under this clause is not required when a manufacturer is distributing medical cannabis to a patient according to a

patient-specific dosage plan established with that manufacturer and is not modifying the dosage or product being distributed under that plan and the medical cannabis is distributed by a pharmacy technician;

(5) properly package medical cannabis in compliance with the United States Poison Prevention Packing Act regarding child-resistant packaging and exemptions for packaging for elderly patients, and label distributed medical cannabis with a list of all active ingredients and individually identifying information, including:

(i) the patient's name and date of birth;

(ii) the name and date of birth of the patient's registered designated caregiver or, if listed on the registry verification, the name of the patient's parent or legal guardian, if applicable;

(iii) the patient's registry identification number;

(iv) the chemical composition of the medical cannabis; and

(v) the dosage; and

(6) ensure that the medical cannabis distributed contains a maximum of a 90-day supply of the dosage determined for that patient.

(d) A manufacturer shall require any employee of the manufacturer who is transporting medical cannabis or medical cannabis products to a distribution facility or to another registered manufacturer to carry identification showing that the person is an employee of the manufacturer.

(e) A manufacturer shall distribute medical cannabis in dried raw cannabis form only to a patient age 21 or older, or to the registered designated caregiver, parent, legal guardian, or spouse of a patient age 21 or older.

EFFECTIVE DATE. Paragraph (e) is effective the earlier of (1) March 1, 2022, or (2) a date, as determined by the commissioner of health, by which (i) the rules adopted or amended under Minnesota Statutes, section 152.26, paragraph (b), are in effect and (ii) the independent laboratories under contract with the manufacturers have the necessary procedures and equipment in place to perform the required testing of dried raw cannabis. If this section is effective before March 1, 2022, the commissioner shall provide notice of that effective date to the public.

Sec. 87. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to read:

Subd. 3b. **Distribution to recipient in a motor vehicle.** A manufacturer may distribute medical cannabis to a patient, registered designated caregiver, or parent, legal guardian, or spouse of a patient who is at the distribution facility but remains in a motor vehicle, provided:

(1) distribution facility staff receive payment and distribute medical cannabis in a designated zone that is as close as feasible to the front door of the distribution facility;

(2) the manufacturer ensures that the receipt of payment and distribution of medical cannabis are visually recorded by a closed-circuit television surveillance camera at the distribution facility and provides any other necessary security safeguards;

(3) the manufacturer does not store medical cannabis outside a restricted access area at the distribution facility, and distribution facility staff transport medical cannabis from a restricted access area at the distribution facility to the designated zone for distribution only after confirming that the patient, designated caregiver, or parent, guardian, or spouse has arrived in the designated zone;

(4) the payment and distribution of medical cannabis take place only after a pharmacist consultation takes place, if required under subdivision 3, paragraph (c), clause (4);

(5) immediately following distribution of medical cannabis, distribution facility staff enter the transaction in the state medical cannabis registry information technology database; and

(6) immediately following distribution of medical cannabis, distribution facility staff take the payment received into the distribution facility.

Sec. 88. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to read:

Subd. 3c. **Disposal of medical cannabis plant root balls.** Notwithstanding Minnesota Rules, part 4770.1200, subpart 2, item C, a manufacturer is not required to grind root balls of medical cannabis plants or incorporate them with a greater quantity of nonconsumable solid waste before transporting root balls to another location for disposal. For purposes of this subdivision, "root ball" means a compact mass of roots formed by a plant and any attached growing medium.

Sec. 89. Minnesota Statutes 2020, section 152.31, is amended to read:

152.31 DATA PRACTICES.

(a) Government data in patient files maintained by the commissioner and the health care practitioner, and data submitted to or by a medical cannabis manufacturer, are private data on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in section 13.02, subdivision 9, but may be used for purposes of complying with chapter 13 and complying with a request from the legislative auditor or the state auditor in the performance of official duties. The provisions of section 13.05, subdivision 11, apply to a registration agreement entered between the commissioner and a medical cannabis manufacturer under section 152.25.

(b) Not public data maintained by the commissioner may not be used for any purpose not provided for in sections 152.22 to 152.37, and may not be combined or linked in any manner with any other list, dataset, or database.

(c) The commissioner may execute data sharing arrangements with the commissioner of agriculture to verify licensing, inspection, and compliance information related to hemp growers and hemp processors under chapter 18K.

Sec. 90. Minnesota Statutes 2020, section 152.32, subdivision 3, is amended to read:

Subd. 3. **Discrimination prohibited.** (a) No school or landlord may refuse to enroll or lease to and may not otherwise penalize a person solely for the person's status as a patient enrolled in the registry program under sections 152.22 to 152.37, unless failing to do so would violate federal law or regulations or cause the school or landlord to lose a monetary or licensing-related benefit under federal law or regulations.

(b) For the purposes of medical care, including organ transplants, a registry program enrollee's use of medical cannabis under sections 152.22 to 152.37 is considered the equivalent of the authorized use of any other medication used at the discretion of a physician or advanced practice registered nurse and does not constitute the use of an illicit substance or otherwise disqualify a patient from needed medical care.

(c) Unless a failure to do so would violate federal law or regulations or cause an employer to lose a monetary or licensing-related benefit under federal law or regulations, an employer may not discriminate against a person in hiring, termination, or any term or condition of employment, or otherwise penalize a person, if the discrimination is based upon either of the following:

(1) the person's status as a patient enrolled in the registry program under sections 152.22 to 152.37; or

(2) a patient's positive drug test for cannabis components or metabolites, unless the patient used, possessed, or was impaired by medical cannabis on the premises of the place of employment or during the hours of employment.

(d) An employee who is required to undergo employer drug testing pursuant to section 181.953 may present verification of enrollment in the patient registry as part of the employee's explanation under section 181.953, subdivision 6.

(e) A person shall not be denied custody of a minor child or visitation rights or parenting time with a minor child solely based on the person's status as a patient enrolled in the registry program under sections 152.22 to 152.37. There shall be no presumption of neglect or child endangerment for conduct allowed under sections 152.22 to 152.37, unless the person's behavior is such that it creates an unreasonable danger to the safety of the minor as established by clear and convincing evidence.

(f) This subdivision applies to any person enrolled in a Tribal medical cannabis program to the same extent as if the person was enrolled in the registry program under sections 152.22 to 152.37.

Sec. 91. Minnesota Statutes 2020, section 171.07, is amended by adding a subdivision to read:

Subd. 3b. **Identification card for homeless youth.** (a) A homeless youth, as defined in section 256K.45, subdivision 1a, who meets the requirements of this subdivision may obtain a noncompliant identification card, notwithstanding section 171.06, subdivision 3.

(b) An applicant under this subdivision must:

(1) provide the applicant's full name, date of birth, and sex;

(2) provide the applicant's height in feet and inches, weight in pounds, and eye color;

(3) submit a certified copy of a birth certificate issued by a government bureau of vital statistics or equivalent agency in the applicant's state of birth, which must bear the raised or authorized seal of the issuing government entity; and

(4) submit a statement verifying that the applicant is a homeless youth who resides in Minnesota that is signed by:

(i) an employee of a human services agency receiving public funding to provide services to homeless youth, runaway youth, youth with mental illness, or youth with substance use disorders; or

(ii) staff at a school who provide services to homeless youth or a school social worker.

(c) For a noncompliant identification card under this subdivision:

(1) the commissioner must not impose a fee, surcharge, or filing fee under section 171.06, subdivision 2; and

(2) a driver's license agent must not impose a filing fee under section 171.061, subdivision 4.

(d) Minnesota Rules, parts 7410.0400 and 7410.0410, or successor rules, do not apply for an identification card under this subdivision.

EFFECTIVE DATE. This section is effective the day following final enactment for application and issuance of Minnesota identification cards on and after January 1, 2022.

Sec. 92. Minnesota Statutes 2020, section 256.98, subdivision 1, is amended to read:

Subdivision 1. **Wrongfully obtaining assistance.** (a) A person who commits any of the following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897, the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program formerly codified in sections 256.72 to 256.871, chapter 256B, 256D, 256I, 256J, 256K, or 256L, child care assistance programs, and emergency assistance programs under section 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses (1) to (5):

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of any material fact, or by impersonation or other fraudulent device, assistance or the continued receipt of assistance, to include child care assistance or ~~vouchers~~ food benefits produced according to sections 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365, 256.94, and 256L.01 to 256L.15, to which the person is not entitled or assistance greater than that to which the person is entitled;

(2) knowingly aids or abets in buying or in any way disposing of the property of a recipient or applicant of assistance without the consent of the county agency; or

(3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments to which the individual is not entitled as a provider of subsidized child care, or by furnishing or concurring in a willfully false claim for child care assistance.

(b) The continued receipt of assistance to which the person is not entitled or greater than that to which the person is entitled as a result of any of the acts, failure to act, or concealment described in this subdivision shall be deemed to be continuing offenses from the date that the first act or failure to act occurred.

Sec. 93. Minnesota Statutes 2020, section 256B.0625, subdivision 52, is amended to read:

Subd. 52. **Lead risk assessments.** (a) Effective October 1, 2007, or six months after federal approval, whichever is later, medical assistance covers lead risk assessments provided by a lead risk assessor who is licensed by the commissioner of health under section 144.9505 and employed by an assessing agency as defined in section 144.9501. Medical assistance covers a onetime on-site investigation of a recipient's home or primary residence to determine the existence of lead so long as the recipient is under the age of 21 and has a venous blood lead level specified in section 144.9504, subdivision 2, paragraph ~~(a)~~ (b).

(b) Medical assistance reimbursement covers the lead risk assessor's time to complete the following activities:

(1) gathering samples;

(2) interviewing family members;

(3) gathering data, including meter readings; and

(4) providing a report with the results of the investigation and options for reducing lead-based paint hazards.

Medical assistance coverage of lead risk assessment does not include testing of environmental substances such as water, paint, or soil or any other laboratory services. Medical assistance coverage of lead risk assessments is not included in the capitated services for children enrolled in health plans through the prepaid medical assistance program and the MinnesotaCare program.

(c) Payment for lead risk assessment must be cost-based and must meet the criteria for federal financial participation under the Medicaid program. The rate must be based on allowable expenditures from cost information gathered. Under section 144.9507, subdivision 5, federal medical assistance funds may not replace existing funding for lead-related activities. The nonfederal share of costs for services provided under this subdivision must be from

state or local funds and is the responsibility of the agency providing the risk assessment. When the risk assessment is conducted by the commissioner of health, the state share must be from appropriations to the commissioner of health for this purpose. Eligible expenditures for the nonfederal share of costs may not be made from federal funds or funds used to match other federal funds. Any federal disallowances are the responsibility of the agency providing risk assessment services.

Sec. 94. Minnesota Statutes 2020, section 326.71, subdivision 4, is amended to read:

Subd. 4. **Asbestos-related work.** "Asbestos-related work" means the enclosure, removal, or encapsulation of asbestos-containing material in a quantity that meets or exceeds 260 linear feet of friable asbestos-containing material on pipes, 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, a total of 35 cubic feet of friable asbestos-containing material on or off all facility components in one facility. In the case of single or multifamily residences, "asbestos-related work" also means the enclosure, removal, or encapsulation of greater than ten but less than 260 linear feet of friable asbestos-containing material on pipes, greater than six but less than 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, greater than one cubic foot but less than 35 cubic feet of friable asbestos-containing material on or off all facility components in one facility. ~~This provision excludes asbestos-containing floor tiles and sheeting, roofing materials, siding, and all ceilings with asbestos-containing material in single family residences and buildings with no more than four dwelling units.~~ Asbestos-related work includes asbestos abatement area preparation; enclosure, removal, or encapsulation operations; and an air quality monitoring specified in rule to assure that the abatement and adjacent areas are not contaminated with asbestos fibers during the project and after completion.

For purposes of this subdivision, the quantity of ~~asbestos containing~~ asbestos-containing material applies separately for every project.

Sec. 95. Minnesota Statutes 2020, section 326.75, subdivision 1, is amended to read:

Subdivision 1. **Licensing fee.** A person required to be licensed under section 326.72 shall, before receipt of the license and before causing asbestos-related work to be performed, pay the commissioner an annual license fee of ~~$100~~ $105.

Sec. 96. Minnesota Statutes 2020, section 326.75, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** An individual required to be certified as an asbestos worker or asbestos site supervisor under section 326.73, subdivision 1, shall pay the commissioner a certification fee of ~~$50~~ $52.50 before the issuance of the certificate. ~~The commissioner may establish by rule fees required before the issuance of~~ An individual required to be certified as an asbestos inspector, asbestos management planner, and asbestos project designer ~~certificates required~~ under section 326.73, subdivisions 2, 3, and 4, shall pay the commissioner a certification fee of $105 before the issuance of the certificate.

Sec. 97. Minnesota Statutes 2020, section 326.75, subdivision 3, is amended to read:

Subd. 3. **Permit fee.** Five calendar days before beginning asbestos-related work, a person shall pay a project permit fee to the commissioner equal to ~~one~~ two percent of the total costs of the asbestos-related work. For asbestos-related work performed in single or multifamily residences, of greater than ten but less than 260 linear feet of asbestos-containing material on pipes, or greater than six but less than 160 square feet of asbestos-containing material on other facility components, a person shall pay a project permit fee of $35 to the commissioner.

Sec. 98. Laws 2020, Seventh Special Session chapter 1, article 6, section 12, subdivision 4, is amended to read:

Subd. 4. **Housing with services establishment registration; conversion to an assisted living facility license.** (a) Housing with services establishments registered under chapter 144D, providing home care services according to chapter 144A to at least one resident, and intending to provide assisted living services on or after August 1, 2021, must submit an application for an assisted living facility license in accordance with section 144G.12 no later than June 1, 2021. The commissioner shall consider the application in accordance with section ~~144G.16~~ 144G.15.

(b) Notwithstanding the housing with services contract requirements identified in section 144D.04, any existing housing with services establishment registered under chapter 144D that does not intend to convert its registration to an assisted living facility license under this chapter must provide written notice to its residents at least 60 days before the expiration of its registration, or no later than May 31, 2021, whichever is earlier. The notice must:

(1) state that the housing with services establishment does not intend to convert to an assisted living facility;

(2) include the date when the housing with services establishment will no longer provide housing with services;

(3) include the name, e-mail address, and phone number of the individual associated with the housing with services establishment that the recipient of home care services may contact to discuss the notice;

(4) include the contact information consisting of the phone number, e-mail address, mailing address, and website for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and

(5) for residents who receive home and community-based waiver services under section 256B.49 and chapter 256S, also be provided to the resident's case manager at the same time that it is provided to the resident.

(c) A housing with services registrant that obtains an assisted living facility license, but does so under a different business name as a result of reincorporation, and continues to provide services to the recipient, is not subject to the 60-day notice required under paragraph (b). However, the provider must otherwise provide notice to the recipient as required under sections 144D.04 and 144D.045, as applicable, and section 144D.09.

(d) All registered housing with services establishments providing assisted living under sections 144G.01 to 144G.07 prior to August 1, 2021, must have an assisted living facility license under this chapter.

(e) Effective August 1, 2021, any housing with services establishment registered under chapter 144D that has not converted its registration to an assisted living facility license under this chapter is prohibited from providing assisted living services.

EFFECTIVE DATE. This section is effective retroactively from December 17, 2020.

Sec. 99. **ADDITIONAL MEMBER TO COVID-19 VACCINE ALLOCATION ADVISORY GROUP.**

The commissioner of health shall appoint an individual who is an expert on vaccine disinformation to the state COVID-19 Vaccine Allocation Advisory Group no later than .....

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

Sec. 100. **FEDERAL SCHEDULE I EXEMPTION APPLICATION FOR MEDICAL USE OF CANNABIS.**

By September 1, 2021, the commissioner of health shall apply to the Drug Enforcement Administration's Office of Diversion Control for an exception under Code of Federal Regulations, title 21, section 1307.03, and request formal written acknowledgment that the listing of marijuana, marijuana extract, and tetrahydrocannabinols as controlled substances in federal Schedule I does not apply to the protected activities in Minnesota Statutes, section 152.32, subdivision 2, pursuant to the medical cannabis program established under Minnesota Statutes, sections 152.22 to 152.37. The application shall include the presumption in Minnesota Statutes, section 152.32, subdivision 1.

Sec. 101. **MENTAL HEALTH CULTURAL COMMUNITY CONTINUING EDUCATION GRANT PROGRAM.**

The commissioner of health shall develop a grant program, in consultation with the relevant mental health licensing boards, to provide for the continuing education necessary for social workers, marriage and family therapists, psychologists, and professional clinical counselors who are members of communities of color or underrepresented communities, as defined in Minnesota Statutes, section 148E.010, subdivision 20, and who work for community mental health providers, to become supervisors for individuals pursuing licensure in mental health professions.

Sec. 102. **RECOMMENDATIONS; EXPANDED ACCESS TO DATA FROM ALL-PAYER CLAIMS DATABASE.**

The commissioner of health shall develop recommendations to expand access to data in the all-payer claims database under Minnesota Statutes, section 62U.04, to additional outside entities for public health or research purposes. In the recommendations, the commissioner must address an application process for outside entities to access the data, how the department will exercise ongoing oversight over data use by outside entities, purposes for which the data may be used by outside entities, establishment of a data access committee to advise the department on selecting outside entities that may access the data, and steps outside entities must take to protect data held by those entities from unauthorized use. Following development of these recommendations, an outside entity that accesses data in compliance with these recommendations may publish results that identify hospitals, clinics, and medical practices so long as no individual health professionals are identified and the commissioner finds the data to be accurate, valid, and suitable for publication for

such use. The commissioner shall submit these recommendations by December 15, 2021, to the chairs and ranking minority members of the legislative committees with jurisdiction over health policy and civil law.

Sec. 103. **SKIN LIGHTENING PRODUCTS PUBLIC AWARENESS AND EDUCATION GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a grant program for the purpose of increasing public awareness and education on the health dangers associated with using skin lightening creams and products that contain mercury that are manufactured in other countries and brought into this country and sold illegally online or in stores.

Subd. 2. **Grants authorized.** The commissioner shall award grants through a request for proposal process to community-based, nonprofit organizations that serve ethnic communities and that focus on public health outreach to Black, Indigenous, and people of color communities on the issue of skin lightening products and chemical exposure from these products. Priority in awarding grants shall be given to organizations that have historically provided services to ethnic communities on the skin lightening and chemical exposure issue for the past three years.

Subd. 3. **Grant allocation.** (a) Grantees must use the funds to conduct public awareness and education activities that are culturally specific and community-based and focus on:

(1) the dangers of exposure to mercury through dermal absorption, inhalation, hand-to-mouth contact, and through contact with individuals who have used these skin lightening products;

(2) the signs and symptoms of mercury poisoning;

(3) the health effects of mercury poisoning, including the permanent effects on the central nervous system and kidneys;

(4) the dangers of using these products or being exposed to these products during pregnancy and breastfeeding to the mother and to the infant;

(5) knowing how to identify products that contain mercury; and

(6) proper disposal of the product if the product contains mercury.

(b) The grant application must include:

(1) a description of the purpose or project for which the grant funds will be used;

(2) a description of the objectives, a work plan, and a timeline for implementation; and

(3) the community or group the grant proposes to focus on.

Sec. 104. **TRAUMA-INFORMED GUN VIOLENCE REDUCTION; PILOT PROGRAM.**

Subdivision 1. **Pilot program.** (a) The commissioner of health shall establish a pilot program to aid in the reduction of trauma resulting from gun violence and address the root causes of gun violence by making the following resources available to professionals and organizations in health care, public health, mental health, social service, law enforcement, and victim advocacy and other professionals who are most likely to encounter individuals who have been victims, witnesses, or perpetrators of gun violence occurring in a community, or in a domestic or other setting:

(1) training on recognizing trauma as both a result and a cause of gun violence;

(2) developing skills to address the effects of trauma on individuals and family members;

(3) investments in community-based organizations to enable high-quality, targeted services to individuals in need. This may include resources for additional training, hiring of specialized staff needed to address trauma-related issues, management information systems to facilitate data collection, and expansion of existing programming;

(4) replication and expansion of effective community-based gun violence prevention initiatives, such as Project Life, the Minneapolis Group Violence Intervention initiative, to connect at-risk individuals to mental health services, job readiness programs, and employment opportunities; and

(5) education campaigns and outreach materials to educate communities, organizations, and the public about the relationship between trauma and gun violence.

(b) The pilot program shall address the traumatic effects of gun violence exposure using a holistic treatment modality.

Subd. 2. **Program guidelines and protocols.** (a) The commissioner, with advice from an advisory panel knowledgeable about gun violence and its traumatic impact, shall develop protocols and program guidelines that address resources and training to be used by professionals who encounter individuals who have perpetrated or been impacted by gun violence. Educational, training, and outreach material must be culturally appropriate for the community and provided in multiple languages for those with limited English language proficiency. The materials developed must address necessary responses by local, state, and

other governmental entities tasked with addressing gun violence. The protocols must include a method of informing affected communities and local governments representing those communities on effective strategies to target community, domestic, and other forms of gun violence.

(b) The commissioner may enter into contractual agreements with community-based organizations or experts in the field to perform any of the activities under this section.

Subd. 3. **Report.** By November 15, 2021, the commissioner shall submit a report on the progress of the pilot program to the chairs and ranking minority members of the committees with jurisdiction over health and public safety.

Sec. 105. **REVISOR INSTRUCTION.**

The revisor of statutes shall amend the section headnote for Minnesota Statutes, section 62J.63, to read "HEALTH CARE PURCHASING AND PERFORMANCE MEASUREMENT."

Sec. 106. **REPEALER.**

Minnesota Statutes 2020, sections 62J.63, subdivision 3; 144.0721, subdivision 1; 144.0722; 144.0724, subdivision 10; and 144.693, are repealed.

ARTICLE 4
HEALTH-RELATED LICENSING BOARDS

Section 1. Minnesota Statutes 2020, section 148.90, subdivision 2, is amended to read:

Subd. 2. **Members.** (a) The members of the board shall:

(1) be appointed by the governor;

(2) be residents of the state;

(3) serve for not more than two consecutive terms;

(4) designate the officers of the board; and

(5) administer oaths pertaining to the business of the board.

(b) A public member of the board shall represent the public interest and shall not:

(1) be a psychologist or have engaged in the practice of psychology;

(2) be an applicant or former applicant for licensure;

(3) be a member of another health profession and be licensed by a health-related licensing board as defined under section 214.01, subdivision 2; the commissioner of health; or licensed, certified, or registered by another jurisdiction;

(4) be a member of a household that includes a psychologist; or

(5) have conflicts of interest or the appearance of conflicts with duties as a board member.

(c) At the time of their appointments, at least two members of the board must reside outside of the seven-county metropolitan area.

(d) At the time of their appointments, at least two members of the board must be members of:

(1) a community of color; or

(2) an underrepresented community, defined as a group that is not represented in the majority with respect to race, ethnicity, national origin, sexual orientation, gender identity, or physical ability.

Sec. 2. Minnesota Statutes 2020, section 148.911, is amended to read:

148.911 CONTINUING EDUCATION.

(a) Upon application for license renewal, a licensee shall provide the board with satisfactory evidence that the licensee has completed continuing education requirements established by the board. Continuing education programs shall be approved under section 148.905, subdivision 1, clause (10). The board shall establish by rule the number of continuing education training hours required each year and may specify subject or skills areas that the licensee shall address.

(b) At least four of the required continuing education hours must be on increasing the knowledge, understanding, self-awareness, and practice skills to competently address the psychological needs of individuals from diverse socioeconomic and cultural backgrounds. Topics include but are not limited to:

(1) understanding culture, its functions, and strengths that exist in varied cultures;

(2) understanding clients' cultures and differences among and between cultural groups;

(3) understanding the nature of social diversity and oppression;

(4) understanding cultural humility; and

(5) understanding human diversity, meaning individual client differences that are associated with the client's cultural group, including race, ethnicity, national origin, religious

affiliation, language, age, gender, gender identity, physical and mental capabilities, sexual orientation, and socioeconomic status.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 3. Minnesota Statutes 2020, section 148B.30, subdivision 1, is amended to read:

Subdivision 1. **Creation.** (a) There is created a Board of Marriage and Family Therapy that consists of seven members appointed by the governor. Four members shall be licensed, practicing marriage and family therapists, each of whom shall for at least five years immediately preceding appointment, have been actively engaged as a marriage and family therapist, rendering professional services in marriage and family therapy. One member shall be engaged in the professional teaching and research of marriage and family therapy. Two members shall be representatives of the general public who have no direct affiliation with the practice of marriage and family therapy. All members shall have been a resident of the state two years preceding their appointment. Of the first board members appointed, three shall continue in office for two years, two members for three years, and two members, including the chair, for terms of four years respectively. Their successors shall be appointed for terms of four years each, except that a person chosen to fill a vacancy shall be appointed only for the unexpired term of the board member whom the newly appointed member succeeds. Upon the expiration of a board member's term of office, the board member shall continue to serve until a successor is appointed and qualified.

(b) At the time of their appointments, at least two members must reside outside of the seven-county metropolitan area.

(c) At the time of their appointments, at least two members must be members of:

(1) a community of color; or

(2) an underrepresented community, defined as a group that is not represented in the majority with respect to race, ethnicity, national origin, sexual orientation, gender identity, or physical ability.

Sec. 4. Minnesota Statutes 2020, section 148B.31, is amended to read:

148B.31 DUTIES OF THE BOARD.

(a) The board shall:

(1) adopt and enforce rules for marriage and family therapy licensing, which shall be designed to protect the public;

(2) develop by rule appropriate techniques, including examinations and other methods, for determining whether applicants and licensees are qualified under sections 148B.29 to 148B.392;

(3) issue licenses to individuals who are qualified under sections 148B.29 to 148B.392;

(4) establish and implement procedures designed to assure that licensed marriage and family therapists will comply with the board's rules;

(5) study and investigate the practice of marriage and family therapy within the state in order to improve the standards imposed for the licensing of marriage and family therapists and to improve the procedures and methods used for enforcement of the board's standards;

(6) formulate and implement a code of ethics for all licensed marriage and family therapists; and

(7) establish continuing education requirements for marriage and family therapists.

(b) At least four of the 40 continuing education training hours required under Minnesota Rules, part 5300.0320, subpart 2, must be on increasing the knowledge, understanding, self-awareness, and practice skills that enable a marriage and family therapist to serve clients from diverse socioeconomic and cultural backgrounds. Topics include but are not limited to:

(1) understanding culture, its functions, and strengths that exist in varied cultures;

(2) understanding clients' cultures and differences among and between cultural groups;

(3) understanding the nature of social diversity and oppression; and

(4) understanding cultural humility.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 5. Minnesota Statutes 2020, section 148B.51, is amended to read:

148B.51 BOARD OF BEHAVIORAL HEALTH AND THERAPY.

(a) The Board of Behavioral Health and Therapy consists of 13 members appointed by the governor. Five of the members shall be professional counselors licensed or eligible for licensure under sections 148B.50 to 148B.593. Five of the members shall be alcohol and drug counselors licensed under chapter 148F. Three of the members shall be public members as defined in section 214.02. The board shall annually elect from its membership a chair and vice-chair. The board shall appoint and employ an executive director who is not a member of the board. The employment of the executive director shall be subject to the terms

described in section 214.04, subdivision 2a. Chapter 214 applies to the Board of Behavioral Health and Therapy unless superseded by sections 148B.50 to 148B.593.

(b) At the time of their appointments, at least three members must reside outside of the seven-county metropolitan area.

(c) At the time of their appointments, at least three members must be members of:

(1) a community of color; or

(2) an underrepresented community, defined as a group that is not represented in the majority with respect to race, ethnicity, national origin, sexual orientation, gender identity, or physical ability.

Sec. 6. Minnesota Statutes 2020, section 148B.54, subdivision 2, is amended to read:

Subd. 2. **Continuing education.** (a) At the completion of the first four years of licensure, a licensee must provide evidence satisfactory to the board of completion of 12 additional postgraduate semester credit hours or its equivalent in counseling as determined by the board, except that no licensee shall be required to show evidence of greater than 60 semester hours or its equivalent. In addition to completing the requisite graduate coursework, each licensee shall also complete in the first four years of licensure a minimum of 40 hours of continuing education activities approved by the board under Minnesota Rules, part 2150.2540. Graduate credit hours successfully completed in the first four years of licensure may be applied to both the graduate credit requirement and to the requirement for 40 hours of continuing education activities. A licensee may receive 15 continuing education hours per semester credit hour or ten continuing education hours per quarter credit hour. Thereafter, at the time of renewal, each licensee shall provide evidence satisfactory to the board that the licensee has completed during each two-year period at least the equivalent of 40 clock hours of professional postdegree continuing education in programs approved by the board and continues to be qualified to practice under sections 148B.50 to 148B.593.

(b) At least four of the required 40 continuing education clock hours must be on increasing the knowledge, understanding, self-awareness, and practice skills that enable a licensed professional counselor and licensed professional clinical counselor to serve clients from diverse socioeconomic and cultural backgrounds. Topics include but are not limited to:

(1) understanding culture, culture's functions, and strengths that exist in varied cultures;

(2) understanding clients' cultures and differences among and between cultural groups;

(3) understanding the nature of social diversity and oppression; and

(4) understanding cultural humility.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 7. Minnesota Statutes 2020, section 148E.010, is amended by adding a subdivision to read:

Subd. 7f. **Cultural responsiveness.** "Cultural responsiveness" means increasing the knowledge, understanding, self-awareness, and practice skills that enable a social worker to serve clients from diverse socioeconomic and cultural backgrounds including:

(1) understanding culture, its functions, and strengths that exist in varied cultures;

(2) understanding clients' cultures and differences among and between cultural groups;

(3) understanding the nature of social diversity and oppression; and

(4) understanding cultural humility.

Sec. 8. Minnesota Statutes 2020, section 148E.130, subdivision 1, is amended to read:

Subdivision 1. **Total clock hours required.** (a) A licensee must complete 40 hours of continuing education for each two-year renewal term. At the time of license renewal, a licensee must provide evidence satisfactory to the board that the licensee has completed the required continuing education hours during the previous renewal term. Of the total clock hours required:

(1) all licensees must complete:

(i) two hours in social work ethics as defined in section 148E.010; and

(ii) four hours in cultural responsiveness;

(2) licensed independent clinical social workers must complete 12 clock hours in one or more of the clinical content areas specified in section 148E.055, subdivision 5, paragraph (a), clause (2);

(3) licensees providing licensing supervision according to sections 148E.100 to 148E.125, must complete six clock hours in supervision as defined in section 148E.010; and

(4) no more than half of the required clock hours may be completed via continuing education independent learning as defined in section 148E.010.

(b) If the licensee's renewal term is prorated to be less or more than 24 months, the total number of required clock hours is prorated proportionately.

Sec. 9. Minnesota Statutes 2020, section 148E.130, is amended by adding a subdivision to read:

Subd. 1b. **New content clock hours required effective July 1, 2021.** (a) The content clock hours in subdivision 1, paragraph (a), clause (1), item (ii), apply to all new licenses issued effective July 1, 2021, under section 148E.055.

(b) Any licensee issued a license prior to July 1, 2021, under section 148E.055 must comply with the clock hours in subdivision 1, including the content clock hours in subdivision 1, paragraph (a), clause (1), item (ii), at the first two-year renewal term after July 1, 2021.

Sec. 10. Minnesota Statutes 2020, section 156.12, subdivision 2, is amended to read:

Subd. 2. **Authorized activities.** No provision of this chapter shall be construed to prohibit:

(a) a person from rendering necessary gratuitous assistance in the treatment of any animal when the assistance does not amount to prescribing, testing for, or diagnosing, operating, or vaccinating and when the attendance of a licensed veterinarian cannot be procured;

(b) a person who is a regular student in an accredited or approved college of veterinary medicine from performing duties or actions assigned by instructors or preceptors or working under the direct supervision of a licensed veterinarian;

(c) a veterinarian regularly licensed in another jurisdiction from consulting with a licensed veterinarian in this state;

(d) the owner of an animal and the owner's regular employee from caring for and administering to the animal belonging to the owner, except where the ownership of the animal was transferred for purposes of circumventing this chapter;

(e) veterinarians who are in compliance with subdivision 6 and who are employed by the University of Minnesota from performing their duties with the College of Veterinary Medicine, College of Agriculture, Agricultural Experiment Station, Agricultural Extension Service, Medical School, School of Public Health, or other unit within the university; or a person from lecturing or giving instructions or demonstrations at the university or in connection with a continuing education course or seminar to veterinarians or pathologists at the University of Minnesota Veterinary Diagnostic Laboratory;

(f) any person from selling or applying any pesticide, insecticide or herbicide;

(g) any person from engaging in bona fide scientific research or investigations which reasonably requires experimentation involving animals;

(h) any employee of a licensed veterinarian from performing duties other than diagnosis, prescription or surgical correction under the direction and supervision of the veterinarian, who shall be responsible for the performance of the employee;

(i) a graduate of a foreign college of veterinary medicine from working under the direct personal instruction, control, or supervision of a veterinarian faculty member of the College of Veterinary Medicine, University of Minnesota in order to complete the requirements necessary to obtain an ECFVG or PAVE certificate;

(j) a licensed chiropractor registered under section 148.01, subdivision 1a, from practicing animal chiropractic~~.~~; or

(k) a person certified by the Emergency Medical Services Regulatory Board under chapter 144E from providing emergency medical care to a police dog wounded in the line of duty.

Sec. 11. **MENTAL HEALTH PROFESSIONAL LICENSING SUPERVISION.**

(a) The Board of Psychology, the Board of Marriage and Family Therapy, the Board of Social Work, and the Board of Behavioral Health and Therapy must convene to develop recommendations for:

(1) providing certification of individuals across multiple mental health professions who may serve as supervisors;

(2) adopting a single, common supervision certificate for all mental health professional education programs;

(3) determining ways for internship hours to be counted toward licensure in mental health professions; and

(4) determining ways for practicum hours to count toward supervisory experience.

(b) No later than February 1, 2023, the commissioners must submit a written report to the members of the legislative committees with jurisdiction over health and human services on the recommendations developed under paragraph (a).

ARTICLE 5
PRESCRIPTION DRUGS

Section 1. **[62J.841] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 62J.841 to 62J.845, the following definitions apply.

Subd. 2. **Consumer Price Index.** "Consumer Price Index" means the Consumer Price Index, Annual Average, for All Urban Consumers, CPI-U: U.S. City Average, All Items, reported by the United States Department of Labor, Bureau of Labor Statistics, or its successor or, if the index is discontinued, an equivalent index reported by a federal authority or, if no such index is reported, "Consumer Price Index" means a comparable index chosen by the Bureau of Labor Statistics.

Subd. 3. **Generic or off-patent drug.** "Generic or off-patent drug" means any prescription drug for which any exclusive marketing rights granted under the Federal Food, Drug, and Cosmetic Act, section 351 of the federal Public Health Service Act, and federal patent law have expired, including any drug-device combination product for the delivery of a generic drug.

Subd. 4. **Manufacturer.** "Manufacturer" has the meaning provided in section 151.01, subdivision 14a.

Subd. 5. **Prescription drug.** "Prescription drug" means a drug for human use subject to United States Code, title 21, section 353(b)(1).

Subd. 6. **Wholesale acquisition cost.** "Wholesale acquisition cost" has the meaning provided in United States Code, title 42, section 1395w-3a.

Subd. 7. **Wholesale distributor.** "Wholesale distributor" has the meaning provided in section 151.441, subdivision 14.

Sec. 2. **[62J.842] EXCESSIVE PRICE INCREASES PROHIBITED.**

Subdivision 1. **Prohibition.** No manufacturer shall impose, or cause to be imposed, an excessive price increase, whether directly or through a wholesale distributor, pharmacy, or similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or delivered to any consumer in the state.

Subd. 2. **Excessive price increase.** A price increase is excessive for purposes of this section when:

(1) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds:

(i) 15 percent of the wholesale acquisition cost over the immediately preceding calendar year; or

(ii) 40 percent of the wholesale acquisition cost over the immediately preceding three calendar years; and

(2) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds $30 for:

(i) a 30-day supply of the drug; or

(ii) a course of treatment lasting less than 30 days.

Subd. 3. **Exemption.** It is not a violation of this section for a wholesale distributor or pharmacy to increase the price of a generic or off-patent drug if the price increase is directly attributable to additional costs for the drug imposed on the wholesale distributor or pharmacy by the manufacturer of the drug.

Sec. 3. **[62J.843] REGISTERED AGENT AND OFFICE WITHIN THE STATE.**

Any manufacturer that sells, distributes, delivers, or offers for sale any generic or off-patent drug in the state is required to maintain a registered agent and office within the state.

Sec. 4. **[62J.844] ENFORCEMENT.**

Subdivision 1. **Notification.** The commissioner of management and budget and any other state agency that provides or purchases a pharmacy benefit except the Department of Human Services, and any entity under contract with a state agency to provide a pharmacy benefit other than an entity under contract with the Department of Human Services, shall notify the manufacturer of a generic or off-patent drug, the attorney general, and the Board of Pharmacy of any price increase that is in violation of section 62J.842.

Subd. 2. **Submission of drug cost statement and other information by manufacturer; investigation by attorney general.** (a) Within 45 days of receiving a notice under subdivision 1, the manufacturer of the generic or off-patent drug shall submit a drug cost statement to the attorney general. The statement must:

(1) itemize the cost components related to production of the drug;

(2) identify the circumstances and timing of any increase in materials or manufacturing costs that caused any increase during the preceding calendar year, or preceding three calendar years as applicable, in the price of the drug; and

(3) provide any other information that the manufacturer believes to be relevant to a determination of whether a violation of section 62J.842 has occurred.

(b) The attorney general may investigate whether a violation of section 62J.842 has occurred, is occurring, or is about to occur, in accordance with section 8.31, subdivision 2.

Subd. 3. **Petition to court.** (a) On petition of the attorney general, a court may issue an order:

(1) compelling the manufacturer of a generic or off-patent drug to:

(i) provide the drug cost statement required under subdivision 2, paragraph (a); and

(ii) answer interrogatories, produce records or documents, or be examined under oath, as required by the attorney general under subdivision 2, paragraph (b);

(2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including issuing an order requiring that drug prices be restored to levels that comply with section 62J.842;

(3) requiring the manufacturer to provide an accounting to the attorney general of all revenues resulting from a violation of section 62J.842;

(4) requiring the manufacturer to repay to all consumers, including any third-party payers, any money acquired as a result of a price increase that violates section 62J.842;

(5) notwithstanding section 16A.151, requiring that all revenues generated from a violation of section 62J.842 be remitted to the state and deposited into a special fund, to be used for initiatives to reduce the cost to consumers of acquiring prescription drugs, if a manufacturer is unable to determine the individual transactions necessary to provide the repayments described in clause (4);

(6) imposing a civil penalty of up to $10,000 per day for each violation of section 62J.842;

(7) providing for the attorney general's recovery of its costs and disbursements incurred in bringing an action against a manufacturer found in violation of section 62J.842, including the costs of investigation and reasonable attorney's fees; and

(8) providing any other appropriate relief, including any other equitable relief as determined by the court.

(b) For purposes of paragraph (a), clause (6), every individual transaction in violation of section 62J.842 shall be considered a separate violation.

Subd. 4. **Private right of action.** Any action brought pursuant to section 8.31, subdivision 3a, by a person injured by a violation of this section is for the benefit of the public.

Sec. 5. **[62J.845] PROHIBITION ON WITHDRAWAL OF GENERIC OR OFF-PATENT DRUGS FOR SALE.**

Subdivision 1. **Prohibition.** A manufacturer of a generic or off-patent drug is prohibited from withdrawing that drug from sale or distribution within this state for the purpose of avoiding the prohibition on excessive price increases under section 62J.842.

Subd. 2. **Notice to board and attorney general.** Any manufacturer that intends to withdraw a generic or off-patent drug from sale or distribution within the state shall provide a written notice of withdrawal to the Board of Pharmacy and the attorney general, at least 180 days prior to the withdrawal.

Subd. 3. **Financial penalty.** The attorney general shall assess a penalty of $500,000 on any manufacturer of a generic or off-patent drug that it determines has failed to comply with the requirements of this section.

Sec. 6. **[62J.846] SEVERABILITY.**

If any provision of sections 62J.841 to 62J.845 or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of sections 62J.841 to 62J.845 that can be given effect without the invalid provision or application.

Sec. 7. Minnesota Statutes 2020, section 62Q.81, is amended by adding a subdivision to read:

Subd. 6. **Prescription drug benefits.** (a) A health plan company that offers individual health plans must ensure that no fewer than 25 percent of the individual health plans the company offers in each geographic area that the health plan company services at each level of coverage described in subdivision 1, paragraph (b), clause (3), applies a predeductible, flat-dollar amount co-payment structure to the entire drug benefit, including all tiers.

(b) A health plan company that offers small group health plans must ensure that no fewer than 25 percent of small group health plans the company offers in each geographic area that the health plan company services at each level of coverage described in subdivision 1, paragraph (b), clause (3), applies a predeductible, flat-dollar amount co-payment structure to the entire drug benefit, including all tiers.

(c) The highest allowable co-payment for the highest cost drug tier for health plans offered pursuant to this subdivision must be no greater than 1/12 of the plan's out-of-pocket maximum for an individual.

(d) The flat-dollar amount co-payment tier structure for prescription drugs under this subdivision must be graduated and proportionate.

(e) All individual and small group health plans offered pursuant to this subdivision must be:

(1) clearly and appropriately named to aid the purchaser in the selection process;

(2) marketed in the same manner as other health plans offered by the health plan company; and

(3) offered for purchase to any individual or small group.

(f) This subdivision does not apply to catastrophic plans, grandfathered plans, large group health plans, health savings accounts (HSAs), qualified high deductible health benefit plans, limited health benefit plans, or short-term limited-duration health insurance policies.

(g) Health plan companies must meet the requirements in this subdivision separately for plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

EFFECTIVE DATE. This section is effective January 1, 2022, and applies to individual and small group health plans offered, issued, or renewed on or after that date.

Sec. 8. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

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

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Enrollee contract term" means the 12-month term during which benefits associated with health plan company products are in effect. For managed care plans and county-based purchasing plans under section 256B.69 and chapter 256L, enrollee contract term means a single calendar quarter.

(d) "Formulary" means a list of prescription drugs that have been developed by clinical and pharmacy experts and represents the health plan company's medically appropriate and cost-effective prescription drugs approved for use.

(e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and includes an entity that performs pharmacy benefits management for the health plan company.

(f) "Pharmacy benefits management" means the administration or management of prescription drug benefits provided by the health plan company for the benefit of its enrollees

and may include but is not limited to procurement of prescription drugs, clinical formulary development and management services, claims processing, and rebate contracting and administration.

(g) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides prescription drug benefit coverage and uses a formulary must make its formulary and related benefit information available by electronic means and, upon request, in writing at least 30 days prior to annual renewal dates.

(b) Formularies must be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's Model Guidelines.

(c) For each item or category of items on the formulary, the specific enrollee benefit terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan company may, at any time during the enrollee's contract term:

(1) expand its formulary by adding drugs to the formulary;

(2) reduce co-payments or coinsurance; or

(3) move a drug to a benefit category that reduces an enrollee's cost.

(b) A health plan company may remove a brand name drug from its formulary or place a brand name drug in a benefit category that increases an enrollee's cost only upon the addition to the formulary of a generic or multisource brand name drug rated as therapeutically equivalent according to the Food and Drug Administration (FDA) Orange Book or a biologic drug rated as interchangeable according to the FDA Purple Book at a lower cost to the enrollee and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

(c) A health plan company may change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the enrollee's contract term upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided that these changes do not apply to enrollees who are currently taking the drugs affected by these changes for the duration of the enrollee's contract term.

(d) A health plan company may remove any drugs from its formulary that have been deemed unsafe by the FDA; that have been withdrawn by either the FDA or the product manufacturer; or when an independent source of research, clinical guidelines, or

evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

Subd. 4. **Exclusion.** This section does not apply to health coverage provided through the State Employee Group Insurance Plan (SEGIP) under chapter 43A.

Sec. 9. **[62W.0751] ALTERNATIVE BIOLOGICAL PRODUCTS.**

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

(b) "Biological product" has the meaning given in section 151.01, subdivision 40.

(c) "Biosimilar" or "biosimilar product" has the meaning given in section 151.01, subdivision 43.

(d) "Interchangeable biological product" has the meaning given in section 151.01, subdivision 41.

(e) "Reference biological product" has the meaning given in section 151.01, subdivision 44.

Subd. 2. **Pharmacy and provider choice related to dispensing reference biological products, interchangeable biological products, or biosimilar products.** (a) A pharmacy benefit manager or health carrier must not require or demonstrate a preference for a pharmacy or health care provider to prescribe or dispense a single biological product for which there is a United States Food and Drug Administration-approved biosimilar or interchangeable biological product relative to a reference biological product, except as provided in paragraph (b).

(b) If a pharmacy benefit manager or health carrier elects coverage of a product listed in paragraph (a), it must also elect equivalent coverage for at least three reference, biosimilar, or interchangeable biological products, or the total number of products that have been approved by the United States Food and Drug Administration relative to the reference product if less than three, for which the wholesale acquisition cost is less than the wholesale acquisition cost of the product listed in paragraph (a).

(c) A pharmacy benefit manager or health carrier must not impose limits on access to a product required to be covered under paragraph (b) that are more restrictive than limits imposed on access to a product listed in paragraph (a), or that otherwise have the same effect as giving preferred status to a product listed in paragraph (a) over the product required to be covered under paragraph (b).

(d) This section does not apply to coverage provided through a public health care program under chapter 256B or 256L, or health plan coverage through the State Employee Group Insurance Plan (SEGIP) under chapter 43A.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 10. Minnesota Statutes 2020, section 62W.11, is amended to read:

62W.11 GAG CLAUSE PROHIBITION.

(a) No contract between a pharmacy benefit manager or health carrier and a pharmacy or pharmacist shall prohibit, restrict, or penalize a pharmacy or pharmacist from disclosing to an enrollee any health care information that the pharmacy or pharmacist deems appropriate regarding the nature of treatment; the risks or alternatives; the availability of alternative therapies, consultations, or tests; the decision of utilization reviewers or similar persons to authorize or deny services; the process that is used to authorize or deny health care services or benefits; or information on financial incentives and structures used by the health carrier or pharmacy benefit manager.

(b) A pharmacy or pharmacist must provide to an enrollee information regarding the enrollee's total cost for each prescription drug dispensed where part or all of the cost of the prescription is being paid or reimbursed by the employer-sponsored plan or by a health carrier or pharmacy benefit manager, in accordance with section 151.214, subdivision 1.

(c) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or pharmacy from discussing information regarding the total cost for pharmacy services for a prescription drug, including the patient's co-payment amount ~~and~~, the pharmacy's own usual and customary price ~~of~~ for the prescription drug, the pharmacy's acquisition cost for the prescription drug, and the amount the pharmacy is being reimbursed by the pharmacy benefit manager or health carrier for the prescription drug.

(d) A pharmacy benefit manager must not prohibit a pharmacist or pharmacy from discussing with a health carrier the amount the pharmacy is being paid or reimbursed for a prescription drug by the pharmacy benefit manager or the pharmacy's acquisition cost for a prescription drug.

~~(d)~~ (e) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or pharmacy from discussing the availability of any therapeutically equivalent alternative prescription drugs or alternative methods for purchasing the prescription drug, including but not limited to paying out-of-pocket the pharmacy's usual and customary price when that

amount is less expensive to the enrollee than the amount the enrollee is required to pay for the prescription drug under the enrollee's health plan.

Sec. 11. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to read:

Subd. 43. **Biosimilar product.** "Biosimilar" or "interchangeable biological product" means a biological product that the United States Food and Drug Administration has licensed, and determined to be "biosimilar" under United States Code, title 42, section 262(i)(2).

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 12. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to read:

Subd. 44. **Reference biological product.** "Reference biological product" means the single biological product for which the United States Food and Drug Administration has approved an initial biological product license application, against which other biological products are evaluated for licensure as biosimilar products or interchangeable biological products.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 13. Minnesota Statutes 2020, section 151.071, subdivision 1, is amended to read:

Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee, registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do one or more of the following:

(1) deny the issuance of a license or registration;

(2) refuse to renew a license or registration;

(3) revoke the license or registration;

(4) suspend the license or registration;

(5) impose limitations, conditions, or both on the license or registration, including but not limited to: the limitation of practice to designated settings; the limitation of the scope of practice within designated settings; the imposition of retraining or rehabilitation requirements; the requirement of practice under supervision; the requirement of participation in a diversion program such as that established pursuant to section 214.31 or the conditioning

of continued practice on demonstration of knowledge or skills by appropriate examination or other review of skill and competence;

(6) impose a civil penalty not exceeding $10,000 for each separate violation, except that a civil penalty not exceeding $25,000 may be imposed for each separate violation of section 62J.842, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant of any economic advantage gained by reason of the violation, to discourage similar violations by the licensee or registrant or any other licensee or registrant, or to reimburse the board for the cost of the investigation and proceeding, including but not limited to, fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members; and

(7) reprimand the licensee or registrant.

Sec. 14. Minnesota Statutes 2020, section 151.071, subdivision 2, is amended to read:

Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is grounds for disciplinary action:

(1) failure to demonstrate the qualifications or satisfy the requirements for a license or registration contained in this chapter or the rules of the board. The burden of proof is on the applicant to demonstrate such qualifications or satisfaction of such requirements;

(2) obtaining a license by fraud or by misleading the board in any way during the application process or obtaining a license by cheating, or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to: (i) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (ii) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf;

(3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration, conviction of a felony reasonably related to the practice of pharmacy. Conviction as used

in this subdivision includes a conviction of an offense that if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon. The board may delay the issuance of a new license or registration if the applicant has been charged with a felony until the matter has been adjudicated;

(4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner or applicant is convicted of a felony reasonably related to the operation of the facility. The board may delay the issuance of a new license or registration if the owner or applicant has been charged with a felony until the matter has been adjudicated;

(5) for a controlled substance researcher, conviction of a felony reasonably related to controlled substances or to the practice of the researcher's profession. The board may delay the issuance of a registration if the applicant has been charged with a felony until the matter has been adjudicated;

(6) disciplinary action taken by another state or by one of this state's health licensing agencies:

(i) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration in another state or jurisdiction, failure to report to the board that charges or allegations regarding the person's license or registration have been brought in another state or jurisdiction, or having been refused a license or registration by any other state or jurisdiction. The board may delay the issuance of a new license or registration if an investigation or disciplinary action is pending in another state or jurisdiction until the investigation or action has been dismissed or otherwise resolved; and

(ii) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration issued by another of this state's health licensing agencies, failure to report to the board that charges regarding the person's license or registration have been brought by another of this state's health licensing agencies, or having been refused a license or registration by another of this state's health licensing agencies. The board may delay the issuance of a new license or registration if a disciplinary action is pending before another of this state's health licensing agencies until the action has been dismissed or otherwise resolved;

(7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of any order of the board, of any of the provisions of this chapter or any rules of the board or

violation of any federal, state, or local law or rule reasonably pertaining to the practice of pharmacy;

(8) for a facility, other than a pharmacy, licensed by the board, violations of any order of the board, of any of the provisions of this chapter or the rules of the board or violation of any federal, state, or local law relating to the operation of the facility;

(9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient; or pharmacy practice that is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established;

(10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy technician or pharmacist intern if that person is performing duties allowed by this chapter or the rules of the board;

(11) for an individual licensed or registered by the board, adjudication as mentally ill or developmentally disabled, or as a chemically dependent person, a person dangerous to the public, a sexually dangerous person, or a person who has a sexual psychopathic personality, by a court of competent jurisdiction, within or without this state. Such adjudication shall automatically suspend a license for the duration thereof unless the board orders otherwise;

(12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist intern or performing duties specifically reserved for pharmacists under this chapter or the rules of the board;

(13) for a pharmacy, operation of the pharmacy without a pharmacist present and on duty except as allowed by a variance approved by the board;

(14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills. In the case of registered pharmacy technicians, pharmacist interns, or controlled substance researchers, the inability to carry out duties allowed under this chapter or the rules of the board with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type

of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills;

(15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas dispenser, or controlled substance researcher, revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law;

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

(17) fee splitting, including without limitation:

(i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

(ii) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the licensee or registrant has a financial or economic interest as defined in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the licensee's or registrant's financial or economic interest in accordance with section 144.6521; and

(iii) any arrangement through which a pharmacy, in which the prescribing practitioner does not have a significant ownership interest, fills a prescription drug order and the prescribing practitioner is involved in any manner, directly or indirectly, in setting the price for the filled prescription that is charged to the patient, the patient's insurer or pharmacy benefit manager, or other person paying for the prescription or, in the case of veterinary patients, the price for the filled prescription that is charged to the client or other person paying for the prescription, except that a veterinarian and a pharmacy may enter into such an arrangement provided that the client or other person paying for the prescription is notified, in writing and with each prescription dispensed, about the arrangement, unless such arrangement involves pharmacy services provided for livestock, poultry, and agricultural production systems, in which case client notification would not be required;

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

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

(20) failure to make reports as required by section 151.072 or to cooperate with an investigation of the board as required by section 151.074;

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

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

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

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

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

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

(23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For a pharmacist intern, pharmacy technician, or controlled substance researcher, performing duties permitted to such individuals by this chapter or the rules of the board under a lapsed or nonrenewed registration. For a facility required to be licensed under this chapter, operation of the facility under a lapsed or nonrenewed license or registration; ~~and~~

(24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge from the health professionals services program for reasons other than the satisfactory completion of the program~~.~~; and

(25) for a manufacturer, a violation of section 62J.842 or section 62J.845.

Sec. 15. **[151.335] DELIVERY THROUGH COMMON CARRIER; COMPLIANCE WITH TEMPERATURE REQUIREMENTS.**

In addition to complying with the requirements of Minnesota Rules, part 6800.3000, a mail order or specialty pharmacy that employs the United States Postal Service or other common carrier to deliver a filled prescription directly to a patient must ensure that the drug is delivered in compliance with temperature requirements established by the manufacturer of the drug. The pharmacy must develop written policies and procedures that are consistent

with United States Pharmacopeia, chapters 1079 and 1118, and with nationally recognized standards issued by standard-setting or accreditation organizations recognized by the board through guidance. The policies and procedures must be provided to the board upon request.

Sec. 16. Minnesota Statutes 2020, section 151.555, subdivision 1, is amended to read:

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

(b) "Central repository" means a wholesale distributor that meets the requirements under subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this section.

(c) "Distribute" means to deliver, other than by administering or dispensing.

(d) "Donor" means:

(1) a health care facility as defined in this subdivision;

(2) a skilled nursing facility licensed under chapter 144A;

(3) an assisted living facility registered under chapter 144D where there is centralized storage of drugs and 24-hour on-site licensed nursing coverage provided seven days a week;

(4) a pharmacy licensed under section 151.19, and located either in the state or outside the state;

(5) a drug wholesaler licensed under section 151.47;

(6) a drug manufacturer licensed under section 151.252; or

(7) an individual at least 18 years of age, provided that the drug or medical supply that is donated was obtained legally and meets the requirements of this section for donation.

(e) "Drug" means any prescription drug that has been approved for medical use in the United States, is listed in the United States Pharmacopoeia or National Formulary, and meets the criteria established under this section for donation; or any over-the-counter medication that meets the criteria established under this section for donation. This definition includes cancer drugs and antirejection drugs, but does not include controlled substances, as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed to a patient registered with the drug's manufacturer in accordance with federal Food and Drug Administration requirements.

(f) "Health care facility" means:

(1) a physician's office or health care clinic where licensed practitioners provide health care to patients;

(2) a hospital licensed under section 144.50;

(3) a pharmacy licensed under section 151.19 and located in Minnesota; or

(4) a nonprofit community clinic, including a federally qualified health center; a rural health clinic; public health clinic; or other community clinic that provides health care utilizing a sliding fee scale to patients who are low-income, uninsured, or underinsured.

(g) "Local repository" means a health care facility that elects to accept donated drugs and medical supplies and meets the requirements of subdivision 4.

(h) "Medical supplies" or "supplies" means any prescription and nonprescription medical supplies needed to administer a prescription drug.

(i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules, part 6800.3750.

(j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that it does not include a veterinarian.

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

Sec. 17. Minnesota Statutes 2020, section 151.555, subdivision 7, is amended to read:

Subd. 7. **Standards and procedures for inspecting and storing donated prescription drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or under contract with the central repository or a local repository shall inspect all donated prescription drugs and supplies before the drug or supply is dispensed to determine, to the extent reasonably possible in the professional judgment of the pharmacist or practitioner, that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing, has not been subject to a recall, and meets the requirements for donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an inspection record stating that the requirements for donation have been met. If a local repository receives drugs and supplies from the central repository, the local repository does not need to reinspect the drugs and supplies.

(b) The central repository and local repositories shall store donated drugs and supplies in a secure storage area under environmental conditions appropriate for the drug or supply being stored. Donated drugs and supplies may not be stored with nondonated inventory. ~~If donated drugs or supplies are not inspected immediately upon receipt, a repository must quarantine the donated drugs or supplies separately from all dispensing stock until the donated drugs or supplies have been inspected and (1) approved for dispensing under the program; (2) disposed of pursuant to paragraph (c); or (3) returned to the donor pursuant to paragraph (d).~~

(c) The central repository and local repositories shall dispose of all prescription drugs and medical supplies that are not suitable for donation in compliance with applicable federal and state statutes, regulations, and rules concerning hazardous waste.

(d) In the event that controlled substances or prescription drugs that can only be dispensed to a patient registered with the drug's manufacturer are shipped or delivered to a central or local repository for donation, the shipment delivery must be documented by the repository and returned immediately to the donor or the donor's representative that provided the drugs.

(e) Each repository must develop drug and medical supply recall policies and procedures. If a repository receives a recall notification, the repository shall destroy all of the drug or medical supply in its inventory that is the subject of the recall and complete a record of destruction form in accordance with paragraph (f). If a drug or medical supply that is the subject of a Class I or Class II recall has been dispensed, the repository shall immediately notify the recipient of the recalled drug or medical supply. A drug that potentially is subject to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

(f) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation shall be maintained by the repository for at least ~~five~~ two years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the drug destroyed; and

(3) the name of the person or firm that destroyed the drug.

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

Sec. 18. Minnesota Statutes 2020, section 151.555, subdivision 11, is amended to read:

Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed for the administration of this program shall be utilized by the participants of the program and shall be available on the board's website:

(1) intake application form described under subdivision 5;

(2) local repository participation form described under subdivision 4;

(3) local repository withdrawal form described under subdivision 4;

(4) drug repository donor form described under subdivision 6;

(5) record of destruction form described under subdivision 7; and

(6) drug repository recipient form described under subdivision 8.

(b) All records, including drug inventory, inspection, and disposal of donated prescription drugs and medical supplies, must be maintained by a repository for a minimum of ~~five~~ two years. Records required as part of this program must be maintained pursuant to all applicable practice acts.

(c) Data collected by the drug repository program from all local repositories shall be submitted quarterly or upon request to the central repository. Data collected may consist of the information, records, and forms required to be collected under this section.

(d) The central repository shall submit reports to the board as required by the contract or upon request of the board.

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

Sec. 19. Minnesota Statutes 2020, section 151.555, is amended by adding a subdivision to read:

Subd. 14. **Cooperation.** The central repository, as approved by the Board of Pharmacy, may enter into an agreement with another state that has an established drug repository or drug donation program if the other state's program includes regulations to ensure the purity, integrity, and safety of the drugs and supplies donated, to permit the central repository to offer to another state program inventory that is not needed by a Minnesota resident and to accept inventory from another state program to be distributed to local repositories and dispensed to Minnesota residents in accordance with this program.

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

Sec. 20. Minnesota Statutes 2020, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

(c) Managed care plans and county-based purchasing plans must comply with section 62Q.83.

Sec. 21. **STUDY OF PHARMACY AND PROVIDER CHOICE OF BIOLOGICAL PRODUCTS.**

The commissioner of health, within the limits of existing resources, shall analyze the effect of Minnesota Statutes, section 62W.0751, on the net price for different payors of biological products, interchangeable biological products, and biosimilar products. The commissioner of health shall report findings to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, and insurance, by December 15, 2023.

Sec. 22. **STUDY OF TEMPERATURE MONITORING.**

The Board of Pharmacy shall conduct a study to determine the appropriateness and feasibility of requiring mail order and specialty pharmacies to enclose in each medication's packaging a method by which the patient can easily detect improper storage or temperature variations that may have occurred during the delivery of a medication. The board shall report the results of the study by January 15, 2022, to the chairs and ranking minority members of the legislative committees with jurisdiction over health finance and policy.

ARTICLE 6
HEALTH INSURANCE

Section 1. Minnesota Statutes 2020, section 62A.04, subdivision 2, is amended to read:

Subd. 2. **Required provisions.** Except as provided in subdivision 4 each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subdivision in the words in which the same appear in this section. The insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subdivision or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) A provision as follows:

TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two year period, nor to limit the application of clauses (1), (2), (3), (4) and (5), in the event of misstatement with respect to age or occupation or other insurance. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(3)(a) Except as required for qualified health plans sold through MNsure to individuals receiving advance payments of the premium tax credit, a provision as follows:

GRACE PERIOD: A grace period of ..... (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

A policy which contains a cancellation provision may add, at the end of the above provision,

subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision,

Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.

(b) For ~~qualified~~ individual and small group health plans ~~sold through MNsure to individuals receiving advance payments of the premium tax credit~~, a grace period provision must be included that complies with ~~the Affordable Care Act and is no less restrictive than the grace period required by the Affordable Care Act~~ section 62A.65, subdivision 2a.

(4) A provision as follows:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. For health plans described in section 62A.011, subdivision 3, clause (10), an insurer must accept payment of a renewal premium and reinstate the policy, if the insured applies for reinstatement no later than 60 days after the due date for the premium payment, unless:

(1) the insured has in the interim left the state or the insurer's service area; or

(2) the insured has applied for reinstatement on two or more prior occasions.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement. The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.

(5) A provision as follows:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the

beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

(6) A provision as follows:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(7) A provision as follows:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(8) A provision as follows:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(9) A provision as follows:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $..... (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

(10) A provision as follows:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it

may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision as follows:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(12) A provision as follows:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy. The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2020, section 62A.10, is amended by adding a subdivision to read:

Subd. 5. **Prohibition on waiting periods that exceed 90 days.** (a) For purposes of this subdivision, "waiting period" means the period that must pass before coverage becomes effective for an individual who is otherwise eligible to enroll under the terms of a group health plan.

(b) A health carrier offering a group health plan must not apply a waiting period that exceeds 90 days, with exceptions for the circumstances described in paragraphs (c) to (e). A health carrier does not violate this subdivision solely because an individual is permitted to take additional time to elect coverage beyond the end of the 90-day waiting period.

(c) If a group health plan conditions eligibility on an employee working full time or regularly having a specified number of service hours per period, and the plan is unable to determine whether a newly hired employee is full time or reasonably expected to regularly work the specific number of hours per period, the plan may take a reasonable period of time, not to exceed 12 months beginning on any date between the employee's start date and the first day of the first calendar month after the employee's start date, to determine whether the employee meets the plan's eligibility condition.

(d) If a group health plan conditions eligibility on an employee having completed a cumulative number of service hours, the cumulative hours-of-service requirement must not exceed 1,200 hours.

(e) An orientation period may be added to the 90-day waiting period if the orientation period is one month or less. The one-month period is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage.

(f) A group health plan may treat an employee whose employment has terminated and is later rehired as newly eligible upon rehire and require the rehired employee to meet the plan's eligibility criteria and waiting period again, if doing so is reasonable under the circumstances. Treating an employee as rehired is reasonable if the employee has a break in service of at least 13 weeks, or at least 26 weeks if the employer is an educational institution.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2020, section 62A.15, is amended by adding a subdivision to read:

Subd. 3c. **Mental health services.** All benefits provided by a policy or contract referred to in subdivision 1 relating to expenses incurred for mental health treatment or services provided by a mental health professional must also include treatment and services provided by a clinical trainee to the extent that the services and treatment are within the scope of practice of the clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C. This subdivision is intended to provide equal payment of benefits for mental health treatment and services provided by a mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee and is not intended to change or add to the benefits provided for in those policies or contracts.

EFFECTIVE DATE. This section is effective January 1, 2022, and applies to policies and contracts offered, issued, or renewed on or after that date.

Sec. 4. Minnesota Statutes 2020, section 62A.15, subdivision 4, is amended to read:

Subd. 4. **Denial of benefits.** (a) No carrier referred to in subdivision 1 may, in the payment of claims to employees in this state, deny benefits payable for services covered by the policy or contract if the services are lawfully performed by a licensed chiropractor,

licensed optometrist, a registered nurse meeting the requirements of subdivision 3a, ~~or~~ a licensed acupuncture practitioner, or a mental health clinical trainee.

(b) When carriers referred to in subdivision 1 make claim determinations concerning the appropriateness, quality, or utilization of chiropractic health care for Minnesotans, any of these determinations that are made by health care professionals must be made by, or under the direction of, or subject to the review of licensed doctors of chiropractic.

(c) When a carrier referred to in subdivision 1 makes a denial of payment claim determination concerning the appropriateness, quality, or utilization of acupuncture services for individuals in this state performed by a licensed acupuncture practitioner, a denial of payment claim determination that is made by a health professional must be made by, under the direction of, or subject to the review of a licensed acupuncture practitioner.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 5. Minnesota Statutes 2020, section 62A.65, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** No health carrier, as defined in section 62A.011, shall offer, sell, issue, or renew any individual health plan, as defined in section 62A.011, to a Minnesota resident except in compliance with this section. ~~This section does not apply to the Comprehensive Health Association established in section 62E.10.~~ A health carrier must only offer, sell, issue, or renew individual health plans on a guaranteed issue basis and at a premium rate that does not vary based on the health status of the individual.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 6. Minnesota Statutes 2020, section 62A.65, is amended by adding a subdivision to read:

Subd. 2a. **Grace period for nonpayment of premium.** (a) Notwithstanding any other law to the contrary, an individual health plan may be canceled for nonpayment of premiums, but must include a grace period as described in this subdivision.

(b) The grace period must be three consecutive months. During the grace period, the health carrier must:

(1) pay all claims for services that would have been covered if the premium had been paid, which are provided to the enrollee during the first month of the grace period, and may pend claims for services provided to an enrollee in the second and third months of the grace period; and

(2) notify health care providers of the possibility of denied claims when an enrollee is in the second and third month of the grace period.

(c) In order to stop a cancellation, an enrollee must pay all outstanding premiums before the end of the grace period.

(d) If a health plan is canceled under this subdivision, the final day of the enrollment is the last day of the first month of the three-month grace period.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 7. Minnesota Statutes 2020, section 62D.095, subdivision 2, is amended to read:

Subd. 2. **Co-payments.** A health maintenance contract may impose a co-payment and coinsurance consistent with ~~the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a~~ state and federal law.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 8. Minnesota Statutes 2020, section 62D.095, subdivision 3, is amended to read:

Subd. 3. **Deductibles.** A health maintenance contract may impose a deductible consistent with ~~the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a~~ state and federal law.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 9. Minnesota Statutes 2020, section 62D.095, subdivision 4, is amended to read:

Subd. 4. **Annual out-of-pocket maximums.** A health maintenance contract may impose an annual out-of-pocket maximum consistent with the provisions of ~~the Affordable Care Act as defined under section 62A.011, subdivision 1a~~ section 62Q.677, subdivision 6a.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 10. Minnesota Statutes 2020, section 62D.095, subdivision 5, is amended to read:

Subd. 5. **Exceptions.** No co-payments or deductibles may be imposed on preventive ~~health care~~ items and services ~~consistent with the provisions of the Affordable Care Act as~~

~~defined under section 62A.011, subdivision 1a~~, as defined in section 62Q.46, subdivision 1.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 11. Minnesota Statutes 2020, section 62Q.01, subdivision 2a, is amended to read:

Subd. 2a. **Dependent child to the limiting age.** "Dependent child to the limiting age" or "dependent children to the limiting age" means those individuals who are eligible and covered as a dependent child under the terms of a health plan who have not yet attained 26 years of age. A health plan company must not deny or restrict eligibility for a dependent child to the limiting age based on financial dependency, residency, marital status, or student status. For coverage under plans offered by the Minnesota Comprehensive Health Association, dependent to the limiting age means dependent as defined in section 62A.302, subdivision 3. Notwithstanding the provisions in this subdivision, a health plan may include:

(1) eligibility requirements regarding the absence of other health plan coverage ~~as permitted by the Affordable Care Act~~ for grandfathered plan coverage; or

(2) an age greater than 26 in its policy, contract, or certificate of coverage.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 12. **[62Q.097] REQUIREMENTS FOR TIMELY PROVIDER CREDENTIALING.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Clean application for provider credentialing" or "clean application" means an application for provider credentialing submitted by a health care provider to a health plan company that is complete, is in the format required by the health plan company, and includes all information and substantiation required by the health plan company and does not require evaluation of any identified potential quality or safety concern.

(c) "Provider credentialing" means the process undertaken by a health plan company to evaluate and approve a health care provider's education, training, residency, licenses, certifications, and history of significant quality or safety concerns in order to approve the health care provider to provide health care services to patients at a clinic or facility.

Subd. 2. **Time limit for credentialing determination.** A health plan company that receives an application for provider credentialing must:

(1) if the application is determined to be a clean application for provider credentialing and if the health care provider submitting the application or the clinic or facility at which the health care provider provides services requests the information, affirm that the health care provider's application is a clean application and notify the health care provider or clinic or facility of the date by which the health plan company will make a determination on the health care provider's application;

(2) if the application is determined not to be a clean application, inform the health care provider of the application's deficiencies or missing information or substantiation within three business days after the health plan company determines the application is not a clean application; and

(3) make a determination on the health care provider's clean application within 45 days after receiving the clean application unless the health plan company identifies a substantive quality or safety concern in the course of provider credentialing that requires further investigation. Upon notice to the health care provider, clinic, or facility, the health plan company is allowed 30 additional days to investigate any quality or safety concerns.

EFFECTIVE DATE; APPLICATION. This section applies to applications for provider credentialing submitted to a health plan company on or after January 1, 2022.

Sec. 13. Minnesota Statutes 2020, section 62Q.46, is amended to read:

62Q.46 PREVENTIVE ITEMS AND SERVICES.

Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and services" ~~has the meaning specified in the Affordable Care Act~~ means the items and services categorized as preventive under subdivision 1a.

(b) A health plan company must provide coverage for preventive items and services at a participating provider without imposing cost-sharing requirements, including a deductible, coinsurance, or co-payment. Nothing in this section prohibits a health plan company that has a network of providers from excluding coverage or imposing cost-sharing requirements for preventive items or services that are delivered by an out-of-network provider.

(c) A health plan company is not required to provide coverage for any items or services specified in any recommendation or guideline described in paragraph (a) if the recommendation or guideline is no longer included as a preventive item or service as defined in paragraph (a). Annually, a health plan company must determine whether any additional

items or services must be covered without cost-sharing requirements or whether any items or services are no longer required to be covered.

(d) Nothing in this section prevents a health plan company from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for a preventive item or service to the extent not specified in the recommendation or guideline.

(e) This section does not apply to grandfathered plans.

(f) This section does not apply to plans offered by the Minnesota Comprehensive Health Association.

Subd. 1a. **Preventive items and services.** The commissioner of commerce must provide health plan companies with information regarding which items and services must be categorized as preventive.

Subd. 2. **Coverage for office visits in conjunction with preventive items and services.** (a) A health plan company may impose cost-sharing requirements with respect to an office visit if a preventive item or service is billed separately or is tracked separately as individual encounter data from the office visit.

(b) A health plan company must not impose cost-sharing requirements with respect to an office visit if a preventive item or service is not billed separately or is not tracked separately as individual encounter data from the office visit and the primary purpose of the office visit is the delivery of the preventive item or service.

(c) A health plan company may impose cost-sharing requirements with respect to an office visit if a preventive item or service is not billed separately or is not tracked separately as individual encounter data from the office visit and the primary purpose of the office visit is not the delivery of the preventive item or service.

Subd. 3. **Additional services not prohibited.** Nothing in this section prohibits a health plan company from providing coverage for preventive items and services in addition to those specified in ~~the Affordable Care Act~~ subdivision 1a, or from denying coverage for preventive items and services that are not recommended as preventive items and services under ~~the Affordable Care Act~~ subdivision 1a. A health plan company may impose cost-sharing requirements for a treatment not described in ~~the Affordable Care Act~~ subdivision 1a even if the treatment results from a preventive item or service described in ~~the Affordable Care Act~~ subdivision 1a.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 14. **[62Q.472] SCREENING AND TESTING FOR OPIOIDS.**

(a) A health plan company shall not place a lifetime or annual limit on screenings and urinalysis testing for opioids for an enrollee in an inpatient or outpatient substance use disorder treatment program when ordered by a health care provider and performed by an accredited clinical laboratory. A health plan company is not prohibited from conducting a medical necessity review when screenings or urinalysis testing for an enrollee exceeds 24 tests in any 12-month period.

(b) This section does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to public health care program enrollees under chapter 256B or 256L.

EFFECTIVE DATE. This section is effective January 1, 2022, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 15. **[62Q.521] COVERAGE OF CONTRACEPTIVES AND CONTRACEPTIVE SERVICES.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Closely held for-profit entity" means an entity that:

(1) is not a nonprofit entity;

(2) has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer individuals, or has an ownership structure that is substantially similar; and

(3) has no publicly traded ownership interest, having any class of common equity securities required to be registered under United States Code, title 15, section 781.

For purposes of this paragraph:

(i) ownership interests owned by a corporation, partnership, estate, or trust are considered owned proportionately by that entity's shareholders, partners, or beneficiaries;

(ii) ownership interests owned by a nonprofit entity are considered owned by a single owner;

(iii) ownership interests owned by an individual are considered owned, directly or indirectly, by or for the individual's family. For purposes of this item, "family" means brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

(iv) if an individual or entity holds an option to purchase an ownership interest, the individual or entity is considered to be the owner of those ownership interests.

(c) "Contraceptive" means a drug, device, or other product approved by the Food and Drug Administration to prevent unintended pregnancy.

(d) "Contraceptive service" means consultation, examination, procedure, and medical service related to the prevention of unintended pregnancy. This includes but is not limited to voluntary sterilization procedures, patient education, counseling on contraceptives, and follow-up services related to contraceptives or contraceptive services, management of side effects, counseling for continued adherence, and device insertion or removal.

(e) "Eligible organization" means an organization that opposes providing coverage for some or all contraceptives or contraceptive services on account of religious objections and that is:

(1) organized as a nonprofit entity and holds itself as a religious employer; or

(2) organized and operates as a closely held for-profit entity, and the organization's highest governing body has adopted, under the organization's applicable rules of governance and consistent with state law, a resolution or similar action establishing that it objects to covering some or all contraceptives or contraceptive services on account of the owners' sincerely held religious beliefs.

(f) "Medical necessity" includes but is not limited to considerations such as severity of side effects, difference in permanence and reversibility of a contraceptive or contraceptive service, and ability to adhere to the appropriate use of the contraceptive method or service, as determined by the attending provider.

(g) "Religious employer" means an organization that is organized and operates as a nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(h) "Therapeutic equivalent version" means a drug, device, or product that can be expected to have the same clinical effect and safety profile when administered to a patient under the conditions specified in the labeling, and that:

(1) is approved as safe and effective;

(2) is a pharmaceutical equivalent, (i) containing identical amounts of the same active drug ingredient in the same dosage form and route of administration, and (ii) meeting compendial or other applicable standards of strength, quality, purity, and identity;

(3) is bioequivalent in that:

(i) the drug, device, or product does not present a known or potential bioequivalence problem and meets an acceptable in vitro standard; or

(ii) if the drug, device, or product does present a known or potential bioequivalence problem, it is shown to meet an appropriate bioequivalence standard;

(4) is adequately labeled; and

(5) is manufactured in compliance with current manufacturing practice regulations.

Subd. 2. **Required coverage; cost-sharing prohibited.** (a) A health plan must provide coverage for all prescription contraceptives and contraceptive services.

(b) A health plan company must not impose cost-sharing requirements, including co-pays, deductibles, or co-insurance, for contraceptives or contraceptive services.

(c) Notwithstanding paragraph (b), a health plan that is a high-deductible health plan in conjunction with a health savings account must include cost-sharing for contraceptives and contraceptive services at the minimum level necessary to preserve the enrollee's ability to make tax exempt contributions and withdrawals from the health savings account, as provided by section 223 of the Internal Revenue Code of 1986, as amended.

(d) A health plan company must not impose any referral requirements, restrictions, or delays for contraceptives or contraceptive services.

(e) If more than one therapeutic equivalent version of a contraceptive is approved by the FDA, a health plan must cover at least one therapeutic equivalent version, but is not required to cover all therapeutic equivalent versions.

(f) For each health plan, a health plan company must list the contraceptives and contraceptive services that are covered without cost-sharing in a manner that is easily accessible to enrollees, health care providers, and representatives of health care providers. The list for each health plan must be promptly updated to reflect changes to the coverage.

(g) If an enrollee's attending provider recommends a particular contraceptive or contraceptive service based on a determination of medical necessity for that enrollee, the health plan must cover that contraceptive or contraceptive service without cost-sharing. The health plan company issuing the health plan must defer to the attending provider's determination that the particular contraceptive or contraceptive service is medically necessary for the enrollee.

Subd. 3. **Religious employers; exempt.** (a) A religious employer is not required to cover contraceptives or contraceptive services if the employer has religious objections to the coverage. A religious employer that chooses not to provide coverage for some or all contraceptives and contraceptive services must notify employees as part of the hiring process and all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(b) If the religious employer provides coverage for some contraceptives or contraceptive services, the notice must provide a list of the contraceptives or contraceptive services the employer refuses to cover.

Subd. 4. **Accommodation for eligible organizations.** (a) A health plan established or maintained by an eligible organization complies with the requirements of subdivision 2 to provide coverage of contraceptives and contraceptive services if the eligible organization provides notice to any health plan company the eligible organization contracts with that it is an eligible organization and that the eligible organization has a religious objection to coverage for all or a subset of contraceptives or contraceptive services.

(b) The notice from an eligible organization to a health plan company under paragraph (a) must include the name of the eligible organization, a statement that it objects to coverage for some or all of contraceptives or contraceptive services, including a list of the contraceptive services the eligible organization objects to, if applicable, and the health plan name. The notice must be executed by a person authorized to provide notice on behalf of the eligible organization.

(c) An eligible organization must provide a copy of the notice under paragraph (b) to prospective employees as part of the hiring process and to all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(d) A health plan company that receives a copy of the notice under paragraph (a) with respect to a health plan established or maintained by an eligible organization must:

(1) expressly exclude coverage for some or all contraceptives or contraceptive services from the health plan and provide separate payments for any contraceptive or contraceptive service required to be covered under subdivision 2 for enrollees as long as the enrollee remains enrolled in the health plan; or

(2) arrange for an issuer or other entity to provide payments for contraceptive services for plan participants and beneficiaries without imposing any cost-sharing requirements, or imposing a premium fee or other charge, or any portion thereof directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries.

(e) The health plan company must not impose any cost-sharing requirements, including co-pays, deductibles, or co-insurance, or directly or indirectly impose any premium, fee, or other charge for contraceptive services or contraceptives on the eligible organization, health plan, or enrollee.

(f) On January 1, 2022, and every year thereafter a health plan company must notify the commissioner, in a manner to be determined by the commissioner, regarding the number of eligible organizations granted an accommodation under this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2022, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 16. **[62Q.522] COVERAGE FOR PRESCRIPTION CONTRACEPTIVES; SUPPLY REQUIREMENTS.**

Subdivision 1. **Scope of coverage.** Except as otherwise provided in section 62Q.521, subdivision 3, all health plans that provide prescription coverage must comply with the requirements of this section.

Subd. 2. **Definition.** For purposes of this section, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug that prevents pregnancy when administered after sexual contact.

Subd. 3. **Required coverage.** (a) Health plan coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive, regardless of whether the enrollee was covered by the health plan at the time of the first dispensing.

(b) The prescribing health care provider must determine the appropriate number of months to prescribe the prescription contraceptives for, up to 12 months.

EFFECTIVE DATE. This section is effective January 1, 2022, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 17. Minnesota Statutes 2020, section 62Q.677, is amended by adding a subdivision to read:

Subd. 6a. **Out-of-pocket annual maximum.** By October of each year, the commissioner of commerce must determine the maximum annual out-of-pocket limits applicable to individual health plans and small group health plans.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 18. Minnesota Statutes 2020, section 62Q.81, is amended to read:

62Q.81 ESSENTIAL HEALTH BENEFIT PACKAGE REQUIREMENTS.

Subdivision 1. **Essential health benefits package.** (a) Health plan companies offering individual and small group health plans must include the essential health benefits package ~~required under section 1302(a) of the Affordable Care Act and as~~ described in this subdivision.

(b) The essential health benefits package means insurance coverage that:

(1) provides the essential health benefits ~~as outlined in the Affordable Care Act~~ described in subdivision 4;

(2) limits cost-sharing for ~~such~~ the coverage ~~in accordance with the Affordable Care Act~~, as described in subdivision 2; and

(3) ~~subject to subdivision 3,~~ provides bronze, silver, gold, or platinum level of coverage ~~in accordance with the Affordable Care Act~~, as described in subdivision 3.

Subd. 2. **Cost-sharing; coverage for enrollees under the age of 21.** (a) Cost-sharing includes (1) deductibles, coinsurance, co-payments, or similar charges, and (2) qualified medical expenses, as defined in section 223(d)(2) of the Internal Revenue Code of 1986, as amended. Cost-sharing does not include premiums, balance billing from non-network providers, or spending for noncovered services.

(b) Cost-sharing per year for individual health plans is limited to the amount allowed under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, as amended, increased by an amount equal to the product of that amount and the premium adjustment percentage. The premium adjustment percentage is the percentage that the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds the average per capita premium for 2017. If the amount of the increase is not a multiple of $50, the increases must be rounded to the next lowest multiple of $50.

(c) Cost-sharing per year for small group health plans is limited to twice the amount allowed under paragraph (b).

(d) If a health plan company offers health plans in any level of coverage ~~specified under section 1302(d) of the Affordable Care Act, as~~ described in subdivision ~~1, paragraph (b), clause (3)~~ 3, the health plan company shall also offer coverage in that level to individuals who have not attained 21 years of age as of the beginning of a policy year.

Subd. 3. **Levels of coverage; alternative compliance for catastrophic plans.** (a) A health plan in the bronze level must provide a level of coverage designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(b) A health plan in the silver level must provide a level of coverage designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(c) A health plan in the gold level must provide a level of coverage designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(d) A health plan in the platinum level must provide a level of coverage designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(e) A health plan company that does not provide an individual or small group health plan in the bronze, silver, gold, or platinum level of coverage~~, as described in subdivision 1, paragraph (b), clause (3), shall be treated as meeting~~ meets the requirements of this section ~~1302(d) of the Affordable Care Act~~ with respect to any ~~policy~~ plan year if the health plan company provides a catastrophic plan that meets the following requirements ~~of section 1302(e) of the Affordable Care Act.~~:

(1) enrollment in the health plan is limited only to individuals that:

(i) have not attained age 30 before the beginning of the plan year;

(ii) are unable to access affordable coverage; or

(iii) are experiencing a hardship in reference to the individual's capability to access coverage; and

(2) the health plan provides:

(i) essential health benefits, except that the plan does not provide benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the limitation in effect under subdivision 2; and

(ii) coverage for at least three primary care visits.

Subd. 4. **Essential health benefits; definition.** (a) For purposes of this section, "essential health benefits" ~~has the meaning given under section 1302(b) of the Affordable Care Act and includes~~ means:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) laboratory services;

(5) maternity and newborn care;

(6) mental health and substance use disorder services, including behavioral health treatment;

(7) pediatric services, including oral and vision care;

(8) prescription drugs;

(9) preventive and wellness services and chronic disease management;

(10) rehabilitative and habilitative services and devices; and

(11) additional essential health benefits included in the ~~EHB-benchmark plan, as defined under the Affordable Care Act~~ health plan described in paragraph (c).

(b) If a service provider does not have a contractual relationship with the health plan to provide services, emergency services must be provided without imposing any prior authorization requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from providers who have a contractual relationship with the health plan. If services are provided out-of-network, the cost-sharing must be equivalent to services provided in-network.

(c) The scope of essential health benefits under paragraph (a) must be equal to the scope of benefits provided under a typical employer plan.

(d) Essential health benefits must:

(1) reflect an appropriate balance among the categories to ensure benefits are not unduly weighted toward any category;

(2) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in a manner that discriminates against individuals on the basis of age, disability, or expected length of life;

(3) account for the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups; and

(4) ensure that health benefits established as essential are not subject to denial against the individual's wishes on the basis of the individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency, or quality of life.

Subd. 5. **Exception.** This section does not apply to a dental plan ~~described in section 1311(d)(2)(B)(ii) of the Affordable Care Act~~ that is limited in scope and provides pediatric dental benefits.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 19. Minnesota Statutes 2020, section 256B.0625, subdivision 10, is amended to read:

Subd. 10. **Laboratory ~~and~~, x-ray, and opioid screening services.** (a) Medical assistance covers laboratory and x-ray services.

(b) Medical assistance covers screening and urinalysis tests for opioids without lifetime or annual limits.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 20. Minnesota Statutes 2020, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, a physician assistant, or an advanced practice registered nurse employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner or as provided in paragraph (h).

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the Formulary Committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States

Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

(g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 16.

(h) Medical assistance coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive. The prescribing health care provider must determine the appropriate number of months to prescribe the prescription contraceptives, up to 12 months. For the purposes of this paragraph, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug approved to prevent pregnancy when administered after sexual contact.

EFFECTIVE DATE. This section applies to medical assistance and MinnesotaCare coverage effective January 1, 2022.

Sec. 21. **COMMISSIONER OF COMMERCE; DETERMINATION OF PREVENTIVE ITEMS AND SERVICES.**

The commissioner of commerce must determine the items and services that are preventive under Minnesota Statutes, section 62Q.46, subdivision 1a. Items and services that are preventive must include:

(1) evidence-based items or services that have in effect a rating of A or B pursuant to the recommendations of the United States Preventive Services Task Force in effect January 1, 2021, and with respect to the individual involved;

(2) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers

for Disease Control and Prevention with respect to the individual involved. For the purposes of this clause, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, additional preventive care and screenings not described in clause (1), as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

ARTICLE 7
TELEHEALTH

Section 1. **[62A.673] COVERAGE OF SERVICES PROVIDED THROUGH TELEHEALTH.**

Subdivision 1. **Citation.** This section may be cited as the "Minnesota Telehealth Act."

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

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

(c) "Health care provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law. A health care provider includes a mental health professional as defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; a mental health practitioner as defined under section 245.462, subdivision 17, or 245.4871, subdivision 26; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

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

(e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental

plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

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

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

(h) "Telehealth" means the delivery of health care services or consultations through the use of real-time, two-way interactive audio and visual or audio-only communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward transfers, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Telehealth includes audio-only communication between a health care provider and a patient if the communication is a scheduled appointment and the standard of care for the service can be met through the use of audio-only communication. Telehealth does not include communication between health care providers or between a health care provider and a patient that consists solely of an e-mail or facsimile transmission. Telehealth does not include communication between health care providers that consists solely of a telephone conversation.

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

Subd. 3. **Coverage of telehealth.** (a) A health plan sold, issued, or renewed by a health carrier in Minnesota must (1) cover benefits delivered through telehealth in the same manner as any other benefits covered under the health plan, and (2) comply with this section.

(b) Coverage for services delivered through telehealth must not be limited on the basis of geography, location, or distance for travel.

(c) A health carrier must not create a separate provider network or provide incentives to enrollees to use a separate provider network to deliver services through telehealth that

does not include network providers who provide in-person care to patients for the same service.

(d) A health carrier may require a deductible, co-payment, or coinsurance payment for a health care service provided through telehealth, provided that the deductible, co-payment, or coinsurance payment is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable for the same service provided through in-person contact.

(e) Nothing in this section:

(1) requires a health carrier to provide coverage for services that are not medically necessary or are not covered under the enrollee's health plan; or

(2) prohibits a health carrier from:

(i) establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service through telehealth for which the health carrier does not already reimburse other health care providers for delivering the service through telehealth;

(ii) establishing reasonable medical management techniques, provided the criteria or techniques are not unduly burdensome or unreasonable for the particular service; or

(iii) requiring documentation or billing practices designed to protect the health carrier or patient from fraudulent claims, provided the practices are not unduly burdensome or unreasonable for the particular service.

(f) Nothing in this section requires the use of telehealth when a health care provider determines that the delivery of a health care service through telehealth is not appropriate or when an enrollee chooses not to receive a health care service through telehealth.

Subd. 4. **Parity between telehealth and in-person services.** (a) A health carrier must not restrict or deny coverage of a health care service that is covered under a health plan solely:

(1) because the health care service provided by the health care provider through telehealth is not provided through in-person contact; or

(2) based on the communication technology or application used to deliver the health care service through telehealth, provided the technology or application complies with this section and is appropriate for the particular service.

(b) Prior authorization may be required for health care services delivered through telehealth only if prior authorization is required before the delivery of the same service through in-person contact.

(c) A health carrier may require a utilization review for services delivered through telehealth, provided the utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for the same services delivered through in-person contact.

Subd. 5. **Reimbursement for services delivered through telehealth.** (a) A health carrier must reimburse the health care provider for services delivered through telehealth on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered by the health care provider through in-person contact.

(b) A health carrier must not deny or limit reimbursement based solely on a health care provider delivering the service or consultation through telehealth instead of through in-person contact.

(c) A health carrier must not deny or limit reimbursement based solely on the technology and equipment used by the health care provider to deliver the health care service or consultation through telehealth, provided the technology and equipment used by the provider meets the requirements of this section and is appropriate for the particular service.

Subd. 6. **Telehealth equipment.** (a) A health carrier must not require a health care provider to use specific telecommunications technology and equipment as a condition of coverage under this section, provided the health care provider uses telecommunications technology and equipment that complies with current industry interoperable standards and complies with standards required under the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and regulations promulgated under that Act, unless authorized under this section.

(b) A health carrier must provide coverage for health care services delivered through telehealth by means of the use of audio-only telephone communication if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication.

Subd. 7. **Telemonitoring services.** A health carrier must provide coverage for telemonitoring services if:

(1) the telemonitoring service is medically appropriate based on the enrollee's medical condition or status;

(2) the enrollee is cognitively and physically capable of operating the monitoring device or equipment, or the enrollee has a caregiver who is willing and able to assist with the monitoring device or equipment; and

(3) the enrollee resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 2. Minnesota Statutes 2020, section 147.033, is amended to read:

147.033 PRACTICE OF ~~TELEMEDICINE~~ TELEHEALTH.

Subdivision 1. **Definition.** For the purposes of this section, ~~"telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way interactive audio, and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, that facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.~~ "telehealth" has the meaning given in section 62A.673, subdivision 2, paragraph (h).

Subd. 2. **Physician-patient relationship.** A physician-patient relationship may be established through ~~telemedicine~~ telehealth.

Subd. 3. **Standards of practice and conduct.** A physician providing health care services by ~~telemedicine~~ telehealth in this state shall be held to the same standards of practice and conduct as provided in this chapter for in-person health care services.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 3. Minnesota Statutes 2020, section 151.37, subdivision 2, is amended to read:

Subd. 2. **Prescribing and filing.** (a) A licensed practitioner in the course of professional practice only, may prescribe, administer, and dispense a legend drug, and may cause the same to be administered by a nurse, a physician assistant, or medical student or resident under the practitioner's direction and supervision, and may cause a person who is an appropriately certified, registered, or licensed health care professional to prescribe, dispense,

and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference to a specific patient, by directing a licensed dietitian or licensed nutritionist, pursuant to section 148.634; a nurse, pursuant to section 148.235, subdivisions 8 and 9; physician assistant; medical student or resident; or pharmacist according to section 151.01, subdivision 27, to adhere to a particular practice guideline or protocol when treating patients whose condition falls within such guideline or protocol, and when such guideline or protocol specifies the circumstances under which the legend drug is to be prescribed and administered. An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug. This paragraph applies to a physician assistant only if the physician assistant meets the requirements of ~~section 147A.18~~ sections 147A.02 and 147A.09.

(b) The commissioner of health, if a licensed practitioner, or a person designated by the commissioner who is a licensed practitioner, may prescribe a legend drug to an individual or by protocol for mass dispensing purposes where the commissioner finds that the conditions triggering section 144.4197 or 144.4198, subdivision 2, paragraph (b), exist. The commissioner, if a licensed practitioner, or a designated licensed practitioner, may prescribe, dispense, or administer a legend drug or other substance listed in subdivision 10 to control tuberculosis and other communicable diseases. The commissioner may modify state drug labeling requirements, and medical screening criteria and documentation, where time is critical and limited labeling and screening are most likely to ensure legend drugs reach the maximum number of persons in a timely fashion so as to reduce morbidity and mortality.

(c) A licensed practitioner that dispenses for profit a legend drug that is to be administered orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the practitioner's licensing board a statement indicating that the practitioner dispenses legend drugs for profit, the general circumstances under which the practitioner dispenses for profit, and the types of legend drugs generally dispensed. It is unlawful to dispense legend drugs for profit after July 31, 1990, unless the statement has been filed with the appropriate licensing board. For purposes of this paragraph, "profit" means (1) any amount received by the practitioner in excess of the acquisition cost of a legend drug for legend drugs that are purchased in prepackaged form, or (2) any amount received by the practitioner in excess of the acquisition cost of a legend drug plus the cost of making the drug available if the legend drug requires compounding, packaging, or other treatment. The statement filed under this paragraph is public data under section 13.03. This paragraph does not apply to a licensed doctor of veterinary medicine or a registered pharmacist. Any person other than a licensed

practitioner with the authority to prescribe, dispense, and administer a legend drug under paragraph (a) shall not dispense for profit. To dispense for profit does not include dispensing by a community health clinic when the profit from dispensing is used to meet operating expenses.

(d) A prescription drug order for the following drugs is not valid, unless it can be established that the prescription drug order was based on a documented patient evaluation, including an examination, adequate to establish a diagnosis and identify underlying conditions and contraindications to treatment:

(1) controlled substance drugs listed in section 152.02, subdivisions 3 to 5;

(2) drugs defined by the Board of Pharmacy as controlled substances under section 152.02, subdivisions 7, 8, and 12;

(3) muscle relaxants;

(4) centrally acting analgesics with opioid activity;

(5) drugs containing butalbital; or

(6) phosphodiesterase type 5 inhibitors when used to treat erectile dysfunction.

~~For purposes of prescribing drugs listed in clause (6), the requirement for a documented patient evaluation, including an examination, may be met through the use of telemedicine, as defined in section 147.033, subdivision 1.~~

(e) For the purposes of paragraph (d), the requirement for an examination shall be met if:

(1) an in-person examination has been completed in any of the following circumstances:

~~(1)~~ (i) the prescribing practitioner examines the patient at the time the prescription or drug order is issued;

~~(2)~~ (ii) the prescribing practitioner has performed a prior examination of the patient;

~~(3)~~ (iii) another prescribing practitioner practicing within the same group or clinic as the prescribing practitioner has examined the patient;

~~(4)~~ (iv) a consulting practitioner to whom the prescribing practitioner has referred the patient has examined the patient; or

~~(5)~~ (v) the referring practitioner has performed an examination in the case of a consultant practitioner issuing a prescription or drug order when providing services by means of telemedicine~~.~~; or

(2) the prescription order is for a drug listed in paragraph (d), clause (6), or for medication assisted therapy for a substance use disorder, and the prescribing practitioner has completed an examination of the patient via telehealth as defined in section 62A.673, subdivision 2, paragraph (h).

(f) Nothing in paragraph (d) or (e) prohibits a licensed practitioner from prescribing a drug through the use of a guideline or protocol pursuant to paragraph (a).

(g) Nothing in this chapter prohibits a licensed practitioner from issuing a prescription or dispensing a legend drug in accordance with the Expedited Partner Therapy in the Management of Sexually Transmitted Diseases guidance document issued by the United States Centers for Disease Control.

(h) Nothing in paragraph (d) or (e) limits prescription, administration, or dispensing of legend drugs through a public health clinic or other distribution mechanism approved by the commissioner of health or a community health board in order to prevent, mitigate, or treat a pandemic illness, infectious disease outbreak, or intentional or accidental release of a biological, chemical, or radiological agent.

(i) No pharmacist employed by, under contract to, or working for a pharmacy located within the state and licensed under section 151.19, subdivision 1, may dispense a legend drug based on a prescription that the pharmacist knows, or would reasonably be expected to know, is not valid under paragraph (d).

(j) No pharmacist employed by, under contract to, or working for a pharmacy located outside the state and licensed under section 151.19, subdivision 1, may dispense a legend drug to a resident of this state based on a prescription that the pharmacist knows, or would reasonably be expected to know, is not valid under paragraph (d).

(k) Nothing in this chapter prohibits the commissioner of health, if a licensed practitioner, or, if not a licensed practitioner, a designee of the commissioner who is a licensed practitioner, from prescribing legend drugs for field-delivered therapy in the treatment of a communicable disease according to the Centers For Disease Control and Prevention Partner Services Guidelines.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 4. Minnesota Statutes 2020, section 245G.01, subdivision 13, is amended to read:

Subd. 13. **Face-to-face.** "Face-to-face" means two-way, real-time, interactive ~~and visual~~ communication between a client and a treatment service provider and includes services delivered in person or via ~~telemedicine~~ telehealth with priority being given to interactive

audio and visual communication, if available. Meetings required by section 245G.22, subdivision 4, must be conducted by interactive video and visual communication.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. Minnesota Statutes 2020, section 245G.01, subdivision 26, is amended to read:

Subd. 26. ~~**Telemedicine**~~ **Telehealth.** ~~"Telemedicine"~~ "Telehealth" means the delivery of a substance use disorder treatment service while the client is at an originating site and the ~~licensed~~ health care provider is at a distant site via telehealth as defined in section 256B.0625, subdivision 3b, and as specified in section 254B.05, subdivision 5, paragraph (f).

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 6. Minnesota Statutes 2020, section 245G.06, subdivision 1, is amended to read:

Subdivision 1. **General.** Each client must have a person-centered individual treatment plan developed by an alcohol and drug counselor within ten days from the day of service initiation for a residential program and within five calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. The individual treatment plan is developed upon the qualified staff member's dated signature. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition, the client's level of participation, and on whether methods identified have the intended effect. A change to the plan must be signed by the client and the alcohol and drug counselor. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. If a client is receiving treatment services or an assessment via telehealth and the license holder documents the reason the client's signature cannot be obtained, the alcohol and drug counselor may document the client's verbal approval or electronic written approval of the treatment plan or change to the treatment plan in lieu of the client's signature.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 7. Minnesota Statutes 2020, section 254A.19, subdivision 5, is amended to read:

Subd. 5. **Assessment via ~~telemedicine~~ telehealth.** Notwithstanding Minnesota Rules, part 9530.6615, subpart 3, item A, a chemical use assessment may be conducted via ~~telemedicine~~ telehealth as defined in section 256B.0625, subdivision 3b.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 8. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

(3) care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) medication-assisted therapy services that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(9) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(12) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs

treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via ~~two-way interactive video~~ telehealth as defined in section 256B.0625, subdivision 3b. The use of ~~two-way interactive video~~ telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. ~~The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.~~

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2020, section 256B.0621, subdivision 10, is amended to read:

Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

(1) for relocation targeted case management, case managers may bill for direct case management activities, including face-to-face contact, telephone contact, and interactive video contact ~~according to section 256B.0924, subdivision 4a~~, in the lesser of:

(i) 180 days preceding an eligible recipient's discharge from an institution; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service;

(2) for home care targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts; and

(3) billings for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **~~Telemedicine~~ Telehealth services.** (a) Medical assistance covers medically necessary services and consultations delivered by a ~~licensed~~ health care provider ~~via telemedicine~~ through telehealth in the same manner as if the service or consultation was delivered ~~in person~~ through in-person contact. ~~Coverage is limited to three telemedicine services per enrollee per calendar week, except as provided in paragraph (f). Telemedicine~~ Services or consultations delivered through telehealth shall be paid at the full allowable rate.

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

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

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

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

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

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

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

(1) the type of service ~~provided by telemedicine~~ delivered through telehealth;

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

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

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

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

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

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

(d) For purposes of this subdivision, unless otherwise covered under this chapter~~,~~ ~~"telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.~~:

(1) "telehealth" means the delivery of health care services or consultations through the use of real-time, two-way interactive audio and visual or audio-only communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward transfers, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Unless interactive visual and audio communication is specifically required, telehealth includes audio-only communication between a health care provider and a patient, if the communication is a scheduled appointment with the health care provider and the standard of care for the service can be met through the use of audio-only communication. Telehealth does not include communication between health care providers, or communication between a health care provider and a patient that consists solely of an e-mail or facsimile transmission;

~~(e) For purposes of this section, "licensed~~ (2) "health care provider" means a ~~licensed~~ health care provider ~~under section 62A.671, subdivision 6~~ as defined under section 62A.673, a community paramedic as defined under section 144E.001, subdivision 5f, ~~or a mental~~

~~health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional, and~~ a community health worker who meets the criteria under subdivision 49, paragraph (a)~~; "health care provider" is defined under section 62A.671, subdivision 3;~~, a mental health certified peer specialist under section 256B.0615, subdivision 5, a mental health certified family peer specialist under section 256B.0616, subdivision 5, a mental health rehabilitation worker under section 256B.0623, subdivision 5, paragraph (a), clause (4), and paragraph (b), a mental health behavioral aide under section 256B.0943, subdivision 7, paragraph (b), clause (3), a treatment coordinator under section 245G.11, subdivision 7, an alcohol and drug counselor under section 245G.11, subdivision 5, a recovery peer under section 245G.11, subdivision 8, and a mental health case manager under section 245.462, subdivision 4; and

(3) "originating site" ~~is defined under section 62A.671, subdivision 7~~, "distant site," and "store-and-forward transfer" have the meanings given in section 62A.673, subdivision 2.

~~(f) The limit on coverage of three telemedicine services per enrollee per calendar week does not apply if:~~

~~(1) the telemedicine services provided by the licensed health care provider are for the treatment and control of tuberculosis; and~~

~~(2) the services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the commissioner of health.~~

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 3h. **Telemonitoring services.** (a) Medical assistance covers telemonitoring services if a recipient:

(1) has been diagnosed and is receiving services for at least one of the following chronic conditions: hypertension, cancer, congestive heart failure, chronic obstructive pulmonary disease, asthma, or diabetes;

(2) requires at least five times per week monitoring to manage the chronic condition, as ordered by the recipient's health care provider;

(3) has had two or more emergency room or inpatient hospitalization stays within the last 12 months due to the chronic condition or the recipient's health care provider has identified that telemonitoring services would likely prevent the recipient's admission or readmission to a hospital, emergency room, or nursing facility;

(4) is cognitively and physically capable of operating the monitoring device or equipment, or the recipient has a caregiver who is willing and able to assist with the monitoring device or equipment; and

(5) resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

(b) For purposes of this subdivision, "telemonitoring services" means the remote monitoring of data related to a recipient's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a provider for analysis. The assessment and monitoring of the health data transmitted by telemonitoring must be performed by one of the following licensed health care professionals: physician, podiatrist, registered nurse, advanced practice registered nurse, physician assistant, respiratory therapist, or licensed professional working under the supervision of a medical director.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 12. Minnesota Statutes 2020, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance covers medication therapy management services for a recipient taking prescriptions to treat or prevent one or more chronic medical conditions. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan, which may include prescribing medications or products in accordance with section 151.37, subdivision 14, 15, or 16;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued by the Board of Pharmacy of the state in which the medication therapy management service is being performed;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements; and

~~(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, including long-term care settings, group homes, and facilities providing assisted living services, but excluding skilled nursing facilities; and~~

~~(4)~~ (3) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance providers. The commissioner may also establish ~~contact requirements between the pharmacist and recipient, including limiting~~ limits on the number of reimbursable consultations per recipient.

(d) ~~If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide The~~ Medication therapy management services may be provided

via ~~two-way interactive video~~ telehealth as defined in subdivision 3b and may be delivered into a patient's residence. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b)~~, and must be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3). The patient must also be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3). Services provided under this paragraph may not be transmitted into the patient's residence~~.

~~(c) Medication therapy management services may be delivered into a patient's residence via secure interactive video if the medication therapy management services are performed electronically during a covered home care visit by an enrolled provider. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b) and must be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3).~~

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 13. Minnesota Statutes 2020, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 20b with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact, or a contact by interactive video that meets the requirements of subdivision 20b, with the adult or the adult's legal representative or a contact by interactive video that meets the requirements of subdivision 20b; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 20b with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state

without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include the federal earnings, the state share, and the county share.

(m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

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

(1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or

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

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

(p) If the recipient is receiving care in a hospital, nursing facility, or residential setting licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week, mental health targeted case management services must actively support identification of community alternatives for the recipient and discharge planning.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 14. Minnesota Statutes 2020, section 256B.0625, subdivision 20b, is amended to read:

Subd. 20b. ~~**Mental health**~~ **Targeted case management face-to-face contact through interactive video.** ~~(a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment if:~~

~~(1) the person receiving targeted case management services is residing in:~~

~~(i) a hospital;~~

~~(ii) a nursing facility; or~~

~~(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;~~

~~(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;~~

~~(3) the use of interactive video is approved as part of the person's written personal service or case plan, taking into consideration the person's vulnerability and active personal relationships; and~~

~~(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contact.~~ (a) Minimum required face-to-face contacts for targeted case management may be provided through interactive video if interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian and the case management provider.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner ~~shall~~ may establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of ~~delivering the service~~ meeting the minimum face-to-face contact requirements for targeted case management via interactive video. ~~The attestation may include that the case management provider has:~~

~~(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;~~

~~(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;~~

~~(3) established protocols addressing how and when to discontinue interactive video services; and~~

~~(4) established a quality assurance process related to interactive video services.~~

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video for the purpose of face-to-face contact:

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

(2) the basis for determining that interactive video is an appropriate and effective means for ~~delivering the service to~~ contacting the person receiving targeted case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized; and

(4) the location of the originating site and the distant site~~; and~~.

~~(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).~~

(e) Interactive video must not be used to meet minimum face-to-face contact requirements for children who are in out-of-home placement or receiving case management services for child protection reasons.

(f) For the purposes of this section, "interactive video" means real-time, two-way interactive audio and visual communications.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 15. Minnesota Statutes 2020, section 256B.0625, subdivision 46, is amended to read:

Subd. 46. **Mental health ~~telemedicine~~ telehealth.** ~~Effective January 1, 2006, and~~ Subject to federal approval, mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via ~~two-way interactive video~~ telehealth as defined in subdivision 3b. Use of ~~two-way interactive video~~ telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the service. ~~The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.~~

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 16. Minnesota Statutes 2020, section 256B.0911, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) Until additional requirements apply under paragraph (b), "long-term care consultation services" means:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations for and referrals to cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) ~~face-to-face~~ long-term care consultation assessments conducted according to subdivision 3a, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) determination of home and community-based waiver and other service eligibility as required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on a long-term care consultation assessment and community support plan development, appropriate referrals to obtain necessary diagnostic

information, and including an eligibility determination for consumer-directed community supports;

(7) providing recommendations for institutional placement when there are no cost-effective community services available;

(8) providing access to assistance to transition people back to community settings after institutional admission;

(9) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Hub and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made. For the purposes of this subdivision, "competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities;

(10) providing information about independent living to ensure that an informed choice about independent living can be made; and

(11) providing information about self-directed services and supports, including self-directed funding options, to ensure that an informed choice about self-directed options can be made.

(b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c, and 3a, "long-term care consultation services" also means:

(1) service eligibility determination for the following state plan services:

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

(ii) consumer support grants under section 256.476; or

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

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, gaining access to:

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

(ii) case management services targeted to vulnerable adults or developmental disabilities under section 256B.0924; and

(iii) case management services targeted to people with developmental disabilities under Minnesota Rules, part 9525.0016;

(3) determination of eligibility for semi-independent living services under section 252.275; and

(4) obtaining necessary diagnostic information to determine eligibility under clauses (2) and (3).

(c) "Long-term care options counseling" means the services provided by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(d) "Minnesota health care programs" means the medical assistance program under this chapter and the alternative care program under section 256B.0913.

(e) "Lead agencies" means counties administering or tribes and health plans under contract with the commissioner to administer long-term care consultation services.

(f) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives, the settings in which the person receives the services, and the setting in which the person lives.

(g) "Informed choice" means a voluntary choice of services, settings, living arrangement, and work by a person from all available service and setting options based on accurate and complete information concerning all available service and setting options and concerning the person's own preferences, abilities, goals, and objectives. In order for a person to make an informed choice, all available options must be developed and presented to the person in a way the person can understand to empower the person to make fully informed choices.

(h) "Available service and setting options" or "available options," with respect to the home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49, means all services and settings defined under the waiver plan for which a waiver applicant or waiver participant is eligible.

(i) "Independent living" means living in a setting that is not controlled by a provider.

Sec. 17. Minnesota Statutes 2020, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons

who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. ~~Face-to-face~~ Assessments must be conducted according to paragraphs (b) to ~~(i)~~ (q).

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, conversation-based, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a person-centered community support plan that meets the individual's needs and preferences.

(d) Except as provided in paragraph (q), the assessment must be conducted by a certified assessor in a face-to-face conversational interview with the person being assessed. The person's legal representative must provide input during the assessment process and may do so remotely if requested. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under chapter 256S, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs the person completed in consultation with someone who is known to the person and has interaction

with the person on a regular basis. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

(e) The certified assessor and the individual responsible for developing the coordinated service and support plan must complete the community support plan and the coordinated service and support plan no more than 60 calendar days from the assessment visit. The person or the person's legal representative must be provided with a written community support plan within the timelines established by the commissioner, regardless of whether the person is eligible for Minnesota health care programs.

(f) For a person being assessed for elderly waiver services under chapter 256S, a provider who submitted information under paragraph (d) shall receive the final written community support plan when available and the Residential Services Workbook.

(g) The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including:

(i) all available options for case management services and providers;

(ii) all available options for employment services, settings, and providers;

(iii) all available options for living arrangements;

(iv) all available options for self-directed services and supports, including self-directed budget options; and

(v) service provided in a non-disability-specific setting;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(h) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling

services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(i) The person has the right to make the final decision:

(1) between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

(2) between community placement in a setting controlled by a provider and living independently in a setting not controlled by a provider;

(3) between day services and employment services; and

(4) regarding available options for self-directed services and supports, including self-directed funding options.

(j) The lead agency must give the person receiving long-term care consultation services or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated; and

(10) documentation that available options for employment services, independent living, and self-directed services and supports were described to the individual.

(k) ~~Face-to-face~~ Assessment completed as part of an eligibility determination for multiple programs for the alternative care, elderly waiver, developmental disabilities, community access for disability inclusion, community alternative care, and brain injury waiver programs under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(l) The effective eligibility start date for programs in paragraph (k) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (k) cannot be prior to the date the most recent updated assessment is completed.

(m) If an eligibility update is completed within 90 days of the previous ~~face-to-face~~ assessment and documented in the department's Medicaid Management Information System (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date of the previous ~~face-to-face~~ assessment when all other eligibility requirements are met.

(n) At the time of reassessment, the certified assessor shall assess each person receiving waiver residential supports and services currently residing in a community residential setting, licensed adult foster care home that is either not the primary residence of the license holder or in which the license holder is not the primary caregiver, family adult foster care residence, customized living setting, or supervised living facility to determine if that person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23, in a setting not controlled by a provider, or to receive integrated community supports as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified assessor shall offer the person, through a person-centered planning process, the option to receive alternative housing and service options.

(o) At the time of reassessment, the certified assessor shall assess each person receiving waiver day services to determine if that person would prefer to receive employment services as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified assessor shall describe to the person through a person-centered planning process the option to receive employment services.

(p) At the time of reassessment, the certified assessor shall assess each person receiving non-self-directed waiver services to determine if that person would prefer an available service and setting option that would permit self-directed services and supports. The certified assessor shall describe to the person through a person-centered planning process the option to receive self-directed services and supports.

(q) All assessments performed according to this subdivision must be face-to-face unless the assessment is a reassessment meeting the requirements of this paragraph. Subject to federal approval, remote reassessments conducted by interactive video or telephone may substitute for face-to-face reassessments for services provided by alternative care under section 256B.0913, the elderly waiver under chapter 256S, the developmental disabilities waiver under section 256B.092, and the community access for disability inclusion, community alternative care, and brain injury waiver programs under section 256B.49. Remote reassessments may be substituted for two consecutive reassessments if followed by a face-to-face reassessment. A remote reassessment is permitted only if the person being reassessed, the person's legal representative, and the lead agency case manager all agree that there is no change in the person's condition, there is no need for a change in service, and that a remote reassessment is appropriate. The person being reassessed, or the person's legal representative, has the right to refuse a remote reassessment at any time. During a remote reassessment, if the certified assessor determines in the assessor's sole judgment that a remote reassessment is inappropriate, the certified assessor shall suspend the remote

reassessment and schedule a face-to-face reassessment to complete the reassessment. All other requirements of a face-to-face reassessment apply to a remote reassessment.

Sec. 18. Minnesota Statutes 2020, section 256B.0911, subdivision 3f, is amended to read:

Subd. 3f. **Long-term care reassessments and community support plan updates.** (a) Prior to a ~~face-to-face~~ reassessment, the certified assessor must review the person's most recent assessment. Reassessments must be tailored using the professional judgment of the assessor to the person's known needs, strengths, preferences, and circumstances. Reassessments provide information to support the person's informed choice and opportunities to express choice regarding activities that contribute to quality of life, as well as information and opportunity to identify goals related to desired employment, community activities, and preferred living environment. Reassessments require a review of the most recent assessment, review of the current coordinated service and support plan's effectiveness, monitoring of services, and the development of an updated person-centered community support plan. Reassessments must verify continued eligibility, offer alternatives as warranted, and provide an opportunity for quality assurance of service delivery. ~~Face-to-face~~ Reassessments must be conducted annually or as required by federal and state laws and rules. For reassessments, the certified assessor and the individual responsible for developing the coordinated service and support plan must ensure the continuity of care for the person receiving services and complete the updated community support plan and the updated coordinated service and support plan no more than 60 days from the reassessment visit.

(b) The commissioner shall develop mechanisms for providers and case managers to share information with the assessor to facilitate a reassessment and support planning process tailored to the person's current needs and preferences.

Sec. 19. Minnesota Statutes 2020, section 256B.0911, subdivision 4d, is amended to read:

Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing facility must be screened prior to admission according to the requirements outlined in section 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as required under section 256.975, subdivision 7.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within the timeline established by the commissioner, based on review of data.

(d) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3b.

(e) For individuals under 21 years of age, a screening interview which recommends nursing facility admission must be face-to-face and approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the Senior LinkAge Line must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within the timeline established by the commissioner, based on review of data.

(g) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options, including consumer-directed options, so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

(h) An individual under 65 years of age residing in a nursing facility shall receive a ~~face-to-face assessment~~ reassessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a ~~face-to-face assessment~~ reassessment at least once every 36 months for the same purposes. A remote reassessment is permitted only if the person being reassessed, the person's legal representative, and the lead agency case manager all agree that there is no change in the person's condition, there is no need for a change in service, and that a remote reassessment is appropriate. The person being reassessed, or the person's legal representative, has the right to refuse a remote reassessment at any time. During a remote reassessment, if the certified assessor determines in the assessor's sole judgment that a remote reassessment is inappropriate, the certified assessor shall suspend the remote reassessment and schedule a face-to-face reassessment

to complete the reassessment. All other requirements of a face-to-face reassessment apply to a remote reassessment.

(i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for ~~face-to-face~~ assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

(j) Funding for preadmission screening follow-up shall be provided to the Disability Hub for the under-60 population by the Department of Human Services to cover options counseling salaries and expenses to provide the services described in subdivisions 7a to 7c. The Disability Hub shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening follow-up services and shall seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (aa).

Sec. 20. Minnesota Statutes 2020, section 256B.0924, subdivision 6, is amended to read:

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

(b) Payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of December 31, 2001. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

(c) Payment for targeted case management provided by county-contracted vendors shall be based on a monthly rate negotiated by the host county. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate

among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

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

(e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for targeted case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2020, section 256B.094, subdivision 6, is amended to read:

Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical assistance reimbursement for services under this section shall be made on a monthly basis. Payment is based on face-to-face, interactive video, or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. These contacts must meet the minimum standards in clauses (1) and (2):

(1) there must be a face-to-face contact, or a contact by interactive video that meets the requirements of section 256B.0625, subdivision 20b, at least once a month except as provided in clause (2); and

(2) for a client placed outside of the county of financial responsibility, or a client served by tribal social services placed outside the reservation, in an excluded time facility under section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of Children, section 260.93, and the placement in either case is more than 60 miles beyond the county or reservation boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face contact.

Face-to-face contacts under this paragraph may be conducted using interactive video for up to two consecutive contacts following each in-person contact.

(b) Except as provided under paragraph (c), the payment rate is established using time study data on activities of provider service staff and reports required under sections 245.482 and 256.01, subdivision 2, paragraph (p).

(c) Payments for tribes may be made according to section 256B.0625 or other relevant federally approved rate setting methodology for child welfare targeted case management provided by Indian health services and facilities operated by a tribe or tribal organization.

(d) Payment for case management provided by county or tribal social services contracted vendors shall be based on a monthly rate negotiated by the host county or tribal social services. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribal social services may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribal social services, except to reimburse the county or tribal social services for advance funding provided by the county or tribal social services to the vendor.

(e) If the service is provided by a team that includes contracted vendors and county or tribal social services staff, the costs for county or tribal social services staff participation in the team shall be included in the rate for county or tribal social services provided services. In this case, the contracted vendor and the county or tribal social services may each receive separate payment for services provided by each entity in the same month. To prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles and services of the team members.

(f) Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study, or under paragraph (c), shall be distributed according to earnings, to counties, reservations, or groups of counties or reservations which have the same payment rate under this subdivision, and to the group of counties or reservations which are not certified providers under section 256F.10. The commissioner shall modify the requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2020, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only ~~face-to-face~~ assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

(d) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

Sec. 23. Minnesota Statutes 2020, section 256J.09, subdivision 3, is amended to read:

Subd. 3. **Submitting application form.** (a) A county agency must offer, in person or by mail, the application forms prescribed by the commissioner as soon as a person makes a written or oral inquiry. At that time, the county agency must:

(1) inform the person that assistance begins ~~with~~ on the date that the ~~signed~~ application is received by the county agency either as a written application; an application submitted by telephone; or an application submitted through Internet telepresence; or on the date that all eligibility criteria are met, whichever is later;

(2) inform a person that the person may submit the application by telephone or through Internet telepresence;

(3) inform a person that when the person submits the application by telephone or through Internet telepresence, the county agency must receive a signed written application within 30 days of the date that the person submitted the application by telephone or through Internet telepresence;

(4) inform the person that any delay in submitting the application will reduce the amount of assistance paid for the month of application;

~~(3)~~ (5) inform a person that the person may submit the application before an interview;

~~(4)~~ (6) explain the information that will be verified during the application process by the county agency as provided in section 256J.32;

~~(5)~~ (7) inform a person about the county agency's average application processing time and explain how the application will be processed under subdivision 5;

~~(6)~~ (8) explain how to contact the county agency if a person's application information changes and how to withdraw the application;

~~(7)~~ (9) inform a person that the next step in the application process is an interview and what a person must do if the application is approved including, but not limited to, attending orientation under section 256J.45 and complying with employment and training services requirements in sections 256J.515 to 256J.57;

~~(8)~~ (10) inform the person that ~~the~~ an interview must be conducted. The interview may be conducted face-to-face in the county office or at a location mutually agreed upon, through Internet telepresence, or ~~at a location mutually agreed upon~~ by telephone;

~~(9) inform a person who has received MFIP or DWP in the past 12 months of the option to have a face-to-face, Internet telepresence, or telephone interview;~~

~~(10)~~ (11) explain the child care and transportation services that are available under paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

~~(11)~~ (12) identify any language barriers and arrange for translation assistance during appointments, including, but not limited to, screening under subdivision 3a, orientation under section 256J.45, and assessment under section 256J.521.

(b) Upon receipt of a signed application, the county agency must stamp the date of receipt on the face of the application. The county agency must process the application within the time period required under subdivision 5. An applicant may withdraw the application at any time by giving written or oral notice to the county agency. The county agency must issue a written notice confirming the withdrawal. The notice must inform the applicant of the county agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a county agency, in writing, that the applicant does not wish to withdraw the application, the county agency must reinstate the application and finish processing the application.

(c) Upon a participant's request, the county agency must arrange for transportation and child care or reimburse the participant for transportation and child care expenses necessary

to enable participants to attend the screening under subdivision 3a and orientation under section 256J.45.

Sec. 24. Minnesota Statutes 2020, section 256J.45, subdivision 1, is amended to read:

Subdivision 1. **County agency to provide orientation.** A county agency must provide ~~a face-to-face~~ an orientation to each MFIP caregiver unless the caregiver is:

(1) a single parent, or one parent in a two-parent family, employed at least 35 hours per week; or

(2) a second parent in a two-parent family who is employed for 20 or more hours per week provided the first parent is employed at least 35 hours per week.

The county agency must inform caregivers who are not exempt under clause (1) or (2) that failure to attend the orientation is considered an occurrence of noncompliance with program requirements, and will result in the imposition of a sanction under section 256J.46. If the client complies with the orientation requirement prior to the first day of the month in which the grant reduction is proposed to occur, the orientation sanction shall be lifted.

Sec. 25. Minnesota Statutes 2020, section 256S.05, subdivision 2, is amended to read:

Subd. 2. **Nursing facility level of care determination required.** Notwithstanding other assessments identified in section 144.0724, subdivision 4, only ~~face-to-face~~ assessments conducted according to section 256B.0911, subdivisions 3, 3a, and 3b, that result in a nursing facility level of care determination at initial and subsequent assessments shall be accepted for purposes of a participant's initial and ongoing participation in the elderly waiver and a service provider's access to service payments under this chapter.

Sec. 26. **STUDY OF TELEHEALTH.**

(a) The commissioner of health, in consultation with the commissioners of human services and commerce, shall study the impact of telehealth payment methodologies and expansion under the Minnesota Telehealth Act on the coverage and provision of health care services under public health care programs and private health insurance. The study shall review and make recommendations related to:

(1) the impact of telehealth payment methodologies and expansion on access to health care services, quality of care, and value-based payments and innovation in care delivery;

(2) the short-term and long-term impacts of telehealth payment methodologies and expansion in reducing health care disparities and providing equitable access for underserved communities;

(3) the use of audio-only communication in supporting equitable access to health care services, including behavioral health services for the elderly, rural communities, and communities of color, and eliminating barriers for vulnerable and underserved populations;

(4) whether there is evidence to suggest that increased access to telehealth improves health outcomes and, if so, for which services and populations; and

(5) the effect of payment parity on public and private health care costs, health care premiums, and health outcomes.

(b) When conducting the study, the commissioner shall consult with stakeholders and communities impacted by telehealth payment and expansion. The commissioner, notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, may use data available under that section to conduct the study. The commissioner shall report findings to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance and commerce, by February 15, 2023.

Sec. 27. **EXPIRATION DATE.**

(a) Sections 1 to 15, 20, and 21 expire July 1, 2023.

(b) Notwithstanding paragraph (a), the definition of "originating site" in Minnesota Statutes, section 256B.0625, subdivision 3b, paragraph (d), clause (3), shall not expire.

Sec. 28. **REVISOR INSTRUCTION.**

The revisor of statutes shall substitute the term "telemedicine" with "telehealth" whenever the term appears in Minnesota Statutes and substitute Minnesota Statutes, section 62A.673, whenever references to Minnesota Statutes, sections 62A.67, 62A.671, and 62A.672, appear in Minnesota Statutes.

Sec. 29. **REPEALER.**

(a) Minnesota Statutes 2020, sections 62A.67; 62A.671; and 62A.672, are repealed January 1, 2022, and are revived and reenacted July 1, 2023.

(b) Minnesota Statutes 2020, sections 256B.0596; and 256B.0924, subdivision 4a, are repealed upon federal approval and are revived and reenacted July 1, 2023. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 8
ECONOMIC SUPPORTS

Section 1. Minnesota Statutes 2020, section 119B.011, subdivision 15, is amended to read:

Subd. 15. **Income.** "Income" means earned income as defined under section 256P.01, subdivision 3, unearned income as defined under section 256P.01, subdivision 8, and public assistance cash benefits, including the Minnesota family investment program, diversionary work program, work benefit, Minnesota supplemental aid, general assistance, refugee cash assistance, at-home infant child care subsidy payments, and child support and maintenance distributed to ~~the~~ a family under section 256.741, subdivision 2a, and nonrecurring income over $60 per quarter unless earmarked and used for the purpose for which it was intended. The following are deducted from income: funds used to pay for health insurance premiums for family members, and child or spousal support paid to or on behalf of a person or persons who live outside of the household. Income sources that are not included in this subdivision and section 256P.06, subdivision 3, are not counted as income.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 2. Minnesota Statutes 2020, section 119B.025, subdivision 4, is amended to read:

Subd. 4. **Changes in eligibility.** (a) The county shall process a change in eligibility factors according to paragraphs (b) to (g).

(b) A family is subject to the reporting requirements in section 256P.07, subdivision 6.

(c) If a family reports a change or a change is known to the agency before the family's regularly scheduled redetermination, the county must act on the change. The commissioner shall establish standards for verifying a change.

(d) A change in income occurs on the day the participant received the first payment reflecting the change in income.

(e) During a family's 12-month eligibility period, if the family's income increases and remains at or below 85 percent of the state median income, adjusted for family size, there is no change to the family's eligibility. The county shall not request verification of the change. The co-payment fee shall not increase during the remaining portion of the family's 12-month eligibility period.

(f) During a family's 12-month eligibility period, if the family's income increases and exceeds 85 percent of the state median income, adjusted for family size, the family is not eligible for child care assistance. The family must be given 15 calendar days to provide

verification of the change. If the required verification is not returned or confirms ineligibility, the family's eligibility ends following a subsequent 15-day adverse action notice.

(g) Notwithstanding Minnesota Rules, parts 3400.0040, subpart 3, and 3400.0170, subpart 1, if an applicant or participant reports that employment ended, the agency may accept a signed statement from the applicant or participant as verification that employment ended.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 3. Minnesota Statutes 2020, section 256D.03, is amended by adding a subdivision to read:

Subd. 2b. **Budgeting and reporting.** County agencies shall determine eligibility and calculate benefit amounts for general assistance according to the provisions in sections 256P.06, 256P.07, 256P.09, and 256P.10.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 4. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 20. **SNAP employment and training.** The commissioner shall implement a Supplemental Nutrition Assistance Program (SNAP) employment and training program that meets the SNAP employment and training participation requirements of the United States Department of Agriculture governed by Code of Federal Regulations, title 7, section 273.7. The commissioner shall operate a SNAP employment and training program in which SNAP recipients elect to participate. In order to receive SNAP assistance beyond the time limit, unless residing in an area covered by a time-limit waiver governed by Code of Federal Regulations, title 7, section 273.24, nonexempt SNAP recipients who do not meet federal SNAP work requirements must participate in an employment and training program. In addition to county and tribal agencies that administer SNAP, the commissioner may contract with third-party providers for SNAP employment and training services.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 5. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 21. **County and tribal agency duties.** County or tribal agencies that administer SNAP shall inform adult SNAP recipients about employment and training services and

providers in the recipient's area. County or tribal agencies that administer SNAP may elect to subcontract with a public or private entity approved by the commissioner to provide SNAP employment and training services.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 6. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 22. **Duties of commissioner.** In addition to any other duties imposed by law, the commissioner shall:

(1) supervise the administration of SNAP employment and training services to county, tribal, and contracted agencies under this section and Code of Federal Regulations, title 7, section 273.7;

(2) disburse money allocated and reimbursed for SNAP employment and training services to county, tribal, and contracted agencies;

(3) accept and supervise the disbursement of any funds that may be provided by the federal government or other sources for SNAP employment and training services;

(4) cooperate with other agencies, including any federal agency or agency of another state, in all matters concerning the powers and duties of the commissioner under this section;

(5) coordinate with the commissioner of employment and economic development to deliver employment and training services statewide;

(6) work in partnership with counties, tribes, and other agencies to enhance the reach and services of a statewide SNAP employment and training program; and

(7) identify eligible nonfederal funds to earn federal reimbursement for SNAP employment and training services.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 7. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 23. **Recipient duties.** Unless residing in an area covered by a time-limit waiver, nonexempt SNAP recipients must meet federal SNAP work requirements to receive SNAP assistance beyond the time limit.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 8. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 24. **Program funding.** (a) The United States Department of Agriculture annually allocates SNAP employment and training funds to the commissioner of human services for the operation of the SNAP employment and training program.

(b) The United States Department of Agriculture authorizes the disbursement of SNAP employment and training reimbursement funds to the commissioner of human services for the operation of the SNAP employment and training program.

(c) Except for funds allocated for state program development and administrative purposes or designated by the United States Department of Agriculture for a specific project, the commissioner of human services shall disburse money allocated for federal SNAP employment and training to counties and tribes that administer SNAP based on a formula determined by the commissioner that includes but is not limited to the county's or tribe's proportion of adult SNAP recipients as compared to the statewide total.

(d) The commissioner of human services shall disburse federal funds that the commissioner receives as reimbursement for SNAP employment and training costs to the state agency, county, tribe, or contracted agency that incurred the costs being reimbursed.

(e) The commissioner of human services may reallocate unexpended money disbursed under this section to county, tribal, or contracted agencies that demonstrate a need for additional funds.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 9. Minnesota Statutes 2020, section 256D.0515, is amended to read:

256D.0515 ASSET LIMITATIONS FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM HOUSEHOLDS.

All Supplemental Nutrition Assistance Program (SNAP) households must be determined eligible for the benefit discussed under section 256.029. SNAP households must demonstrate that their gross income is equal to or less than ~~165~~ 200 percent of the federal poverty guidelines for the same family size.

Sec. 10. Minnesota Statutes 2020, section 256D.0516, subdivision 2, is amended to read:

Subd. 2. **SNAP reporting requirements.** The commissioner of human services shall implement simplified reporting as permitted under the Food and Nutrition Act of 2008, as

amended, and the SNAP regulations in Code of Federal Regulations, title 7, part 273. SNAP benefit recipient households required to report periodically shall not be required to report more often than one time every six months. ~~This provision shall not apply to households receiving food benefits under the Minnesota family investment program waiver.~~

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 11. Minnesota Statutes 2020, section 256E.34, subdivision 1, is amended to read:

Subdivision 1. **Distribution of appropriation.** The commissioner must distribute funds appropriated to the commissioner by law for that purpose to Hunger Solutions, a statewide association of food shelves organized as a nonprofit corporation as defined under section 501(c)(3) of the Internal Revenue Code of 1986, to distribute to qualifying food shelves. A food shelf qualifies under this section if:

(1) it is a nonprofit corporation, or is affiliated with a nonprofit corporation, as defined in section 501(c)(3) of the Internal Revenue Code of 1986 or a federally recognized tribal nation;

(2) it distributes standard food orders without charge to needy individuals. The standard food order must consist of at least a two-day supply or six pounds per person of nutritionally balanced food items;

(3) it does not limit food distributions to individuals of a particular religious affiliation, race, or other criteria unrelated to need or to requirements necessary to administration of a fair and orderly distribution system;

(4) it does not use the money received or the food distribution program to foster or advance religious or political views; and

(5) it has a stable address and directly serves individuals.

Sec. 12. Minnesota Statutes 2020, section 256I.03, subdivision 13, is amended to read:

Subd. 13. **Prospective budgeting.** "Prospective budgeting" ~~means estimating the amount of monthly income a person will have in the payment month~~ has the meaning given in section 256P.01, subdivision 9.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 13. Minnesota Statutes 2020, section 256I.06, subdivision 6, is amended to read:

Subd. 6. **Reports.** Recipients must report changes in circumstances according to section 256P.07 ~~that affect eligibility or housing support payment amounts, other than changes in earned income, within ten days of the change~~. Recipients with countable earned income must complete a household report form at least once every six months according to section 256P.10. ~~If the report form is not received before the end of the month in which it is due, the county agency must terminate eligibility for housing support payments. The termination shall be effective on the first day of the month following the month in which the report was due. If a complete report is received within the month eligibility was terminated, the individual is considered to have continued an application for housing support payment effective the first day of the month the eligibility was terminated.~~

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 14. Minnesota Statutes 2020, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the room and board rate for that same month. The housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

~~(b) For an individual with earned income under paragraph (a), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.~~

~~(c)~~ (b) For an individual who receives housing support payments under section 256I.04, subdivision 1, paragraph (c), the amount of the housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 15. Minnesota Statutes 2020, section 256J.08, subdivision 15, is amended to read:

Subd. 15. **Countable income.** "Countable income" means earned and unearned income that is ~~not excluded under section 256J.21, subdivision 2~~ described in section 256P.06, subdivision 3, or disregarded under section 256J.21, subdivision 3, or section 256P.03.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 16. Minnesota Statutes 2020, section 256J.08, subdivision 71, is amended to read:

Subd. 71. **Prospective budgeting.** "Prospective budgeting" ~~means a method of determining the amount of the assistance payment in which the budget month and payment month are the same~~ has the meaning given in section 256P.01, subdivision 9.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 17. Minnesota Statutes 2020, section 256J.08, subdivision 79, is amended to read:

Subd. 79. **Recurring income.** "Recurring income" means a form of income which is:

(1) received periodically, and may be received irregularly when receipt can be anticipated even though the date of receipt cannot be predicted; and

(2) from the same source or of the same type that is received and budgeted in a prospective month ~~and is received in one or both of the first two retrospective months~~.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 18. Minnesota Statutes 2020, section 256J.10, is amended to read:

256J.10 MFIP ELIGIBILITY REQUIREMENTS.

To be eligible for MFIP, applicants must meet the general eligibility requirements in sections 256J.11 to 256J.15, the property limitations in section 256P.02, and the income limitations in ~~section~~ sections 256J.21 and 256P.06.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 19. Minnesota Statutes 2020, section 256J.21, subdivision 3, is amended to read:

Subd. 3. **Initial income test.** The agency shall determine initial eligibility by considering all earned and unearned income ~~that is not excluded under subdivision 2~~ as defined in section 256P.06. To be eligible for MFIP, the assistance unit's countable income minus the earned income disregards in paragraph (a) and section 256P.03 must be below the family wage level according to section 256J.24, subdivision 7, for that size assistance unit.

(a) The initial eligibility determination must disregard the following items:

(1) the earned income disregard as determined in section 256P.03;

(2) dependent care costs must be deducted from gross earned income for the actual amount paid for dependent care up to a maximum of $200 per month for each child less than two years of age, and $175 per month for each child two years of age and older;

(3) all payments made according to a court order for spousal support or the support of children not living in the assistance unit's household shall be disregarded from the income of the person with the legal obligation to pay support; and

(4) an allocation for the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible and who lives with the caregiver according to section 256J.36.

(b) ~~After initial eligibility is established,~~ The income test is for a six-month period. The assistance payment calculation is based on ~~the monthly income test~~ prospective budgeting according to section 256P.09.

EFFECTIVE DATE. This section is effective August 1, 2021, except for the amendments in subdivision 3, paragraph (b), which are effective March 1, 2023.

Sec. 20. Minnesota Statutes 2020, section 256J.21, subdivision 4, is amended to read:

Subd. 4. **~~Monthly~~ Income test and determination of assistance payment.** ~~The county agency shall determine ongoing eligibility and the assistance payment amount according to the monthly income test.~~ To be eligible for MFIP, the result of the computations in paragraphs (a) to (e) applied to prospective budgeting must be at least $1.

(a) Apply an income disregard as defined in section 256P.03, to gross earnings and subtract this amount from the family wage level. If the difference is equal to or greater than the MFIP transitional standard, the assistance payment is equal to the MFIP transitional standard. If the difference is less than the MFIP transitional standard, the assistance payment is equal to the difference. The earned income disregard in this paragraph must be deducted every month there is earned income.

(b) All payments made according to a court order for spousal support or the support of children not living in the assistance unit's household must be disregarded from the income of the person with the legal obligation to pay support.

(c) An allocation for the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible and who lives with the caregiver must be made according to section 256J.36.

(d) Subtract unearned income dollar for dollar from the MFIP transitional standard to determine the assistance payment amount.

(e) When income is both earned and unearned, the amount of the assistance payment must be determined by first treating gross earned income as specified in paragraph (a). After determining the amount of the assistance payment under paragraph (a), unearned income must be subtracted from that amount dollar for dollar to determine the assistance payment amount.

~~(f) When the monthly income is greater than the MFIP transitional standard after deductions and the income will only exceed the standard for one month, the county agency must suspend the assistance payment for the payment month.~~

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 21. Minnesota Statutes 2020, section 256J.21, subdivision 5, is amended to read:

Subd. 5. **Distribution of income.** (a) The income of all members of the assistance unit must be counted. Income may also be deemed from ineligible persons to the assistance unit. Income must be attributed to the person who earns it or to the assistance unit according to paragraphs ~~(a) to~~ (b) and (c).

~~(a) Funds distributed from a trust, whether from the principal holdings or sale of trust property or from the interest and other earnings of the trust holdings, must be considered income when the income is legally available to an applicant or participant. Trusts are presumed legally available unless an applicant or participant can document that the trust is not legally available.~~

(b) Income from jointly owned property must be divided equally among property owners unless the terms of ownership provide for a different distribution.

(c) Deductions are not allowed from the gross income of a financially responsible household member or by the members of an assistance unit to meet a current or prior debt.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 22. Minnesota Statutes 2020, section 256J.24, subdivision 5, is amended to read:

Subd. 5. **MFIP transitional standard.** (a) The MFIP transitional standard is based on the number of persons in the assistance unit eligible for both food and cash assistance. The amount of the transitional standard is published annually by the Department of Human Services.

(b) The amount of the MFIP cash assistance portion of the transitional standard is increased $100 per month per household. This increase shall be reflected in the MFIP cash assistance portion of the transitional standard published annually by the commissioner.

(c) On October 1 of each year, the commissioner of human services shall adjust the cash assistance portion under paragraph (a) for inflation based on the CPI-U for the prior calendar year.

EFFECTIVE DATE. This section is effective for the fiscal year beginning on July 1, 2021.

Sec. 23. Minnesota Statutes 2020, section 256J.30, subdivision 8, is amended to read:

Subd. 8. **Late MFIP household report forms.** (a) Paragraphs (b) to (e) apply to the reporting requirements in subdivision 7.

(b) When the county agency receives an incomplete MFIP household report form, the county agency must immediately ~~return the incomplete form and clearly state what the caregiver must do for the form to be complete~~ contact the caregiver by phone or in writing to acquire the necessary information to complete the form.

(c) The automated eligibility system must send a notice of proposed termination of assistance to the assistance unit if a complete MFIP household report form is not received by a county agency. The automated notice must be mailed to the caregiver by approximately the 16th of the month. When a caregiver submits an incomplete form on or after the date a notice of proposed termination has been sent, the termination is valid unless the caregiver submits a complete form before the end of the month.

(d) An assistance unit required to submit an MFIP household report form is considered to have continued its application for assistance if a complete MFIP household report form is received within a calendar month after the month in which the form was due and assistance shall be paid for the period beginning with the first day of that calendar month.

(e) A county agency must allow good cause exemptions from the reporting requirements under subdivision 5 when any of the following factors cause a caregiver to fail to provide the county agency with a completed MFIP household report form before the end of the month in which the form is due:

(1) an employer delays completion of employment verification;

(2) a county agency does not help a caregiver complete the MFIP household report form when the caregiver asks for help;

(3) a caregiver does not receive an MFIP household report form due to mistake on the part of the department or the county agency or due to a reported change in address;

(4) a caregiver is ill, or physically or mentally incapacitated; or

(5) some other circumstance occurs that a caregiver could not avoid with reasonable care which prevents the caregiver from providing a completed MFIP household report form before the end of the month in which the form is due.

Sec. 24. Minnesota Statutes 2020, section 256J.33, subdivision 1, is amended to read:

Subdivision 1. **Determination of eligibility.** (a) A county agency must determine MFIP eligibility prospectively ~~for a payment month~~ based on ~~retrospectively~~ assessing income and the county agency's best estimate of the circumstances that will exist in the payment month.

~~Except as described in section 256J.34, subdivision 1, when prospective eligibility exists,~~ (b) A county agency must calculate the amount of the assistance payment using ~~retrospective~~ prospective budgeting. To determine MFIP eligibility and the assistance payment amount, a county agency must apply countable income, described in ~~section~~ sections 256P.06 and 256J.37, subdivisions 3 to ~~10~~ 9, received by members of an assistance unit or by other persons whose income is counted for the assistance unit, described under sections ~~256J.21 and~~ 256J.37, subdivisions 1 to 2, and 256P.06, subdivision 1.

(c) This income must be applied to the MFIP standard of need or family wage level subject to this section and sections 256J.34 to 256J.36. Countable income received ~~in a calendar month and not otherwise excluded under section 256J.21, subdivision 2,~~ must be applied to the needs of an assistance unit.

(d) An assistance unit is not eligible when the countable income equals or exceeds the MFIP standard of need or the family wage level for the assistance unit.

EFFECTIVE DATE. Paragraph (a) is effective March 1, 2023. Paragraph (b) is effective March 1, 2023, except the amendment striking section 256J.21 and inserting section 256P.06 is effective August 1, 2021. Paragraph (c) is effective August 1, 2021, except the amendment striking "in a calendar month" is effective March 1, 2023. Paragraph (d) is effective March 1, 2023.

Sec. 25. Minnesota Statutes 2020, section 256J.33, subdivision 2, is amended to read:

Subd. 2. **Prospective eligibility.** An agency must determine whether the eligibility requirements that pertain to an assistance unit, including those in sections 256J.11 to 256J.15

and 256P.02, will be met prospectively for the payment ~~month~~ period. ~~Except for the provisions in section 256J.34, subdivision 1,~~ The income test will be applied ~~retrospectively~~ prospectively.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 26. Minnesota Statutes 2020, section 256J.33, subdivision 4, is amended to read:

Subd. 4. **Monthly income test.** A county agency must apply the monthly income test retrospectively for each month of MFIP eligibility. An assistance unit is not eligible when the countable income equals or exceeds the MFIP standard of need or the family wage level for the assistance unit. The income applied against the monthly income test must include:

(1) gross earned income from employment as described in chapter 256P, prior to mandatory payroll deductions, voluntary payroll deductions, wage authorizations, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36~~, unless the employment income is specifically excluded under section 256J.21, subdivision 2~~;

(2) gross earned income from self-employment less deductions for self-employment expenses in section 256J.37, subdivision 5, but prior to any reductions for personal or business state and federal income taxes, personal FICA, personal health and life insurance, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36;

(3) unearned income as described in section 256P.06, subdivision 3, after deductions for allowable expenses in section 256J.37, subdivision 9, and allocations in section 256J.36~~, unless the income has been specifically excluded in section 256J.21, subdivision 2~~;

(4) gross earned income from employment as determined under clause (1) which is received by a member of an assistance unit who is a minor child or minor caregiver and less than a half-time student;

(5) child support received by an assistance unit, excluded under ~~section 256J.21, subdivision 2, clause (49), or~~ section 256P.06, subdivision 3, clause (2), item (xvi);

(6) spousal support received by an assistance unit;

(7) the income of a parent when that parent is not included in the assistance unit;

(8) the income of an eligible relative and spouse who seek to be included in the assistance unit; and

(9) the unearned income of a minor child included in the assistance unit.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 27. Minnesota Statutes 2020, section 256J.37, subdivision 1, is amended to read:

Subdivision 1. **Deemed income from ineligible assistance unit members.** The income of ineligible assistance unit members, except individuals identified in section 256J.24, subdivision 3, paragraph (a), clause (1), must be deemed after allowing the following disregards:

(1) an earned income disregard as determined under section 256P.03;

(2) all payments made by the ineligible person according to a court order for spousal support or the support of children not living in the assistance unit's household; and

(3) an amount for the unmet needs of the ineligible persons who live in the household who, if eligible, would be assistance unit members under section 256J.24, subdivision 2 or 4, paragraph (b). This amount is equal to the difference between the MFIP transitional standard when the ineligible persons are included in the assistance unit and the MFIP transitional standard when the ineligible persons are not included in the assistance unit.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 28. Minnesota Statutes 2020, section 256J.37, subdivision 1b, is amended to read:

Subd. 1b. **Deemed income from parents of minor caregivers.** In households where minor caregivers live with a parent or parents or a stepparent who do not receive MFIP for themselves or their minor children, the income of the parents or a stepparent must be deemed after allowing the following disregards:

(1) income of the parents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor parent's child in the household ~~according to section 256J.21, subdivision 2, clause (43)~~; and

(2) all payments made by parents according to a court order for spousal support or the support of children not living in the parent's household.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 29. Minnesota Statutes 2020, section 256J.37, subdivision 3, is amended to read:

Subd. 3. **Earned income of wage, salary, and contractual employees.** The agency must include gross earned income less any disregards in the initial ~~and monthly~~ income test. Gross earned income received by persons employed on a contractual basis must be

prorated over the period covered by the contract even when payments are received over a lesser period of time.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 30. Minnesota Statutes 2020, section 256J.37, subdivision 3a, is amended to read:

Subd. 3a. **Rental subsidies; unearned income.** (a) Effective July 1, 2003, the agency shall count $50 of the value of public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) as unearned income to the cash portion of the MFIP grant. The full amount of the subsidy must be counted as unearned income when the subsidy is less than $50. The income from this subsidy shall be budgeted according to section ~~256J.34~~ 256P.09.

(b) The provisions of this subdivision shall not apply to an MFIP assistance unit which includes a participant who is:

(1) age 60 or older;

(2) a caregiver who is suffering from an illness, injury, or incapacity that has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and severely limits the person's ability to obtain or maintain suitable employment; or

(3) a caregiver whose presence in the home is required due to the illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness or incapacity and the need for the participant's presence in the home has been certified by a qualified professional and is expected to continue for more than 30 days.

(c) The provisions of this subdivision shall not apply to an MFIP assistance unit where the parental caregiver is an SSI participant.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 31. Minnesota Statutes 2020, section 256J.626, subdivision 1, is amended to read:

Subdivision 1. **Consolidated fund.** The consolidated fund is established to support counties and tribes in meeting their duties under this chapter. Counties and tribes must use funds from the consolidated fund to develop programs and services that are designed to improve participant outcomes as measured in section 256J.751, subdivision 2. Counties and tribes that administer MFIP eligibility may use the funds for any allowable expenditures

under subdivision 2, including case management. Tribes that do not administer MFIP eligibility may use the funds for any allowable expenditures under subdivision 2, including case management, except those in subdivision 2, paragraph (a), clauses (1) and (6). All payments made through the MFIP consolidated fund to support a caregiver's pursuit of greater economic stability does not count when determining a family's available income.

Sec. 32. Minnesota Statutes 2020, section 256J.95, subdivision 9, is amended to read:

Subd. 9. **Property and income limitations.** The asset limits and exclusions in section 256P.02 apply to applicants and participants of DWP. All payments, ~~unless excluded in section 256J.21~~ as described in section 256P.06, subdivision 3, must be counted as income to determine eligibility for the diversionary work program. The agency shall treat income as outlined in section 256J.37, except for subdivision 3a. The initial income test and the disregards in section 256J.21, subdivision 3, shall be followed for determining eligibility for the diversionary work program.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 33. Minnesota Statutes 2020, section 256P.01, subdivision 3, is amended to read:

Subd. 3. **Earned income.** "Earned income" means ~~cash or in-kind~~ income earned through the receipt of wages, salary, commissions, bonuses, tips, gratuities, profit from employment activities, net profit from self-employment activities, payments made by an employer for regularly accrued vacation or sick leave, severance pay based on accrued leave time, ~~payments from training programs at a rate at or greater than the state's minimum wage,~~ royalties, honoraria, or other profit from activity that results from the client's work, ~~service,~~ effort, or labor for purposes other than student financial assistance, rehabilitation programs, student training programs, or service programs such as AmeriCorps. The income must be in return for, or as a result of, legal activity.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 34. Minnesota Statutes 2020, section 256P.01, is amended by adding a subdivision to read:

Subd. 9. **Prospective budgeting.** "Prospective budgeting" means estimating the amount of monthly income that an assistance unit will have in the payment month.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 35. Minnesota Statutes 2020, section 256P.04, subdivision 4, is amended to read:

Subd. 4. **Factors to be verified.** (a) The agency shall verify the following at application:

(1) identity of adults;

(2) age, if necessary to determine eligibility;

(3) immigration status;

(4) income;

(5) spousal support and child support payments made to persons outside the household;

(6) vehicles;

(7) checking and savings accounts;

(8) inconsistent information, if related to eligibility;

(9) residence; and

(10) Social Security number~~; and~~.

~~(11) use of nonrecurring income under section 256P.06, subdivision 3, clause (2), item (ix), for the intended purpose for which it was given and received.~~

(b) Applicants who are qualified noncitizens and victims of domestic violence as defined under section 256J.08, subdivision 73, ~~clause (7)~~ clauses (8) and (9), are not required to verify the information in paragraph (a), clause (10). When a Social Security number is not provided to the agency for verification, this requirement is satisfied when each member of the assistance unit cooperates with the procedures for verification of Social Security numbers, issuance of duplicate cards, and issuance of new numbers which have been established jointly between the Social Security Administration and the commissioner.

EFFECTIVE DATE. This section is effective March 1, 2023, except for paragraph (b), which is effective July 1, 2021.

Sec. 36. Minnesota Statutes 2020, section 256P.04, subdivision 8, is amended to read:

Subd. 8. **Recertification.** The agency shall recertify eligibility ~~in an annual interview with the participant. The interview may be conducted by telephone, by Internet telepresence, or face-to-face in the county office or in another location mutually agreed upon. A participant must be given the option of a telephone interview or Internet telepresence to recertify eligibility~~ annually. During ~~the interview~~ recertification and reporting under section 256P.10, the agency shall verify the following:

(1) income, unless excluded, including self-employment earnings;

(2) assets when the value is within $200 of the asset limit; and

(3) inconsistent information, if related to eligibility.

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

Sec. 37. Minnesota Statutes 2020, section 256P.06, subdivision 2, is amended to read:

Subd. 2. ~~**Exempted individuals**~~ **Exemptions.** (a) The following members of an assistance unit under chapters 119B and 256J are exempt from having their earned income count ~~towards~~ toward the income of an assistance unit:

(1) children under six years old;

(2) caregivers under 20 years of age enrolled at least half-time in school; and

(3) minors enrolled in school full time.

(b) The following members of an assistance unit are exempt from having their earned and unearned income count ~~towards~~ toward the income of an assistance unit for 12 consecutive calendar months, beginning the month following the marriage date, for benefits under chapter 256J if the household income does not exceed 275 percent of the federal poverty guideline:

(1) a new spouse to a caretaker in an existing assistance unit; and

(2) the spouse designated by a newly married couple, both of whom were already members of an assistance unit under chapter 256J.

(c) If members identified in paragraph (b) also receive assistance under section 119B.05, they are exempt from having their earned and unearned income count ~~towards~~ toward the income of the assistance unit if the household income prior to the exemption does not exceed 67 percent of the state median income for recipients for 26 consecutive biweekly periods beginning the second biweekly period after the marriage date.

(d) For individuals who are members of an assistance unit under chapters 256I and 256J, the assistance standard effective in January 2020 for a household of one under chapter 256J shall be counted as income under chapter 256I, and any subsequent increases to unearned income under chapter 256J shall be exempt.

Sec. 38. Minnesota Statutes 2020, section 256P.06, subdivision 3, is amended to read:

Subd. 3. **Income inclusions.** The following must be included in determining the income of an assistance unit:

(1) earned income; and

(2) unearned income, which includes:

(i) interest and dividends from investments and savings;

(ii) capital gains as defined by the Internal Revenue Service from any sale of real property;

(iii) proceeds from rent and contract for deed payments in excess of the principal and interest portion owed on property;

(iv) income from trusts, excluding special needs and supplemental needs trusts;

(v) interest income from loans made by the participant or household;

(vi) cash prizes and winnings according to guidance provided for the Supplemental Nutrition Assistance Program;

(vii) unemployment insurance income that is received by an adult member of the assistance unit unless the individual receiving unemployment insurance income is:

(A) 18 years of age and enrolled in a secondary school; or

(B) 18 or 19 years of age, a caregiver, and is enrolled in school at least half-time;

(viii) retirement, survivors, and disability insurance payments;

~~(ix) nonrecurring income over $60 per quarter unless earmarked and used for the purpose for which it is intended. Income and use of this income is subject to verification requirements under section 256P.04;~~

~~(x)~~ (ix) retirement benefits;

~~(xi)~~ (x) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I, and 256J;

~~(xii)~~ (xi) tribal per capita payments unless excluded by federal and state law;

~~(xiii)~~ (xii) income and payments from service and rehabilitation programs that meet or exceed the state's minimum wage rate;

~~(xiv)~~ (xiii) income from members of the United States armed forces unless excluded from income taxes according to federal or state law;

~~(xv)~~ (xiv) all child support payments for programs under chapters 119B, 256D, and 256I;

~~(xvi)~~ (xv) the amount of child support received that exceeds $100 for assistance units with one child and $200 for assistance units with two or more children for programs under chapter 256J; ~~and~~

~~(xvii)~~ (xvi) spousal support~~.~~; and

(xvii) workers' compensation.

EFFECTIVE DATE. This section is effective March 1, 2023, except subdivision 3, clause (2), item (vii), which is effective the day following final enactment and subdivision 3, clause (2), item (xvii), which is effective August 1, 2021.

Sec. 39. Minnesota Statutes 2020, section 256P.07, is amended to read:

256P.07 REPORTING OF ~~INCOME AND~~ CHANGES.

Subdivision 1. **Exempted programs.** Participants who receive Supplemental Security Income and qualify for Minnesota supplemental aid under chapter 256D ~~and~~ or for housing support under chapter 256I ~~on the basis of eligibility for Supplemental Security Income~~ are exempt from ~~this section~~ reporting income.

Subd. 1a. **Child care assistance programs.** Participants who qualify for child care assistance programs under chapter 119B are exempt from this section except for the reporting requirements in subdivision 6.

Subd. 2. **Reporting requirements.** An applicant or participant must provide information on an application and any subsequent reporting forms about the assistance unit's circumstances that affect eligibility or benefits. An applicant or assistance unit must report changes identified in ~~subdivision~~ subdivisions 3, 4, 5, 7, 8, and 9 during the application period or by the tenth of the month following the month that the change occurred. When information is not accurately reported, both an overpayment and a referral for a fraud investigation may result. When information or documentation is not provided, the receipt of any benefit may be delayed or denied, depending on the type of information required and its effect on eligibility.

Subd. 3. **Changes that must be reported.** ~~An assistance unit must report the changes or anticipated changes specified in clauses (1) to (12) within ten days of the date they occur, at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or within eight calendar days of a reporting period, whichever occurs first. An assistance unit must report other changes at the time of recertification of eligibility under section 256P.04,~~

~~subdivisions 8 and 9, or at the end of a reporting period, as applicable. When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under clauses (1) to (12) had not occurred, the agency must determine whether a timely notice could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under section 119B.11, subdivision 2a, or 256P.08. Changes in circumstances that must be reported within ten days must also be reported for the reporting period in which those changes occurred. Within ten days, an assistance unit must report:~~

~~(1) a change in earned income of $100 per month or greater with the exception of a program under chapter 119B;~~

~~(2) a change in unearned income of $50 per month or greater with the exception of a program under chapter 119B;~~

~~(3) a change in employment status and hours with the exception of a program under chapter 119B;~~

~~(4) a change in address or residence;~~

~~(5) a change in household composition with the exception of programs under chapter 256I;~~

~~(6) a receipt of a lump-sum payment with the exception of a program under chapter 119B;~~

~~(7) an increase in assets if over $9,000 with the exception of programs under chapter 119B;~~

~~(8) a change in citizenship or immigration status;~~

~~(9) a change in family status with the exception of programs under chapter 256I;~~

~~(10) a change in disability status of a unit member, with the exception of programs under chapter 119B;~~

~~(11) a new rent subsidy or a change in rent subsidy with the exception of a program under chapter 119B; and~~

~~(12) a sale, purchase, or transfer of real property with the exception of a program under chapter 119B.~~ An assistance unit must report changes or anticipated changes as described in this section.

(a) An assistance unit must report:

(1) a change in eligibility for Supplemental Security Income, Retirement Survivors Disability Insurance, or another federal income support;

(2) a change in address or residence;

(3) a change in household composition with the exception of programs under chapter 256I;

(4) cash prizes and winnings according to guidance provided for the Supplemental Nutrition Assistance Program;

(5) a change in citizenship or immigration status;

(6) a change in family status with the exception of programs under chapter 256I; and

(7) assets when the value is at or above the asset limit.

(b) When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified in clauses (1) to (7) had not occurred, the agency must determine whether a timely notice could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to the notice must be considered a client error overpayment under section 256P.08.

Subd. 4. **MFIP-specific reporting.** In addition to subdivision 3, an assistance unit under chapter 256J, ~~within ten days of the change,~~ must report:

(1) a pregnancy not resulting in birth when there are no other minor children; ~~and~~

(2) a change in school attendance of a parent under 20 years of age ~~or of an employed child.~~; and

(3) an individual who is 18 or 19 years of age attending high school who graduates or drops out of school.

Subd. 5. **DWP-specific reporting.** In addition to subdivisions 3 and 4, an assistance unit participating in the diversionary work program under section 256J.95 must report on an application:

(1) shelter expenses; and

(2) utility expenses.

Subd. 6. **Child care assistance programs-specific reporting.** (a) ~~In addition to subdivision 3,~~ An assistance unit under chapter 119B, within ten days of the change, must report:

(1) a change in a parentally responsible individual's custody schedule for any child receiving child care assistance program benefits;

(2) a permanent end in a parentally responsible individual's authorized activity; ~~and~~

(3) if the unit's family's annual included income exceeds 85 percent of the state median income, adjusted for family size~~.~~;

(4) a change in address or residence;

(5) a change in household composition;

(6) a change in citizenship or immigration status; and

(7) a change in family status.

(b) An assistance unit subject to section 119B.095, subdivision 1, paragraph (b), must report a change in the unit's authorized activity status.

(c) An assistance unit must notify the county when the unit wants to reduce the number of authorized hours for children in the unit.

Subd. 7. **Minnesota supplemental aid-specific reporting.** (a) In addition to subdivision 3 and notwithstanding the exemption in subdivision 1, an assistance unit participating in the Minnesota supplemental aid program under ~~section 256D.44, subdivision 5, paragraph (g), within ten days of the change,~~ chapter 256D must report ~~shelter expenses.~~:

(1) a change in unearned income of $50 per month or greater; and

(2) a change in earned income of $100 per month or greater.

(b) An assistance unit receiving housing assistance under section 256D.44, subdivision 5, paragraph (g), including assistance units who also receive Supplemental Security Income, must report:

(1) a change in shelter expenses; and

(2) a new rent subsidy or a change in a rent subsidy.

Subd. 8. **Housing support-specific reporting.** (a) In addition to subdivision 3, an assistance unit participating in the housing support program under chapter 256I must report:

(1) a change in unearned income of $50 per month or greater; and

(2) a change in earned income of $100 per month or greater, with the exception of participants already subject to six-month reporting requirements in section 256P.10.

(b) Notwithstanding the exemptions in subdivisions 1 and 3, an assistance unit receiving housing support under chapter 256I, including an assistance unit that receives Supplemental Security Income, must report:

(1) a new rent subsidy or a change in a rent subsidy;

(2) a change in the disability status of a unit member; and

(3) a change in household composition if the assistance unit is a participant in housing support under section 256I.04, subdivision 3, paragraph (a), clause (3).

Subd. 9. **General assistance-specific reporting.** In addition to subdivision 3, an assistance unit participating in the general assistance program under chapter 256D must report:

(1) a change in unearned income of $50 per month or greater;

(2) a change in earned income of $100 per month or greater, with the exception of participants who are already subject to six-month reporting requirements in section 256P.10; and

(3) changes in any condition that would result in the loss of a basis for eligibility in section 256D.05, subdivision 1, paragraph (a).

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 40. **[256P.09] PROSPECTIVE BUDGETING OF BENEFITS.**

Subdivision 1. **Exempted programs.** Assistance units who qualify for child care assistance programs under chapter 119B; housing support assistance units under chapter 256I who are not subject to reporting under section 256P.10; and assistance units who qualify for Minnesota Supplemental Aid under chapter 256D are exempt from this section.

Subd. 2. **Prospective budgeting of benefits.** An agency must use prospective budgeting to calculate an assistance payment amount.

Subd. 3. **Income changes.** Prospective budgeting must be used to determine the amount of the assistance unit's benefit for the following six-month period. An increase in income shall not affect an assistance unit's eligibility or benefit amount until the next case review unless otherwise required by section 256P.07. A decrease in income shall be effective on the date that the change occurs if the change is reported by the tenth of the month following the month when the change occurred. If the decrease in income is not reported by the tenth of the month following the month when the change occurred, the change in income shall be effective the month following the month when the change is reported.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 41. **[256P.10] SIX-MONTH REPORTING.**

Subdivision 1. **Exempted programs.** Assistance units who qualify for child care assistance programs under chapter 119B; assistance units who qualify for Minnesota Supplemental Aid under chapter 256D; and assistance units who qualify for housing support under chapter 256I and also receive Supplemental Security Income are exempt from this section.

Subd. 2. **Reporting.** (a) Every six months, an assistance unit that qualifies for the Minnesota family investment program under chapter 256J; an assistance unit that qualifies for general assistance under chapter 256D with earned income of $100 per month or greater; or an assistance unit that qualifies for housing support under chapter 256I with earned income of $100 per month or greater is subject to six month case reviews. The initial reporting period may be shorter than six months in order to align with other program reporting periods.

(b) An assistance unit that qualifies for the Minnesota family investment program and an assistance unit that qualifies for general assistance as described in paragraph (a) must complete household report forms as prescribed by the commissioner for redetermination of benefits.

(c) An assistance unit that qualifies for housing support as described in paragraph (a) must complete household report forms as prescribed by the commissioner to provide information about earned income.

(d) An assistance unit that qualifies for housing support and also receives assistance through the Minnesota family investment program shall be subject to the requirements of this section for purposes of the Minnesota family investment program but not for housing support.

(e) An assistance unit must submit a household report form in compliance with the provisions in section 256P.04, subdivision 11.

(f) An assistance unit may choose to report changes under this section at any time.

Subd. 3. **When to terminate assistance.** (a) An agency must terminate benefits when the participant fails to submit the household report form before the end of the six month review period. If the participant submits the household report form within 30 days of the termination of benefits, benefits must be reinstated and made available retroactively for the full benefit month.

(b) When an assistance unit is determined to be ineligible for assistance according to this section and chapter 256D, 256I, or 256J, the agency must terminate assistance.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 42. Laws 2020, First Special Session chapter 7, section 1, as amended by Laws 2020, Third Special Session chapter 1, section 3, is amended by adding a subdivision to read:

Subd. 5. **Waivers and modifications.** When the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, the following waivers and modifications to human services programs issued by the commissioner of human services pursuant to Executive Orders 20-12 and 20-42, including any amendments to the waivers or modifications issued before the peacetime emergency expires, shall remain in effect until December 31, 2021, unless necessary federal approval is not received at any time for a waiver or modification:

(1) Executive Order 21-15: when determining eligibility for cash assistance programs, not counting as income any emergency economic relief provided through the American Rescue Plan Act of 2021; and

(2) CV.04.A4: waiving interviews for annual eligibility recertifications of households receiving cash assistance in which all necessary information has been submitted and verified.

Sec. 43. **DIRECTION TO COMMISSIONER; LONG-TERM HOMELESS SUPPORTIVE SERVICES REPORT.**

(a) No later than January 15, 2023, the commissioner of human services shall produce a report which shows the projects funded under Minnesota Statutes, section 256K.26, and provide a copy of the report to the chairs and ranking minority members of the legislative committees with jurisdiction over services for persons experiencing homelessness.

(b) This report must be updated annually for two additional years and the commissioner must provide copies of the updated reports to the chairs and ranking minority members of the legislative committees with jurisdiction over services for persons experiencing homelessness by January 15, 2024, and January 15, 2025.

Sec. 44. **2022 REPORT TO LEGISLATURE ON RUNAWAY AND HOMELESS YOUTH.**

Subdivision 1. **Report development.** The commissioner of human services is exempt from preparing the report required under Minnesota Statutes, section 256K.45, subdivision

2, in 2023 and shall instead update the information in the 2007 legislative report on runaway and homeless youth. In developing the updated report, the commissioner must use existing data, studies, and analysis provided by state, county, and other entities including:

(1) Minnesota Housing Finance Agency analysis on housing availability;

(2) the Minnesota state plan to end homelessness;

(3) the continuum of care counts of youth experiencing homelessness and assessments as provided by Department of Housing and Urban Development (HUD) required coordinated entry systems;

(4) the biannual Department of Human Services report on the Homeless Youth Act;

(5) the Wilder Research homeless study;

(6) the Voices of Youth Count sponsored by Hennepin County; and

(7) privately funded analysis, including:

(i) nine evidence-based principles to support youth in overcoming homelessness;

(ii) the return on investment analysis conducted for YouthLink by Foldes Consulting; and

(iii) the evaluation of Homeless Youth Act resources conducted by Rainbow Research.

Subd. 2. **Key elements; due date.** (a) The report must include three key elements where significant learning has occurred in the state since the 2007 report, including:

(1) the unique causes of youth homelessness;

(2) targeted responses to youth homelessness, including the significance of positive youth development as fundamental to each targeted response; and

(3) recommendations based on existing reports and analysis on how to end youth homelessness.

(b) To the extent that data is available, the report must include:

(1) a general accounting of the federal and philanthropic funds leveraged to support homeless youth activities;

(2) a general accounting of the increase in volunteer responses to support youth experiencing homelessness; and

(3) a data-driven accounting of geographic areas or distinct populations that have gaps in service or are not yet served by homeless youth responses.

(c) The commissioner of human services shall consult with and incorporate the expertise of community-based providers of homeless youth services and other expert stakeholders to complete the report. The commissioner shall submit the report to the chairs and ranking minority members of the legislative committees with jurisdiction over youth homelessness by December 15, 2022.

Sec. 45. **REPEALER.**

(a) Minnesota Statutes 2020, sections 256D.051, subdivisions 1, 1a, 2, 2a, 3, 3a, 3b, 6b, 6c, 7, 8, 9, and 18; 256D.052, subdivision 3; and 256J.21, subdivisions 1 and 2, are repealed.

(b) Minnesota Statutes 2020, sections 256J.08, subdivisions 10, 53, 61, 62, 81, and 83; 256J.30, subdivisions 5, 7, and 8; 256J.33, subdivisions 3, 4, and 5; 256J.34, subdivisions 1, 2, 3, and 4; and 256J.37, subdivision 10, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective August 1, 2021. Paragraph (b) is effective March 1, 2023.

ARTICLE 9
CHILD CARE ASSISTANCE

Section 1. Minnesota Statutes 2020, section 119B.03, subdivision 4, is amended to read:

Subd. 4. **Funding priority.** (a) First priority for child care assistance under the basic sliding fee program must be given to eligible non-MFIP families who do not have a high school diploma or commissioner of education-selected high school equivalency certification or who need remedial and basic skill courses in order to pursue employment or to pursue education leading to employment and who need child care assistance to participate in the education program. This includes student parents as defined under section 119B.011, subdivision 19b. Within this priority, the following subpriorities must be used:

(1) child care needs of minor parents;

(2) child care needs of parents under 21 years of age; and

(3) child care needs of other parents within the priority group described in this paragraph.

(b) Second priority must be given to ~~parents who have completed their MFIP or DWP transition year, or parents who are no longer receiving or eligible for diversionary work program supports~~ families in which at least one parent is a veteran, as defined under section 197.447.

(c) Third priority must be given to eligible families who ~~are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9~~ do not meet the specifications of paragraph (a), (b), (d), or (e).

(d) Fourth priority must be given to families ~~in which at least one parent is a veteran as defined under section 197.447~~ who are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9.

(e) Fifth priority must be given to eligible families receiving services under section 119B.011, subdivision 20a, if the parents have completed their MFIP or DWP transition year, or if the parents are no longer receiving or eligible for DWP supports.

~~(e)~~ (f) Families under paragraph ~~(b)~~ (e) must be added to the basic sliding fee waiting list on the date they ~~begin the~~ complete their transition year under section 119B.011, subdivision 20~~, and must be moved into the basic sliding fee program as soon as possible after they complete their transition year~~.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 2. Minnesota Statutes 2020, section 119B.03, subdivision 6, is amended to read:

Subd. 6. **Allocation formula.** The allocation component of basic sliding fee state and federal funds shall be allocated on a calendar year basis. Funds shall be allocated first in amounts equal to each county's guaranteed floor according to subdivision 8, with any remaining available funds allocated according to the following formula:

(a) One-fourth of the funds shall be allocated in proportion to each county's total expenditures for the basic sliding fee child care program reported during the most recent fiscal year completed at the time of the notice of allocation.

(b) Up to one-fourth of the funds shall be allocated in proportion to the number of families participating in the transition year child care program as reported during and averaged over the most recent six months completed at the time of the notice of allocation. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph ~~(f)~~ (e).

~~(c) Up to one-fourth of the funds shall be allocated in proportion to the average of each county's most recent six months of reported first, second, and third priority waiting list as defined in subdivision 2 and the reinstatement list of those families whose assistance was terminated with the approval of the commissioner under Minnesota Rules, part 3400.0183, subpart 1. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph (f).~~

~~(d)~~ (c) Up to ~~one-fourth~~ one-half of the funds shall be allocated in proportion to the average of each county's most recent ~~six~~ 12 months of reported waiting list as defined in subdivision 2 and the reinstatement list of those families whose assistance was terminated with the approval of the commissioner under Minnesota Rules, part 3400.0183, subpart 1. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph ~~(f)~~ (e).

~~(e)~~ (d) The amount necessary to serve all families in paragraphs (b)~~, (c),~~ and ~~(d)~~ (c) shall be calculated based on the basic sliding fee average cost of care per family in the county with the highest cost in the most recently completed calendar year.

~~(f)~~ (e) Funds in excess of the amount necessary to serve all families in paragraphs (b)~~, (c),~~ and ~~(d)~~ (c) shall be allocated in proportion to each county's total expenditures for the basic sliding fee child care program reported during the most recent fiscal year completed at the time of the notice of allocation.

EFFECTIVE DATE. This section is effective January 1, 2022. The 2022 calendar year shall be a phase-in year for the allocation formula in this section using phase-in provisions determined by the commissioner of human services.

Sec. 3. Minnesota Statutes 2020, section 119B.09, subdivision 4, is amended to read:

Subd. 4. **Eligibility; annual income; calculation.** (a) Annual income of the applicant family is the current monthly income of the family multiplied by 12 or the income for the 12-month period immediately preceding the date of application, or income calculated by the method which provides the most accurate assessment of income available to the family.

(b) Self-employment income must be calculated based on gross receipts less operating expenses.

(c) Income changes are processed under section 119B.025, subdivision 4. Included lump sums counted as income under section ~~256P.06, subdivision 3~~ 119B.011, subdivision 15, must be annualized over 12 months. Income must be verified with documentary evidence. If the applicant does not have sufficient evidence of income, verification must be obtained from the source of the income.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 4. Minnesota Statutes 2020, section 119B.11, subdivision 2a, is amended to read:

Subd. 2a. **Recovery of overpayments.** (a) An amount of child care assistance paid to a recipient or provider in excess of the payment due is recoverable by the county agency or

commissioner under paragraphs (b) and (c), even when the overpayment was caused by agency error or circumstances outside the responsibility and control of the family or provider.

(b) An overpayment must be recouped or recovered from the family if the overpayment benefited the family by causing the family to pay less for child care expenses than the family otherwise would have been required to pay under child care assistance program requirements. If the family remains eligible for child care assistance, the overpayment must be recovered through recoupment as identified in Minnesota Rules, part 3400.0187, except that the overpayments must be calculated and collected on a service period basis. If the family no longer remains eligible for child care assistance, the county or commissioner may choose to initiate efforts to recover overpayments from the family for overpayment less than $50. If the overpayment is greater than or equal to $50, the county or commissioner shall seek voluntary repayment of the overpayment from the family. If the county or commissioner is unable to recoup the overpayment through voluntary repayment, the county or commissioner shall initiate civil court proceedings to recover the overpayment unless the county's or commissioner's costs to recover the overpayment will exceed the amount of the overpayment. A family with an outstanding debt under this subdivision is not eligible for child care assistance until: (1) the debt is paid in full; ~~or~~ (2) satisfactory arrangements are made with the county or commissioner to retire the debt consistent with the requirements of this chapter and Minnesota Rules, chapter 3400, and the family is in compliance with the arrangements; or (3) the commissioner determines that it is in the best interests of the state to compromise debts owed to the state pursuant to section 16D.15. The commissioner's authority to recoup and recover overpayments from families in this paragraph is limited to investigations conducted under chapter 245E.

(c) The county or commissioner must recover an overpayment from a provider if the overpayment did not benefit the family by causing it to receive more child care assistance or to pay less for child care expenses than the family otherwise would have been eligible to receive or required to pay under child care assistance program requirements, and benefited the provider by causing the provider to receive more child care assistance than otherwise would have been paid on the family's behalf under child care assistance program requirements. If the provider continues to care for children receiving child care assistance, the overpayment must be recovered through ~~reductions in child care assistance payments for services as described in an agreement with the county~~ recoupment as identified in Minnesota Rules, part 3400.0187. The provider may not charge families using that provider more to cover the cost of recouping the overpayment. If the provider no longer cares for children receiving child care assistance, the county or commissioner may choose to initiate

efforts to recover overpayments of less than $50 from the provider. If the overpayment is greater than or equal to $50, the county or commissioner shall seek voluntary repayment of the overpayment from the provider. If the county or commissioner is unable to recoup the overpayment through voluntary repayment, the county or commissioner shall initiate civil court proceedings to recover the overpayment unless the county's or commissioner's costs to recover the overpayment will exceed the amount of the overpayment. A provider with an outstanding debt under this subdivision is not eligible to care for children receiving child care assistance until:

(1) the debt is paid in full; ~~or~~

(2) satisfactory arrangements are made with the county or commissioner to retire the debt consistent with the requirements of this chapter and Minnesota Rules, chapter 3400, and the provider is in compliance with the arrangements~~.~~; or

(3) the commissioner determines that it is in the best interests of the state to compromise debts owed to the state pursuant to section 16D.15.

(d) When both the family and the provider acted together to intentionally cause the overpayment, both the family and the provider are jointly liable for the overpayment regardless of who benefited from the overpayment. The county or commissioner must recover the overpayment as provided in paragraphs (b) and (c). When the family or the provider is in compliance with a repayment agreement, the party in compliance is eligible to receive child care assistance or to care for children receiving child care assistance despite the other party's noncompliance with repayment arrangements.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 5. Minnesota Statutes 2020, section 119B.125, subdivision 1, is amended to read:

Subdivision 1. **Authorization.** ~~Except as provided in subdivision 5,~~ A county or the commissioner must authorize the provider chosen by an applicant or a participant before the county can authorize payment for care provided by that provider. The commissioner must establish the requirements necessary for authorization of providers. A provider must be reauthorized every two years. A legal, nonlicensed family child care provider also must be reauthorized when another person over the age of 13 joins the household, a current household member turns 13, or there is reason to believe that a household member has a factor that prevents authorization. The provider is required to report all family changes that would require reauthorization. When a provider has been authorized for payment for providing care for families in more than one county, the county responsible for

reauthorization of that provider is the county of the family with a current authorization for that provider and who has used the provider for the longest length of time.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 6. Minnesota Statutes 2020, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) The maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be ~~the greater of the 25th percentile of the 2018 child care provider rate survey or the rates in effect at the time of the update.~~ set in accordance with rates and policies established by the commissioner, dependent on federal funds, and consistent with federal law, up to a maximum of the 75th percentile of the most recent child care provider rate survey, but in no event shall the maximum rate be less than the greater of the 50th percentile of the most recent child care provider rate survey or the rates in effect at the time of the update. The rate increase is effective no later than the first full service period on or after January 1 of the year following the provider rate survey. For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid for child care assistance shall be equal to the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

(b) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(c) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

(d) If a child uses one provider, the maximum payment for one day of care must not exceed the daily rate. The maximum payment for one week of care must not exceed the weekly rate.

(e) If a child uses two providers under section 119B.097, the maximum payment must not exceed:

(1) the daily rate for one day of care;

(2) the weekly rate for one week of care by the child's primary provider; and

(3) two daily rates during two weeks of care by a child's secondary provider.

(f) Child care providers receiving reimbursement under this chapter must not be paid activity fees or an additional amount above the maximum rates for care provided during nonstandard hours for families receiving assistance.

(g) If the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

~~(h) All maximum provider rates changes shall be implemented on the Monday following the effective date of the maximum provider rate.~~

~~(i) Beginning September 21, 2020,~~ (h) The maximum registration fee paid for child care assistance in any county or county price cluster under the child care fund shall be ~~the greater of the 25th percentile of the 2018 child care provider rate survey or the registration fee in effect at the time of the update.~~ set in accordance with rates and policies established by the commissioner, dependent on federal funds, and consistent with federal law, up to a maximum of the 75th percentile of the most recent child care provider rate survey, but in no event shall the maximum registration fee be less than the greater of the 50th percentile of the most recent child care provider rate survey or the registration fee in effect at the time of the update. Each maximum registration fee update must be implemented on the same schedule as maximum child care assistance rate increases under paragraph (a). Maximum registration fees must be set for licensed family child care and for child care centers. For a child care provider located in the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum registration fee paid for child care assistance shall be equal to the maximum registration fee paid in the county with the highest maximum registration fee or the provider's charge, whichever is less.

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

Sec. 7. Minnesota Statutes 2020, section 119B.13, subdivision 1a, is amended to read:

Subd. 1a. **Legal nonlicensed family child care provider rates.** (a) Legal nonlicensed family child care providers receiving reimbursement under this chapter must be paid on an hourly basis for care provided to families receiving assistance.

(b) The maximum rate paid to legal nonlicensed family child care providers must be ~~68~~ 90 percent of the county maximum hourly rate for licensed family child care providers. The rate increase is effective the first full service period on or after January 1 of the year following the provider rate survey. In counties or county price clusters where the maximum hourly

rate for licensed family child care providers is higher than the maximum weekly rate for those providers divided by 50, the maximum hourly rate that may be paid to legal nonlicensed family child care providers is the rate equal to the maximum weekly rate for licensed family child care providers divided by 50 and then multiplied by ~~0.68~~ 0.90. The maximum payment to a provider for one day of care must not exceed the maximum hourly rate times ten. The maximum payment to a provider for one week of care must not exceed the maximum hourly rate times 50.

(c) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(d) Legal nonlicensed family child care providers receiving reimbursement under this chapter may not be paid registration fees for families receiving assistance.

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

Sec. 8. Minnesota Statutes 2020, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **Provider payments.** (a) A provider shall bill only for services documented according to section 119B.125, subdivision 6. The provider shall bill for services provided within ten days of the end of the service period. Payments under the child care fund shall be made within 21 days of receiving a complete bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(b) If a provider has received an authorization of care and been issued a billing form for an eligible family, the bill must be submitted within 60 days of the last date of service on the bill. A bill submitted more than 60 days after the last date of service must be paid if the county determines that the provider has shown good cause why the bill was not submitted within 60 days. Good cause must be defined in the county's child care fund plan under section 119B.08, subdivision 3, and the definition of good cause must include county error. Any bill submitted more than a year after the last date of service on the bill must not be paid.

(c) If a provider provided care for a time period without receiving an authorization of care and a billing form for an eligible family, payment of child care assistance may only be made retroactively for a maximum of ~~six~~ three months from the date the provider is issued an authorization of care and billing form. For a family at application, if a provider provided child care during a time period without receiving an authorization of care and a billing form, a county may only make child care assistance payments to the provider retroactively from the date that child care began, or from the date that the family's eligibility began under

section 119B.09, subdivision 7, or from the date that the family meets authorization requirements, not to exceed six months from the date the provider is issued an authorization of care and billing form, whichever is later.

(d) A county or the commissioner may refuse to issue a child care authorization to a certified, licensed, or legal nonlicensed provider, revoke an existing child care authorization to a certified, licensed, or legal nonlicensed provider, stop payment issued to a certified, licensed, or legal nonlicensed provider, or refuse to pay a bill submitted by a certified, licensed, or legal nonlicensed provider if:

(1) the provider admits to intentionally giving the county materially false information on the provider's billing forms;

(2) a county or the commissioner finds by a preponderance of the evidence that the provider intentionally gave the county materially false information on the provider's billing forms, or provided false attendance records to a county or the commissioner;

(3) the provider is in violation of child care assistance program rules, until the agency determines those violations have been corrected;

(4) the provider is operating after:

(i) an order of suspension of the provider's license issued by the commissioner;

(ii) an order of revocation of the provider's license issued by the commissioner; or

(iii) ~~a final order of conditional license issued by the commissioner for as long as the conditional license is in effect~~ an order of decertification issued to the provider;

(5) the provider submits false attendance reports or refuses to provide documentation of the child's attendance upon request;

(6) the provider gives false child care price information; or

(7) the provider fails to report decreases in a child's attendance as required under section 119B.125, subdivision 9.

(e) For purposes of paragraph (d), clauses (3), (5), (6), and (7), the county or the commissioner may withhold the provider's authorization or payment for a period of time not to exceed three months beyond the time the condition has been corrected.

(f) A county's payment policies must be included in the county's child care plan under section 119B.08, subdivision 3. If payments are made by the state, in addition to being in compliance with this subdivision, the payments must be made in compliance with section 16A.124.

(g) If the commissioner or responsible county agency suspends or refuses payment to a provider under paragraph (d), clause (1) or (2), or chapter 245E and the provider has:

(1) a disqualification for wrongfully obtaining assistance under section 256.98, subdivision 8, paragraph (c);

(2) an administrative disqualification under section 256.046, subdivision 3; or

(3) a termination under section 245E.02, subdivision 4, paragraph (c), clause (4), or 245E.06;

then the provider forfeits the payment to the commissioner or the responsible county agency, regardless of the amount assessed in an overpayment, charged in a criminal complaint, or ordered as criminal restitution.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 9. Minnesota Statutes 2020, section 119B.13, subdivision 7, is amended to read:

Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers must not be reimbursed for more than 25 full-day absent days per child, excluding holidays, in a calendar year, or for more than ten consecutive full-day absent days. "Absent day" means any day that the child is authorized and scheduled to be in care with a licensed provider or license-exempt center, and the child is absent from the care for the entire day. Legal nonlicensed family child care providers must not be reimbursed for absent days. If a child attends for part of the time authorized to be in care in a day, but is absent for part of the time authorized to be in care in that same day, the absent time must be reimbursed but the time must not count toward the absent days limit. Child care providers must only be reimbursed for absent days if the provider has a written policy for child absences and charges all other families in care for similar absences.

(b) Notwithstanding paragraph (a), children with documented medical conditions that cause more frequent absences may exceed the 25 absent days limit, or ten consecutive full-day absent days limit. Absences due to a documented medical condition of a parent or sibling who lives in the same residence as the child receiving child care assistance do not count against the absent days limit in a calendar year. Documentation of medical conditions must be on the forms and submitted according to the timelines established by the commissioner. A public health nurse or school nurse may verify the illness in lieu of a medical practitioner. If a provider sends a child home early due to a medical reason, including, but not limited to, fever or contagious illness, the child care center director or lead teacher may verify the illness in lieu of a medical practitioner.

(c) Notwithstanding paragraph (a), children in families may exceed the absent days limit if at least one parent: (1) is under the age of 21; (2) does not have a high school diploma or commissioner of education-selected high school equivalency certification; and (3) is a student in a school district or another similar program that provides or arranges for child care, parenting support, social services, career and employment supports, and academic support to achieve high school graduation, upon request of the program and approval of the county. If a child attends part of an authorized day, payment to the provider must be for the full amount of care authorized for that day.

(d) Child care providers must be reimbursed for up to ten federal or state holidays or designated holidays per year when the provider charges all families for these days and the holiday or designated holiday falls on a day when the child is authorized to be in attendance. Parents may substitute other cultural or religious holidays for the ten recognized state and federal holidays. Holidays do not count toward the absent days limit.

(e) A family ~~or child care provider~~ must not be assessed an overpayment for an absent day payment unless (1) there was an error in the amount of care authorized for the family, or (2) all of the allowed full-day absent payments for the child have been paid~~, or (3) the family or provider did not timely report a change as required under law~~.

(f) The provider and family shall receive notification of the number of absent days used upon initial provider authorization for a family and ongoing notification of the number of absent days used as of the date of the notification.

(g) For purposes of this subdivision, "absent days limit" means 25 full-day absent days per child, excluding holidays, in a calendar year; and ten consecutive full-day absent days.

(h) For purposes of this subdivision, "holidays limit" means ten full-day holidays per child, excluding absent days, in a calendar year.

(i) If a day meets the criteria of an absent day or a holiday under this subdivision, the provider must bill that day as an absent day or holiday. A provider's failure to properly bill an absent day or a holiday results in an overpayment, regardless of whether the child reached, or is exempt from, the absent days limit or holidays limit for the calendar year.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 10. Minnesota Statutes 2020, section 119B.25, subdivision 3, is amended to read:

Subd. 3. **Financing program.** A nonprofit corporation that receives a grant under this section shall use the money to:

(1) establish a revolving loan fund to make loans to existing, expanding, and new licensed and legal unlicensed child care and early childhood education sites;

(2) establish a fund to guarantee private loans to improve or construct a child care or early childhood education site;

(3) establish a fund to provide forgivable loans or grants to match all or part of a loan made under this section;

(4) establish a fund as a reserve against bad debt; ~~and~~

(5) establish a fund to provide business planning assistance for child care providers~~.~~; and

(6) provide training and consultation for child care providers to build and strengthen their businesses and acquire key business skills.

The nonprofit corporation shall establish the terms and conditions for loans and loan guarantees including, but not limited to, interest rates, repayment agreements, private match requirements, and conditions for loan forgiveness. The nonprofit corporation shall establish a minimum interest rate for loans to ensure that necessary loan administration costs are covered. The nonprofit corporation may use interest earnings for administrative expenses.

Sec. 11. **REPEALER.**

Minnesota Statutes 2020, sections 119B.04; and 119B.125, subdivision 5, are repealed.

EFFECTIVE DATE. This section is effective August 1, 2021.

ARTICLE 10
CHILD PROTECTION

Section 1. Minnesota Statutes 2020, section 256N.25, subdivision 2, is amended to read:

Subd. 2. **Negotiation of agreement.** (a) When a child is determined to be eligible for Northstar kinship assistance or adoption assistance, the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, must negotiate with the caregiver to develop an agreement under subdivision 1. If and when the caregiver and agency reach concurrence as to the terms of the agreement, both parties shall sign the agreement. The agency must submit the agreement, along with the eligibility determination outlined in sections 256N.22, subdivision 7, and 256N.23, subdivision 7, to the commissioner for final review, approval, and signature according to subdivision 1.

(b) A monthly payment is provided as part of the adoption assistance or Northstar kinship assistance agreement to support the care of children unless the child is eligible for adoption assistance and determined to be an at-risk child, in which case no payment will be made unless and until the caregiver obtains written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself.

(1) The amount of the payment made on behalf of a child eligible for Northstar kinship assistance or adoption assistance is determined through agreement between the prospective relative custodian or the adoptive parent and the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, using the assessment tool established by the commissioner in section 256N.24, subdivision 2, and the associated benefit and payments outlined in section 256N.26. Except as provided under section 256N.24, subdivision 1, paragraph (c), the assessment tool establishes the monthly benefit level for a child under foster care. The monthly payment under a Northstar kinship assistance agreement or adoption assistance agreement may be negotiated up to the monthly benefit level under foster care. In no case may the amount of the payment under a Northstar kinship assistance agreement or adoption assistance agreement exceed the foster care maintenance payment which would have been paid during the month if the child with respect to whom the Northstar kinship assistance or adoption assistance payment is made had been in a foster family home in the state.

(2) The rate schedule for the agreement is determined based on the age of the child on the date that the prospective adoptive parent or parents or relative custodian or custodians sign the agreement.

(3) The income of the relative custodian or custodians or adoptive parent or parents must not be taken into consideration when determining eligibility for Northstar kinship assistance or adoption assistance or the amount of the payments under section 256N.26.

(4) With the concurrence of the relative custodian or adoptive parent, the amount of the payment may be adjusted periodically using the assessment tool established by the commissioner in section 256N.24, subdivision 2, and the agreement renegotiated under subdivision 3 when there is a change in the child's needs or the family's circumstances.

(5) An adoptive parent of an at-risk child with an adoption assistance agreement may request a reassessment of the child under section 256N.24, subdivision 10, and renegotiation of the adoption assistance agreement under subdivision 3 to include a monthly payment, if the caregiver has written documentation from a qualified expert that the potential disability

upon which eligibility for the agreement was based has manifested itself. Documentation of the disability must be limited to evidence deemed appropriate by the commissioner.

(c) For Northstar kinship assistance agreements:

(1) the initial amount of the monthly Northstar kinship assistance payment must be equivalent to the foster care rate in effect at the time that the agreement is signed ~~less any offsets under section 256N.26, subdivision 11~~, or a lesser negotiated amount if agreed to by the prospective relative custodian and specified in that agreement, unless the Northstar kinship assistance agreement is entered into when a child is under the age of six; and

(2) the amount of the monthly payment for a Northstar kinship assistance agreement for a child who is under the age of six must be as specified in section 256N.26, subdivision 5.

(d) For adoption assistance agreements:

(1) for a child in foster care with the prospective adoptive parent immediately prior to adoptive placement, the initial amount of the monthly adoption assistance payment must be equivalent to the foster care rate in effect at the time that the agreement is signed ~~less any offsets in section 256N.26, subdivision 11~~, or a lesser negotiated amount if agreed to by the prospective adoptive parents and specified in that agreement, unless the child is identified as at-risk or the adoption assistance agreement is entered into when a child is under the age of six;

(2) for an at-risk child who must be assigned level A as outlined in section 256N.26, no payment will be made unless and until the potential disability manifests itself, as documented by an appropriate professional, and the commissioner authorizes commencement of payment by modifying the agreement accordingly;

(3) the amount of the monthly payment for an adoption assistance agreement for a child under the age of six, other than an at-risk child, must be as specified in section 256N.26, subdivision 5;

(4) for a child who is in the Northstar kinship assistance program immediately prior to adoptive placement, the initial amount of the adoption assistance payment must be equivalent to the Northstar kinship assistance payment in effect at the time that the adoption assistance agreement is signed or a lesser amount if agreed to by the prospective adoptive parent and specified in that agreement, unless the child is identified as an at-risk child; and

(5) for a child who is not in foster care placement or the Northstar kinship assistance program immediately prior to adoptive placement or negotiation of the adoption assistance agreement, the initial amount of the adoption assistance agreement must be determined

using the assessment tool and process in this section and the corresponding payment amount outlined in section 256N.26.

Sec. 2. Minnesota Statutes 2020, section 256N.25, subdivision 3, is amended to read:

Subd. 3. **Renegotiation of agreement.** (a) A relative custodian or adoptive parent of a child with a Northstar kinship assistance or adoption assistance agreement may request renegotiation of the agreement when there is a change in the needs of the child or in the family's circumstances. When a relative custodian or adoptive parent requests renegotiation of the agreement, a reassessment of the child must be completed consistent with section 256N.24, subdivisions 10 and 11. If the reassessment indicates that the child's level has changed, the financially responsible agency or, if there is no financially responsible agency, the agency designated by the commissioner or the commissioner's designee, and the caregiver must renegotiate the agreement to include a payment with the level determined through the reassessment process. The agreement must not be renegotiated unless the commissioner, the financially responsible agency, and the caregiver mutually agree to the changes. The effective date of any renegotiated agreement must be determined by the commissioner.

(b) An adoptive parent of an at-risk child with an adoption assistance agreement may request renegotiation of the agreement to include a monthly payment under section 256N.26 if the caregiver has written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself. Documentation of the disability must be limited to evidence deemed appropriate by the commissioner. Prior to renegotiating the agreement, a reassessment of the child must be conducted as outlined in section 256N.24, subdivision 10. The reassessment must be used to renegotiate the agreement to include an appropriate monthly payment. The agreement must not be renegotiated unless the commissioner, the financially responsible agency, and the caregiver mutually agree to the changes. The effective date of any renegotiated agreement must be determined by the commissioner.

~~(c) Renegotiation of a Northstar kinship assistance or adoption assistance agreement is required when one of the circumstances outlined in section 256N.26, subdivision 13, occurs.~~

Sec. 3. Minnesota Statutes 2020, section 256N.26, subdivision 11, is amended to read:

Subd. 11. **Child income or income attributable to the child.** (a) A monthly Northstar kinship assistance or adoption assistance payment must be considered as income and resources attributable to the child. Northstar kinship assistance and adoption assistance are

exempt from garnishment, except as permissible under the laws of the state where the child resides.

(b) When a child is placed into foster care, any income and resources attributable to the child are treated as provided in sections 252.27 and 260C.331, or 260B.331, as applicable to the child being placed.

(c) ~~Consideration of income and resources attributable to the child must be part of the negotiation process outlined in section 256N.25, subdivision 2. In some circumstances, the receipt of other income on behalf of the child may impact the amount of the monthly payment received by the relative custodian or adoptive parent on behalf of the child through Northstar Care for Children.~~ Supplemental Security Income (SSI), retirement survivor's disability insurance (RSDI), veteran's benefits, railroad retirement benefits, and black lung benefits are considered income and resources attributable to the child.

Sec. 4. Minnesota Statutes 2020, section 256N.26, subdivision 13, is amended to read:

Subd. 13. **Treatment of retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, and black lung benefits.** ~~(a)~~ If a child placed in foster care receives retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits at the time of foster care placement or subsequent to placement in foster care, the financially responsible agency may apply to be the payee for the child for the duration of the child's placement in foster care. If it is anticipated that a child will be eligible to receive retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits after finalization of the adoption or assignment of permanent legal and physical custody, the permanent caregiver shall apply to be the payee of those benefits on the child's behalf. ~~The monthly amount of the other benefits must be considered an offset to the amount of the payment the child is determined eligible for under Northstar Care for Children.~~

~~(b) If a child becomes eligible for retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits, after the initial amount of the payment under Northstar Care for Children is finalized, the permanent caregiver shall contact the commissioner to redetermine the payment under Northstar Care for Children. The monthly amount of the other benefits must be considered an offset to the amount of the payment the child is determined eligible for under Northstar Care for Children.~~

~~(c) If a child ceases to be eligible for retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits after the initial amount of the payment under Northstar Care for Children is finalized, the permanent caregiver shall contact~~

~~the commissioner to redetermine the payment under Northstar Care for Children. The monthly amount of the payment under Northstar Care for Children must be the amount the child was determined to be eligible for prior to consideration of any offset.~~

~~(d) If the monthly payment received on behalf of the child under retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits changes after the adoption assistance or Northstar kinship assistance agreement is finalized, the permanent caregiver shall notify the commissioner as to the new monthly payment amount, regardless of the amount of the change in payment. If the monthly payment changes by $75 or more, even if the change occurs incrementally over the duration of the term of the adoption assistance or Northstar kinship assistance agreement, the monthly payment under Northstar Care for Children must be adjusted without further consent to reflect the amount of the increase or decrease in the offset amount. Any subsequent change to the payment must be reported and handled in the same manner. A change of monthly payments of less than $75 is not a permissible reason to renegotiate the adoption assistance or Northstar kinship assistance agreement under section 256N.25, subdivision 3. The commissioner shall review and revise the limit at which the adoption assistance or Northstar kinship assistance agreement must be renegotiated in accordance with subdivision 9.~~

Sec. 5. Minnesota Statutes 2020, section 260.761, subdivision 2, is amended to read:

Subd. 2. **Agency and court notice to tribes.** (a) When a local social services agency has information that a family assessment ~~or~~, investigation, or noncaregiver sex trafficking assessment being conducted may involve an Indian child, the local social services agency shall notify the Indian child's tribe of the family assessment ~~or~~, investigation, or noncaregiver sex trafficking assessment according to section 260E.18. The local social services agency shall provide initial notice ~~shall be provided~~ by telephone and by e-mail or facsimile. The local social services agency shall request that the tribe or a designated tribal representative participate in evaluating the family circumstances, identifying family and tribal community resources, and developing case plans.

(b) When a local social services agency has information that a child receiving services may be an Indian child, the local social services agency shall notify the tribe by telephone and by e-mail or facsimile of the child's full name and date of birth, the full names and dates of birth of the child's biological parents, and, if known, the full names and dates of birth of the child's grandparents and of the child's Indian custodian. This notification must be provided ~~so~~ for the tribe ~~can~~ to determine if the child is enrolled in the tribe or eligible for tribal membership, and ~~must be provided~~ the agency must provide this notification to the tribe

within seven days of receiving information that the child may be an Indian child. If information regarding the child's grandparents or Indian custodian is not available within the seven-day period, the local social services agency shall continue to request this information and shall notify the tribe when it is received. Notice shall be provided to all tribes to which the child may have any tribal lineage. If the identity or location of the child's parent or Indian custodian and tribe cannot be determined, the local social services agency shall provide the notice required in this paragraph to the United States secretary of the interior.

(c) In accordance with sections 260C.151 and 260C.152, when a court has reason to believe that a child placed in emergency protective care is an Indian child, the court administrator or a designee shall, as soon as possible and before a hearing takes place, notify the tribal social services agency by telephone and by e-mail or facsimile of the date, time, and location of the emergency protective case hearing. The court shall make efforts to allow appearances by telephone for tribal representatives, parents, and Indian custodians.

(d) A local social services agency must provide the notices required under this subdivision at the earliest possible time to facilitate involvement of the Indian child's tribe. Nothing in this subdivision is intended to hinder the ability of the local social services agency and the court to respond to an emergency situation. Lack of participation by a tribe shall not prevent the tribe from intervening in services and proceedings at a later date. A tribe may participate in a case at any time. At any stage of the local social services agency's involvement with an Indian child, the agency shall provide full cooperation to the tribal social services agency, including disclosure of all data concerning the Indian child. Nothing in this subdivision relieves the local social services agency of satisfying the notice requirements in the Indian Child Welfare Act.

Sec. 6. Minnesota Statutes 2020, section 260C.007, subdivision 14, is amended to read:

Subd. 14. **Egregious harm.** "Egregious harm" means the infliction of bodily harm to a child or neglect of a child which demonstrates a grossly inadequate ability to provide minimally adequate parental care. ~~The~~ Egregious harm need not have occurred in the state or in the county where a termination of parental rights action is otherwise properly venued. Egregious harm includes, but is not limited to:

(1) conduct ~~towards~~ toward a child that constitutes a violation of sections 609.185 to 609.2114, 609.222, subdivision 2, 609.223, or any other similar law of any other state;

(2) the infliction of "substantial bodily harm" to a child, as defined in section 609.02, subdivision 7a;

(3) conduct ~~towards~~ toward a child that constitutes felony malicious punishment of a child under section 609.377;

(4) conduct ~~towards~~ toward a child that constitutes felony unreasonable restraint of a child under section 609.255, subdivision 3;

(5) conduct ~~towards~~ toward a child that constitutes felony neglect or endangerment of a child under section 609.378;

(6) conduct ~~towards~~ toward a child that constitutes assault under section 609.221, 609.222, or 609.223;

(7) conduct ~~towards~~ toward a child that constitutes sex trafficking, solicitation, inducement, ~~or~~ promotion of, or receiving profit derived from prostitution under section 609.322;

(8) conduct ~~towards~~ toward a child that constitutes murder or voluntary manslaughter as defined by United States Code, title 18, section 1111(a) or 1112(a);

(9) conduct ~~towards~~ toward a child that constitutes aiding or abetting, attempting, conspiring, or soliciting to commit a murder or voluntary manslaughter that constitutes a violation of United States Code, title 18, section 1111(a) or 1112(a); or

(10) conduct toward a child that constitutes criminal sexual conduct under sections 609.342 to 609.345.

Sec. 7. Minnesota Statutes 2020, section 260E.01, is amended to read:

260E.01 POLICY.

(a) The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through maltreatment. While it is recognized that most parents want to keep their children safe, sometimes circumstances or conditions interfere with their ability to do so. When this occurs, the health and safety of the children must be of paramount concern. Intervention and prevention efforts must address immediate concerns for child safety and the ongoing risk of maltreatment and should engage the protective capacities of families. In furtherance of this public policy, it is the intent of the legislature under this chapter to:

(1) protect children and promote child safety;

(2) strengthen the family;

(3) make the home, school, and community safe for children by promoting responsible child care in all settings; and

(4) provide, when necessary, a safe temporary or permanent home environment for maltreated children.

(b) In addition, it is the policy of this state to:

(1) require the reporting of maltreatment of children in the home, school, and community settings;

(2) provide for ~~the~~ voluntary reporting of maltreatment of children;

(3) require an investigation when the report alleges sexual abuse or substantial child endangerment, except when the report alleges sex trafficking by a noncaregiver sex trafficker;

(4) provide a family assessment, if appropriate, when the report does not allege sexual abuse or substantial child endangerment; ~~and~~

(5) provide a noncaregiver sex trafficking assessment when the report alleges sex trafficking by a noncaregiver sex trafficker; and

(6) provide protective, family support, and family preservation services when needed in appropriate cases.

Sec. 8. Minnesota Statutes 2020, section 260E.02, subdivision 1, is amended to read:

Subdivision 1. **Establishment of team.** A county shall establish a multidisciplinary child protection team that may include, but is not ~~be~~ limited to, the director of the local welfare agency or designees, the county attorney or designees, the county sheriff or designees, representatives of health and education, representatives of mental health, representatives of agencies providing specialized services or responding to youth who experience or are at risk of experiencing sex trafficking or sexual exploitation, or other appropriate human services or community-based agencies, and parent groups. As used in this section, a "community-based agency" may include, but is not limited to, schools, social services agencies, family service and mental health collaboratives, children's advocacy centers, early childhood and family education programs, Head Start, or other agencies serving children and families. A member of the team must be designated as the lead person of the team responsible for the planning process to develop standards for the team's activities with battered women's and domestic abuse programs and services.

Sec. 9. Minnesota Statutes 2020, section 260E.03, is amended by adding a subdivision to read:

Subd. 15a. **Noncaregiver sex trafficker.** "Noncaregiver sex trafficker" means an individual who is alleged to have engaged in the act of sex trafficking a child, who is not a person responsible for the child's care, who does not have a significant relationship with the child as defined in section 609.341, and who is not a person in a current or recent position of authority as defined in section 609.341, subdivision 10.

Sec. 10. Minnesota Statutes 2020, section 260E.03, is amended by adding a subdivision to read:

Subd. 15b. **Noncaregiver sex trafficking assessment.** "Noncaregiver sex trafficking assessment" is a comprehensive assessment of child safety, the risk of subsequent child maltreatment, and strengths and needs of the child and family. The local welfare agency shall only perform a noncaregiver sex trafficking assessment when a maltreatment report alleges sex trafficking of a child by someone other than the child's caregiver. A noncaregiver sex trafficking assessment does not include a determination of whether child maltreatment occurred. A noncaregiver sex trafficking assessment includes a determination of a family's need for services to address the safety of the child or children, the safety of family members, and the risk of subsequent child maltreatment.

Sec. 11. Minnesota Statutes 2020, section 260E.03, subdivision 22, is amended to read:

Subd. 22. **Substantial child endangerment.** "Substantial child endangerment" means that a person responsible for a child's care, by act or omission, commits or attempts to commit an act against a child ~~under their~~ in the person's care that constitutes any of the following:

(1) egregious harm under subdivision 5;

(2) abandonment under section 260C.301, subdivision 2;

(3) neglect under subdivision 15, paragraph (a), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

(5) manslaughter in the first or second degree under section 609.20 or 609.205;

(6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

(7) sex trafficking, solicitation, inducement, ~~and~~ or promotion of prostitution under section 609.322;

(8) criminal sexual conduct under sections 609.342 to 609.3451;

(9) solicitation of children to engage in sexual conduct under section 609.352;

(10) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;

(11) use of a minor in sexual performance under section 617.246; or

(12) parental behavior, status, or condition ~~that mandates that~~ requiring the county attorney to file a termination of parental rights petition under section 260C.503, subdivision 2.

Sec. 12. Minnesota Statutes 2020, section 260E.14, subdivision 2, is amended to read:

Subd. 2. **Sexual abuse.** (a) The local welfare agency is the agency responsible for investigating an allegation of sexual abuse if the alleged offender is the parent, guardian, sibling, or an individual functioning within the family unit as a person responsible for the child's care, or a person with a significant relationship to the child if that person resides in the child's household.

(b) The local welfare agency is also responsible for assessing or investigating when a child is identified as a victim of sex trafficking.

Sec. 13. Minnesota Statutes 2020, section 260E.14, subdivision 5, is amended to read:

Subd. 5. **Law enforcement.** (a) The local law enforcement agency is the agency responsible for investigating a report of maltreatment if a violation of a criminal statute is alleged.

(b) Law enforcement and the responsible agency must coordinate their investigations or assessments as required under this chapter when ~~the~~: (1) a report alleges maltreatment that is a violation of a criminal statute by a person who is a parent, guardian, sibling, person responsible for the child's care ~~functioning~~ within the family unit, or by a person who lives in the child's household and who has a significant relationship to the child~~,~~ in a setting other than a facility as defined in section 260E.03; or (2) a report alleges sex trafficking of a child.

Sec. 14. Minnesota Statutes 2020, section 260E.17, subdivision 1, is amended to read:

Subdivision 1. **Local welfare agency.** (a) Upon receipt of a report, the local welfare agency shall determine whether to conduct a family assessment ~~or~~, an investigation, or a noncaregiver sex trafficking assessment as appropriate to prevent or provide a remedy for maltreatment.

(b) The local welfare agency shall conduct an investigation when the report involves sexual abuse, except as indicated in paragraph (f), or substantial child endangerment.

(c) The local welfare agency shall begin an immediate investigation ~~if,~~ at any time when the local welfare agency is ~~using~~ responding with a family assessment ~~response,~~ and the local welfare agency determines that there is reason to believe that sexual abuse ~~or~~, substantial child endangerment, or a serious threat to the child's safety exists.

(d) The local welfare agency may conduct a family assessment for reports that do not allege sexual abuse, except as indicated in paragraph (f), or substantial child endangerment. In determining that a family assessment is appropriate, the local welfare agency may consider issues of child safety, parental cooperation, and the need for an immediate response.

(e) The local welfare agency may conduct a family assessment ~~on~~ for a report that was initially screened and assigned for an investigation. In determining that a complete investigation is not required, the local welfare agency must document the reason for terminating the investigation and notify the local law enforcement agency if the local law enforcement agency is conducting a joint investigation.

(f) The local welfare agency shall conduct a noncaregiver sex trafficking assessment when a maltreatment report alleges sex trafficking of a child and the alleged offender is a noncaregiver sex trafficker as defined by section 260E.03, subdivision 15a.

(g) During a noncaregiver sex trafficking assessment, the local welfare agency shall initiate an immediate investigation if there is reason to believe that a child's parent, caregiver, or household member allegedly engaged in the act of sex trafficking a child or was alleged to have engaged in any conduct requiring the agency to conduct an investigation.

Sec. 15. Minnesota Statutes 2020, section 260E.18, is amended to read:

260E.18 NOTICE TO CHILD'S TRIBE.

The local welfare agency shall provide immediate notice, according to section 260.761, subdivision 2, to an Indian child's tribe when the agency has reason to believe that the family assessment ~~or~~, investigation, or noncaregiver sex trafficking assessment may involve an

Indian child. For purposes of this section, "immediate notice" means notice provided within 24 hours.

Sec. 16. Minnesota Statutes 2020, section 260E.20, subdivision 2, is amended to read:

Subd. 2. **Face-to-face contact.** (a) Upon receipt of a screened in report, the local welfare agency shall ~~conduct a~~ have face-to-face contact with the child reported to be maltreated and with the child's primary caregiver sufficient to complete a safety assessment and ensure the immediate safety of the child.

(b) Except in a noncaregiver sex trafficking assessment, the local welfare agency shall have face-to-face contact with the child and primary caregiver ~~shall occur~~ immediately if sexual abuse or substantial child endangerment is alleged and within five calendar days for all other reports. If the alleged offender was not already interviewed as the primary caregiver, the local welfare agency shall also conduct a face-to-face interview with the alleged offender in the early stages of the assessment or investigation, except in a noncaregiver sex trafficking assessment.

(c) At the initial contact with the alleged offender, the local welfare agency or the agency responsible for assessing or investigating the report must inform the alleged offender of the complaints or allegations made against the individual in a manner consistent with laws protecting the rights of the person who made the report. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation. In a noncaregiver sex trafficking assessment, the local child welfare agency is not required to interview the alleged offender.

(d) The local welfare agency or the agency responsible for assessing or investigating the report must provide the alleged offender with an opportunity to make a statement, except in a noncaregiver sex trafficking assessment where the local welfare agency may rely on law enforcement data. The alleged offender may submit supporting documentation relevant to the assessment or investigation.

Sec. 17. Minnesota Statutes 2020, section 260E.24, subdivision 2, is amended to read:

Subd. 2. **Determination after family assessment or a noncaregiver sex trafficking assessment.** After conducting a family assessment or a noncaregiver sex trafficking assessment, the local welfare agency shall determine whether child protective services are needed to address the safety of the child and other family members and the risk of subsequent maltreatment.

Sec. 18. Minnesota Statutes 2020, section 260E.24, subdivision 7, is amended to read:

Subd. 7. **Notification at conclusion of family assessment or a noncaregiver sex trafficking assessment.** Within ten working days of the conclusion of a family assessment or a noncaregiver sex trafficking assessment, the local welfare agency shall notify the parent or guardian of the child of the need for services to address child safety concerns or significant risk of subsequent maltreatment. The local welfare agency and the family may also jointly agree that family support and family preservation services are needed.

Sec. 19. Minnesota Statutes 2020, section 260E.33, subdivision 1, is amended to read:

Subdivision 1. **Following a family assessment or a noncaregiver sex trafficking assessment.** Administrative reconsideration is not applicable to a family assessment or noncaregiver sex trafficking assessment since no determination concerning maltreatment is made.

Sec. 20. Minnesota Statutes 2020, section 260E.35, subdivision 6, is amended to read:

Subd. 6. **Data retention.** (a) Notwithstanding sections 138.163 and 138.17, a record maintained or a record derived from a report of maltreatment by a local welfare agency, agency responsible for assessing or investigating the report, court services agency, or school under this chapter shall be destroyed as provided in paragraphs (b) to (e) by the responsible authority.

(b) For a report alleging maltreatment that was not accepted for an assessment or an investigation, a family assessment case, a noncaregiver sex trafficking assessment case, and a case where an investigation results in no determination of maltreatment or the need for child protective services, the record must be maintained for a period of five years after the date that the report was not accepted for assessment or investigation or the date of the final entry in the case record. A record of a report that was not accepted must contain sufficient information to identify the subjects of the report, the nature of the alleged maltreatment, and the reasons ~~as to~~ why the report was not accepted. Records under this paragraph may not be used for employment, background checks, or purposes other than to assist in future screening decisions and risk and safety assessments.

(c) All records relating to reports that, upon investigation, indicate ~~either~~ maltreatment or a need for child protective services shall be maintained for ten years after the date of the final entry in the case record.

(d) All records regarding a report of maltreatment, including a notification of intent to interview that was received by a school under section 260E.22, subdivision 7, shall be destroyed by the school when ordered to do so by the agency conducting the assessment or investigation. The agency shall order the destruction of the notification when other records relating to the report under investigation or assessment are destroyed under this subdivision.

(e) Private or confidential data released to a court services agency under subdivision 3, paragraph (d), must be destroyed by the court services agency when ordered to do so by the local welfare agency that released the data. The local welfare agency or agency responsible for assessing or investigating the report shall order destruction of the data when other records relating to the assessment or investigation are destroyed under this subdivision.

ARTICLE 11
CHILD PROTECTION POLICY

Section 1. Minnesota Statutes 2020, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the case of an emergency, all children referred for treatment of severe emotional disturbance in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center shall undergo an assessment to determine the appropriate level of care if public funds are used to pay for the child's services.

(b) The responsible social services agency shall determine the appropriate level of care for a child when county-controlled funds are used to pay for the child's services or placement in a qualified residential treatment facility under chapter 260C and licensed by the commissioner under chapter 245A. In accordance with section 260C.157, a juvenile treatment screening team shall conduct a screening of a child before the team may recommend whether to place a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d. When a social services agency does not have responsibility for a child's placement and the child is enrolled in a prepaid health program under section 256B.69, the enrolled child's contracted health plan must determine the appropriate level of care for the child. When Indian Health Services funds or funds of a tribally owned facility funded under the Indian Self-Determination and Education Assistance Act, Public Law 93-638, are to be used for a child, the Indian Health Services or 638 tribal health facility must determine the appropriate level of care for the child. When more than one entity bears responsibility for a child's coverage, the entities shall coordinate level of care determination activities for the child to the extent possible.

(c) The responsible social services agency must make the child's level of care determination available to the child's juvenile treatment screening team, as permitted under chapter 13. The level of care determination shall inform the juvenile treatment screening team process and the assessment in section 260C.704 when considering whether to place the child in a qualified residential treatment program. When the responsible social services agency is not involved in determining a child's placement, the child's level of care determination shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's ~~need~~ needs.

(d) When a level of care determination is conducted, the responsible social services agency or other entity may not determine that a screening of a child under section 260C.157 or referral or admission to a treatment foster care setting or residential treatment facility is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. The level of care determination must be based on a diagnostic assessment of a child that includes a functional assessment which evaluates the child's family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care to the child. The validated tool must be approved by the commissioner of human services and may be the validated tool approved for the child's assessment under section 260C.704 if the juvenile treatment screening team recommended placement of the child in a qualified residential treatment program. If a diagnostic assessment including a functional assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether ~~or not~~ these services are available and accessible to the child and the child's family.

(e) During the level of care determination process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

(f) When the responsible social services agency has authority, the agency must engage the child's parents in case planning under sections 260C.212 and 260C.708 and chapter 260D unless a court terminates the parent's rights or court orders restrict the parent from participating in case planning, visitation, or parental responsibilities.

(g) The level of care determination, ~~and~~ placement decision, and recommendations for mental health services must be documented in the child's record, as required in ~~chapter~~ chapters 260C and 260D.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 2. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 3c. **At risk of becoming a victim of sex trafficking or commercial sexual exploitation.** For the purposes of section 245A.25, a youth who is "at risk of becoming a victim of sex trafficking or commercial sexual exploitation" means a youth who meets the criteria established by the commissioner of human services for this purpose.

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

Sec. 3. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 4a. **Children's residential facility.** "Children's residential facility" is defined as a residential program licensed under this chapter or chapter 241 according to the applicable standards in Minnesota Rules, parts 2960.0010 to 2960.0710.

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

Sec. 4. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 6d. **Foster family setting.** "Foster family setting" has the meaning given in Minnesota Rules, chapter 2960.3010, subpart 23, and includes settings licensed by the commissioner of human services or the commissioner of corrections.

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

Sec. 5. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 6e. **Foster residence setting.** "Foster residence setting" has the meaning given in Minnesota Rules, chapter 2960.3010, subpart 26, and includes settings licensed by the commissioner of human services or the commissioner of corrections.

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

Sec. 6. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 18a. **Trauma.** For the purposes of section 245A.25, "trauma" means an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma includes the cumulative emotional or psychological harm of group traumatic experiences transmitted across generations within a community that are often associated with racial and ethnic population groups that have suffered major intergenerational losses.

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

Sec. 7. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 23. **Victim of sex trafficking or commercial sexual exploitation.** For the purposes of section 245A.25, "victim of sex trafficking or commercial sexual exploitation" means a person who meets the definitions in section 260C.007, subdivision 31, clauses (4) and (5).

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

Sec. 8. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 24. **Youth.** For the purposes of section 245A.25, "youth" means a "child" as defined in section 260C.007, subdivision 4, and includes individuals under 21 years of age who are in foster care pursuant to section 260C.451.

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

Sec. 9. Minnesota Statutes 2020, section 245A.041, is amended by adding a subdivision to read:

Subd. 6. **First date of working in a facility or setting; documentation requirements.** Children's residential facility and foster residence setting license holders must document the first date that a person who is a background study subject begins working in the license holder's facility or setting. If the license holder does not maintain documentation of each background study subject's first date of working in the facility or setting in the license holder's personnel files, the license holder must provide documentation to the commissioner that contains the first date that each background study subject began working in the license holder's program upon the commissioner's request.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 10. **[245A.25] RESIDENTIAL PROGRAM CERTIFICATIONS FOR COMPLIANCE WITH THE FAMILY FIRST PREVENTION SERVICES ACT.**

Subdivision 1. **Certification scope and applicability.** (a) This section establishes the requirements that a children's residential facility or child foster residence setting must meet to be certified for the purposes of Title IV-E funding requirements as:

(1) a qualified residential treatment program;

(2) a residential setting specializing in providing care and supportive services for youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation;

(3) a residential setting specializing in providing prenatal, postpartum, or parenting support for youth; or

(4) a supervised independent living setting for youth who are 18 years of age or older.

(b) This section does not apply to a foster family setting in which the license holder resides in the foster home.

(c) Children's residential facilities licensed as detention settings according to Minnesota Rules, parts 2960.0230 to 2960.0290, or secure programs according to Minnesota Rules, parts 2960.0300 to 2960.0420, may not be certified under this section.

(d) For purposes of this section, "license holder" means an individual, organization, or government entity that was issued a children's residential facility or foster residence setting license by the commissioner of human services under this chapter or by the commissioner of corrections under chapter 241.

(e) Certifications issued under this section for foster residence settings may only be issued by the commissioner of human services and are not delegated to county or private licensing agencies under section 245A.16.

Subd. 2. **Program certification types and requests for certification.** (a) By July 1, 2021, the commissioner of human services must offer certifications to license holders for the following types of programs:

(1) qualified residential treatment programs;

(2) residential settings specializing in providing care and supportive services for youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation;

(3) residential settings specializing in providing prenatal, postpartum, or parenting support for youth; and

(4) supervised independent living settings for youth who are 18 years of age or older.

(b) An applicant or license holder must submit a request for certification under this section on a form and in a manner prescribed by the commissioner of human services. The decision of the commissioner of human services to grant or deny a certification request is final and not subject to appeal under chapter 14.

Subd. 3. **Trauma-informed care.** (a) Programs certified under subdivisions 4 or 5 must provide services to a person according to a trauma-informed model of care that meets the requirements of this subdivision, except that programs certified under subdivision 5 are not required to meet the requirements of paragraph (e).

(b) For the purposes of this section, "trauma-informed care" is defined as care that:

(1) acknowledges the effects of trauma on a person receiving services and on the person's family;

(2) modifies services to respond to the effects of trauma on the person receiving services;

(3) emphasizes skill and strength-building rather than symptom management; and

(4) focuses on the physical and psychological safety of the person receiving services and the person's family.

(c) The license holder must have a process for identifying the signs and symptoms of trauma in a youth and must address the youth's needs related to trauma. This process must include:

(1) screening for trauma by completing a trauma-specific screening tool with each youth upon the youth's admission or obtaining the results of a trauma-specific screening tool that was completed with the youth within 30 days prior to the youth's admission to the program; and

(2) ensuring that trauma-based interventions targeting specific trauma-related symptoms are available to each youth when needed to assist the youth in obtaining services. For qualified residential treatment programs, this must include the provision of services in paragraph (e).

(d) The license holder must develop and provide services to each youth according to the principles of trauma-informed care including:

(1) recognizing the impact of trauma on a youth when determining the youth's service needs and providing services to the youth;

(2) allowing each youth to participate in reviewing and developing the youth's individualized treatment or service plan;

(3) providing services to each youth that are person-centered and culturally responsive; and

(4) adjusting services for each youth to address additional needs of the youth.

(e) In addition to the other requirements of this subdivision, qualified residential treatment programs must use a trauma-based treatment model that includes:

(1) assessing each youth to determine if the youth needs trauma-specific treatment interventions;

(2) identifying in each youth's treatment plan how the program will provide trauma-specific treatment interventions to the youth;

(3) providing trauma-specific treatment interventions to a youth that target the youth's specific trauma-related symptoms; and

(4) training all clinical staff of the program on trauma-specific treatment interventions.

(f) At the license holder's program, the license holder must provide a physical, social, and emotional environment that:

(1) promotes the physical and psychological safety of each youth;

(2) avoids aspects that may be retraumatizing;

(3) responds to trauma experienced by each youth and the youth's other needs; and

(4) includes designated spaces that are available to each youth for engaging in sensory and self-soothing activities.

(g) The license holder must base the program's policies and procedures on trauma-informed principles. In the program's policies and procedures, the license holder must:

(1) describe how the program provides services according to a trauma-informed model of care;

(2) describe how the program's environment fulfills the requirements of paragraph (f);

(3) prohibit the use of aversive consequences for a youth's violation of program rules or any other reason;

(4) describe the process for how the license holder incorporates trauma-informed principles and practices into the organizational culture of the license holder's program; and

(5) if the program is certified to use restrictive procedures under Minnesota Rules, part 2960.0710, describe how the program uses restrictive procedures only when necessary for a youth in a manner that addresses the youth's history of trauma and avoids causing the youth additional trauma.

(h) Prior to allowing a staff person to have direct contact, as defined in section 245C.02, subdivision 11, with a youth and annually thereafter, the license holder must train each staff person about:

(1) concepts of trauma-informed care and how to provide services to each youth according to these concepts; and

(2) impacts of each youth's culture, race, gender, and sexual orientation on the youth's behavioral health and traumatic experiences.

Subd. 4. **Qualified residential treatment programs; certification requirements.** (a) To be certified as a qualified residential treatment program, a license holder must meet:

(1) the definition of a qualified residential treatment program in section 260C.007, subdivision 26d;

(2) the requirements for providing trauma-informed care and using a trauma-based treatment model in subdivision 3; and

(3) the requirements of this subdivision.

(b) For each youth placed at the license holder's program, the license holder must collaborate with the responsible social services agency and other appropriate parties to implement the youth's out-of-home placement plan and the youth's short-term and long-term mental health and behavioral health goals in the assessment required by sections 260C.212, subdivision 1; 260C.704; and 260C.708.

(c) A qualified residential treatment program must use a trauma-based treatment model that meets all of the requirements of subdivision 3 that is designed to address the needs, including clinical needs, of youth with serious emotional or behavioral disorders or disturbances. The license holder must develop, document, and review a treatment plan for each youth according to the requirements of Minnesota Rules, parts 2960.0180, subpart 2, item B; and 2960.0190, subpart 2.

(d) The following types of staff must be on-site according to the program's treatment model and must be available 24 hours a day and seven days a week to provide care within the scope of their practice:

(1) a registered nurse or licensed practical nurse licensed by the Minnesota Board of Nursing to practice professional nursing or practical nursing as defined in section 148.171, subdivisions 14 and 15; and

(2) other licensed clinical staff to meet each youth's clinical needs.

(e) A qualified residential treatment program must be accredited by one of the following independent, not-for-profit organizations:

(1) the Commission on Accreditation of Rehabilitation Facilities (CARF);

(2) the Joint Commission;

(3) the Council on Accreditation (COA); or

(4) another independent, not-for-profit accrediting organization approved by the Secretary of the United States Department of Health and Human Services.

(f) The license holder must facilitate participation of a youth's family members in the youth's treatment program, consistent with the youth's best interests and according to the youth's out-of-home placement plan required by sections 260C.212, subdivision 1; and 260C.708.

(g) The license holder must contact and facilitate outreach to each youth's family members, including the youth's siblings, and must document outreach to the youth's family members in the youth's file, including the contact method and each family member's contact

information. In the youth's file, the license holder must record and maintain the contact information for all known biological family members and fictive kin of the youth.

(h) The license holder must document in the youth's file how the program integrates family members into the treatment process for the youth, including after the youth's discharge from the program, and how the program maintains the youth's connections to the youth's siblings.

(i) The program must provide discharge planning and family-based aftercare support to each youth for at least six months after the youth's discharge from the program. When providing aftercare to a youth, the program must have monthly contact with the youth and the youth's caregivers to promote the youth's engagement in aftercare services and to regularly evaluate the family's needs. The program's monthly contact with the youth may be face-to-face, by telephone, or virtual.

(j) The license holder must maintain a service delivery plan that describes how the program provides services according to the requirements in paragraphs (b) to (i).

Subd. 5. **Residential settings specializing in providing care and supportive services for youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation; certification requirements.** (a) To be certified as a residential setting specializing in providing care and supportive services for youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation, a license holder must meet the requirements of this subdivision.

(b) Settings certified according to this subdivision are exempt from the requirements of section 245A.04, subdivision 11, paragraph (b).

(c) The program must use a trauma-informed model of care that meets all of the applicable requirements of subdivision 3, and that is designed to address the needs, including emotional and mental health needs, of youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation.

(d) The program must provide high quality care and supportive services for youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation and must:

(1) offer a safe setting to each youth designed to prevent ongoing and future trafficking of the youth;

(2) provide equitable, culturally responsive, and individualized services to each youth;

(3) assist each youth with accessing medical, mental health, legal, advocacy, and family services based on the youth's individual needs;

(4) provide each youth with relevant educational, life skills, and employment supports based on the youth's individual needs;

(5) offer a trafficking prevention education curriculum and provide support for each youth at risk of future sex trafficking or commercial sexual exploitation; and

(6) engage with the discharge planning process for each youth and the youth's family.

(e) The license holder must maintain a service delivery plan that describes how the program provides services according to the requirements in paragraphs (c) and (d).

(f) The license holder must ensure that each staff person who has direct contact, as defined in section 245C.02, subdivision 11, with a youth served by the license holder's program completes a human trafficking training approved by the Department of Human Services' Children and Family Services Administration before the staff person has direct contact with a youth served by the program and annually thereafter. For programs certified prior to January 1, 2022, the license holder must ensure that each staff person at the license holder's program completes the initial training by January 1, 2022.

Subd. 6. **Residential settings specializing in providing prenatal, postpartum, or parenting supports for youth; certification requirements.** (a) To be certified as a residential setting specializing in providing prenatal, postpartum, or parenting supports for youth, a license holder must meet the requirements of this subdivision.

(b) The license holder must collaborate with the responsible social services agency and other appropriate parties to implement each youth's out-of-home placement plan required by section 260C.212, subdivision 1.

(c) The license holder must specialize in providing prenatal, postpartum, or parenting supports for youth and must:

(1) provide equitable, culturally responsive, and individualized services to each youth;

(2) assist each youth with accessing postpartum services during the same period of time that a woman is considered pregnant for the purposes of medical assistance eligibility under section 256B.055, subdivision 6, including providing each youth with:

(i) sexual and reproductive health services and education; and

(ii) a postpartum mental health assessment and follow-up services; and

(3) discharge planning that includes the youth and the youth's family.

(d) On or before the date of a child's initial physical presence at the facility, the license holder must provide education to the child's parent related to safe bathing and reducing the risk of sudden unexpected infant death and abusive head trauma from shaking infants and young children. The license holder must use the educational material developed by the commissioner of human services to comply with this requirement. At a minimum, the education must address:

(1) instruction that: (i) a child or infant should never be left unattended around water; (ii) a tub should be filled with only two to four inches of water for infants; and (iii) an infant should never be put into a tub when the water is running; and

(2) the risk factors related to sudden unexpected infant death and abusive head trauma from shaking infants and young children and means of reducing the risks, including the safety precautions identified in section 245A.1435 and the risks of co-sleeping.

The license holder must document the parent's receipt of the education and keep the documentation in the parent's file. The documentation must indicate whether the parent agrees to comply with the safeguards described in this paragraph. If the parent refuses to comply, program staff must provide additional education to the parent as described in the parental supervision plan. The parental supervision plan must include the intervention, frequency, and staff responsible for the duration of the parent's participation in the program or until the parent agrees to comply with the safeguards described in this paragraph.

(e) On or before the date of a child's initial physical presence at the facility, the license holder must document the parent's capacity to meet the health and safety needs of the child while on the facility premises considering the following factors:

(1) the parent's physical and mental health;

(2) the parent being under the influence of drugs, alcohol, medications, or other chemicals;

(3) the child's physical and mental health; and

(4) any other information available to the license holder indicating that the parent may not be able to adequately care for the child.

(f) The license holder must have written procedures specifying the actions that staff shall take if a parent is or becomes unable to adequately care for the parent's child.

(g) If the parent refuses to comply with the safeguards described in paragraph (d) or is unable to adequately care for the child, the license holder must develop a parental supervision plan in conjunction with the parent. The plan must account for any factors in paragraph (e)

that contribute to the parent's inability to adequately care for the child. The plan must be dated and signed by the staff person who completed the plan.

(h) The license holder must have written procedures addressing whether the program permits a parent to arrange for supervision of the parent's child by another youth in the program. If permitted, the facility must have a procedure that requires staff approval of the supervision arrangement before the supervision by the nonparental youth occurs. The procedure for approval must include an assessment of the nonparental youth's capacity to assume the supervisory responsibilities using the criteria in paragraph (e). The license holder must document the license holder's approval of the supervisory arrangement and the assessment of the nonparental youth's capacity to supervise the child and must keep this documentation in the file of the parent whose child is being supervised by the nonparental youth.

(i) The license holder must maintain a service delivery plan that describes how the program provides services according to paragraphs (b) to (h).

Subd. 7. **Supervised independent living settings for youth 18 years of age or older; certification requirements.** (a) To be certified as a supervised independent living setting for youth who are 18 years of age or older, a license holder must meet the requirements of this subdivision.

(b) A license holder must provide training, counseling, instruction, supervision, and assistance for independent living, to meet the needs of the youth being served.

(c) A license holder may provide services to assist the youth with locating housing, money management, meal preparation, shopping, health care, transportation, and any other support services necessary to meet the youth's needs and improve the youth's ability to conduct such tasks independently.

(d) The service plan for the youth must contain an objective of independent living skills.

(e) The license holder must maintain a service delivery plan that describes how the program provides services according to paragraphs (b) to (d).

Subd. 8. **Monitoring and inspections.** (a) For a program licensed by the commissioner of human services, the commissioner of human services may review a program's compliance with certification requirements by conducting an inspection, a licensing review, or an investigation of the program. The commissioner may issue a correction order to the license holder for a program's noncompliance with the certification requirements of this section. For a program licensed by the commissioner of human services, a license holder must make

a request for reconsideration of a correction order according to section 245A.06, subdivision 2.

(b) For a program licensed by the commissioner of corrections, the commissioner of human services may review the program's compliance with the requirements for a certification issued under this section biennially and may issue a correction order identifying the program's noncompliance with the requirements of this section. The correction order must state the following:

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

(2) the specific law or rule violated; and

(3) the time allowed for the program to correct each violation.

(c) For a program licensed by the commissioner of corrections, if a license holder believes that there are errors in the correction order of the commissioner of human services, the license holder may ask the Department of Human Services to reconsider the parts of the correction order that the license holder alleges are in error. To submit a request for reconsideration, the license holder must send a written request for reconsideration by United States mail to the commissioner of human services. The request for reconsideration must be postmarked within 20 calendar days of the date that the correction order was received by the license holder and must:

(1) specify the parts of the correction order that are alleged to be in error;

(2) explain why the parts of the correction order are in error; and

(3) include documentation to support the allegation of error.

A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner of human services' disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

(d) Nothing in this subdivision prohibits the commissioner of human services from decertifying a license holder according to subdivision 9 prior to issuing a correction order.

Subd. 9. **Decertification.** (a) The commissioner of human services may rescind a certification issued under this section if a license holder fails to comply with the certification requirements in this section.

(b) The license holder may request reconsideration of a decertification by notifying the commissioner of human services by certified mail or personal service. The license holder must request reconsideration of a decertification in writing. If the license holder sends the

request for reconsideration of a decertification by certified mail, the license holder must send the request by United States mail to the commissioner of human services and the request must be postmarked within 20 calendar days after the license holder received the notice of decertification. If the license holder requests reconsideration of a decertification by personal service, the request for reconsideration must be received by the commissioner of human services within 20 calendar days after the license holder received the notice of decertification. When submitting a request for reconsideration of a decertification, the license holder must submit a written argument or evidence in support of the request for reconsideration.

(c) The commissioner of human services' disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

Subd. 10. **Variances.** The commissioner of human services may grant variances to the requirements in this section that do not affect a youth's health or safety or compliance with federal requirements for Title IV-E funding if the conditions in section 245A.04, subdivision 9, are met.

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

Sec. 11. Minnesota Statutes 2020, section 256.01, subdivision 14b, is amended to read:

Subd. 14b. **American Indian child welfare projects.** (a) The commissioner of human services may authorize projects to initiate tribal delivery of child welfare services to American Indian children and their parents and custodians living on the reservation. The commissioner has authority to solicit and determine which tribes may participate in a project. Grants may be issued to Minnesota Indian tribes to support the projects. The commissioner may waive existing state rules as needed to accomplish the projects. The commissioner may authorize projects to use alternative methods of (1) screening, investigating, and assessing reports of child maltreatment, and (2) administrative reconsideration, administrative appeal, and judicial appeal of maltreatment determinations, provided the alternative methods used by the projects comply with the provisions of section 256.045 and chapter 260E that deal with the rights of individuals who are the subjects of reports or investigations, including notice and appeal rights and data practices requirements. The commissioner shall only authorize alternative methods that comply with the public policy under section 260E.01. The commissioner may seek any federal approval necessary to carry out the projects as well as seek and use any funds available to the commissioner, including use of federal funds, foundation funds, existing grant funds, and other funds. The commissioner is authorized to advance state funds as necessary to operate the projects. Federal reimbursement applicable

to the projects is appropriated to the commissioner for the purposes of the projects. The projects must be required to address responsibility for safety, permanency, and well-being of children.

(b) For the purposes of this section, "American Indian child" means a person under 21 years old and who is a tribal member or eligible for membership in one of the tribes chosen for a project under this subdivision and who is residing on the reservation of that tribe.

(c) In order to qualify for an American Indian child welfare project, a tribe must:

(1) be one of the existing tribes with reservation land in Minnesota;

(2) have a tribal court with jurisdiction over child custody proceedings;

(3) have a substantial number of children for whom determinations of maltreatment have occurred;

(4)(i) have capacity to respond to reports of abuse and neglect under chapter 260E; or (ii) have codified the tribe's screening, investigation, and assessment of reports of child maltreatment procedures, if authorized to use an alternative method by the commissioner under paragraph (a);

(5) provide a wide range of services to families in need of child welfare services; ~~and~~

(6) have a tribal-state title IV-E agreement in effect~~.~~; and

(7) enter into host Tribal contracts pursuant to section 256.0112, subdivision 6.

(d) Grants awarded under this section may be used for the nonfederal costs of providing child welfare services to American Indian children on the tribe's reservation, including costs associated with:

(1) assessment and prevention of child abuse and neglect;

(2) family preservation;

(3) facilitative, supportive, and reunification services;

(4) out-of-home placement for children removed from the home for child protective purposes; and

(5) other activities and services approved by the commissioner that further the goals of providing safety, permanency, and well-being of American Indian children.

(e) When a tribe has initiated a project and has been approved by the commissioner to assume child welfare responsibilities for American Indian children of that tribe under this section, the affected county social service agency is relieved of responsibility for responding

to reports of abuse and neglect under chapter 260E for those children during the time within which the tribal project is in effect and funded. The commissioner shall work with tribes and affected counties to develop procedures for data collection, evaluation, and clarification of ongoing role and financial responsibilities of the county and tribe for child welfare services prior to initiation of the project. Children who have not been identified by the tribe as participating in the project shall remain the responsibility of the county. Nothing in this section shall alter responsibilities of the county for law enforcement or court services.

(f) Participating tribes may conduct children's mental health screenings under section 245.4874, subdivision 1, paragraph (a), clause (12), for children who are eligible for the initiative and living on the reservation and who meet one of the following criteria:

(1) the child must be receiving child protective services;

(2) the child must be in foster care; or

(3) the child's parents must have had parental rights suspended or terminated.

Tribes may access reimbursement from available state funds for conducting the screenings. Nothing in this section shall alter responsibilities of the county for providing services under section 245.487.

(g) Participating tribes may establish a local child mortality review panel. In establishing a local child mortality review panel, the tribe agrees to conduct local child mortality reviews for child deaths or near-fatalities occurring on the reservation under subdivision 12. Tribes with established child mortality review panels shall have access to nonpublic data and shall protect nonpublic data under subdivision 12, paragraphs (c) to (e). The tribe shall provide written notice to the commissioner and affected counties when a local child mortality review panel has been established and shall provide data upon request of the commissioner for purposes of sharing nonpublic data with members of the state child mortality review panel in connection to an individual case.

(h) The commissioner shall collect information on outcomes relating to child safety, permanency, and well-being of American Indian children who are served in the projects. Participating tribes must provide information to the state in a format and completeness deemed acceptable by the state to meet state and federal reporting requirements.

(i) In consultation with the White Earth Band, the commissioner shall develop and submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a plan to transfer legal responsibility for providing child protective services to White Earth Band member children residing in Hennepin County to

the White Earth Band. The plan shall include a financing proposal, definitions of key terms, statutory amendments required, and other provisions required to implement the plan. The commissioner shall submit the plan by January 15, 2012.

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

Sec. 12. Minnesota Statutes 2020, section 256.0112, subdivision 6, is amended to read:

Subd. 6. **Contracting within and across county lines; lead county contracts; lead tribal contracts.** Paragraphs (a) to (e) govern contracting within and across county lines and lead county contracts. Paragraphs (a) to (e) govern contracting within and across reservation boundaries and lead tribal contracts for initiative tribes under section 256.01, subdivision 14b. For purposes of this subdivision, "local agency" includes a tribe or a county agency.

(a) Once a local agency and an approved vendor execute a contract that meets the requirements of this subdivision, the contract governs all other purchases of service from the vendor by all other local agencies for the term of the contract. The local agency that negotiated and entered into the contract becomes the lead tribe or county for the contract.

(b) When the local agency in the county or reservation where a vendor is located wants to purchase services from that vendor and the vendor has no contract with the local agency or any other tribe or county, the local agency must negotiate and execute a contract with the vendor.

(c) When a local agency ~~in one county~~ wants to purchase services from a vendor located in another county or reservation, it must notify the local agency in the county or reservation where the vendor is located. Within 30 days of being notified, the local agency in the vendor's county or reservation must:

(1) if it has a contract with the vendor, send a copy to the inquiring local agency;

(2) if there is a contract with the vendor for which another local agency is the lead tribe or county, identify the lead tribe or county to the inquiring agency; or

(3) if no local agency has a contract with the vendor, inform the inquiring agency whether it will negotiate a contract and become the lead tribe or county. If the agency where the vendor is located will not negotiate a contract with the vendor because of concerns related to clients' health and safety, the agency must share those concerns with the inquiring local agency.

(d) If the local agency in the county where the vendor is located declines to negotiate a contract with the vendor or fails to respond within 30 days of receiving the notification under paragraph (c), the inquiring agency is authorized to negotiate a contract and must notify the local agency that declined or failed to respond.

(e) When the inquiring ~~county~~ local agency under paragraph (d) becomes the lead tribe or county for a contract and the contract expires and needs to be renegotiated, that tribe or county must again follow the requirements under paragraph (c) and notify the local agency where the vendor is located. The local agency where the vendor is located has the option of becoming the lead tribe or county for the new contract. If the local agency does not exercise the option, paragraph (d) applies.

(f) This subdivision does not affect the requirement to seek county concurrence under section 256B.092, subdivision 8a, when the services are to be purchased for a person with a developmental disability or under section 245.4711, subdivision 3, when the services to be purchased are for an adult with serious and persistent mental illness.

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

Sec. 13. Minnesota Statutes 2020, section 260C.007, subdivision 6, is amended to read:

Subd. 6. **Child in need of protection or services.** "Child in need of protection or services" means a child who is in need of protection or services because the child:

(1) is abandoned or without parent, guardian, or custodian;

(2)(i) has been a victim of physical or sexual abuse as defined in section 260E.03, subdivision 18 or 20, (ii) resides with or has resided with a victim of child abuse as defined in subdivision 5 or domestic child abuse as defined in subdivision 13, (iii) resides with or would reside with a perpetrator of domestic child abuse as defined in subdivision 13 or child abuse as defined in subdivision 5 or 13, or (iv) is a victim of emotional maltreatment as defined in subdivision 15;

(3) is without necessary food, clothing, shelter, education, or other required care for the child's physical or mental health or morals because the child's parent, guardian, or custodian is unable or unwilling to provide that care;

(4) is without the special care made necessary by a physical, mental, or emotional condition because the child's parent, guardian, or custodian is unable or unwilling to provide that care;

(5) is medically neglected, which includes, but is not limited to, the withholding of medically indicated treatment from an infant with a disability with a life-threatening condition. The term "withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening conditions by providing treatment, including appropriate nutrition, hydration, and medication which, in the treating physician's or advanced practice registered nurse's reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all conditions, except that the term does not include the failure to provide treatment other than appropriate nutrition, hydration, or medication to an infant when, in the treating physician's or advanced practice registered nurse's reasonable medical judgment:

(i) the infant is chronically and irreversibly comatose;

(ii) the provision of the treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant; or

(iii) the provision of the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under the circumstances would be inhumane;

(6) is one whose parent, guardian, or other custodian for good cause desires to be relieved of the child's care and custody, including a child who entered foster care under a voluntary placement agreement between the parent and the responsible social services agency under section 260C.227;

(7) has been placed for adoption or care in violation of law;

(8) is without proper parental care because of the emotional, mental, or physical disability, or state of immaturity of the child's parent, guardian, or other custodian;

(9) is one whose behavior, condition, or environment is such as to be injurious or dangerous to the child or others. An injurious or dangerous environment may include, but is not limited to, the exposure of a child to criminal activity in the child's home;

(10) is experiencing growth delays, which may be referred to as failure to thrive, that have been diagnosed by a physician and are due to parental neglect;

(11) is a sexually exploited youth;

(12) has committed a delinquent act or a juvenile petty offense before becoming ~~ten~~ 13 years old;

(13) is a runaway;

(14) is a habitual truant;

(15) has been found incompetent to proceed or has been found not guilty by reason of mental illness or mental deficiency in connection with a delinquency proceeding, a certification under section 260B.125, an extended jurisdiction juvenile prosecution, or a proceeding involving a juvenile petty offense; or

(16) has a parent whose parental rights to one or more other children were involuntarily terminated or whose custodial rights to another child have been involuntarily transferred to a relative and there is a case plan prepared by the responsible social services agency documenting a compelling reason why filing the termination of parental rights petition under section 260C.503, subdivision 2, is not in the best interests of the child.

Sec. 14. Minnesota Statutes 2020, section 260C.007, subdivision 26c, is amended to read:

Subd. 26c. **Qualified individual.** (a) "Qualified individual" means a trained culturally competent professional or licensed clinician, including a mental health professional under section 245.4871, subdivision 27, who is ~~not~~ qualified to conduct the assessment approved by the commissioner. The qualified individual must not be an employee of the responsible social services agency and who is not connected to or affiliated with any placement setting in which a responsible social services agency has placed children.

(b) When the Indian Child Welfare Act of 1978, United States Code, title 25, sections 1901 to 1963, applies to a child, the county must contact the child's tribe without delay to give the tribe the option to designate a qualified individual who is a trained culturally competent professional or licensed clinician, including a mental health professional under section 245.4871, subdivision 27, who is not employed by the responsible social services agency and who is not connected to or affiliated with any placement setting in which a responsible social services agency has placed children. Only a federal waiver that demonstrates maintained objectivity may allow a responsible social services agency employee or tribal employee affiliated with any placement setting in which the responsible social services agency has placed children to be designated the qualified individual.

Sec. 15. Minnesota Statutes 2020, section 260C.007, subdivision 31, is amended to read:

Subd. 31. **Sexually exploited youth.** "Sexually exploited youth" means an individual who:

(1) is alleged to have engaged in conduct which would, if committed by an adult, violate any federal, state, or local law relating to being hired, offering to be hired, or agreeing to be hired by another individual to engage in sexual penetration or sexual conduct;

(2) is a victim of a crime described in section 609.342, 609.343, 609.344, 609.345, 609.3451, 609.3453, 609.352, 617.246, or 617.247;

(3) is a victim of a crime described in United States Code, title 18, section 2260; 2421; 2422; 2423; 2425; 2425A; or 2256; ~~or~~

(4) is a sex trafficking victim as defined in section 609.321, subdivision 7b~~.~~; or

(5) is a victim of commercial sexual exploitation as defined in United States Code, title 22, section 7102(11)(A) and (12).

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 16. Minnesota Statutes 2020, section 260C.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services agency shall establish a juvenile treatment screening team to conduct screenings under this chapter ~~and section 245.487, subdivision 3,~~ and chapter 260D for a child to receive treatment for an emotional disturbance, a developmental disability, or related condition in a residential treatment facility licensed by the commissioner of human services under chapter 245A, or licensed or approved by a tribe. A screening team is not required for a child to be in: (1) a residential facility specializing in prenatal, postpartum, or parenting support; (2) a facility specializing in high-quality residential care and supportive services to children and youth who ~~are~~ have been or are at risk of becoming victims of sex-trafficking ~~victims or are at risk of becoming sex-trafficking victims~~ or commercial sexual exploitation; (3) supervised settings for youth who are 18 years ~~old~~ of age or older and living independently; or (4) a licensed residential family-based treatment facility for substance abuse consistent with section 260C.190. Screenings are also not required when a child must be placed in a facility due to an emotional crisis or other mental health emergency.

(b) The responsible social services agency shall conduct screenings within 15 days of a request for a screening, unless the screening is for the purpose of residential treatment and the child is enrolled in a prepaid health program under section 256B.69, in which case the agency shall conduct the screening within ten working days of a request. The responsible social services agency shall convene the juvenile treatment screening team, which may be constituted under section 245.4885 or 256B.092 or Minnesota Rules, parts 9530.6600 to 9530.6655. The team shall consist of social workers; persons with expertise in the treatment

of juveniles who are emotionally ~~disabled~~ disturbed, chemically dependent, or have a developmental disability; and the child's parent, guardian, or permanent legal custodian. The team may include the child's relatives as defined in section 260C.007, subdivisions 26b and 27, the child's foster care provider, and professionals who are a resource to the child's family such as teachers, medical or mental health providers, and clergy, as appropriate, consistent with the family and permanency team as defined in section 260C.007, subdivision 16a. Prior to forming the team, the responsible social services agency must consult with the child's parents, the child if the child is age 14 or older, ~~the child's parents,~~ and, if applicable, the child's tribe to obtain recommendations regarding which individuals to include on the team and to ensure that the team is family-centered and will act in the child's best ~~interest~~ interests. If the child, child's parents, or legal guardians raise concerns about specific relatives or professionals, the team should not include those individuals. This provision does not apply to paragraph (c).

(c) If the agency provides notice to tribes under section 260.761, and the child screened is an Indian child, the responsible social services agency must make a rigorous and concerted effort to include a designated representative of the Indian child's tribe on the juvenile treatment screening team, unless the child's tribal authority declines to appoint a representative. The Indian child's tribe may delegate its authority to represent the child to any other federally recognized Indian tribe, as defined in section 260.755, subdivision 12. The provisions of the Indian Child Welfare Act of 1978, United States Code, title 25, sections 1901 to 1963, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835, apply to this section.

(d) If the court, prior to, or as part of, a final disposition or other court order, proposes to place a child with an emotional disturbance or developmental disability or related condition in residential treatment, the responsible social services agency must conduct a screening. If the team recommends treating the child in a qualified residential treatment program, the agency must follow the requirements of sections 260C.70 to 260C.714.

The court shall ascertain whether the child is an Indian child and shall notify the responsible social services agency and, if the child is an Indian child, shall notify the Indian child's tribe as paragraph (c) requires.

(e) When the responsible social services agency is responsible for placing and caring for the child and the screening team recommends placing a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, the agency must: (1) begin the assessment and processes required in section 260C.704 without delay; and (2) conduct a relative search according to section 260C.221 to assemble the child's family and

permanency team under section 260C.706. Prior to notifying relatives regarding the family and permanency team, the responsible social services agency must consult with the child's parent or legal guardian, the child if the child is age 14 or older, ~~the child's parents~~ and, if applicable, the child's tribe to ensure that the agency is providing notice to individuals who will act in the child's best ~~interest~~ interests. The child and the child's parents may identify a culturally competent qualified individual to complete the child's assessment. The agency shall make efforts to refer the assessment to the identified qualified individual. The assessment may not be delayed for the purpose of having the assessment completed by a specific qualified individual.

(f) When a screening team determines that a child does not need treatment in a qualified residential treatment program, the screening team must:

(1) document the services and supports that will prevent the child's foster care placement and will support the child remaining at home;

(2) document the services and supports that the agency will arrange to place the child in a family foster home; or

(3) document the services and supports that the agency has provided in any other setting.

(g) When the Indian child's tribe or tribal health care services provider or Indian Health Services provider proposes to place a child for the primary purpose of treatment for an emotional disturbance, a developmental disability, or co-occurring emotional disturbance and chemical dependency, the Indian child's tribe or the tribe delegated by the child's tribe shall submit necessary documentation to the county juvenile treatment screening team, which must invite the Indian child's tribe to designate a representative to the screening team.

(h) The responsible social services agency must conduct and document the screening in a format approved by the commissioner of human services.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 17. Minnesota Statutes 2020, section 260C.212, subdivision 1a, is amended to read:

Subd. 1a. **Out-of-home placement plan update.** (a) Within 30 days of placing the child in foster care, the agency must file the child's initial out-of-home placement plan with the court. After filing the child's initial out-of-home placement plan, the agency shall update and file the child's out-of-home placement plan with the court as follows:

(1) when the agency moves a child to a different foster care setting, the agency shall inform the court within 30 days of the child's placement change or court-ordered trial home

visit. The agency must file the child's updated out-of-home placement plan with the court at the next required review hearing;

(2) when the agency places a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, or moves a child from one qualified residential treatment program to a different qualified residential treatment program, the agency must update the child's out-of-home placement plan within 60 days. To meet the requirements of section 260C.708, the agency must file the child's out-of-home placement plan ~~with the court as part of the 60-day hearing and~~ along with the agency's report seeking the court's approval of the child's placement at a qualified residential treatment program under section 260C.71. After the court issues an order, the agency must update the child's out-of-home placement plan ~~after the court hearing~~ to document the court's approval or disapproval of the child's placement in a qualified residential treatment program;

(3) when the agency places a child with the child's parent in a licensed residential family-based substance use disorder treatment program under section 260C.190, the agency must identify the treatment program where the child will be placed in the child's out-of-home placement plan prior to the child's placement. The agency must file the child's out-of-home placement plan with the court at the next required review hearing; and

(4) under sections 260C.227 and 260C.521, the agency must update the child's out-of-home placement plan and file the child's out-of-home placement plan with the court.

(b) When none of the items in paragraph (a) apply, the agency must update the child's out-of-home placement plan no later than 180 days after the child's initial placement and every six months thereafter, consistent with section 260C.203, paragraph (a).

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 18. Minnesota Statutes 2020, section 260C.212, subdivision 13, is amended to read:

Subd. 13. **Protecting missing and runaway children and youth at risk of sex trafficking or commercial sexual exploitation.** (a) The local social services agency shall expeditiously locate any child missing from foster care.

(b) The local social services agency shall report immediately, but no later than 24 hours, after receiving information on a missing or abducted child to the local law enforcement agency for entry into the National Crime Information Center (NCIC) database of the Federal Bureau of Investigation, and to the National Center for Missing and Exploited Children.

(c) The local social services agency shall not discharge a child from foster care or close the social services case until diligent efforts have been exhausted to locate the child and the court terminates the agency's jurisdiction.

(d) The local social services agency shall determine the primary factors that contributed to the child's running away or otherwise being absent from care and, to the extent possible and appropriate, respond to those factors in current and subsequent placements.

(e) The local social services agency shall determine what the child experienced while absent from care, including screening the child to determine if the child is a possible sex trafficking or commercial sexual exploitation victim as defined in section ~~609.321, subdivision 7b~~ 260C.007, subdivision 31.

(f) The local social services agency shall report immediately, but no later than 24 hours, to the local law enforcement agency any reasonable cause to believe a child is, or is at risk of being, a sex trafficking or commercial sexual exploitation victim.

(g) The local social services agency shall determine appropriate services as described in section 145.4717 with respect to any child for whom the local social services agency has responsibility for placement, care, or supervision when the local social services agency has reasonable cause to believe that the child is, or is at risk of being, a sex trafficking or commercial sexual exploitation victim.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 19. Minnesota Statutes 2020, section 260C.4412, is amended to read:

260C.4412 PAYMENT FOR RESIDENTIAL PLACEMENTS.

(a) When a child is placed in a foster care group residential setting under Minnesota Rules, parts 2960.0020 to 2960.0710, a foster residence licensed under chapter 245A that meets the standards of Minnesota Rules, parts 2960.3200 to 2960.3230, or a children's residential facility licensed or approved by a tribe, foster care maintenance payments must be made on behalf of the child to cover the cost of providing food, clothing, shelter, daily supervision, school supplies, child's personal incidentals and supports, reasonable travel for visitation, or other transportation needs associated with the items listed. Daily supervision in the group residential setting includes routine day-to-day direction and arrangements to ensure the well-being and safety of the child. It may also include reasonable costs of administration and operation of the facility.

(b) The commissioner of human services shall specify the title IV-E administrative procedures under section 256.82 for each of the following residential program settings:

(1) residential programs licensed under chapter 245A or licensed by a tribe, including:

(i) qualified residential treatment programs as defined in section 260C.007, subdivision 26d;

(ii) program settings specializing in providing prenatal, postpartum, or parenting supports for youth; and

(iii) program settings providing high-quality residential care and supportive services to children and youth who are, or are at risk of becoming, sex trafficking victims;

(2) licensed residential family-based substance use disorder treatment programs as defined in section 260C.007, subdivision 22a; and

(3) supervised settings in which a foster child age 18 or older may live independently, consistent with section 260C.451.

(c) A lead county contract under section 256.0112, subdivision 6, is not required to establish the foster care maintenance payment in paragraph (a) for foster residence settings licensed under chapter 245A that meet the standards of Minnesota Rules, parts 2960.3200 to 2960.3230. The foster care maintenance payment for these settings must be consistent with section 256N.26, subdivision 3, and subject to the annual revision as specified in section 256N.26, subdivision 9.

Sec. 20. Minnesota Statutes 2020, section 260C.452, is amended to read:

260C.452 SUCCESSFUL TRANSITION TO ADULTHOOD.

Subdivision 1. **Scope and purpose.** (a) For purposes of this section, "youth" means a person who is at least 14 years of age and under 23 years of age.

(b) This section pertains to a ~~child~~ youth who:

(1) is in foster care and is 14 years of age or older, including a youth who is under the guardianship of the commissioner of human services~~, or who~~;

(2) has a permanency disposition of permanent custody to the agency~~, or who~~;

(3) will leave foster care ~~at 18 to 21 years of age.~~ when the youth is 18 years of age or older and under 21 years of age;

(4) has left foster care due to adoption when the youth was 16 years of age or older;

(5) has left foster care due to a transfer of permanent legal and physical custody to a relative, or Tribal equivalent, when the youth was 16 years of age or older; or

(6) was reunified with the youth's primary caretaker when the youth was 14 years of age or older and under 18 years of age.

(c) The purpose of this section is to provide support to each youth who is transitioning to adulthood by providing services to the youth in the areas of:

(1) education;

(2) employment;

(3) daily living skills such as financial literacy training and driving instruction; preventive health activities including promoting abstinence from substance use and smoking; and nutrition education and pregnancy prevention;

(4) forming meaningful, permanent connections with caring adults;

(5) engaging in age and developmentally appropriate activities under section 260C.212, subdivision 14, and positive youth development;

(6) financial, housing, counseling, and other services to assist a youth over 18 years of age in achieving self-sufficiency and accepting personal responsibility for the transition from adolescence to adulthood; and

(7) making vouchers available for education and training.

(d) The responsible social services agency may provide support and case management services to a youth as defined in paragraph (a) until the youth reaches the age of 23 years. According to section 260C.451, a youth's placement in a foster care setting will end when the youth reaches the age of 21 years.

Subd. 1a. **Case management services.** Case management services include the responsibility for planning, coordinating, authorizing, monitoring, and evaluating services for a youth and shall be provided to a youth by the responsible social services agency or the contracted agency. Case management services include the out-of-home placement plan under section 260C.212, subdivision 1, when the youth is in out-of-home placement.

Subd. 2. **Independent living plan.** When the ~~child~~ youth is 14 years of age or older and is receiving support from the responsible social services agency under this section, the responsible social services agency, in consultation with the ~~child~~ youth, shall complete the youth's independent living plan according to section 260C.212, subdivision 1, paragraph (c), clause (12), regardless of the youth's current placement status.

~~Subd. 3. **Notification.** Six months before the child is expected to be discharged from foster care, the responsible social services agency shall provide written notice to the child~~

~~regarding the right to continued access to services for certain children in foster care past 18 years of age and of the right to appeal a denial of social services under section 256.045.~~

Subd. 4. **Administrative or court review of placements.** (a) When the ~~child~~ youth is 14 years of age or older, the court, in consultation with the ~~child~~ youth, shall review the youth's independent living plan according to section 260C.203, paragraph (d).

(b) The responsible social services agency shall file a copy of the notification ~~required in subdivision 3~~ of foster care benefits for a youth who is 18 years of age or older according to section 260C.451, subdivision 1, with the court. If the responsible social services agency does not file the notice by the time the ~~child~~ youth is 17-1/2 years of age, the court shall require the responsible social services agency to file the notice.

(c) When a youth is 18 years of age or older, the court shall ensure that the responsible social services agency assists the ~~child~~ youth in obtaining the following documents before the ~~child~~ youth leaves foster care: a Social Security card; an official or certified copy of the ~~child's~~ youth's birth certificate; a state identification card or driver's license, tribal enrollment identification card, green card, or school visa; health insurance information; the ~~child's~~ youth's school, medical, and dental records; a contact list of the ~~child's~~ youth's medical, dental, and mental health providers; and contact information for the ~~child's~~ youth's siblings, if the siblings are in foster care.

(d) For a ~~child~~ youth who will be discharged from foster care at 18 years of age or older because the youth is not eligible for extended foster care benefits or chooses to leave foster care, the responsible social services agency must develop a personalized transition plan as directed by the ~~child~~ youth during the 90-day period immediately prior to the expected date of discharge. The transition plan must be as detailed as the ~~child~~ youth elects and include specific options, including but not limited to:

(1) affordable housing with necessary supports that does not include a homeless shelter;

(2) health insurance, including eligibility for medical assistance as defined in section 256B.055, subdivision 17;

(3) education, including application to the Education and Training Voucher Program;

(4) local opportunities for mentors and continuing support services~~, including the Healthy Transitions and Homeless Prevention program, if available~~;

(5) workforce supports and employment services;

(6) a copy of the ~~child's~~ youth's consumer credit report as defined in section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report, at no cost to the ~~child~~ youth;

(7) information on executing a health care directive under chapter 145C and on the importance of designating another individual to make health care decisions on behalf of the ~~child~~ youth if the ~~child~~ youth becomes unable to participate in decisions;

(8) appropriate contact information through 21 years of age if the ~~child~~ youth needs information or help dealing with a crisis situation; and

(9) official documentation that the youth was previously in foster care.

Subd. 5. **Notice of termination of ~~foster care~~ social services.** (a) ~~When~~ Before a ~~child~~ youth who is 18 years of age or older leaves foster care ~~at 18 years of age or older~~, the responsible social services agency shall give the ~~child~~ youth written notice that foster care shall terminate 30 days from the date that the notice is sent by the agency according to section 260C.451, subdivision 8.

~~(b) The child or the child's guardian ad litem may file a motion asking the court to review the responsible social services agency's determination within 15 days of receiving the notice. The child shall not be discharged from foster care until the motion is heard. The responsible social services agency shall work with the child to transition out of foster care.~~

~~(c) The written notice of termination of benefits shall be on a form prescribed by the commissioner and shall give notice of the right to have the responsible social services agency's determination reviewed by the court under this section or sections 260C.203, 260C.317, and 260C.515, subdivision 5 or 6. A copy of the termination notice shall be sent to the child and the child's attorney, if any, the foster care provider, the child's guardian ad litem, and the court. The responsible social services agency is not responsible for paying foster care benefits for any period of time after the child leaves foster care.~~

(b) Before case management services will end for a youth who is at least 18 years of age and under 23 years of age, the responsible social services agency shall give the youth: (1) written notice that case management services for the youth shall terminate; and (2) written notice that the youth has the right to appeal the termination of case management services under section 256.045, subdivision 3, by responding in writing within ten days of the date that the agency mailed the notice. The termination notice must include information about services for which the youth is eligible and how to access the services.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 21. Minnesota Statutes 2020, section 260C.704, is amended to read:

260C.704 REQUIREMENTS FOR THE QUALIFIED INDIVIDUAL'S ASSESSMENT OF THE CHILD FOR PLACEMENT IN A QUALIFIED RESIDENTIAL TREATMENT PROGRAM.

(a) A qualified individual must complete an assessment of the child prior to ~~or within 30 days of~~ the child's placement in a qualified residential treatment program in a format approved by the commissioner of human services~~, and~~ unless, due to a crisis, the child must immediately be placed in a qualified residential treatment program. When a child must immediately be placed in a qualified residential treatment program without an assessment, the qualified individual must complete the child's assessment within 30 days of the child's placement. The qualified individual must:

(1) assess the child's needs and strengths, using an age-appropriate, evidence-based, validated, functional assessment approved by the commissioner of human services;

(2) determine whether the child's needs can be met by the child's family members or through placement in a family foster home; or, if not, determine which residential setting would provide the child with the most effective and appropriate level of care to the child in the least restrictive environment;

(3) develop a list of short- and long-term mental and behavioral health goals for the child; and

(4) work with the child's family and permanency team using culturally competent practices.

If a level of care determination was conducted under section 245.4885, that information must be shared with the qualified individual and the juvenile treatment screening team.

(b) The child and the child's parents, when appropriate, may request that a specific culturally competent qualified individual complete the child's assessment. The agency shall make efforts to refer the child to the identified qualified individual to complete the assessment. The assessment must not be delayed for a specific qualified individual to complete the assessment.

(c) The qualified individual must provide the assessment, when complete, to the responsible social services agency~~, the child's parents or legal guardians, the guardian ad litem, and the court~~. If the assessment recommends placement of the child in a qualified residential treatment facility, the agency must distribute the assessment to the child's parent or legal guardian and file the assessment with the court report as required in section 260C.71,

subdivision 2. If the assessment does not recommend placement in a qualified residential treatment facility, the agency must provide a copy of the assessment to the parents or legal guardians and the guardian ad litem and file the assessment determination with the court at the next required hearing as required in section 260C.71, subdivision 5. If court rules and chapter 13 permit disclosure of the results of the child's assessment, the agency may share the results of the child's assessment with the child's foster care provider, other members of the child's family, and the family and permanency team. The agency must not share the child's private medical data with the family and permanency team unless: (1) chapter 13 permits the agency to disclose the child's private medical data to the family and permanency team; or (2) the child's parent has authorized the agency to disclose the child's private medical data to the family and permanency team.

(d) For an Indian child, the assessment of the child must follow the order of placement preferences in the Indian Child Welfare Act of 1978, United States Code, title 25, section 1915.

(e) In the assessment determination, the qualified individual must specify in writing:

(1) the reasons why the child's needs cannot be met by the child's family or in a family foster home. A shortage of family foster homes is not an acceptable reason for determining that a family foster home cannot meet a child's needs;

(2) why the recommended placement in a qualified residential treatment program will provide the child with the most effective and appropriate level of care to meet the child's needs in the least restrictive environment possible and how placing the child at the treatment program is consistent with the short-term and long-term goals of the child's permanency plan; and

(3) if the qualified individual's placement recommendation is not the placement setting that the parent, family and permanency team, child, or tribe prefer, the qualified individual must identify the reasons why the qualified individual does not recommend the parent's, family and permanency team's, child's, or tribe's placement preferences. The out-of-home placement plan under section 260C.708 must also include reasons why the qualified individual did not recommend the preferences of the parents, family and permanency team, child, or tribe.

(f) If the qualified individual determines that the child's family or a family foster home or other less restrictive placement may meet the child's needs, the agency must move the child out of the qualified residential treatment program and transition the child to a less restrictive setting within 30 days of the determination. If the responsible social services

agency has placement authority of the child, the agency must make a plan for the child's placement according to section 260C.212, subdivision 2. The agency must file the child's assessment determination with the court at the next required hearing.

(g) If the qualified individual recommends placing the child in a qualified residential treatment program and if the responsible social services agency has placement authority of the child, the agency shall make referrals to appropriate qualified residential treatment programs and upon acceptance by an appropriate program, place the child in an approved or certified qualified residential treatment program.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 22. Minnesota Statutes 2020, section 260C.706, is amended to read:

260C.706 FAMILY AND PERMANENCY TEAM REQUIREMENTS.

(a) When the responsible social services agency's juvenile treatment screening team, as defined in section 260C.157, recommends placing the child in a qualified residential treatment program, the agency must assemble a family and permanency team within ten days.

(1) The team must include all appropriate biological family members, the child's parents, legal guardians or custodians, foster care providers, and relatives as defined in section 260C.007, subdivisions ~~26e~~ 26b and 27, and professionals, as appropriate, who are a resource to the child's family, such as teachers, medical or mental health providers, or clergy.

(2) When a child is placed in foster care prior to the qualified residential treatment program, the agency shall include relatives responding to the relative search notice as required under section 260C.221 on this team, unless the juvenile court finds that contacting a specific relative would ~~endanger~~ present a safety or health risk to the parent, guardian, child, sibling, or any other family member.

(3) When a qualified residential treatment program is the child's initial placement setting, the responsible social services agency must engage with the child and the child's parents to determine the appropriate family and permanency team members.

(4) When the permanency goal is to reunify the child with the child's parent or legal guardian, the purpose of the relative search and focus of the family and permanency team is to preserve family relationships and identify and develop supports for the child and parents.

(5) The responsible agency must make a good faith effort to identify and assemble all appropriate individuals to be part of the child's family and permanency team and request input from the parents regarding relative search efforts consistent with section 260C.221.

The out-of-home placement plan in section 260C.708 must include all contact information for the team members, as well as contact information for family members or relatives who are not a part of the family and permanency team.

(6) If the child is age 14 or older, the team must include members of the family and permanency team that the child selects in accordance with section 260C.212, subdivision 1, paragraph (b).

(7) Consistent with section 260C.221, a responsible social services agency may disclose relevant and appropriate private data about the child to relatives in order for the relatives to participate in caring and planning for the child's placement.

(8) If the child is an Indian child under section 260.751, the responsible social services agency must make active efforts to include the child's tribal representative on the family and permanency team.

(b) The family and permanency team shall meet regarding the assessment required under section 260C.704 to determine whether it is necessary and appropriate to place the child in a qualified residential treatment program and to participate in case planning under section 260C.708.

(c) When reunification of the child with the child's parent or legal guardian is the permanency plan, the family and permanency team shall support the parent-child relationship by recognizing the parent's legal authority, consulting with the parent regarding ongoing planning for the child, and assisting the parent with visiting and contacting the child.

(d) When the agency's permanency plan is to transfer the child's permanent legal and physical custody to a relative or for the child's adoption, the team shall:

(1) coordinate with the proposed guardian to provide the child with educational services, medical care, and dental care;

(2) coordinate with the proposed guardian, the agency, and the foster care facility to meet the child's treatment needs after the child is placed in a permanent placement with the proposed guardian;

(3) plan to meet the child's need for safety, stability, and connection with the child's family and community after the child is placed in a permanent placement with the proposed guardian; and

(4) in the case of an Indian child, communicate with the child's tribe to identify necessary and appropriate services for the child, transition planning for the child, the child's treatment

needs, and how to maintain the child's connections to the child's community, family, and tribe.

(e) The agency shall invite the family and permanency team to participate in case planning and the agency shall give the team notice of court reviews under sections 260C.152 and 260C.221 until: (1) the child is reunited with the child's parents; or (2) the child's foster care placement ends and the child is in a permanent placement.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 23. Minnesota Statutes 2020, section 260C.708, is amended to read:

260C.708 OUT-OF-HOME PLACEMENT PLAN FOR QUALIFIED RESIDENTIAL TREATMENT PROGRAM PLACEMENTS.

(a) When the responsible social services agency places a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, the out-of-home placement plan must include:

(1) the case plan requirements in section ~~260.212, subdivision 1~~ 260C.212;

(2) the reasonable and good faith efforts of the responsible social services agency to identify and include all of the individuals required to be on the child's family and permanency team under section 260C.007;

(3) all contact information for members of the child's family and permanency team and for other relatives who are not part of the family and permanency team;

(4) evidence that the agency scheduled meetings of the family and permanency team, including meetings relating to the assessment required under section 260C.704, at a time and place convenient for the family;

(5) evidence that the family and permanency team is involved in the assessment required under section 260C.704 to determine the appropriateness of the child's placement in a qualified residential treatment program;

(6) the family and permanency team's placement preferences for the child in the assessment required under section 260C.704. When making a decision about the child's placement preferences, the family and permanency team must recognize:

(i) that the agency should place a child with the child's siblings unless a court finds that placing a child with the child's siblings is not possible due to a child's specialized placement needs or is otherwise contrary to the child's best interests; and

(ii) that the agency should place an Indian child according to the requirements of the Indian Child Welfare Act, the Minnesota Family Preservation Act under sections 260.751 to 260.835, and section 260C.193, subdivision 3, paragraph (g);

~~(5)~~ (7) when reunification of the child with the child's parent or legal guardian is the agency's goal, evidence demonstrating that the parent or legal guardian provided input about the members of the family and permanency team under section 260C.706;

~~(6)~~ (8) when the agency's permanency goal is to reunify the child with the child's parent or legal guardian, the out-of-home placement plan must identify services and supports that maintain the parent-child relationship and the parent's legal authority, decision-making, and responsibility for ongoing planning for the child. In addition, the agency must assist the parent with visiting and contacting the child;

~~(7)~~ (9) when the agency's permanency goal is to transfer permanent legal and physical custody of the child to a proposed guardian or to finalize the child's adoption, the case plan must document the agency's steps to transfer permanent legal and physical custody of the child or finalize adoption, as required in section 260C.212, subdivision 1, paragraph (c), clauses (6) and (7); and

~~(8)~~ (10) the qualified individual's recommendation regarding the child's placement in a qualified residential treatment program and the court approval or disapproval of the placement as required in section 260C.71.

(b) If the placement preferences of the family and permanency team, child, and tribe, if applicable, are not consistent with the placement setting that the qualified individual recommends, the case plan must include the reasons why the qualified individual did not recommend following the preferences of the family and permanency team, child, and the tribe.

(c) The agency must file the out-of-home placement plan with the court as part of the 60-day ~~hearing~~ court order under section 260C.71.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 24. Minnesota Statutes 2020, section 260C.71, is amended to read:

260C.71 COURT APPROVAL REQUIREMENTS.

Subdivision 1. **Judicial review.** When the responsible social services agency has legal authority to place a child at a qualified residential treatment facility under section 260C.007, subdivision 21a, and the child's assessment under section 260C.704 recommends placing

the child in a qualified residential treatment facility, the agency shall place the child at a qualified residential facility. Within 60 days of placing the child at a qualified residential treatment facility, the agency must obtain a court order finding that the child's placement is appropriate and meets the child's individualized needs.

Subd. 2. **Qualified residential treatment program; agency report to court.** (a) The responsible social services agency shall file a written report with the court after receiving the qualified individual's assessment as specified in section 260C.704 prior to the child's placement or within 35 days of the date of the child's placement in a qualified residential treatment facility. The written report shall contain or have attached:

(1) the child's name, date of birth, race, gender, and current address;

(2) the names, races, dates of birth, residence, and post office address of the child's parents or legal custodian, or guardian;

(3) the name and address of the qualified residential treatment program, including a chief administrator of the facility;

(4) a statement of the facts that necessitated the child's foster care placement;

(5) the child's out-of-home placement plan under section 260C.212, subdivision 1, including the requirements in section 260C.708;

(6) if the child is placed in an out-of-state qualified residential treatment program, the compelling reasons why the child's needs cannot be met by an in-state placement;

(7) the qualified individual's assessment of the child under section 260C.704, paragraph (c), in a format approved by the commissioner;

(8) if, at the time required for the report under this subdivision, the child's parent or legal guardian, a child who is ten years of age or older, the family and permanency team, or a tribe disagrees with the recommended qualified residential treatment program placement, the agency shall include information regarding the disagreement, and to the extent possible, the basis for the disagreement in the report;

(9) any other information that the responsible social services agency, child's parent, legal custodian or guardian, child, or in the case of an Indian child, tribe would like the court to consider; and

(10) the agency shall file the written report with the court and serve on the parties a request for a hearing or a court order without a hearing.

(b) The agency must inform the child's parent or legal guardian and a child who is ten years of age or older of the court review requirements of this section and the child's and child's parent's or legal guardian's right to submit information to the court:

(1) the agency must inform the child's parent or legal guardian and a child who is ten years of age or older of the reporting date and the date by which the agency must receive information from the child and child's parent so that the agency is able to submit the report required by this subdivision to the court;

(2) the agency must inform the child's parent or legal guardian and a child who is ten years of age or older that the court will hold a hearing upon the request of the child or the child's parent; and

(3) the agency must inform the child's parent or legal guardian and a child who is ten years of age or older that they have the right to request a hearing and the right to present information to the court for the court's review under this subdivision.

Subd. 3. **Court hearing.** (a) The court shall hold a hearing when a party or a child who is ten years of age or older requests a hearing.

(b) In all other circumstances, the court has the discretion to hold a hearing or issue an order without a hearing.

Subd. 4. **Court findings and order.** (a) Within 60 days from the beginning of each placement in a qualified residential treatment program when the qualified individual's assessment of the child recommends placing the child in a qualified residential treatment program, the court must consider the qualified individual's assessment of the child under section 260C.704 and issue an order to:

~~(1) consider the qualified individual's assessment of whether it is necessary and appropriate to place the child in a qualified residential treatment program under section 260C.704;~~

~~(2)~~ (1) determine whether a family foster home can meet the child's needs, whether it is necessary and appropriate to place a child in a qualified residential treatment program that is the least restrictive environment possible, and whether the child's placement is consistent with the child's short and long term goals as specified in the permanency plan; and

~~(3)~~ (2) approve or disapprove of the child's placement.

(b) ~~In the out-of-home placement plan, the agency must document the court's approval or disapproval of the placement, as specified in section 260C.708.~~ If the court disapproves of the child's placement in a qualified residential treatment program, the responsible social

services agency shall: (1) remove the child from the qualified residential treatment program within 30 days of the court's order; and (2) make a plan for the child's placement that is consistent with the child's best interests under section 260C.212, subdivision 2.

Subd. 5. **Court review and approval not required.** When the responsible social services agency has legal authority to place a child under section 260C.007, subdivision 21a, and the qualified individual's assessment of the child does not recommend placing the child in a qualified residential treatment program, the court is not required to hold a hearing and the court is not required to issue an order. Pursuant to section 260C.704, paragraph (f), the responsible social services agency shall make a plan for the child's placement consistent with the child's best interests under section 260C.212, subdivision 2. The agency must file the agency's assessment determination for the child with the court at the next required hearing.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 25. Minnesota Statutes 2020, section 260C.712, is amended to read:

260C.712 ONGOING REVIEWS AND PERMANENCY HEARING REQUIREMENTS.

As long as a child remains placed in a qualified residential treatment program, the responsible social services agency shall submit evidence at each administrative review under section 260C.203; each court review under sections 260C.202, 260C.203, ~~and~~ 260C.204, 260D.06, 260D.07, and 260D.08; and each permanency hearing under section 260C.515, 260C.519, ~~or~~ 260C.521, or 260D.07 that:

(1) demonstrates that an ongoing assessment of the strengths and needs of the child continues to support the determination that the child's needs cannot be met through placement in a family foster home;

(2) demonstrates that the placement of the child in a qualified residential treatment program provides the most effective and appropriate level of care for the child in the least restrictive environment;

(3) demonstrates how the placement is consistent with the short-term and long-term goals for the child, as specified in the child's permanency plan;

(4) documents how the child's specific treatment or service needs will be met in the placement;

(5) documents the length of time that the agency expects the child to need treatment or services; ~~and~~

(6) documents the responsible social services agency's efforts to prepare the child to return home or to be placed with a fit and willing relative, legal guardian, adoptive parent, or foster family~~.~~; and

(7) if the child is placed in a qualified residential treatment program out-of-state, the compelling reasons for placing the child out-of-state and the reasons that the child's needs cannot be met by an in-state placement.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 26. Minnesota Statutes 2020, section 260C.714, is amended to read:

260C.714 REVIEW OF EXTENDED QUALIFIED RESIDENTIAL TREATMENT PROGRAM PLACEMENTS.

(a) When a responsible social services agency places a child in a qualified residential treatment program for more than 12 consecutive months or 18 nonconsecutive months or, in the case of a child who is under 13 years of age, for more than six consecutive or nonconsecutive months, the agency must submit: (1) the signed approval by the county social services director of the responsible social services agency; and (2) the evidence supporting the child's placement at the most recent court review or permanency hearing under section 260C.712~~, paragraph (b)~~.

(b) The commissioner shall specify the procedures and requirements for the agency's review and approval of a child's extended qualified residential treatment program placement. The commissioner may consult with counties, tribes, child-placing agencies, mental health providers, licensed facilities, the child, the child's parents, and the family and permanency team members to develop case plan requirements and engage in periodic reviews of the case plan.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 27. Minnesota Statutes 2020, section 260D.01, is amended to read:

260D.01 CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.

(a) Sections 260D.01 to 260D.10, may be cited as the "child in voluntary foster care for treatment" provisions of the Juvenile Court Act.

(b) The juvenile court has original and exclusive jurisdiction over a child in voluntary foster care for treatment upon the filing of a report or petition required under this chapter. All obligations of the responsible social services agency to a child and family in foster care contained in chapter 260C not inconsistent with this chapter are also obligations of the agency with regard to a child in foster care for treatment under this chapter.

(c) This chapter shall be construed consistently with the mission of the children's mental health service system as set out in section 245.487, subdivision 3, and the duties of an agency under sections 256B.092 and 260C.157 and Minnesota Rules, parts 9525.0004 to 9525.0016, to meet the needs of a child with a developmental disability or related condition. This chapter:

(1) establishes voluntary foster care through a voluntary foster care agreement as the means for an agency and a parent to provide needed treatment when the child must be in foster care to receive necessary treatment for an emotional disturbance or developmental disability or related condition;

(2) establishes court review requirements for a child in voluntary foster care for treatment due to emotional disturbance or developmental disability or a related condition;

(3) establishes the ongoing responsibility of the parent as legal custodian to visit the child, to plan together with the agency for the child's treatment needs, to be available and accessible to the agency to make treatment decisions, and to obtain necessary medical, dental, and other care for the child; ~~and~~

(4) applies to voluntary foster care when the child's parent and the agency agree that the child's treatment needs require foster care either:

(i) due to a level of care determination by the agency's screening team informed by the child's diagnostic and functional assessment under section 245.4885; or

(ii) due to a determination regarding the level of services needed by the child by the responsible social ~~services'~~ services agency's screening team under section 256B.092, and Minnesota Rules, parts 9525.0004 to 9525.0016~~.~~; and

(5) includes the requirements for a child's placement in sections 260C.70 to 260C.714, when the juvenile treatment screening team recommends placing a child in a qualified residential treatment program, except as modified by this chapter.

(d) This chapter does not apply when there is a current determination under chapter 260E that the child requires child protective services or when the child is in foster care for any reason other than treatment for the child's emotional disturbance or developmental

disability or related condition. When there is a determination under chapter 260E that the child requires child protective services based on an assessment that there are safety and risk issues for the child that have not been mitigated through the parent's engagement in services or otherwise, or when the child is in foster care for any reason other than the child's emotional disturbance or developmental disability or related condition, the provisions of chapter 260C apply.

(e) The paramount consideration in all proceedings concerning a child in voluntary foster care for treatment is the safety, health, and the best interests of the child. The purpose of this chapter is:

(1) to ensure that a child with a disability is provided the services necessary to treat or ameliorate the symptoms of the child's disability;

(2) to preserve and strengthen the child's family ties whenever possible and in the child's best interests, approving the child's placement away from the child's parents only when the child's need for care or treatment requires ~~it~~ out-of-home placement and the child cannot be maintained in the home of the parent; and

(3) to ensure that the child's parent retains legal custody of the child and associated decision-making authority unless the child's parent willfully fails or is unable to make decisions that meet the child's safety, health, and best interests. The court may not find that the parent willfully fails or is unable to make decisions that meet the child's needs solely because the parent disagrees with the agency's choice of foster care facility, unless the agency files a petition under chapter 260C, and establishes by clear and convincing evidence that the child is in need of protection or services.

(f) The legal parent-child relationship shall be supported under this chapter by maintaining the parent's legal authority and responsibility for ongoing planning for the child and by the agency's assisting the parent, ~~where~~ when necessary, to exercise the parent's ongoing right and obligation to visit or to have reasonable contact with the child. Ongoing planning means:

(1) actively participating in the planning and provision of educational services, medical, and dental care for the child;

(2) actively planning and participating with the agency and the foster care facility for the child's treatment needs; ~~and~~

(3) planning to meet the child's need for safety, stability, and permanency, and the child's need to stay connected to the child's family and community~~.~~;

(4) engaging with the responsible social services agency to ensure that the family and permanency team under section 260C.706 consists of appropriate family members. For purposes of voluntary placement of a child in foster care for treatment under chapter 260D, prior to forming the child's family and permanency team, the responsible social services agency must consult with the child's parent or legal guardian, the child if the child is 14 years of age or older, and, if applicable, the child's tribe to obtain recommendations regarding which individuals to include on the team and to ensure that the team is family-centered and will act in the child's best interests. If the child, child's parents, or legal guardians raise concerns about specific relatives or professionals, the team should not include those individuals unless the individual is a treating professional or an important connection to the youth as outlined in the case or crisis plan; and

(5) For a voluntary placement under this chapter in a qualified residential treatment program, as defined in section 260C.007, subdivision 26d, for purposes of engaging in a relative search as provided in section 260C.221, the county agency must consult with the child's parent or legal guardian, the child if the child is 14 years of age or older, and, if applicable, the child's tribe to obtain recommendations regarding which adult relatives the county agency should notify. If the child, child's parents, or legal guardians raise concerns about specific relatives, the county agency should not notify those relatives.

(g) The provisions of section 260.012 to ensure placement prevention, family reunification, and all active and reasonable effort requirements of that section apply. This chapter shall be construed consistently with the requirements of the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901, et al., and the provisions of the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 28. Minnesota Statutes 2020, section 260D.05, is amended to read:

260D.05 ADMINISTRATIVE REVIEW OF CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.

The administrative reviews required under section 260C.203 must be conducted for a child in voluntary foster care for treatment, except that the initial administrative review must take place prior to the submission of the report to the court required under section 260D.06, subdivision 2. When a child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, the responsible social services agency must submit evidence to the court as specified in section 260C.712.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 29. Minnesota Statutes 2020, section 260D.06, subdivision 2, is amended to read:

Subd. 2. **Agency report to court; court review.** The agency shall obtain judicial review by reporting to the court according to the following procedures:

(a) A written report shall be forwarded to the court within 165 days of the date of the voluntary placement agreement. The written report shall contain or have attached:

(1) a statement of facts that necessitate the child's foster care placement;

(2) the child's name, date of birth, race, gender, and current address;

(3) the names, race, date of birth, residence, and post office addresses of the child's parents or legal custodian;

(4) a statement regarding the child's eligibility for membership or enrollment in an Indian tribe and the agency's compliance with applicable provisions of sections 260.751 to 260.835;

(5) the names and addresses of the foster parents or chief administrator of the facility in which the child is placed, if the child is not in a family foster home or group home;

(6) a copy of the out-of-home placement plan required under section 260C.212, subdivision 1;

(7) a written summary of the proceedings of any administrative review required under section 260C.203; ~~and~~

(8) evidence as specified in section 260C.712 when a child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d; and

(9) any other information the agency, parent or legal custodian, the child or the foster parent, or other residential facility wants the court to consider.

(b) In the case of a child in placement due to emotional disturbance, the written report shall include as an attachment, the child's individual treatment plan developed by the child's treatment professional, as provided in section 245.4871, subdivision 21, or the child's standard written plan, as provided in section 125A.023, subdivision 3, paragraph (e).

(c) In the case of a child in placement due to developmental disability or a related condition, the written report shall include as an attachment, the child's individual service plan, as provided in section 256B.092, subdivision 1b; the child's individual program plan, as provided in Minnesota Rules, part 9525.0004, subpart 11; the child's waiver care plan;

or the child's standard written plan, as provided in section 125A.023, subdivision 3, paragraph (e).

(d) The agency must inform the child, age 12 or older, the child's parent, and the foster parent or foster care facility of the reporting and court review requirements of this section and of their right to submit information to the court:

(1) if the child or the child's parent or the foster care provider wants to send information to the court, the agency shall advise those persons of the reporting date and the date by which the agency must receive the information they want forwarded to the court so the agency is timely able submit it with the agency's report required under this subdivision;

(2) the agency must also inform the child, age 12 or older, the child's parent, and the foster care facility that they have the right to be heard in person by the court and how to exercise that right;

(3) the agency must also inform the child, age 12 or older, the child's parent, and the foster care provider that an in-court hearing will be held if requested by the child, the parent, or the foster care provider; and

(4) if, at the time required for the report under this section, a child, age 12 or older, disagrees about the foster care facility or services provided under the out-of-home placement plan required under section 260C.212, subdivision 1, the agency shall include information regarding the child's disagreement, and to the extent possible, the basis for the child's disagreement in the report required under this section.

(e) After receiving the required report, the court has jurisdiction to make the following determinations and must do so within ten days of receiving the forwarded report, whether a hearing is requested:

(1) whether the voluntary foster care arrangement is in the child's best interests;

(2) whether the parent and agency are appropriately planning for the child; and

(3) in the case of a child age 12 or older, who disagrees with the foster care facility or services provided under the out-of-home placement plan, whether it is appropriate to appoint counsel and a guardian ad litem for the child using standards and procedures under section 260C.163.

(f) Unless requested by a parent, representative of the foster care facility, or the child, no in-court hearing is required in order for the court to make findings and issue an order as required in paragraph (e).

(g) If the court finds the voluntary foster care arrangement is in the child's best interests and that the agency and parent are appropriately planning for the child, the court shall issue an order containing explicit, individualized findings to support its determination. The individualized findings shall be based on the agency's written report and other materials submitted to the court. The court may make this determination notwithstanding the child's disagreement, if any, reported under paragraph (d).

(h) The court shall send a copy of the order to the county attorney, the agency, parent, child, age 12 or older, and the foster parent or foster care facility.

(i) The court shall also send the parent, the child, age 12 or older, the foster parent, or representative of the foster care facility notice of the permanency review hearing required under section 260D.07, paragraph (e).

(j) If the court finds continuing the voluntary foster care arrangement is not in the child's best interests or that the agency or the parent are not appropriately planning for the child, the court shall notify the agency, the parent, the foster parent or foster care facility, the child, age 12 or older, and the county attorney of the court's determinations and the basis for the court's determinations. In this case, the court shall set the matter for hearing and appoint a guardian ad litem for the child under section 260C.163, subdivision 5.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 30. Minnesota Statutes 2020, section 260D.07, is amended to read:

260D.07 REQUIRED PERMANENCY REVIEW HEARING.

(a) When the court has found that the voluntary arrangement is in the child's best interests and that the agency and parent are appropriately planning for the child pursuant to the report submitted under section 260D.06, and the child continues in voluntary foster care as defined in section 260D.02, subdivision 10, for 13 months from the date of the voluntary foster care agreement, or has been in placement for 15 of the last 22 months, the agency must:

(1) terminate the voluntary foster care agreement and return the child home; or

(2) determine whether there are compelling reasons to continue the voluntary foster care arrangement and, if the agency determines there are compelling reasons, seek judicial approval of its determination; or

(3) file a petition for the termination of parental rights.

(b) When the agency is asking for the court's approval of its determination that there are compelling reasons to continue the child in the voluntary foster care arrangement, the agency

shall file a "Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment" and ask the court to proceed under this section.

(c) The "Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment" shall be drafted or approved by the county attorney and be under oath. The petition shall include:

(1) the date of the voluntary placement agreement;

(2) whether the petition is due to the child's developmental disability or emotional disturbance;

(3) the plan for the ongoing care of the child and the parent's participation in the plan;

(4) a description of the parent's visitation and contact with the child;

(5) the date of the court finding that the foster care placement was in the best interests of the child, if required under section 260D.06, or the date the agency filed the motion under section 260D.09, paragraph (b);

(6) the agency's reasonable efforts to finalize the permanent plan for the child, including returning the child to the care of the child's family; ~~and~~

(7) a citation to this chapter as the basis for the petition~~.~~; and

(8) evidence as specified in section 260C.712 when a child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d.

(d) An updated copy of the out-of-home placement plan required under section 260C.212, subdivision 1, shall be filed with the petition.

(e) The court shall set the date for the permanency review hearing no later than 14 months after the child has been in placement or within 30 days of the petition filing date when the child has been in placement 15 of the last 22 months. The court shall serve the petition together with a notice of hearing by United States mail on the parent, the child age 12 or older, the child's guardian ad litem, if one has been appointed, the agency, the county attorney, and counsel for any party.

(f) The court shall conduct the permanency review hearing on the petition no later than 14 months after the date of the voluntary placement agreement, within 30 days of the filing of the petition when the child has been in placement 15 of the last 22 months, or within 15 days of a motion to terminate jurisdiction and to dismiss an order for foster care under chapter 260C, as provided in section 260D.09, paragraph (b).

(g) At the permanency review hearing, the court shall:

(1) inquire of the parent if the parent has reviewed the "Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment," whether the petition is accurate, and whether the parent agrees to the continued voluntary foster care arrangement as being in the child's best interests;

(2) inquire of the parent if the parent is satisfied with the agency's reasonable efforts to finalize the permanent plan for the child, including whether there are services available and accessible to the parent that might allow the child to safely be with the child's family;

(3) inquire of the parent if the parent consents to the court entering an order that:

(i) approves the responsible agency's reasonable efforts to finalize the permanent plan for the child, which includes ongoing future planning for the safety, health, and best interests of the child; and

(ii) approves the responsible agency's determination that there are compelling reasons why the continued voluntary foster care arrangement is in the child's best interests; and

(4) inquire of the child's guardian ad litem and any other party whether the guardian or the party agrees that:

(i) the court should approve the responsible agency's reasonable efforts to finalize the permanent plan for the child, which includes ongoing and future planning for the safety, health, and best interests of the child; and

(ii) the court should approve of the responsible agency's determination that there are compelling reasons why the continued voluntary foster care arrangement is in the child's best interests.

(h) At a permanency review hearing under this section, the court may take the following actions based on the contents of the sworn petition and the consent of the parent:

(1) approve the agency's compelling reasons that the voluntary foster care arrangement is in the best interests of the child; and

(2) find that the agency has made reasonable efforts to finalize the permanent plan for the child.

(i) A child, age 12 or older, may object to the agency's request that the court approve its compelling reasons for the continued voluntary arrangement and may be heard on the reasons for the objection. Notwithstanding the child's objection, the court may approve the agency's compelling reasons and the voluntary arrangement.

(j) If the court does not approve the voluntary arrangement after hearing from the child or the child's guardian ad litem, the court shall dismiss the petition. In this case, either:

(1) the child must be returned to the care of the parent; or

(2) the agency must file a petition under section 260C.141, asking for appropriate relief under sections 260C.301 or 260C.503 to 260C.521.

(k) When the court approves the agency's compelling reasons for the child to continue in voluntary foster care for treatment, and finds that the agency has made reasonable efforts to finalize a permanent plan for the child, the court shall approve the continued voluntary foster care arrangement, and continue the matter under the court's jurisdiction for the purposes of reviewing the child's placement every 12 months while the child is in foster care.

(l) A finding that the court approves the continued voluntary placement means the agency has continued legal authority to place the child while a voluntary placement agreement remains in effect. The parent or the agency may terminate a voluntary agreement as provided in section 260D.10. Termination of a voluntary foster care placement of an Indian child is governed by section 260.765, subdivision 4.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 31. Minnesota Statutes 2020, section 260D.08, is amended to read:

260D.08 ANNUAL REVIEW.

(a) After the court conducts a permanency review hearing under section 260D.07, the matter must be returned to the court for further review of the responsible social services reasonable efforts to finalize the permanent plan for the child and the child's foster care placement at least every 12 months while the child is in foster care. The court shall give notice to the parent and child, age 12 or older, and the foster parents of the continued review requirements under this section at the permanency review hearing.

(b) Every 12 months, the court shall determine whether the agency made reasonable efforts to finalize the permanency plan for the child, which means the exercise of due diligence by the agency to:

(1) ensure that the agreement for voluntary foster care is the most appropriate legal arrangement to meet the child's safety, health, and best interests and to conduct a genuine examination of whether there is another permanency disposition order under chapter 260C, including returning the child home, that would better serve the child's need for a stable and permanent home;

(2) engage and support the parent in continued involvement in planning and decision making for the needs of the child;

(3) strengthen the child's ties to the parent, relatives, and community;

(4) implement the out-of-home placement plan required under section 260C.212, subdivision 1, and ensure that the plan requires the provision of appropriate services to address the physical health, mental health, and educational needs of the child; ~~and~~

(5) submit evidence to the court as specified in section 260C.712 when a child is placed in a qualified residential treatment program setting as defined in section 260C.007, subdivision 26d; and

~~(5)~~ (6) ensure appropriate planning for the child's safe, permanent, and independent living arrangement after the child's 18th birthday.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 32. Minnesota Statutes 2020, section 260D.14, is amended to read:

260D.14 SUCCESSFUL TRANSITION TO ADULTHOOD FOR ~~CHILDREN~~ YOUTH IN VOLUNTARY PLACEMENT.

Subdivision 1. **Case planning.** When ~~the child~~ a youth is 14 years of age or older, the responsible social services agency shall ensure that a ~~child~~ youth in foster care under this chapter is provided with the case plan requirements in section 260C.212, subdivisions 1 and 14.

Subd. 2. **Notification.** The responsible social services agency shall provide a youth with written notice of ~~the right to continued access to services for certain children in foster care past 18 years of age under section 260C.452, subdivision 3~~ foster care benefits that a youth who is 18 years of age or older may continue to receive according to section 260C.451, subdivision 1, and of the right to appeal a denial of social services under section 256.045. The notice must be provided to the ~~child~~ youth six months before the ~~child's~~ youth's 18th birthday.

Subd. 3. **Administrative or court reviews.** When ~~the child~~ a youth is ~~17~~ 14 years of age or older, the administrative review or court hearing must include a review of the responsible social services agency's support for the ~~child's~~ youth's successful transition to adulthood as required in section 260C.452, subdivision 4.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 33. Minnesota Statutes 2020, section 260E.06, subdivision 1, is amended to read:

Subdivision 1. **Mandatory reporters.** (a) A person who knows or has reason to believe a child is being maltreated, as defined in section 260E.03, or has been maltreated within the preceding three years shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, tribal social services agency, or tribal police department if the person is:

(1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement; ~~or~~

(2) employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c)~~.~~; or

(3) an owner, administrator, or employee who is 18 years of age or older of a public or private youth recreation program or other organization that provides services or activities requiring face-to-face contact with and supervision of children.

(b) "Practice of social services" for the purposes of this subdivision includes but is not limited to employee assistance counseling and the provision of guardian ad litem and parenting time expeditor services.

Sec. 34. Minnesota Statutes 2020, section 260E.20, subdivision 2, is amended to read:

Subd. 2. **Face-to-face contact.** (a) Upon receipt of a screened in report, the local welfare agency shall conduct a face-to-face contact with the child reported to be maltreated and with the child's primary caregiver sufficient to complete a safety assessment and ensure the immediate safety of the child.

(b) ~~The~~ Face-to-face contact with the child and primary caregiver shall occur immediately if sexual abuse or substantial child endangerment is alleged and within five calendar days for all other reports. If the alleged offender was not already interviewed as the primary caregiver, the local welfare agency shall also conduct a face-to-face interview with the alleged offender in the early stages of the assessment or investigation. Face-to-face contact with the child and primary caregiver in response to a report alleging sexual abuse or substantial child endangerment may be postponed for no more than five calendar days if the child is residing in a location that is confirmed to restrict contact with the alleged offender

as established in guidelines issued by the commissioner, or if the local welfare agency is pursuing a court order for the child's caregiver to produce the child for questioning under section 260E.22, subdivision 5.

(c) At the initial contact with the alleged offender, the local welfare agency or the agency responsible for assessing or investigating the report must inform the alleged offender of the complaints or allegations made against the individual in a manner consistent with laws protecting the rights of the person who made the report. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation.

(d) The local welfare agency or the agency responsible for assessing or investigating the report must provide the alleged offender with an opportunity to make a statement. The alleged offender may submit supporting documentation relevant to the assessment or investigation.

Sec. 35. Minnesota Statutes 2020, section 260E.31, subdivision 1, is amended to read:

Subdivision 1. **Reports required.** (a) Except as provided in paragraph (b), a person mandated to report under this chapter shall immediately report to the local welfare agency if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy, including but not limited to tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive.

(b) A health care professional or a social service professional who is mandated to report under this chapter is exempt from reporting under paragraph (a) ~~a woman's use or consumption of tetrahydrocannabinol or alcoholic beverages during pregnancy~~ if the professional is providing or collaborating with other professionals to provide the woman with prenatal care, postpartum care, or other health care services, including care of the woman's infant. If the woman does not continue to receive regular prenatal or postpartum care, after the woman's health care professional has made attempts to contact the woman, then the professional is required to report under paragraph (a).

(c) Any person may make a voluntary report if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy, including but not limited to tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive.

(d) An oral report shall be made immediately by telephone or otherwise. An oral report made by a person required to report shall be followed within 72 hours, exclusive of weekends

and holidays, by a report in writing to the local welfare agency. Any report shall be of sufficient content to identify the pregnant woman, the nature and extent of the use, if known, and the name and address of the reporter. The local welfare agency shall accept a report made under paragraph (c) notwithstanding refusal by a voluntary reporter to provide the reporter's name or address as long as the report is otherwise sufficient.

(e) For purposes of this section, "prenatal care" means the comprehensive package of medical and psychological support provided throughout the pregnancy.

Sec. 36. Minnesota Statutes 2020, section 260E.33, is amended by adding a subdivision to read:

Subd. 6a. **Notification of contested case hearing.** When an appeal of a lead investigative agency determination results in a contested case hearing under chapter 245A or 245C, the administrative law judge shall notify the parent, legal custodian, or guardian of the child who is the subject of the maltreatment determination. The notice must be sent by certified mail and inform the parent, legal custodian, or guardian of the child of the right to file a signed written statement in the proceedings and the right to attend and participate in the hearing. The parent, legal custodian, or guardian of the child may file a written statement with the administrative law judge hearing the case no later than five business days before commencement of the hearing. The administrative law judge shall include the written statement in the hearing record and consider the statement in deciding the appeal. The lead investigative agency shall provide to the administrative law judge the address of the parent, legal custodian, or guardian of the child. If the lead investigative agency is not reasonably able to determine the address of the parent, legal custodian, or guardian of the child, the administrative law judge is not required to send a hearing notice under this subdivision.

Sec. 37. Minnesota Statutes 2020, section 260E.36, is amended by adding a subdivision to read:

Subd. 1b. **Sex trafficking and sexual exploitation training requirement.** As required by the Child Abuse Prevention and Treatment Act amendments through Public Law 114-22 and to implement Public Law 115-123, all child protection social workers and social services staff who have responsibility for child protective duties under this chapter or chapter 260C shall complete training implemented by the commissioner of human services regarding sex trafficking and sexual exploitation of children and youth.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 38. **DIRECTION TO THE COMMISSIONER; QUALIFIED RESIDENTIAL TREATMENT TRANSITION SUPPORTS.**

The commissioner of human services shall consult with stakeholders to develop policies regarding aftercare supports for the transition of a child from a qualified residential treatment program, as defined in Minnesota Statutes, section 260C.007, subdivision 26d, to reunification with the child's parent or legal guardian, including potential placement in a less restrictive setting prior to reunification that aligns with the child's permanency plan and person-centered support plan, when applicable. The policies must be consistent with Minnesota Rules, part 2960.0190, and Minnesota Statutes, section 245A.25, subdivision 4, paragraph (i), and address the coordination of the qualified residential treatment program discharge planning and aftercare supports where needed, the county social services case plan, and services from community-based providers, to maintain the child's progress with behavioral health goals in the child's treatment plan. The commissioner must complete development of the policy guidance by December 31, 2022.

Sec. 39. **REVISOR INSTRUCTION.**

The revisor of statutes shall place the following first grade headnote in Minnesota Statutes, chapter 260C, preceding Minnesota Statutes, sections 260C.70 to 260C.714: PLACEMENT OF CHILDREN IN QUALIFIED RESIDENTIAL TREATMENT.

ARTICLE 12
BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2020, section 245.462, subdivision 17, is amended to read:

Subd. 17. **Mental health practitioner.** (a) "Mental health practitioner" means a person providing services to adults with mental illness or children with emotional disturbance who is qualified in at least one of the ways described in paragraphs (b) to (g). A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults.

(b) For purposes of this subdivision, a practitioner is qualified through relevant coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:

(1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:

(i) mental illness, substance use disorder, or emotional disturbance; or

(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects;

(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to adults with mental illness or children with emotional disturbance, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;

(3) is working in a day treatment program under section 245.4712, subdivision 2; ~~or~~

(4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields~~.~~; or

(5) is in the process of completing a practicum or internship as part of a formal undergraduate or graduate training program in social work, psychology, or counseling.

(c) For purposes of this subdivision, a practitioner is qualified through work experience if the person:

(1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with:

(i) mental illness, substance use disorder, or emotional disturbance; or

(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; or

(2) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:

(i) mental illness, emotional disturbance, or substance use disorder, and receives clinical supervision as required by applicable statutes and rules from a mental health professional at least once a week until the requirement of 4,000 hours of supervised experience is met; or

(ii) traumatic brain injury or developmental disabilities; completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; and receives clinical supervision as required by applicable statutes and rules at least once a week

from a mental health professional until the requirement of 4,000 hours of supervised experience is met.

(d) For purposes of this subdivision, a practitioner is qualified through a graduate student internship if the practitioner is a graduate student in behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training.

(e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's degree if the practitioner:

(1) holds a master's or other graduate degree in behavioral sciences or related fields; or

(2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.

(f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical care if the practitioner meets the definition of vendor of medical care in section 256B.02, subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.

(g) For purposes of medical assistance coverage of diagnostic assessments, explanations of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health practitioner working as a clinical trainee means that the practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of direct practice, treatment team collaboration, continued professional learning, and job management. The practitioner must also:

(1) comply with requirements for licensure or board certification as a mental health professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or

(2) be a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.

(h) For purposes of this subdivision, "behavioral sciences or related fields" has the meaning given in section 256B.0623, subdivision 5, paragraph (d).

(i) Notwithstanding the licensing requirements established by a health-related licensing board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other statute or rule.

Sec. 2. Minnesota Statutes 2020, section 245.4876, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** All providers of outpatient services, day treatment services, professional home-based family treatment, residential treatment, and acute care hospital inpatient treatment, and all regional treatment centers that provide mental health services for children must develop an individual treatment plan for each child client. The individual treatment plan must be based on a diagnostic assessment. To the extent appropriate, the child and the child's family shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment, professional home-based family treatment, and acute care hospital inpatient treatment, and regional treatment centers must develop the individual treatment plan within ten working days of client intake or admission and must review the individual treatment plan every 90 days after intake~~, except that the administrative review of the treatment plan of a child placed in a residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9~~. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Providers of outpatient and day treatment services must review the individual treatment plan every 90 days after intake.

Sec. 3. Minnesota Statutes 2020, section 245.4882, subdivision 1, is amended to read:

Subdivision 1. **Availability of residential treatment services.** County boards must provide or contract for enough residential treatment services to meet the needs of each child with severe emotional disturbance residing in the county and needing this level of care. Length of stay is based on the child's residential treatment need and shall be ~~subject to the six-month review process established in section 260C.203, and for children in voluntary placement for treatment, the court review process in section 260D.06~~ reviewed every 90 days. Services must be appropriate to the child's age and treatment needs and must be made available as close to the county as possible. Residential treatment must be designed to:

(1) help the child improve family living and social interaction skills;

(2) help the child gain the necessary skills to return to the community;

(3) stabilize crisis admissions; and

(4) work with families throughout the placement to improve the ability of the families to care for children with severe emotional disturbance in the home.

Sec. 4. Minnesota Statutes 2020, section 245.4882, subdivision 3, is amended to read:

Subd. 3. **Transition to community.** Residential treatment facilities and regional treatment centers serving children must plan for and assist those children and their families in making a transition to less restrictive community-based services. Discharge planning for the child to return to the community must include identification of and referrals to appropriate home and community supports that meet the needs of the child and family. Discharge planning must begin within 30 days after the child enters residential treatment and be updated every 60 days. Residential treatment facilities must also arrange for appropriate follow-up care in the community. Before a child is discharged, the residential treatment facility or regional treatment center shall provide notification to the child's case manager, if any, so that the case manager can monitor and coordinate the transition and make timely arrangements for the child's appropriate follow-up care in the community.

Sec. 5. Minnesota Statutes 2020, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the case of an emergency, all children referred for treatment of severe emotional disturbance in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center shall undergo an assessment to determine the appropriate level of care if ~~public~~ county funds are used to pay for the child's services.

(b) The ~~responsible social services agency~~ county board shall determine the appropriate level of care for a child when county-controlled funds are used to pay for the child's ~~services or placement in a qualified residential treatment facility under chapter 260C and licensed by the commissioner under chapter 245A. In accordance with section 260C.157, a juvenile treatment screening team shall conduct a screening before the team may recommend whether to place a child~~ residential treatment under this chapter, including residential treatment provided in a qualified residential treatment program as defined in section 260C.007, subdivision 26d. When a ~~social services agency~~ county board does not have responsibility for a child's placement and the child is enrolled in a prepaid health program under section

256B.69, the enrolled child's contracted health plan must determine the appropriate level of care for the child. When Indian Health Services funds or funds of a tribally owned facility funded under the Indian Self-Determination and Education Assistance Act, Public Law 93-638, are ~~to be~~ used for the child, the Indian Health Services or 638 tribal health facility must determine the appropriate level of care for the child. When more than one entity bears responsibility for a child's coverage, the entities shall coordinate level of care determination activities for the child to the extent possible.

(c) The ~~responsible social services agency must make the level of care determination available to the juvenile treatment screening team, as permitted under chapter 13. The level of care determination shall inform the juvenile treatment screening team process and the assessment in section 260C.704 when considering whether to place the child in a qualified residential treatment program. When the responsible social services agency is not involved in determining a child's placement, the~~ child's level of care determination shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's ~~need~~ needs.

(d) When a level of care determination is conducted, the ~~responsible social services agency~~ county board or other entity may not determine that a screening ~~under section 260C.157 or~~, referral, or admission to a ~~treatment foster care setting or~~ residential treatment facility is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. The level of care determination must be based on a diagnostic assessment of a child that ~~includes a functional assessment which~~ evaluates family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care to the child. The validated tool must be approved by the commissioner of human services. If a diagnostic assessment ~~including a functional assessment~~ has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed

and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether or not these services are available and accessible to the child and the child's family. The child and the child's family must be invited to any meeting where the level of care determination is discussed and decisions regarding residential treatment are made. The child and the child's family may invite other relatives, friends, or advocates to attend these meetings.

(e) During the level of care determination process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

~~(f) When the responsible social services agency has authority, the agency must engage the child's parents in case planning under sections 260C.212 and 260C.708 unless a court terminates the parent's rights or court orders restrict the parent from participating in case planning, visitation, or parental responsibilities.~~

~~(g)~~ (f) The level of care determination, and placement decision, and recommendations for mental health services must be documented in the child's record~~, as required in chapter 260C~~ and made available to the child's family, as appropriate.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 6. Minnesota Statutes 2020, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with emotional disturbances or severe emotional disturbances who are at risk of out-of-home placement. A child is not required to have case management services to receive respite care services;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color, providing services in clinics that serve clients enrolled in medical assistance;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services under section 245.4901;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(16) psychiatric consultation for primary care practitioners; ~~and~~

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants~~.~~; and

(18) mental health services based on traditional, spiritual, and holistic healing practices, provided by cultural healers from African American, American Indian, Asian American, Latinx, Pacific Islander, and Pan-African communities.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

Sec. 7. **[245.4902] CULTURALLY INFORMED AND CULTURALLY RESPONSIVE MENTAL HEALTH TASK FORCE.**

Subdivision 1. **Establishment; duties.** The Culturally Informed and Culturally Responsive Mental Health Task Force is established to evaluate and make recommendations on improving the provision of culturally informed and culturally responsive mental health services throughout Minnesota. The task force must make recommendations on:

(1) recruiting mental health providers from diverse racial and ethnic communities;

(2) training all mental health providers on cultural competency and cultural humility;

(3) assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services; and

(4) increasing the number of mental health organizations owned, managed, or led by individuals who are Black, indigenous, or people of color.

Subd. 2. **Membership.** (a) The task force must consist of the following 16 members:

(1) the commissioner of human services or the commissioner's designee;

(2) one representative from the Board of Psychology;

(3) one representative from the Board of Marriage and Family Therapy;

(4) one representative from the Board of Behavioral Health and Therapy;

(5) one representative from the Board of Social Work;

(6) three members representing undergraduate and graduate-level mental health professional education programs, appointed by the governor;

(7) three mental health providers who are members of communities of color or underrepresented communities, as defined in section 148E.010, subdivision 20, appointed by the governor;

(8) two members representing mental health advocacy organizations, appointed by the governor;

(9) two mental health providers, appointed by the governor; and

(10) one expert in providing training and education in cultural competency and cultural responsiveness, appointed by the governor.

(b) Appointments to the task force must be made no later than June 1, 2022.

(c) Member compensation and reimbursement for expenses are governed by section 15.059, subdivision 3.

Subd. 3. **Chairs; meetings.** The members of the task force must elect two cochairs of the task force no earlier than July 1, 2022, and the cochairs must convene the first meeting of the task force no later than August 15, 2022. The task force must meet upon the call of the cochairs, sufficiently often to accomplish the duties identified in this section. The task force is subject to the open meeting law under chapter 13D.

Subd. 4. **Administrative support.** The Department of Human Services must provide administrative support and meeting space for the task force.

Subd. 5. **Reports.** No later than January 1, 2023, and by January 1 of each year thereafter, the task force must submit a written report to the members of the legislative committees with jurisdiction over health and human services on the recommendations developed under subdivision 1.

Subd. 6. **Expiration.** The task force expires on January 1, 2025.

Sec. 8. Minnesota Statutes 2020, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification process for certified community behavioral health clinics (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this section to be eligible for reimbursement under medical assistance, without service area limits based on geographic area or region. The commissioner shall consult with CCBHC stakeholders before establishing and implementing changes in the certification process and requirements. Entities that choose to be CCBHCs must:

~~(1) comply with the CCBHC criteria published by the United States Department of Health and Human Services;~~

(1) comply with state licensing requirements and other requirements issued by the commissioner;

(2) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors, and staff who are culturally and linguistically trained to meet the needs of the population the clinic serves;

(3) ensure that clinic services are available and accessible to individuals and families of all ages and genders and that crisis management services are available 24 hours per day;

(4) establish fees for clinic services for individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to an individual's inability to pay for services;

(5) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

(6) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services through existing mobile crisis services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans~~;~~. CCBHCs must directly provide the majority of these services to enrollees, but may coordinate some services with another entity through a collaboration or agreement, pursuant to paragraph (b);

(7) provide coordination of care across settings and providers to ensure seamless transitions for individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be certified as mental health clinics under section 245.69, subdivision 2;

(9) comply with standards established by the commissioner relating to ~~mental health services in Minnesota Rules, parts 9505.0370 to 9505.0372~~ CCBHC screenings, assessments, and evaluations;

(10) be licensed to provide substance use disorder treatment under chapter 245G;

(11) be certified to provide children's therapeutic services and supports under section 256B.0943;

(12) be certified to provide adult rehabilitative mental health services under section 256B.0623;

(13) be enrolled to provide mental health crisis response services under sections 256B.0624 and 256B.0944;

(14) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

(15) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926;

(16) provide services that comply with the evidence-based practices described in paragraph (e); and

(17) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer services are provided.

(b) If ~~an entity~~ a certified CCBHC is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the ~~commissioner may certify the entity as a~~ CCBHC~~,~~ ~~if the entity has a current~~ may contract with another entity that has the required authority to provide that service and that meets ~~federal CCBHC~~ the following criteria as a designated collaborating organization~~, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.~~:

(1) the entity has a formal agreement with the CCBHC to furnish one or more of the services under paragraph (a), clause (6);

(2) the entity provides assurances that it will provide services according to CCBHC service standards and provider requirements;

(3) the entity agrees that the CCBHC is responsible for coordinating care and has clinical and financial responsibility for the services that the entity provides under the agreement; and

(4) the entity meets any additional requirements issued by the commissioner.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under section 256B.0625, subdivision 5m, for those services without a county contract or county approval. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

(f) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

Sec. 9. Minnesota Statutes 2020, section 245.735, subdivision 5, is amended to read:

Subd. 5. **Information systems support.** The commissioner and the state chief information officer shall provide information systems support to the projects as necessary to comply with state and federal requirements.

Sec. 10. Minnesota Statutes 2020, section 245.735, is amended by adding a subdivision to read:

Subd. 6. **Demonstration entities.** The commissioner may operate the demonstration program established by section 223 of the Protecting Access to Medicare Act if federal funding for the demonstration program remains available from the United States Department of Health and Human Services. To the extent practicable, the commissioner shall align the requirements of the demonstration program with the requirements under this section for CCBHCs receiving medical assistance reimbursement. A CCBHC may not apply to participate as a billing provider in both the CCBHC federal demonstration and the benefit for CCBHCs under the medical assistance program.

Sec. 11. Minnesota Statutes 2020, section 254B.01, subdivision 4a, is amended to read:

Subd. 4a. **Culturally specific or culturally responsive program.** (a) "Culturally specific or culturally responsive program" means a substance use disorder treatment service program or subprogram that is ~~recovery-focused and~~ culturally responsive or culturally specific when the program attests that it:

(1) improves service quality to and outcomes of a specific ~~population~~ community that shares a common language, racial, ethnic, or social background by advancing health equity to help eliminate health disparities; ~~and~~

(2) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to an individual within a specific ~~population's~~ community's values, beliefs and practices, health literacy, preferred language, and other communication needs~~.~~; and

(3) is compliant with the national standards for culturally and linguistically appropriate services or other equivalent standards, as determined by the commissioner.

(b) A tribally licensed substance use disorder program that is designated as serving a culturally specific population by the applicable tribal government is deemed to satisfy this subdivision.

(c) A program satisfies the requirements of this subdivision if it attests that the program:

(1) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(2) is governed with significant input from individuals of that specific background; and

(3) employs individuals to provide treatment services, at least 50 percent of whom are members of the specific community being served.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 12. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 4b. **Disability responsive program.** "Disability responsive program" means a program that:

(1) is designed to serve individuals with disabilities, including individuals with traumatic brain injuries, developmental disabilities, cognitive disabilities, and physical disabilities; and

(2) employs individuals to provide treatment services who have the necessary professional training, as approved by the commissioner, to serve individuals with the specific disabilities that the program is designed to serve.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 13. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

(3) care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) medication-assisted therapy services that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(9) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(12) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502~~;~~

(2) culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a~~,~~; or

(3) disability responsive programs as defined in section 254B.01, subdivision 4b.

~~programs or subprograms serving special populations, if the program or subprogram meets the following requirements:~~

~~(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;~~

~~(ii) is governed with significant input from individuals of that specific background; and~~

~~(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve;~~

~~(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and~~

~~(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:~~

~~(i) the program meets the co-occurring requirements in section 245G.20;~~

~~(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff~~

~~may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;~~

~~(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;~~

~~(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;~~

~~(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and~~

~~(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.~~

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

~~(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (e), clause (4), items (i) to (iv).~~

~~(f)~~ (e) Subject to federal approval, ~~chemical dependency~~ substance use disorder services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video according to section 256B.0625, subdivision 3b. ~~The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.~~

~~(g)~~ (f) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

(g) Payment for outpatient substance use disorder services that are licensed according to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless prior authorization of a greater number of hours is obtained from the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later, except paragraph (e) is effective July 1, 2021.

Sec. 14. Minnesota Statutes 2020, section 254B.12, is amended by adding a subdivision to read:

Subd. 4. **Culturally specific or culturally responsive program and disability responsive program provider rate increase.** For the chemical dependency services listed in section 254B.05, subdivision 5, provided by programs that meet the requirements of section 254B.05, subdivision 5, paragraph (c), clauses (1), (2), and (3), on or after January 1, 2022, payment rates shall increase by five percent over the rates in effect on January 1, 2021. The commissioner shall increase prepaid medical assistance capitation rates as appropriate to reflect this increase.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later.

Sec. 15. **[254B.151] SUBSTANCE USE DISORDER COMMUNITY OF PRACTICE.**

Subdivision 1. **Establishment; purpose.** The commissioner of human services, in consultation with substance use disorder subject matter experts, shall establish a substance use disorder community of practice. The purposes of the community of practice are to improve treatment outcomes for individuals with substance use disorders and reduce disparities by using evidence-based and best practices through peer-to-peer and person-to-provider sharing.

Subd. 2. **Participants; meetings.** (a) The community of practice must include the following participants:

(1) researchers or members of the academic community who are substance use disorder subject matter experts, who do not have financial relationships with treatment providers;

(2) substance use disorder treatment providers;

(3) representatives from recovery community organizations;

(4) a representative from the Department of Human Services;

(5) a representative from the Department of Health;

(6) a representative from the Department of Corrections;

(7) representatives from county social services agencies;

(8) representatives from tribal nations or tribal social services providers; and

(9) representatives from managed care organizations.

(b) The community of practice must include individuals who have used substance use disorder treatment services and must highlight the voices and experiences of individuals who are Black, indigenous, people of color, and people from other communities that are disproportionately impacted by substance use disorders.

(c) The community of practice must meet regularly and must hold its first meeting before January 1, 2022.

(d) Compensation and reimbursement for expenses for participants in paragraph (b) are governed by section 15.059, subdivision 3.

Subd. 3. **Duties.** (a) The community of practice must:

(1) identify gaps in substance use disorder treatment services;

(2) enhance collective knowledge of issues related to substance use disorder;

(3) understand evidence-based practices, best practices, and promising approaches to address substance use disorder;

(4) use knowledge gathered through the community of practice to develop strategic plans to improve outcomes for individuals who participate in substance use disorder treatment and related services in Minnesota;

(5) increase knowledge about the challenges and opportunities learned by implementing strategies; and

(6) develop capacity for community advocacy.

(b) The commissioner, in collaboration with subject matter experts and other participants, may issue reports and recommendations to the legislative chairs and ranking minority members of committees with jurisdiction over health and human services policy and finance and local and regional governments.

Sec. 16. Minnesota Statutes 2020, section 256.042, subdivision 2, is amended to read:

Subd. 2. **Membership.** (a) The council shall consist of the following ~~19~~ 28 voting members, appointed by the commissioner of human services except as otherwise specified, and three nonvoting members:

(1) two members of the house of representatives, appointed in the following sequence: the first from the majority party appointed by the speaker of the house and the second from the minority party appointed by the minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area, and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(2) two members of the senate, appointed in the following sequence: the first from the majority party appointed by the senate majority leader and the second from the minority party appointed by the senate minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(3) one member appointed by the Board of Pharmacy;

(4) one member who is a physician appointed by the Minnesota Medical Association;

(5) one member representing opioid treatment programs, sober living programs, or substance use disorder programs licensed under chapter 245G;

(6) one member appointed by the Minnesota Society of Addiction Medicine who is an addiction psychiatrist;

(7) one member representing professionals providing alternative pain management therapies, including, but not limited to, acupuncture, chiropractic, or massage therapy;

(8) one member representing nonprofit organizations conducting initiatives to address the opioid epidemic, with the commissioner's initial appointment being a member representing the Steve Rummler Hope Network, and subsequent appointments representing this or other organizations;

(9) one member appointed by the Minnesota Ambulance Association who is serving with an ambulance service as an emergency medical technician, advanced emergency medical technician, or paramedic;

(10) one member representing the Minnesota courts who is a judge or law enforcement officer;

(11) one public member who is a Minnesota resident and who is in opioid addiction recovery;

(12) ~~two~~ 11 members representing Indian tribes, one representing ~~the Ojibwe tribes and one representing the Dakota tribes~~ each of Minnesota's tribal nations;

(13) one public member who is a Minnesota resident and who is suffering from chronic pain, intractable pain, or a rare disease or condition;

(14) one mental health advocate representing persons with mental illness;

(15) one member appointed by the Minnesota Hospital Association;

(16) one member representing a local health department; and

(17) the commissioners of human services, health, and corrections, or their designees, who shall be ex officio nonvoting members of the council.

(b) The commissioner of human services shall coordinate the commissioner's appointments to provide geographic, racial, and gender diversity, and shall ensure that at least one-half of council members appointed by the commissioner reside outside of the seven-county metropolitan area. Of the members appointed by the commissioner, to the extent practicable, at least one member must represent a community of color disproportionately affected by the opioid epidemic.

(c) The council is governed by section 15.059, except that members of the council shall serve three-year terms and shall receive no compensation other than reimbursement for expenses. Notwithstanding section 15.059, subdivision 6, the council shall not expire.

(d) The chair shall convene the council at least quarterly, and may convene other meetings as necessary. The chair shall convene meetings at different locations in the state to provide geographic access, and shall ensure that at least one-half of the meetings are held at locations outside of the seven-county metropolitan area.

(e) The commissioner of human services shall provide staff and administrative services for the advisory council.

(f) The council is subject to chapter 13D.

Sec. 17. Minnesota Statutes 2020, section 256.042, subdivision 4, is amended to read:

Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the grants proposed by the advisory council to be awarded for the upcoming ~~fiscal~~ calendar year to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by ~~March~~ December 1 of each year, beginning March 1, 2020.

(b) The commissioner of human services shall award grants from the opiate epidemic response fund under section 256.043. The grants shall be awarded to proposals selected by the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1) to (4), unless otherwise appropriated by the legislature. No more than ~~three~~ ten percent of the grant amount may be used by a grantee for administration.

Sec. 18. Minnesota Statutes 2020, section 256.043, subdivision 3, is amended to read:

Subd. 3. **Appropriations from fund.** (a) After the appropriations in Laws 2019, chapter 63, article 3, section 1, paragraphs (e), (f), (g), and (h) are made, $249,000 is appropriated to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph (e).

(b) $126,000 is appropriated to the Board of Pharmacy for the collection of the registration fees under section 151.066.

(c) $672,000 is appropriated to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

(d) After the appropriations in paragraphs (a) to (c) are made, 50 percent of the remaining amount is appropriated to the commissioner of human services for distribution to county social service and tribal social service agencies to provide child protection services to children and families who are affected by addiction. The commissioner shall distribute this money proportionally to counties and tribal social service agencies based on out-of-home placement episodes where parental drug abuse is the primary reason for the out-of-home placement using data from the previous calendar year. County and tribal social service agencies receiving funds from the opiate epidemic response fund must annually report to the commissioner on how the funds were used to provide child protection services, including measurable outcomes, as determined by the commissioner. County social service agencies and tribal social service agencies must not use funds received under this paragraph to supplant

current state or local funding received for child protection services for children and families who are affected by addiction.

(e) After making the appropriations in paragraphs (a) to (d), the remaining amount in the fund is appropriated to the commissioner to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise appropriated by the legislature.

(f) Beginning in fiscal year 2022 and each year thereafter, funds for county social service and tribal social service agencies under paragraph (d) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph (e) shall be distributed on a calendar year basis.

Sec. 19. Minnesota Statutes 2020, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers certified community behavioral health clinic (CCBHC) services that meet the requirements of section 245.735, subdivision 3.

(b) The commissioner shall ~~establish standards and methodologies for a~~ reimburse CCBHCs on a per-visit basis under the prospective payment system for medical assistance payments ~~for services delivered by a CCBHC, in accordance with guidance issued by the Centers for Medicare and Medicaid Services~~ as described in paragraph (c). The commissioner shall include a quality ~~bonus~~ incentive payment in the prospective payment system ~~based on federal criteria~~, as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC prospective payment system.

(c) ~~Unless otherwise indicated in applicable federal requirements, the prospective payment system must continue to be based on the federal instructions issued for the federal section 223 CCBHC demonstration, except:~~ The commissioner shall ensure that the prospective payment system for CCBHC payments under medical assistance meets the following requirements:

(1) the prospective payment rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable costs for CCBHCs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under

section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment shall be limited to one payment per day per medical assistance enrollee for each CCBHC visit eligible for reimbursement. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) new payment rates set by the commissioner for newly certified CCBHCs under section 245.735, subdivision 3, shall be based on rates for established CCBHCs with a similar scope of services. If no comparable CCBHC exists, the commissioner shall establish a clinic-specific rate using audited historical cost report data adjusted for the estimated cost of delivering CCBHC services, including the estimated cost of providing the full scope of services and the projected change in visits resulting from the change in scope;

~~(1)~~ (4) the commissioner shall rebase CCBHC rates ~~at least~~ once every three years and 12 months following an initial rate or a rate change due to a change in the scope of services, whichever is earlier;

~~(2)~~ (5) the commissioner shall provide for a 60-day appeals process after notice of the results of the rebasing;

~~(3) the prohibition against inclusion of new facilities in the demonstration does not apply after the demonstration ends;~~

~~(4)~~ (6) the prospective payment rate under this section does not apply to services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. An entity that receives a prospective payment system rate that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

~~(5)~~ (7) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the prospective payment system in the Medicaid Management Information System (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

~~(6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner~~

~~shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for changes in the scope of services;~~

~~(7)~~ (8) the prospective payment rate for each CCBHC shall be ~~adjusted annually~~ updated by trending each provider-specific rate by the Medicare Economic Index ~~as defined for the federal section 223 CCBHC demonstration~~ for primary care services. This update shall occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Rate adjustments for changes in scope shall occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

~~(8) the commissioner shall seek federal approval for a CCBHC rate methodology that allows for rate modifications based on changes in scope for an individual CCBHC, including for changes to the type, intensity, or duration of services. Upon federal approval, a CCBHC may submit a change of scope request to the commissioner if the change in scope would result in a change of 2.5 percent or more in the prospective payment system rate currently received by the CCBHC. CCBHC change of scope requests must be according to a format and timeline to be determined by the commissioner in consultation with CCBHCs.~~

(d) Managed care plans and county-based purchasing plans shall reimburse CCBHC providers at the prospective payment rate. The commissioner shall monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

(e) The commissioner shall implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments for which the CCBHC is eligible under the prospective payment system described in paragraph (c);

(2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC shall receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner shall notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section shall be submitted directly to, and paid by, the commissioner on the dates specified no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42, section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by managed care plans.

If the conditions in this paragraph are met between January 1 and June 30 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on January 1 of the following year. If the conditions in this paragraph are met between July 1 and December 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on July 1 of the following year.

Sec. 20. Minnesota Statutes 2020, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious

and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative or a contact by interactive video that meets the requirements of subdivision 20b; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 20b with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county ~~or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe~~ must be calculated in accordance with section 256B.076, subdivision 2. Payment for mental health case management provided by vendors who contract with a Tribe must be based on a monthly rate negotiated by the Tribe. The ~~negotiated~~ rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the ~~county or tribe may negotiate a team rate with a vendor~~

~~who is a member of the team. The~~ team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include the federal earnings, the state share, and the county share.

(m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

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

(1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or

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

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

(p) If the recipient is receiving care in a hospital, nursing facility, or residential setting licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week, mental health targeted case management services must actively support identification of community alternatives for the recipient and discharge planning.

Sec. 21. Minnesota Statutes 2020, section 256B.0759, subdivision 2, is amended to read:

Subd. 2. **Provider participation.** (a) Outpatient substance use disorder treatment providers may elect to participate in the demonstration project and meet the requirements of subdivision 3. To participate, a provider must notify the commissioner of the provider's intent to participate in a format required by the commissioner and enroll as a demonstration project provider.

(b) A program licensed by the Department of Human Services as a residential treatment program according to section 245G.21 and that receives payment under this chapter must enroll as a demonstration project provider and meet the requirements of subdivision 3 by January 1, 2022. The commissioner may grant an extension, for a period not to exceed six months, to a program that is unable to meet the requirements of subdivision 3 due to demonstrated extraordinary circumstances. A program seeking an extension must apply in a format approved by the commissioner by November 1, 2021. A program that does not

meet the requirements under this paragraph by July 1, 2023, is ineligible for payment for services provided under sections 254B.05 and 256B.0625.

(c) A program licensed by the Department of Human Services as a withdrawal management program according to chapter 245F and that receives payment under this chapter must enroll as a demonstration project provider and meet the requirements of subdivision 3 by January 1, 2022. The commissioner may grant an extension, for a period not to exceed six months, to a program that is unable to meet the requirements of subdivision 3 due to demonstrated extraordinary circumstances. A program seeking an extension must apply in a format approved by the commissioner by November 1, 2021. A program that does not meet the requirements under this paragraph by July 1, 2023, is ineligible for payment for services provided under sections 254B.05 and 256B.0625.

(d) An out-of-state residential substance use disorder treatment program that receives payment under this chapter must enroll as a demonstration project provider and meet the requirements of subdivision 3 by January 1, 2022. The commissioner may grant an extension, for a period not to exceed six months, to a program that is unable to meet the requirements of subdivision 3 due to demonstrated extraordinary circumstances. A program seeking an extension must apply in a format approved by the commissioner by November 1, 2021. Programs that do not meet the requirements under this paragraph by July 1, 2023, are ineligible for payment for services provided under sections 254B.05 and 256B.0625.

(e) Tribally licensed programs may elect to participate in the demonstration project and meet the requirements of subdivision 3. The Department of Human Services must consult with tribal nations to discuss participation in the substance use disorder demonstration project.

(f) All rate enhancements for services rendered by demonstration project providers that voluntarily enrolled before July 1, 2021, are applicable only to dates of service on or after the effective date of the provider's enrollment in the demonstration project, except as authorized under paragraph (g). The commissioner shall recoup any rate enhancements paid under paragraph (g) to a provider that does not meet the requirements of subdivision 3 by July 1, 2021.

(g) The commissioner may allow providers enrolled in the demonstration project before July 1, 2021, to receive applicable rate enhancements authorized under subdivision 4 for services provided to fee-for-service enrollees on dates of service no earlier than July 22, 2020, and to managed care enrollees on dates of service no earlier than January 1, 2021, if:

(1) the provider attests that during the time period for which it is seeking the rate enhancement, it was taking meaningful steps and had a reasonable plan approved by the commissioner to meet the demonstration project requirements in subdivision 3;

(2) the provider submits the attestation and evidence of meeting the requirements of subdivision 3, including all information requested by the commissioner, in a format specified by the commissioner; and

(3) the commissioner received the provider's application for enrollment on or before June 1, 2021.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later, except paragraphs (f) and (g) are effective the day following final enactment.

Sec. 22. Minnesota Statutes 2020, section 256B.0759, subdivision 4, is amended to read:

Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must be increased for services provided to medical assistance enrollees. To receive a rate increase, participating providers must meet demonstration project requirements, provider standards under subdivision 3, and provide evidence of formal referral arrangements with providers delivering step-up or step-down levels of care.

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

~~(b)~~ (c) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clause (8), provided on or after July 1, 2020, payment rates must be increased by ~~15~~ 30 percent over the rates in effect on December 31, 2019.

~~(c)~~ (d) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clauses (1), (6), and (7), and adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on or after January 1, 2021, payment rates must be increased by ~~ten~~ 25 percent over the rates in effect on December 31, 2020.

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

rate payment for the substance use disorder services described in paragraphs ~~(b)~~ (c) and ~~(c)~~ (d). The commissioner must monitor the effect of this requirement on the rate of access to substance use disorder services and residential substance use disorder rates. Capitation rates paid to managed care organizations and county-based purchasing plans must reflect the impact of this requirement. This paragraph expires if federal approval is not received at any time as required under this paragraph.

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

EFFECTIVE DATE. This section is effective July 1, 2021, except the amendments to the payment rate percentage increases in paragraphs (c) and (d) are effective January 1, 2022.

Sec. 23. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision to read:

Subd. 6. **Data and outcome measures; public posting.** Beginning July 1, 2021, and at least annually thereafter, all data and outcome measures from the previous year of the demonstration project shall be posted publicly on the Department of Human Services website in an accessible and user-friendly format.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 24. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision to read:

Subd. 7. **Federal approval; demonstration project extension.** The commissioner shall seek a five-year extension of the demonstration project under this section and to receive enhanced federal financial participation.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 25. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision to read:

Subd. 8. **Demonstration project evaluation work group.** Beginning October 1, 2021, the commissioner shall assemble a work group of relevant stakeholders, including but not limited to demonstration project participants and the Minnesota Association of Resources for Recovery and Chemical Health, that shall meet quarterly for the duration of the demonstration to evaluate the long-term sustainability of any improvements to quality or access to substance use disorder treatment services caused by participation in the demonstration project. The work group shall also determine how to implement successful outcomes of the demonstration project once the project expires.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 26. **[256B.076] CASE MANAGEMENT SERVICES.**

Subdivision 1. **Generally.** (a) It is the policy of this state to ensure that individuals on medical assistance receive cost-effective and coordinated care, including efforts to address the profound effects of housing instability, food insecurity, and other social determinants of health. Therefore, subject to federal approval, medical assistance covers targeted case management services as described in this section.

(b) The commissioner, in collaboration with tribes, counties, providers, and individuals served, must propose further modifications to targeted case management services to ensure a program that complies with all federal requirements, delivers services in a cost-effective and efficient manner, creates uniform expectations for targeted case management services, addresses health disparities, and promotes person- and family-centered services.

Subd. 2. **Rate setting.** (a) The commissioner must develop and implement a statewide rate methodology for any county that subcontracts targeted case management services to a vendor. On January 1, 2022, or upon federal approval, whichever is later, a county must use this methodology for any targeted case management services paid by medical assistance and delivered through a subcontractor.

(b) In setting this rate, the commissioner must include the following:

(1) prevailing wages;

(2) employee-related expense factor;

(3) paid time off and training factors;

(4) supervision and span of control;

(5) distribution of time factor;

(6) administrative factor;

(7) absence factor;

(8) program support factor; and

(9) caseload sizes as described in subdivision 3.

(c) A county may request that the commissioner authorize a rate based on a lower caseload size when a subcontractor is assigned to serve individuals with needs, such as homelessness or specific linguistic or cultural needs, that significantly exceed other eligible populations. A county must include the following in the request:

(1) the number of clients to be served by a full-time equivalent staffer;

(2) the specific factors that require a case manager to provide significantly more hours of reimbursable services to a client; and

(3) how the county intends to monitor case size and outcomes.

(d) The commissioner must adjust only the factor for caseload in paragraph (b), clause (9), in response to a request under paragraph (c).

Subd. 3. **Caseload sizes.** A county-subcontracted provider of targeted case management services to the following populations must not exceed the following limits:

(1) for children with severe emotional disturbance, 15 clients to one full-time equivalent case manager;

(2) for adults with severe and persistent mental illness, 30 clients to one full-time equivalent case manager;

(3) for child welfare targeted case management, 25 clients to one full-time equivalent case manager; and

(4) for vulnerable adults and adults who have developmental disabilities, 45 clients to one full-time equivalent case manager.

Sec. 27. Minnesota Statutes 2020, section 256B.0924, subdivision 6, is amended to read:

Subd. 6. **Payment for targeted case management.** (a) Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis. In order to receive payment for an eligible adult, the provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact

with the adult or the adult's legal representative, family, primary caregiver, or other relevant persons identified as necessary to the development or implementation of the goals of the personal service plan.

(b) Payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of December 31, 2001. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

(c) Payment for targeted case management provided by county-contracted vendors shall be based on a monthly rate ~~negotiated by the host county~~ calculated in accordance with section 256B.076, subdivision 2. The ~~negotiated~~ rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the ~~county may negotiate a team rate with a vendor who is a member of the team. The~~ team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

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

(e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for targeted case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

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

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

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

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

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

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

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

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

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

Sec. 28. Minnesota Statutes 2020, section 256B.094, subdivision 6, is amended to read:

Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical assistance reimbursement for services under this section shall be made on a monthly basis. Payment is based on face-to-face or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. These contacts must meet the minimum standards in clauses (1) and (2):

(1) there must be a face-to-face contact at least once a month except as provided in clause (2); and

(2) for a client placed outside of the county of financial responsibility, or a client served by tribal social services placed outside the reservation, in an excluded time facility under

section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of Children, section 260.93, and the placement in either case is more than 60 miles beyond the county or reservation boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face contact.

(b) Except as provided under paragraph (c), the payment rate is established using time study data on activities of provider service staff and reports required under sections 245.482 and 256.01, subdivision 2, paragraph (p).

(c) Payments for tribes may be made according to section 256B.0625 or other relevant federally approved rate setting methodology for child welfare targeted case management provided by Indian health services and facilities operated by a tribe or tribal organization.

(d) Payment for case management provided by county ~~or tribal social services~~ contracted vendors ~~shall be based on a monthly rate negotiated by the host county or tribal social services~~ must be calculated in accordance with section 256B.076, subdivision 2. Payment for case management provided by vendors who contract with a Tribe must be based on a monthly rate negotiated by the Tribe. The ~~negotiated~~ rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the ~~county or tribal social services may negotiate a team rate with a vendor who is a member of the team. The~~ team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribal social services, except to reimburse the county or tribal social services for advance funding provided by the county or tribal social services to the vendor.

(e) If the service is provided by a team that includes contracted vendors and county or tribal social services staff, the costs for county or tribal social services staff participation in the team shall be included in the rate for county or tribal social services provided services. In this case, the contracted vendor and the county or tribal social services may each receive separate payment for services provided by each entity in the same month. To prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles and services of the team members.

Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study, or under paragraph (c), shall be distributed according to earnings,

to counties, reservations, or groups of counties or reservations which have the same payment rate under this subdivision, and to the group of counties or reservations which are not certified providers under section 256F.10. The commissioner shall modify the requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.

Sec. 29. **DIRECTION TO THE COMMISSIONER; ADULT MENTAL HEALTH INITIATIVES REFORM.**

In establishing a legislative proposal for reforming the funding formula to distribute adult mental health initiative funds, the commissioner of human services shall ensure that funding currently received as a result of the closure of the Moose Lake Regional Treatment Center is not reallocated from any region that does not have a community behavioral health hospital. Upon finalization of the adult mental health initiatives reform, the commissioner shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy.

Sec. 30. **DIRECTION TO THE COMMISSIONER; ALTERNATIVE MENTAL HEALTH PROFESSIONAL LICENSING PATHWAYS WORK GROUP.**

(a) The commissioners of human services and health must convene a work group consisting of representatives from the Board of Psychology; the Board of Marriage and Family Therapy; the Board of Social Work; the Board of Behavioral Health and Therapy; five mental health providers from diverse cultural communities; a representative from the Minnesota Council of Health Plans; a representative from a state health care program; two representatives from mental health associations or community mental health clinics led by individuals who are Black, indigenous, or people of color; and representatives from mental health professional graduate programs to evaluate and make recommendations on possible alternative pathways to mental health professional licensure in Minnesota. The work group must:

(1) identify barriers to licensure in mental health professions;

(2) collect data on the number of individuals graduating from educational programs but not passing licensing exams;

(3) evaluate the feasibility of alternative pathways for licensure in mental health professions, ensuring provider competency and professionalism; and

(4) consult with national behavioral health testing entities.

(b) Mental health providers participating in the work group may be reimbursed for expenses in the same manner as authorized by the commissioner's plan adopted under Minnesota Statutes, section 43A.18, subdivision 2, upon approval by the commissioner. Members who, as a result of time spent attending work group meetings, incur child care expenses that would not otherwise have been incurred, may be reimbursed for those expenses upon approval by the commissioner. Reimbursements may be approved for no more than five individual providers.

(c) No later than February 1, 2023, the commissioners must submit a written report to the members of the legislative committees with jurisdiction over health and human services on the work group's findings and recommendations developed on alternative licensing pathways.

Sec. 31. **DIRECTION TO THE COMMISSIONER; CHILDREN'S MENTAL HEALTH RESIDENTIAL TREATMENT WORK GROUP.**

The commissioner of human services, in consultation with counties, children's mental health residential providers, and children's mental health advocates, must organize a work group and develop recommendations on how to efficiently and effectively fund room and board costs for children's mental health residential treatment under the children's mental health act. The work group may also provide recommendations on how to address systemic barriers in transitioning children into the community and community-based treatment options. The commissioner shall submit the recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 15, 2022.

Sec. 32. **DIRECTION TO THE COMMISSIONER; CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES.**

The commissioner of human services, in consultation with substance use disorder treatment providers, lead agencies, and individuals who receive substance use disorder treatment services, shall develop a statewide implementation and transition plan for culturally and linguistically appropriate services (CLAS) national standards, including technical assistance for providers to transition to the CLAS standards and to improve disparate treatment outcomes. The commissioner must consult with individuals who are Black, indigenous, people of color, and linguistically diverse in the development of the implementation and transition plans under this section.

Sec. 33. **DIRECTION TO THE COMMISSIONER; RATE RECOMMENDATIONS FOR OPIOID TREATMENT PROGRAMS.**

The commissioner of human services shall evaluate the rate structure for opioid treatment programs licensed under Minnesota Statutes, section 245G.22, and report recommendations, including a revised rate structure and proposed draft legislation, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance by October 1, 2021.

Sec. 34. **DIRECTION TO THE COMMISSIONER; SOBER HOUSING PROGRAM RECOMMENDATIONS.**

(a) The commissioner of human services, in consultation with stakeholders, must develop recommendations on:

(1) increasing access to sober housing programs;

(2) promoting person-centered practices and cultural responsiveness in sober housing programs;

(3) potential oversight of sober housing programs; and

(4) providing consumer protections for individuals in sober housing programs with substance use disorders and individuals with co-occurring mental illnesses.

(b) Stakeholders include but are not limited to the Minnesota Association of Sober Homes, the Minnesota Association of Resources for Recovery and Chemical Health, Minnesota Recovery Connection, NAMI Minnesota, the National Alliance of Recovery Residencies (NARR), Oxford Houses, Inc., sober housing programs based in Minnesota that are not members of the Minnesota Association of Sober Homes, a member of Alcoholics Anonymous, and residents and former residents of sober housing programs based in Minnesota. Stakeholders must equitably represent various geographic areas of the state and must include individuals in recovery and providers representing Black, indigenous, people of color, or immigrant communities.

(c) The commissioner must complete and submit a report on these recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on or before March 1, 2022.

Sec. 35. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER TREATMENT PAPERWORK REDUCTION.**

(a) The commissioner of human services, in consultation with counties, tribes, managed care organizations, substance use disorder treatment professional associations, and other relevant stakeholders, shall develop, assess, and recommend systems improvements to minimize regulatory paperwork and improve systems for substance use disorder programs licensed under Minnesota Statutes, chapter 245A, and regulated under Minnesota Statutes, chapters 245F and 245G, and Minnesota Rules, chapters 2960 and 9530. The commissioner of human services shall make available any resources needed from other divisions within the department to implement systems improvements.

(b) The commissioner of health shall make available needed information and resources from the Division of Health Policy.

(c) The Office of MN.IT Services shall provide advance consultation and implementation of the changes needed in data systems.

(d) The commissioner of human services shall contract with a vendor that has experience with developing statewide system changes for multiple states at the payer and provider levels. If the commissioner, after exercising reasonable diligence, is unable to secure a vendor with the requisite qualifications, then the commissioner may select the best qualified vendor available. When developing recommendations, the commissioner shall consider input from all stakeholders. The commissioner's recommendations shall maximize benefits for clients and utility for providers, regulatory agencies, and payers.

(e) The commissioner of human services and contracted vendor shall follow the recommendations from the report issued in response to Laws 2019, First Special Session chapter 9, article 6, section 76.

(f) By December 15, 2022, the commissioner of human services shall take steps to implement paperwork reductions and systems improvements within the commissioner's authority and submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a report that includes recommendations for changes in statutes that would further enhance systems improvements to reduce paperwork. The report shall include a summary of the approaches developed and assessed by the commissioner of human services and stakeholders and the results of any assessments conducted.

Sec. 36. **DIRECTION TO THE COMMISSIONER; TRIBAL OVERPAYMENT PROTOCOLS.**

The commissioner of human services, in consultation with the Tribal nations, shall develop protocols that must be used to address and attempt to resolve any future overpayment involving any Tribal nation in Minnesota.

Sec. 37. **SUBSTANCE USE DISORDER TREATMENT RATE RESTRUCTURE ANALYSIS.**

(a) By January 1, 2022, the commissioner shall issue a request for proposals for frameworks and modeling of substance use disorder rates. Rates must be predicated on a uniform methodology that is transparent, culturally responsive, supports staffing needed to treat a patient's assessed need, and promotes quality service delivery and patient choice. The commissioner must consult with substance use disorder treatment programs across the spectrum of services, substance use disorder treatment programs from across each region of the state, and culturally responsive providers in the development of the request for proposal process and for the duration of the contract.

(b) By January 15, 2023, the commissioner of human services shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance on the results of the vendor's work. The report must include legislative language necessary to implement a new substance use disorder treatment rate methodology and a detailed fiscal analysis.

Sec. 38. **REVISOR INSTRUCTION.**

The revisor of statutes shall replace "EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT" with "CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC SERVICES" in the section headnote for Minnesota Statutes, section 245.735.

Sec. 39. **REPEALER.**

(a) Minnesota Statutes 2020, section 256B.0596, is repealed.

(b) Minnesota Statutes 2020, section 245.735, subdivisions 1, 2, and 4, are repealed.

(c) Minnesota Statutes 2020, section 245.4871, subdivision 32a, is repealed.

EFFECTIVE DATE. Paragraph (c) is effective September 30, 2021.

ARTICLE 13
DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2020, section 246.54, subdivision 1b, is amended to read:

Subd. 1b. **Community behavioral health hospitals.** A county's payment of the cost of care provided at state-operated community-based behavioral health hospitals for adults and children shall be according to the following schedule:

(1) 100 percent for each day during the stay, including the day of admission, when the facility determines that it is clinically appropriate for the client to be discharged; and

(2) the county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

ARTICLE 14
DISABILITY SERVICES AND CONTINUING CARE FOR OLDER ADULTS

Section 1. Minnesota Statutes 2020, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the ~~commissioner of health~~ federal database MDS assessments that conform with the assessment schedule defined by ~~Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in~~ the Long Term Care Facility Resident Assessment Instrument User's Manual, version 3.0, ~~and subsequent updates when~~ or its successor issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

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

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

(2) an annual comprehensive assessment, which must have an ~~assessment reference date (ARD)~~ ARD within 92 days of ~~the~~ a previous quarterly review assessment ~~and the~~ or a previous comprehensive assessment, which must occur at least once every 366 days;

(3) a significant change in status comprehensive assessment, which must ~~be completed~~ have an ARD within 14 days ~~of the identification of~~ after the facility determines, or should

have determined, that there has been a significant change in the resident's physical or mental condition, whether an improvement or a decline, and regardless of the amount of time since the last ~~significant change in status~~ comprehensive assessment or quarterly review assessment;

(4) ~~all~~ a quarterly ~~assessments~~ review assessment must have an ~~assessment reference date (ARD)~~ ARD within 92 days of the ARD of the previous quarterly review assessment or a previous comprehensive assessment;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; ~~and~~

(6) any significant correction to a prior quarterly review assessment, if the assessment being corrected is the current one being used for RUG classification~~.~~;

(7) a required significant change in status assessment when:

(i) all speech, occupational, and physical therapies have ended. The ARD of this assessment must be set on day eight after all therapy services have ended; and

(ii) isolation for an infectious disease has ended. The ARD of this assessment must be set on day 15 after isolation has ended; and

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

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

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

(2) a nursing facility level of care determination as provided for under section 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment completed under section 256B.0911, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Sec. 2. Minnesota Statutes 2020, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license

holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (h), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

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

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

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

(5) new foster care licenses or community residential setting licenses for people receiving services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and for which a license is required. This exception does not apply to people living in their own home. For purposes of this clause, there is a presumption that a foster care or community residential setting license is required for services provided to three or more people in a dwelling unit when the setting is controlled by the provider. A license holder subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2018. This exception is available when:

(i) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and

(ii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the unlicensed setting as determined by the lead agency~~.~~; or

(6) new foster care licenses or community residential setting licenses for people receiving customized living or 24-hour customized living services under the brain injury or community access for disability inclusion waiver plans under section 256B.49 and residing in the customized living setting before July 1, 2022, for which a license is required. A customized living service provider subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2023. This exception is available when:

(i) the person's customized living services are provided in a customized living service setting serving four or fewer people under the brain injury or community access for disability inclusion waiver plans under section 256B.49 in a single-family home operational on or before June 30, 2021. Operational is defined in section 256B.49, subdivision 28;

(ii) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and

(iii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the customized living setting as determined by the lead agency.

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

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately

inform the Department of Human Services Licensing Division. The department may decrease the statewide licensed capacity for adult foster care settings.

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

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

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

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

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

identified in section 256B.493. Annually, by August 1, the commissioner shall provide information and data on capacity of licensed long-term services and supports, actions taken under the subdivision to manage statewide long-term services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over the health and human services budget.

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

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

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 3. Minnesota Statutes 2020, section 256.9741, subdivision 1, is amended to read:

Subdivision 1. **Long-term care facility.** "Long-term care facility" means a nursing home licensed under sections 144A.02 to 144A.10; a boarding care home licensed under sections 144.50 to 144.56; an assisted living facility or an assisted living facility with dementia care licensed under chapter 144G; ~~or~~ a licensed or registered residential setting that provides or arranges for the provision of home care services; or a setting defined under section 144G.08, subdivision 7, clauses (10) to (13), that provides or arranges for the provision of home care services.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 4. Minnesota Statutes 2020, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, conversation-based, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a person-centered community support plan that meets the individual's needs and preferences.

(d) The assessment must be conducted by a certified assessor in a face-to-face conversational interview with the person being assessed. The person's legal representative must provide input during the assessment process and may do so remotely if requested. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under chapter 256S, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal

representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs the person completed in consultation with someone who is known to the person and has interaction with the person on a regular basis. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

(e) The certified assessor and the individual responsible for developing the coordinated service and support plan must complete the community support plan and the coordinated service and support plan no more than 60 calendar days from the assessment visit. The person or the person's legal representative must be provided with a written community support plan within the timelines established by the commissioner, regardless of whether the person is eligible for Minnesota health care programs.

(f) For a person being assessed for elderly waiver services under chapter 256S, a provider who submitted information under paragraph (d) shall receive the final written community support plan when available and the Residential Services Workbook.

(g) The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including:

(i) all available options for case management services and providers;

(ii) all available options for employment services, settings, and providers;

(iii) all available options for living arrangements;

(iv) all available options for self-directed services and supports, including self-directed budget options; and

(v) service provided in a non-disability-specific setting;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(h) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(i) The person has the right to make the final decision:

(1) between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

(2) between community placement in a setting controlled by a provider and living independently in a setting not controlled by a provider;

(3) between day services and employment services; and

(4) regarding available options for self-directed services and supports, including self-directed funding options.

(j) The lead agency must give the person receiving long-term care consultation services or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case

management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated; and

(10) documentation that available options for employment services, independent living, and self-directed services and supports were described to the individual.

(k) Face-to-face assessment completed as part of an eligibility determination for multiple programs for the alternative care, elderly waiver, developmental disabilities, community access for disability inclusion, community alternative care, and brain injury waiver programs under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(l) The effective eligibility start date for programs in paragraph (k) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (k) cannot be prior to the date the most recent updated assessment is completed.

(m) If an eligibility update is completed within 90 days of the previous face-to-face assessment and documented in the department's Medicaid Management Information System

(MMIS), the effective date of eligibility for programs included in paragraph (k) is the date of the previous face-to-face assessment when all other eligibility requirements are met.

(n) If a person who receives home- and community-based waiver services under section 256B.0913, 256B.092, or 256B.49, or chapter 256S, temporarily enters for 121 days or less a hospital, institution of mental disease, nursing facility, intensive residential treatment services program, transitional care unit, or inpatient substance use disorder treatment setting, the person may return to the community with home- and community-based waiver services under the same waiver, without requiring an assessment or reassessment under this section, unless the person's annual reassessment is otherwise due. Nothing in this section shall change annual long-term care consultation reassessment requirements, payment for institutional or treatment services, medical assistance financial eligibility, or any other law.

~~(n)~~ (o) At the time of reassessment, the certified assessor shall assess each person receiving waiver residential supports and services currently residing in a community residential setting, licensed adult foster care home that is either not the primary residence of the license holder or in which the license holder is not the primary caregiver, family adult foster care residence, customized living setting, or supervised living facility to determine if that person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23, in a setting not controlled by a provider, or to receive integrated community supports as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified assessor shall offer the person, through a person-centered planning process, the option to receive alternative housing and service options.

~~(o)~~ (p) At the time of reassessment, the certified assessor shall assess each person receiving waiver day services to determine if that person would prefer to receive employment services as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified assessor shall describe to the person through a person-centered planning process the option to receive employment services.

~~(p)~~ (q) At the time of reassessment, the certified assessor shall assess each person receiving non-self-directed waiver services to determine if that person would prefer an available service and setting option that would permit self-directed services and supports. The certified assessor shall describe to the person through a person-centered planning process the option to receive self-directed services and supports.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. Minnesota Statutes 2020, section 256B.092, subdivision 4, is amended to read:

Subd. 4. **Home and community-based services for developmental disabilities.** (a) The commissioner shall make payments to approved vendors participating in the medical assistance program to pay costs of providing home and community-based services, including case management service activities provided as an approved home and community-based service, to medical assistance eligible persons with developmental disabilities who have been screened under subdivision 7 and according to federal requirements. Federal requirements include those services and limitations included in the federally approved application for home and community-based services for persons with developmental disabilities and subsequent amendments.

~~(b) Effective July 1, 1995, contingent upon federal approval and state appropriations made available for this purpose, and in conjunction with Laws 1995, chapter 207, article 8, section 40, the commissioner of human services shall allocate resources to county agencies for home and community-based waivered services for persons with developmental disabilities authorized but not receiving those services as of June 30, 1995, based upon the average resource need of persons with similar functional characteristics. To ensure service continuity for service recipients receiving home and community-based waivered services for persons with developmental disabilities prior to July 1, 1995, the commissioner shall make available to the county of financial responsibility home and community-based waivered services resources based upon fiscal year 1995 authorized levels.~~

~~(c) Home and community-based resources for all recipients shall be managed by the county of financial responsibility within an allowable reimbursement average established for each county. Payments for home and community-based services provided to individual recipients shall not exceed amounts authorized by the county of financial responsibility. For specifically identified former residents of nursing facilities, the commissioner shall be responsible for authorizing payments and payment limits under the appropriate home and community-based service program. Payment is available under this subdivision only for persons who, if not provided these services, would require the level of care provided in an intermediate care facility for persons with developmental disabilities.~~

~~(d)~~ (b) The commissioner shall comply with the requirements in the federally approved transition plan for the home and community-based services waivers for the elderly authorized under this section.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2020, section 256B.092, subdivision 5, is amended to read:

Subd. 5. **Federal waivers.** (a) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation under United States Code, title 42, sections 1396 et seq., as amended, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a regional treatment center or a community intermediate care facility for persons with developmental disabilities. The commissioner may seek amendments to the waivers or apply for additional waivers under United States Code, title 42, sections 1396 et seq., as amended, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative services under the federal waiver plan shall not exceed the cost of intermediate care services including day training and habilitation services that would have been provided without the waivered services.

The commissioner shall seek an amendment to the 1915c home and community-based waiver to allow properly licensed adult foster care homes to provide residential services to up to five individuals with developmental disabilities. If the amendment to the waiver is approved, adult foster care providers that can accommodate five individuals shall increase their capacity to five beds, provided the providers continue to meet all applicable licensing requirements.

(b) The commissioner, in administering home and community-based waivers for persons with developmental disabilities, shall ensure that day services for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of day services by the residential service provider. The coordinated service and support plan for individuals who choose to have their residential service provider provide their day services must describe how health, safety, protection, and habilitation needs will be met, including how frequent and regular contact with persons other than the residential service provider will occur. The coordinated service and support plan must address the provision of services during the day outside the residence on weekdays.

(c) When a lead agency is evaluating denials, reductions, or terminations of home and community-based services under section 256B.0916 for an individual, the lead agency shall offer to meet with the individual or the individual's guardian in order to discuss the

prioritization of service needs within the coordinated service and support plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

(d) The commissioner shall seek federal approval to allow for the reconfiguration of the 1915(c) home and community-based waivers in this section, as authorized under section 1915(c) of the federal Social Security Act, to implement a two-waiver program structure.

(e) The transition to two disability home and community-based services waiver programs must align with the independent living first policy under section 256B.4905. Unless superseded by any other state or federal law, waiver eligibility criteria shall be the same for each waiver. The waiver program that a person uses shall be determined by the support planning process and whether the person chooses to live in a provider-controlled setting or in the person's own home.

(f) The commissioner shall seek federal approval for the 1915(c) home and community-based waivers in this section, as authorized under section 1915(c) of the federal Social Security Act, to implement an individual resource allocation methodology.

EFFECTIVE DATE. This section is effective January 1, 2023, or 90 days after federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 7. Minnesota Statutes 2020, section 256B.092, subdivision 12, is amended to read:

Subd. 12. ~~**Waivered**~~ **Waiver services statewide priorities.** (a) The commissioner shall establish statewide priorities for individuals on the waiting list for developmental disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

(1) no longer require the intensity of services provided where they are currently living; or

(2) make a request to move from an institutional setting.

(b) After the priorities in paragraph (a) are met, priority must also be given to individuals who meet at least one of the following criteria:

(1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;

(2) are moving from an institution due to bed closures;

(3) experience a sudden closure of their current living arrangement;

(4) require protection from confirmed abuse, neglect, or exploitation;

(5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or

(6) meet other priorities established by the department.

(c) When allocating new enrollment resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities ~~and the lead agencies' current use of waiver funds and existing service options~~. ~~The commissioner has the authority to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe.~~

Sec. 8. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision to read:

Subd. 7. **Regional quality councils and systems improvement.** The commissioner of human services shall maintain the regional quality councils initially established under Minnesota Statutes 2020, section 256B.097, subdivision 4. The regional quality councils shall:

(1) support efforts and initiatives that drive overall systems and social change to promote inclusion of people who have disabilities in the state of Minnesota;

(2) improve person-centered outcomes in disability services; and

(3) identify or enhance quality of life indicators for people who have disabilities.

Sec. 9. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision to read:

Subd. 8. **Membership and staff.** (a) Regional quality councils shall be comprised of key stakeholders including, but not limited to:

(1) individuals who have disabilities;

(2) family members of people who have disabilities;

(3) disability service providers;

(4) disability advocacy groups;

(5) lead agency staff; and

(6) staff of state agencies with jurisdiction over special education and disability services.

(b) Membership in a regional quality council must be representative of the communities in which the council operates, with an emphasis on individuals with lived experience from diverse racial and cultural backgrounds.

(c) Each regional quality council may hire staff to perform the duties assigned in subdivision 9.

Sec. 10. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision to read:

Subd. 9. **Duties.** (a) Each regional quality council shall:

(1) identify issues and barriers that impede Minnesotans who have disabilities from optimizing choice of home and community-based services;

(2) promote informed decision making, autonomy, and self-direction;

(3) analyze and review quality outcomes and critical incident data, and immediately report incidents of life safety concerns to the Department of Human Services Licensing Division;

(4) inform a comprehensive system for effective incident reporting, investigation, analysis, and follow-up;

(5) collaborate on projects and initiatives to advance priorities shared with state agencies, lead agencies, educational institutions, advocacy organizations, community partners, and other entities engaged in disability service improvements;

(6) establish partnerships and working relationships with individuals and groups in the regions;

(7) identify and implement regional and statewide quality improvement projects;

(8) transform systems and drive social change in alignment with the disability rights and disability justice movements identified by leaders who have disabilities;

(9) provide information and training programs for persons who have disabilities and their families and legal representatives on formal and informal support options and quality expectations;

(10) make recommendations to state agencies and other key decision-makers regarding disability services and supports;

(11) submit every two years a report to committees with jurisdiction over disability services on the status, outcomes, improvement priorities, and activities in the region;

(12) support people by advocating to resolve complaints between the counties, providers, persons receiving services, and their families and legal representatives; and

(13) recruit, train, and assign duties to regional quality council teams, including council members, interns, and volunteers, taking into account the skills necessary for the team members to be successful in this work.

(b) Each regional quality council may engage in quality improvement initiatives related to but not limited to:

(1) the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, or section 256B.49, including brain injuries and services for those persons who qualify for nursing facility level of care or hospital facility level of care and any other services licensed under chapter 245D;

(2) home care services under section 256B.0651;

(3) family support grants under section 252.32;

(4) consumer support grants under section 256.476;

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

(6) services provided through an intermediate care facility for persons with developmental disabilities.

(c) Each regional quality council's work must be informed and directed by the needs and desires of persons who have disabilities in the region in which the council operates.

Sec. 11. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision to read:

Subd. 10. **Compensation.** (a) A member of a regional quality council who does not receive a salary or wages from an employer may be paid a per diem and reimbursed for expenses related to the member's participation in efforts and initiatives described in

subdivision 9 in the same manner and in an amount not to exceed the amount authorized by the commissioner's plan adopted under section 43A.18, subdivision 2.

(b) Regional quality councils may charge fees for their services.

Sec. 12. Minnesota Statutes 2020, section 256B.439, is amended by adding a subdivision to read:

Subd. 3c. **Contact information for consumer surveys for nursing facilities and home and community-based services.** For purposes of conducting the consumer surveys under subdivisions 3 and 3a, the commissioner may request contact information of clients and associated key representatives. Providers must furnish the contact information available to the provider.

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

Sec. 13. Minnesota Statutes 2020, section 256B.439, is amended by adding a subdivision to read:

Subd. 3d. **Resident experience survey and family survey for assisted living facilities.** The commissioner shall develop and administer a resident experience survey for assisted living facility residents and a family survey for families of assisted living facility residents. Money appropriated to the commissioner to administer the resident experience survey and family survey is available in either fiscal year of the biennium in which it is appropriated.

Sec. 14. Minnesota Statutes 2020, section 256B.49, subdivision 11, is amended to read:

Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and community-based service waivers, as authorized under section 1915(c) of the federal Social Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided in a hospital. The commissioner shall apply for the home and community-based waivers in order to:

(1) promote the support of persons with disabilities in the most integrated settings;

(2) expand the availability of services for persons who are eligible for medical assistance;

(3) promote cost-effective options to institutional care; and

(4) obtain federal financial participation.

(b) The provision of ~~waivered~~ waiver services to medical assistance recipients with disabilities shall comply with the requirements outlined in the federally approved applications for home and community-based services and subsequent amendments, including provision of services according to a service plan designed to meet the needs of the individual. For purposes of this section, the approved home and community-based application is considered the necessary federal requirement.

(c) The commissioner shall provide interested persons serving on agency advisory committees, task forces, the Centers for Independent Living, and others who request to be on a list to receive, notice of, and an opportunity to comment on, at least 30 days before any effective dates, (1) any substantive changes to the state's disability services program manual, or (2) changes or amendments to the federally approved applications for home and community-based waivers, prior to their submission to the federal Centers for Medicare and Medicaid Services.

(d) The commissioner shall seek approval, as authorized under section 1915(c) of the federal Social Security Act, to allow medical assistance eligibility under this section for children under age 21 without deeming of parental income or assets.

(e) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Act, to allow medical assistance eligibility under this section for individuals under age 65 without deeming the spouse's income or assets.

(f) The commissioner shall comply with the requirements in the federally approved transition plan for the home and community-based services waivers authorized under this section.

(g) The commissioner shall seek federal approval to allow for the reconfiguration of the 1915(c) home and community-based waivers in this section, as authorized under section 1915(c) of the federal Social Security Act, to implement a two-waiver program structure.

(h) The commissioner shall seek federal approval for the 1915(c) home and community-based waivers in this section, as authorized under section 1915(c) of the federal Social Security Act, to implement an individual resource allocation methodology.

EFFECTIVE DATE. This section is effective January 1, 2023, or 90 days after federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 15. Minnesota Statutes 2020, section 256B.49, subdivision 11a, is amended to read:

Subd. 11a. **~~Waivered~~ Waiver services statewide priorities.** (a) The commissioner shall establish statewide priorities for individuals on the waiting list for community alternative care, community access for disability inclusion, and brain injury waiver services, as of January 1, 2010. The statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

(1) no longer require the intensity of services provided where they are currently living; or

(2) make a request to move from an institutional setting.

(b) After the priorities in paragraph (a) are met, priority must also be given to individuals who meet at least one of the following criteria:

(1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;

(2) are moving from an institution due to bed closures;

(3) experience a sudden closure of their current living arrangement;

(4) require protection from confirmed abuse, neglect, or exploitation;

(5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or

(6) meet other priorities established by the department.

(c) When allocating new enrollment resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities ~~and the lead agencies' current use of waiver funds and existing service options~~. ~~The commissioner has the authority to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe.~~

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 16. Minnesota Statutes 2020, section 256B.49, subdivision 17, is amended to read:

Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure that the average per capita expenditures estimated in any fiscal year for home and community-based waiver recipients does not exceed the average per capita expenditures that would have been made to provide institutional services for recipients in the absence of the waiver.

~~(b) The commissioner shall implement on January 1, 2002, one or more aggregate, need-based methods for allocating to local agencies the home and community-based waivered service resources available to support recipients with disabilities in need of the level of care provided in a nursing facility or a hospital. The commissioner shall allocate resources to single counties and county partnerships in a manner that reflects consideration of:~~

~~(1) an incentive-based payment process for achieving outcomes;~~

~~(2) the need for a state-level risk pool;~~

~~(3) the need for retention of management responsibility at the state agency level; and~~

~~(4) a phase-in strategy as appropriate.~~

~~(c) Until the allocation methods described in paragraph (b) are implemented, the annual allowable reimbursement level of home and community-based waiver services shall be the greater of:~~

~~(1) the statewide average payment amount which the recipient is assigned under the waiver reimbursement system in place on June 30, 2001, modified by the percentage of any provider rate increase appropriated for home and community-based services; or~~

~~(2) an amount approved by the commissioner based on the recipient's extraordinary needs that cannot be met within the current allowable reimbursement level. The increased reimbursement level must be necessary to allow the recipient to be discharged from an institution or to prevent imminent placement in an institution. The additional reimbursement may be used to secure environmental modifications; assistive technology and equipment; and increased costs for supervision, training, and support services necessary to address the recipient's extraordinary needs. The commissioner may approve an increased reimbursement level for up to one year of the recipient's relocation from an institution or up to six months of a determination that a current waiver recipient is at imminent risk of being placed in an institution.~~

~~(d)~~ (b) Beginning July 1, 2001, medically necessary home care nursing services will be authorized under this section as complex and regular care according to sections 256B.0651 to 256B.0654 and 256B.0659. The rate established by the commissioner for registered nurse

or licensed practical nurse services under any home and community-based waiver as of January 1, 2001, shall not be reduced.

~~(c)~~ (c) Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009 legislature adopts a rate reduction that impacts payment to providers of adult foster care services, the commissioner may issue adult foster care licenses that permit a capacity of five adults. The application for a five-bed license must meet the requirements of section 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care services, the county must negotiate a revised per diem rate for room and board and waiver services that reflects the legislated rate reduction and results in an overall average per diem reduction for all foster care recipients in that home. The revised per diem must allow the provider to maintain, as much as possible, the level of services or enhanced services provided in the residence, while mitigating the losses of the legislated rate reduction.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2020, section 256B.49, is amended by adding a subdivision to read:

Subd. 28. **Customized living moratorium for brain injury and community access for disability inclusion waivers.** (a) Notwithstanding section 245A.03, subdivision 2, paragraph (a), clause (23), the commissioner shall not enroll new customized living settings serving four or fewer people in a single-family home to deliver customized living services as defined under the brain injury or community access for disability inclusion waiver plans under section 256B.49 to prevent new developments of customized living settings that otherwise meet the residential program definition under section 245A.02, subdivision 14.

(b) The commissioner may approve an exception to paragraph (a) when:

(1) a customized living setting with a change in ownership at the same address is in existence and operational on or before June 30, 2021; and

(2) a customized living setting is serving four or fewer people in a multiple-family dwelling if each person has a personal self-contained living unit that contains living, sleeping, eating, cooking, and bathroom areas.

(c) Customized living settings operational on or before June 30, 2021, are considered existing customized living settings.

(d) For any new customized living settings operational on or after July 1, 2021, serving four or fewer people in a single-family home to deliver customized living services as defined in paragraph (a), the authorizing lead agency is financially responsible for all home and community-based service payments in the setting.

(e) For purposes of this subdivision, "operational" means customized living services are authorized and delivered to a person on or before June 30, 2021, in the customized living setting.

EFFECTIVE DATE. This section is effective July 1, 2021. This section applies only to customized living services as defined under the brain injury or community access for disability inclusion waiver plans under Minnesota Statutes, section 256B.49.

Sec. 18. Minnesota Statutes 2020, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC code 31-1014); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for adult day services, 70 percent of the median wage for nursing assistant (SOC code 31-1014); and 30 percent of the median wage for personal care aide (SOC code 39-9021);

(3) for day services, day support services, and prevocational services, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for

psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(4) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota for large employers~~, except in a family foster care setting, the wage is 36 percent of the minimum wage in Minnesota for large employers~~;

(5) for positive supports analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(6) for positive supports professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(7) for positive supports specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(8) for supportive living services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(9) for housing access coordination staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099);

(10) for in-home family support and individualized home supports with family training staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for individualized home supports with training services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(12) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(13) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(14) for employment exploration services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(15) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(16) for individualized home support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(17) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(18) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(19) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(20) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(21) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of positive supports professional, positive supports analyst, and positive supports specialists, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(22) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

(23) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for corporate foster care services, corporate supportive living services daily, community residential services, and integrated community support services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

~~(c) Component values for family foster care are:~~

~~(1) competitive workforce factor: 4.7 percent;~~

~~(2) supervisory span of control ratio: 11 percent;~~

~~(3) employee vacation, sick, and training allowance ratio: 8.71 percent;~~

~~(4) employee-related cost ratio: 23.6 percent;~~

~~(5) general administrative support ratio: 3.3 percent;~~

~~(6) program-related expense ratio: 1.3 percent; and~~

~~(7) absence factor: 1.7 percent.~~

~~(d)~~ (c) Component values for day training and habilitation, day support services, and prevocational services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: ten percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(d) Component values for day support services and prevocational services delivered remotely are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 7.67 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(e) Component values for adult day services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 7.4 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(f) Component values for unit-based services with programming are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan supports ratio: 15.5 percent;

(6) client programming and supports ratio: 4.7 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 6.1 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(g) Component values for unit-based services with programming delivered remotely are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan supports ratio: 5.6 percent;

(6) client programming and supports ratio: 1.53 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 6.1 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

~~(g)~~ (h) Component values for unit-based services without programming except respite are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 7.0 percent;

(6) client programming and support ratio: 2.3 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(i) Component values for unit-based services without programming delivered remotely, except respite, are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 1.3 percent;

(6) client programming and support ratio: 1.14 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

~~(h)~~ (j) Component values for unit-based services without programming for respite are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 2.9 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

~~(i)~~ (k) On July 1, 2022, and every two years thereafter, the commissioner shall update the base wage index in paragraph (a) based on wage data by SOC from the Bureau of Labor Statistics available 30 months and one day prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

~~(j)~~ (l) Beginning February 1, 2021, and every two years thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance an analysis of the competitive workforce factor. The report must include recommendations to update the competitive workforce factor using:

(1) the most recently available wage data by SOC code for the weighted average wage for direct care staff for residential services and direct care staff for day services;

(2) the most recently available wage data by SOC code of the weighted average wage of comparable occupations; and

(3) workforce data as required under subdivision 10a, paragraph (g).

The commissioner shall not recommend an increase or decrease of the competitive workforce factor from the current value by more than two percentage points. If, after a biennial analysis for the next report, the competitive workforce factor is less than or equal to zero, the commissioner shall recommend a competitive workforce factor of zero.

~~(k)~~ (m) On July 1, 2022, and every two years thereafter, the commissioner shall update the framework components in paragraph ~~(d)~~ (c), clause (6); paragraph ~~(e)~~ (d), clause (6); paragraph ~~(f)~~ (e), clause (6); ~~and~~ paragraph ~~(g)~~ (f), clause (6); paragraph (g), clause (6); paragraph (h), clause 6; and paragraph (i), clause (6); subdivision 6, paragraphs (b), clauses (9) and (10), and (e), clause (10); and subdivision 7, clauses (11), (17), and (18); and subdivision 18, for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the data available 30 months and one day prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

~~(l)~~ (n) Upon the implementation of the updates under paragraphs ~~(i)~~ (k) and ~~(k)~~ (m), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013, chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall be removed from service rates calculated under this section.

~~(m)~~ (o) Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section shall be removed from rate calculations upon implementation of the updates under paragraphs ~~(i)~~ (k) and ~~(k)~~ (m).

~~(n)~~ (p) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 19. Minnesota Statutes 2020, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Payments for residential support services.** (a) For purposes of this subdivision, residential support services includes 24-hour customized living services, community residential services, customized living services, ~~family residential services, foster care services,~~ and integrated community supports~~, and supportive living services daily~~.

(b) Payments for community residential services~~, corporate foster care services, corporate supportive living services daily, family residential services, and family foster care services~~ must be calculated as follows:

(1) determine the number of shared staffing and individual direct staff hours to meet a recipient's needs provided on site or through monitoring technology;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (b), clause (1);

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages;

(6) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (3). This is defined as the direct staffing cost;

(8) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (4);

(9) for client programming and supports, the commissioner shall add $2,179; and

(10) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport, based on the resident with the highest assessed need.

(c) The total rate must be calculated using the following steps:

(1) subtotal paragraph (b), clauses (8) to (10), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause (8);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(d) The payment methodology for customized living, 24-hour customized living, and residential care services must be the customized living tool. Revisions to the customized living tool must be made to reflect the services and activities unique to disability-related recipient needs. Customized living and 24-hour customized living rates determined under this section shall not include more than 24 hours of support in a daily unit. The commissioner shall establish acuity-based input limits, based on case mix, for customized living and 24-hour customized living rates determined under this section.

(e) Payments for integrated community support services must be calculated as follows:

(1) the base shared staffing shall be eight hours divided by the number of people receiving support in the integrated community support setting;

(2) the individual staffing hours shall be the average number of direct support hours provided directly to the service recipient;

(3) the personnel hourly wage rate must be based on the most recent Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(4) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (3) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (b), clause (1);

(5) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (4);

(6) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the appropriate staff wages;

(7) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the product of the supervisory span of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervisory wage in subdivision 5, paragraph (a), clause (21);

(8) combine the results of clauses (6) and (7) and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (3). This is defined as the direct staffing cost;

(9) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (4); and

(10) for client programming and supports, the commissioner shall add $2,260.21 divided by 365.

(f) The total rate must be calculated as follows:

(1) add the results of paragraph (e), clauses (9) and (10);

(2) add the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(g) The payment methodology for customized living and 24-hour customized living services must be the customized living tool. The commissioner shall revise the customized living tool to reflect the services and activities unique to disability-related recipient needs and adjust for regional differences in the cost of providing services.

(h) The number of days authorized for all individuals enrolling in residential services must include every day that services start and end.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2020, section 256B.4914, subdivision 7, is amended to read:

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day services, day treatment and habilitation, day support services, prevocational services, and structured day services, provided in person or remotely, must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph ~~(d)~~ (c), clause (1);

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of day program direct staff hours and nursing hours by the appropriate staff wage;

(6) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (2), for in-person services or subdivision 5, paragraph (d), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (3), for in-person services or subdivision 5, paragraph (d), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (5), for in-person services or subdivision 5, paragraph (d), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (4), for in-person services or subdivision 5, paragraph (d), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (6), for in-person services or subdivision 5, paragraph (d), clause (6), for remote services;

(11) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs for in-person service only;

(12) for adult day bath services, add $7.01 per 15 minute unit;

(13) this is the subtotal rate;

(14) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(15) divide the result of clause (13) by one minus the result of clause (14). This is the total payment amount;

(16) adjust the result of clause (15) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

(17) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

(18) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2020, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including employment exploration services, employment development services, housing access coordination, individualized home supports with family training, individualized home supports with training, in-home family support, independent living skills training, and hourly supported living services provided to an individual outside of any day or residential service plan, provided in person or remotely, must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (f), clause (1);

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of direct staff hours by the appropriate staff wage;

(6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (f), clause (2), for in-person services or subdivision 5, paragraph (g), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause (3), for in-person services or subdivision 5, paragraph (g), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan supports ratio in subdivision 5, paragraph (f), clause (5), for in-person services or subdivision 5, paragraph (g), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph (f), clause (4), for in-person services or subdivision 5, paragraph (g), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and supports ratio in subdivision 5, paragraph (f), clause (6), for in-person services or subdivision 5, paragraph (g), clause (6), for remote services;

(11) this is the subtotal rate;

(12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for employment exploration services provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed five. For employment support services provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed six. For independent living skills training, individualized home supports with training, and individualized home supports with family training provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed two; and

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2020, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming, including individualized home supports, night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan, provided in person or remotely, must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph ~~(g)~~ (h), clause (1);

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of direct staff hours by the appropriate staff wage;

(6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (2), for in-person services or subdivision 5, paragraph (i), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (3), for in-person services or subdivision 5, paragraph (i), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (5), for in-person services or subdivision 5, paragraph (i), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (4), for in-person services or subdivision 5, paragraph (i), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (6), for in-person services or subdivision 5, paragraph (i), clause (6), for remote services;

(11) this is the subtotal rate;

(12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for respite services, determine the number of day units of service to meet an individual's needs;

(15) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(16) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (15) by the product of one plus the competitive workforce factor in subdivision 5, paragraph ~~(h)~~ (j), clause (1);

(17) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (16);

(18) multiply the number of direct staff hours by the appropriate staff wage;

(19) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph ~~(h)~~ (j), clause (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(20) combine the results of clauses (18) and (19), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(h)~~ (j), clause (3). This is defined as the direct staffing rate;

(21) for employee-related expenses, multiply the result of clause (20) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(h)~~ (j), clause (4);

(22) this is the subtotal rate;

(23) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(24) divide the result of clause (22) by one minus the result of clause (23). This is the total payment amount;

(25) for individualized home supports provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed two;

(26) for respite care services provided in a shared manner, divide the total payment amount in clause (24) by the number of service recipients, not to exceed three; and

(27) adjust the result of clauses (13), (25), and (26) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 23. Minnesota Statutes 2020, section 256B.4914, is amended by adding a subdivision to read:

Subd. 18. **Payments for family residential services.** The commissioner shall establish rates for family residential services based on a person's assessed needs as described in the federally approved waiver plans.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 24. Minnesota Statutes 2020, section 256B.69, subdivision 5a, is amended to read:

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

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B

and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

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

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

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

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

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk

in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and

28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

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

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

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

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

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

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

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

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 25. Minnesota Statutes 2020, section 256B.85, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section and section 256B.851, the terms defined in this subdivision have the meanings given.

(b) "Activities of daily living" or "ADLs" means eating, toileting, grooming, dressing, bathing, mobility, positioning, and transferring.

(c) "Agency-provider model" means a method of CFSS under which a qualified agency provides services and supports through the agency's own employees and policies. The agency must allow the participant to have a significant role in the selection and dismissal of support workers of their choice for the delivery of their specific services and supports.

(d) "Behavior" means a description of a need for services and supports used to determine the home care rating and additional service units. The presence of Level I behavior is used to determine the home care rating.

(e) "Budget model" means a service delivery method of CFSS that allows the use of a service budget and assistance from a financial management services (FMS) provider for a participant to directly employ support workers and purchase supports and goods.

(f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that has been ordered by a physician, and is specified in a community support plan, including:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0651;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(g) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task, or the purchase of goods as defined in subdivision 7, clause (3), that replace the need for human assistance.

(h) "Community first services and supports service delivery plan" or "CFSS service delivery plan" means a written document detailing the services and supports chosen by the participant to meet assessed needs that are within the approved CFSS service authorization, as determined in subdivision 8. Services and supports are based on the coordinated service and support plan identified in section 256S.10.

(i) "Consultation services" means a Minnesota health care program enrolled provider organization that provides assistance to the participant in making informed choices about CFSS services in general and self-directed tasks in particular, and in developing a person-centered CFSS service delivery plan to achieve quality service outcomes.

(j) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

(k) "Dependency" in activities of daily living means a person requires hands-on assistance or constant supervision and cueing to accomplish one or more of the activities of daily living every day or on the days during the week that the activity is performed; however, a child may not be found to be dependent in an activity of daily living if, because of the child's age, an adult would either perform the activity for the child or assist the child with the activity and the assistance needed is the assistance appropriate for a typical child of the same age.

(l) "Extended CFSS" means CFSS services and supports provided under CFSS that are included in the CFSS service delivery plan through one of the home and community-based services waivers and as approved and authorized under chapter 256S and sections 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants.

(m) "Financial management services provider" or "FMS provider" means a qualified organization required for participants using the budget model under subdivision 13 that is an enrolled provider with the department to provide vendor fiscal/employer agent financial management services (FMS).

(n) "Health-related procedures and tasks" means procedures and tasks related to the specific assessed health needs of a participant that can be taught or assigned by a state-licensed health care or mental health professional and performed by a support worker.

(o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community.

(p) "Lead agency" has the meaning given in section 256B.0911, subdivision 1a, paragraph (e).

(q) "Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(r) "Level I behavior" means physical aggression ~~towards~~ toward self or others or destruction of property that requires the immediate response of another person.

(s) "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, and includes any of the following supports listed in clauses (1) to (3) and other types of assistance, except that a support worker may not determine medication dose or time for medication or inject medications into veins, muscles, or skin:

(1) under the direction of the participant or the participant's representative, bringing medications to the participant including medications given through a nebulizer, opening a container of previously set-up medications, emptying the container into the participant's hand, opening and giving the medication in the original container to the participant, or bringing to the participant liquids or food to accompany the medication;

(2) organizing medications as directed by the participant or the participant's representative; and

(3) providing verbal or visual reminders to perform regularly scheduled medications.

(t) "Participant" means a person who is eligible for CFSS.

(u) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant or participant's legal representative, if any, to serve as a representative in connection with the provision of CFSS. This authorization must be in writing or by another method that clearly indicates the participant's free choice and may be withdrawn at any time. The participant's representative must have no financial interest in the provision of any services included in the participant's CFSS service delivery plan and must be capable of providing the support necessary to assist the participant in the use of CFSS. If through the assessment process described in subdivision 5 a participant is determined to be in need of a participant's representative, one must be selected. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one. Two persons may be designated as a participant's

representative for reasons such as divided households and court-ordered custodies. Duties of a participant's representatives may include:

(1) being available while services are provided in a method agreed upon by the participant or the participant's legal representative and documented in the participant's CFSS service delivery plan;

(2) monitoring CFSS services to ensure the participant's CFSS service delivery plan is being followed; and

(3) reviewing and signing CFSS time sheets after services are provided to provide verification of the CFSS services.

(v) "Person-centered planning process" means a process that is directed by the participant to plan for CFSS services and supports.

(w) "Service budget" means the authorized dollar amount used for the budget model or for the purchase of goods.

(x) "Shared services" means the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into an agreement to receive services at the same time and in the same setting by the same employer.

(y) "Support worker" means a qualified and trained employee of the agency-provider as required by subdivision 11b or of the participant employer under the budget model as required by subdivision 14 who has direct contact with the participant and provides services as specified within the participant's CFSS service delivery plan.

(z) "Unit" means the increment of service based on hours or minutes identified in the service agreement.

(aa) "Vendor fiscal employer agent" means an agency that provides financial management services.

(bb) "Wages and benefits" means the hourly wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or other forms of employee compensation and benefits.

(cc) "Worker training and development" means services provided according to subdivision 18a for developing workers' skills as required by the participant's individual CFSS service delivery plan that are arranged for or provided by the agency-provider or purchased by the

participant employer. These services include training, education, direct observation and supervision, and evaluation and coaching of job skills and tasks, including supervision of health-related tasks or behavioral supports.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 26. **[256B.851] COMMUNITY FIRST SERVICES AND SUPPORTS; PAYMENT RATES.**

Subdivision 1. **Application.** (a) The payment methodologies in this section apply to:

(1) community first services and supports (CFSS), extended CFSS, and enhanced rate CFSS under section 256B.85; and

(2) personal care assistance services under section 256B.0625, subdivisions 19a and 19c; extended personal care assistance service as defined in section 256B.0659, subdivision 1; and enhanced rate personal care assistance services under section 256B.0659, subdivision 17a.

(b) This section does not change existing personal care assistance program or community first services and supports policies and procedures.

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given in section 256B.85, subdivision 2, and as follows.

(b) "Commissioner" means the commissioner of human services.

(c) "Component value" means an underlying factor that is built into the rate methodology to calculate service rates and is part of the cost of providing services.

(d) "Payment rate" or "rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

Subd. 3. **Payment rates; base wage index.** When initially establishing the base wage component values, the commissioner must use the Minnesota-specific median wage for the standard occupational classification (SOC) codes published by the Bureau of Labor Statistics in the edition of the Occupational Handbook available January 1, 2021. The commissioner must calculate the base wage component values as follows for:

(1) personal care assistance services, CFSS, extended personal care assistance services, and extended CFSS. The base wage component value equals the median wage for personal care aide (SOC code 31-1120);

(2) enhanced rate personal care assistance services and enhanced rate CFSS. The base wage component value equals the product of median wage for personal care aide (SOC code 31-1120) and the value of the enhanced rate under section 256B.0659, subdivision 17a; and

(3) qualified professional services and CFSS worker training and development. The base wage component value equals the sum of 70 percent of the median wage for registered nurse (SOC code 29-1141), 15 percent of the median wage for health care social worker (SOC code 21-1099), and 15 percent of the median wage for social and human service assistant (SOC code 21-1093).

Subd. 4. **Payment rates; total wage index.** (a) The commissioner must multiply the base wage component values in subdivision 3 by one plus the appropriate competitive workforce factor. The product is the total wage component value.

(b) For personal care assistance services, CFSS, extended personal care assistance services, extended CFSS, enhanced rate personal care assistance services, and enhanced rate CFSS, the initial competitive workforce factor is 4.7 percent.

(c) For qualified professional services and CFSS worker training and development, the competitive workforce factor is zero percent.

(d) On August 1, 2024, and every two years thereafter, the commissioner shall report recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance an update of the competitive workforce factors in this subdivision using the most recently available data. The commissioner shall make adjustments to the competitive workforce factor toward the percent difference between: (1) the median wage for personal care aide (SOC code 31-1120); and (2) the weighted average wage for all other SOC codes with the same Bureau of Labor Statistics classifications for education, experience, and training required for job competency.

(e) The commissioner shall recommend an increase or decrease of the competitive workforce factor from its previous value by no more than three percentage points. If, after a biennial adjustment, the competitive workforce factor is less than or equal to zero, the competitive workforce factor shall be zero.

Subd. 5. **Payment rates; component values.** (a) The commissioner must use the following component values:

(1) employee vacation, sick, and training factor, 8.71 percent;

(2) employer taxes and workers' compensation factor, 11.56 percent;

(3) employee benefits factor, 12.04 percent;

(4) client programming and supports factor, 2.30 percent;

(5) program plan support factor, 7.00 percent;

(6) general business and administrative expenses factor, 13.25 percent;

(7) program administration expenses factor, 2.90 percent; and

(8) absence and utilization factor, 3.90 percent.

(b) For purposes of implementation, the commissioner shall use the following implementation components:

(1) personal care assistance services and CFSS: 75.45 percent;

(2) enhanced rate personal care assistance services and enhanced rate CFSS: 75.45 percent; and

(3) qualified professional services and CFSS worker training and development: 75.45 percent.

Subd. 6. **Payment rates; rate determination.** (a) The commissioner must determine the rate for personal care assistance services, CFSS, extended personal care assistance services, extended CFSS, enhanced rate personal care assistance services, enhanced rate CFSS, qualified professional services, and CFSS worker training and development as follows:

(1) multiply the appropriate total wage component value calculated in subdivision 4 by one plus the employee vacation, sick, and training factor in subdivision 5;

(2) for program plan support, multiply the result of clause (1) by one plus the program plan support factor in subdivision 5;

(3) for employee-related expenses, add the employer taxes and workers' compensation factor in subdivision 5 and the employee benefits factor in subdivision 5. The sum is employee-related expenses. Multiply the product of clause (2) by one plus the value for employee-related expenses;

(4) for client programming and supports, multiply the product of clause (3) by one plus the client programming and supports factor in subdivision 5;

(5) for administrative expenses, add the general business and administrative expenses factor in subdivision 5, the program administration expenses factor in subdivision 5, and the absence and utilization factor in subdivision 5;

(6) divide the result of clause (4) by one minus the result of clause (5). The quotient is the hourly rate;

(7) multiply the hourly rate by the appropriate implementation component under subdivision 5. This is the adjusted hourly rate; and

(8) divide the adjusted hourly rate by four. The quotient is the total adjusted payment rate.

(b) The commissioner must publish the total adjusted payment rates.

Subd. 7. **Personal care provider agency; required reporting and analysis of cost data.** (a) The commissioner shall evaluate on an ongoing basis whether the base wage component values and component values in this section appropriately address the cost to provide the service. The commissioner shall make recommendations to adjust the rate methodology as indicated by the evaluation. As determined by the commissioner and in consultation with stakeholders, agencies enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner. The commissioner may request cost data, including but not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) staff vacancy rates; and

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

(b) At least once in any three-year period, a provider must submit the required cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner must provide each provider a 90-day notice prior to its submission due date. If a provider fails to submit required cost data, the commissioner must provide notice to a provider that has not provided required cost data 30 days after the required submission date and a second notice to a provider that has not provided required cost data 60 days after the required submission date. The commissioner must temporarily suspend payments to a provider if the commissioner has not received required cost data 90 days after the required submission date. The commissioner must make withheld payments when the required cost data is received by the commissioner.

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

(d) The commissioner shall analyze cost documentation in paragraph (a) and may submit recommendations on component values, updated base wage component values, and competitive workforce factors to the chair and ranking minority members of the legislative committees and divisions with jurisdiction over human services policy and finance every two years beginning August 1, 2026. The commissioner shall release cost data in an aggregate form, and cost data from individual providers shall not be released except as provided for in current law.

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

Subd. 8. **Payment rates; reports required.** (a) The commissioner must assess the standard component values and publish evaluation findings and recommended changes to the rate methodology in a report to the legislature by August 1, 2026.

(b) The commissioner must assess the long-term impacts of the rate methodology implementation on staff providing services with rates determined under this section, including but not limited to measuring changes in wages, benefits provided, hours worked, and retention. The commissioner must publish evaluation findings in a report to the legislature by August 1, 2028, and once every two years thereafter.

Subd. 9. **Self-directed services workforce.** Nothing in this section limits the commissioner's authority over terms and conditions for individual providers in covered programs as defined in section 256B.0711. The commissioner's authority over terms and

conditions for individual providers in covered programs remains subject to the state's obligations to meet and negotiate under chapter 179A, as modified and made applicable to individual providers under section 179A.54, and to agreements with any exclusive representative of individual providers, as authorized by chapter 179A, as modified and made applicable to individual providers under section 179A.54. A change in the rate for services within the covered programs defined in section 256B.0711 does not constitute a change in a term or condition for individual providers in covered programs and is not subject to the state's obligation to meet and negotiate under chapter 179A, except that, notwithstanding any other law to the contrary, the state shall meet and negotiate with the exclusive representative of individual providers over wage and benefit increases made possible by rate increases provided between January 1, 2023 and June 30, 2023. Any resulting tentative agreement shall be submitted to the legislature to be accepted or rejected in accordance with sections 3.855 and 179A.22.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 27. Minnesota Statutes 2020, section 256I.04, subdivision 3, is amended to read:

Subd. 3. **Moratorium on development of housing support beds.** (a) Agencies shall not enter into agreements for new housing support beds with total rates in excess of the MSA equivalent rate except:

(1) for establishments licensed under chapter 245D provided the facility is needed to meet the census reduction targets for persons with developmental disabilities at regional treatment centers;

(2) up to 80 beds in a single, specialized facility located in Hennepin County that will provide housing for chronic inebriates who are repetitive users of detoxification centers and are refused placement in emergency shelters because of their state of intoxication, and planning for the specialized facility must have been initiated before July 1, 1991, in anticipation of receiving a grant from the Housing Finance Agency under section 462A.05, subdivision 20a, paragraph (b);

(3) notwithstanding the provisions of subdivision 2a, for up to ~~226~~ 500 supportive housing units in Anoka, Carver, Dakota, Hennepin, ~~or~~ Ramsey, Scott, or Washington County for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter ~~or~~

~~discharged from a regional treatment center, community hospital, or residential treatment program and,~~ has no appropriate housing available, and lacks the resources and support necessary to access appropriate housing. ~~At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, have been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program.~~ If a person meets the requirements of subdivision 1, paragraph (a) or (b), and receives a federal or state housing subsidy, the housing support rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a~~, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the housing support supplementary service rate~~. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a housing support payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate~~. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a~~;

(4) for an additional two beds, resulting in a total of 32 beds, for a facility located in Hennepin County providing services for recovering and chemically dependent men that has had a housing support contract with the county and has been licensed as a board and lodge facility with special services since 1980;

(5) for a housing support provider located in the city of St. Cloud, or a county contiguous to the city of St. Cloud, that operates a 40-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision;

(6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent persons, operated by a housing support provider that currently operates a 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

(7) for a housing support provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, that provide community support and 24-hour-a-day supervision to serve the mental health needs of individuals who have chronically lived unsheltered; and

(8) for a facility authorized for recipients of housing support in Hennepin County with a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility and that until August 1, 2007, operated as a licensed chemical dependency treatment program.

(b) An agency may enter into a housing support agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered under a housing support agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from housing support payment, or as a result of the downsizing of a setting authorized for recipients of housing support. The transfer of available beds from one agency to another can only occur by the agreement of both agencies.

(c) The appropriation for this subdivision must include administrative funding equal to the cost of two full-time equivalent employees to process eligibility. The commissioner must disburse administrative funding to the fiscal agent for the counties under this subdivision.

Sec. 28. Minnesota Statutes 2020, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the ~~county~~ agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the federal Social Security Act; or funding from the medical assistance program under section 256B.0659, for personal care services for residents in the setting; or residing in a setting which receives funding under section 245.73. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section 256B.0659, then the housing support rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service rate exceed $426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and

community-based waiver services under title XIX of the federal Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

(b) The commissioner is authorized to make cost-neutral transfers from the housing support fund for beds under this section to other funding programs administered by the department after consultation with the ~~county or counties~~ agency in which the affected beds are located. The commissioner may also make cost-neutral transfers from the housing support fund to ~~county human service~~ agencies for beds permanently removed from the housing support census under a plan submitted by the ~~county~~ agency and approved by the commissioner. The commissioner shall report the amount of any transfers under this provision annually to the legislature.

(c) ~~Counties~~ Agencies must not negotiate supplementary service rates with providers of housing support that are licensed as board and lodging with special services and that do not encourage a policy of sobriety on their premises and make referrals to available community services for volunteer and employment opportunities for residents.

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

Sec. 29. Minnesota Statutes 2020, section 256I.05, subdivision 1c, is amended to read:

Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for housing support above those in effect on June 30, 1993, except as provided in paragraphs (a) to (f).

(a) An agency may increase the rates for room and board to the MSA equivalent rate for those settings whose current rate is below the MSA equivalent rate.

(b) An agency may increase the rates for residents in adult foster care whose difficulty of care has increased. The total housing support rate for these residents must not exceed the maximum rate specified in subdivisions 1 and 1a. Agencies must not include nor increase difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding by home and community-based waiver programs under title XIX of the Social Security Act.

(c) The room and board rates will be increased each year when the MSA equivalent rate is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less the amount of the increase in the medical assistance personal needs allowance under section 256B.35.

(d) When housing support pays for an individual's room and board, or other costs necessary to provide room and board, the rate payable to the residence must continue for

up to 18 calendar days per incident that the person is temporarily absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences are reported in advance to the county agency's social service staff. Advance reporting is not required for emergency absences due to crisis, illness, or injury. For purposes of maintaining housing while temporarily absent due to residential behavioral health treatment or health care treatment that requires admission to an inpatient hospital, nursing facility, or other health care facility, the room and board rate for an individual is payable beyond an 18-calendar-day absence period, not to exceed 150 days in a calendar year.

(e) For facilities meeting substantial change criteria within the prior year. Substantial change criteria exists if the establishment experiences a 25 percent increase or decrease in the total number of its beds, if the net cost of capital additions or improvements is in excess of 15 percent of the current market value of the residence, or if the residence physically moves, or changes its licensure, and incurs a resulting increase in operation and property costs.

(f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to 9549.0058.

Sec. 30. Minnesota Statutes 2020, section 256I.05, subdivision 11, is amended to read:

Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a cost-neutral transfer of funding from the housing support fund to ~~county human service agencies~~ the agency for emergency shelter beds removed from the housing support census under a biennial plan submitted by the ~~county~~ agency and approved by the commissioner. The plan must describe: (1) anticipated and actual outcomes for persons experiencing homelessness in emergency shelters; (2) improved efficiencies in administration; (3) requirements for individual eligibility; and (4) plans for quality assurance monitoring and quality assurance outcomes. The commissioner shall review the ~~county~~ agency plan to monitor implementation and outcomes at least biennially, and more frequently if the commissioner deems necessary.

(b) The funding under paragraph (a) may be used for the provision of room and board or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding must be allocated annually, and the room and board portion of the allocation shall be adjusted according to the percentage change in the housing support room and board rate. The room and board portion of the allocation shall be determined at the time of transfer. The commissioner or ~~county~~ agency may return beds to the housing support fund with 180 days' notice, including financial reconciliation.

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

Sec. 31. Minnesota Statutes 2020, section 256S.18, subdivision 7, is amended to read:

Subd. 7. **Monthly case mix budget cap exception.** The commissioner shall approve an exception to the monthly case mix budget cap in ~~paragraph (a)~~ subdivision 3 to account for the additional cost of providing enhanced rate personal care assistance services under section 256B.0659 or enhanced rate community first services and supports under section 256B.85. ~~The exception shall not exceed 107.5 percent of the budget otherwise available to the individual.~~ The commissioner must calculate the difference between the rate for personal care assistance services and enhanced rate personal care assistance services. The additional budget amount approved under an exception must not exceed this difference. The exception must be reapproved on an annual basis at the time of a participant's annual reassessment.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 32. Minnesota Statutes 2020, section 256S.20, subdivision 1, is amended to read:

Subdivision 1. **Customized living services provider requirements.** ~~Only a provider licensed by the Department of Health as a comprehensive home care provider may provide~~ (a) To deliver customized living services or 24-hour customized living services~~.~~, a provider must:

(1) be licensed as an assisted living facility under chapter 144G; or

(2) be licensed as a comprehensive home care provider under chapter 144A and be delivering services: (i) in a setting defined under section 144G.08, subdivision 7, clauses (11) to (13); or (ii) in an affordable housing setting under section 144G.08, subdivision 7, clause (10), that is delivering authorized customized living services to a person in the setting

on or before April 1, 2021. A licensed home care provider is subject to section 256B.0651, subdivision 14.

(b) Settings under paragraph (a), clause (2), must comply with section 256S.2003.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 33. **[256S.2003] CUSTOMIZED LIVING SERVICES; REQUIREMENTS OF PROVIDERS IN DESIGNATED SETTINGS.**

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

(b) "Designated provider" means a home care provider licensed under chapter 144A that provides customized living services to some or all of the residents of a designated setting and that is either the setting itself or another entity with which the setting has a contract or business relationship.

(c) "Designated setting" means a setting defined under section 256S.20, subdivision 1, paragraph (a), clause (2).

(d) "Resident" means a person receiving customized living services in a designated setting.

Subd. 2. **Attestation of compliance with requirements.** Upon enrollment with the department to provide customized living services, a designated provider of customized living services must submit an attestation that the provider is in compliance with subdivisions 3 to 8.

Subd. 3. **Contracts.** (a) Every designated provider must execute a written contract with a resident or the resident's representative and must operate in accordance with the terms of the contract. The resident or the resident's representative must be given a complete copy of the contract and all supporting documents and attachments and any changes whenever changes are made.

(b) The contract must include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the designated provider;

(2) the name and mailing address of the owner or owners of the designated provider and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the designated provider, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement identifying the designated provider's home care license number;

(6) the term of the contract;

(7) an itemization and description of the services to be provided to the resident;

(8) a conspicuous notice informing the resident of the policy concerning the conditions under which and the process through which the contract may be modified, amended, or terminated;

(9) a description of the designated provider's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(10) the resident's designated representative, if any;

(11) the designated provider's referral procedures if the contract is terminated;

(12) a statement regarding the ability of a resident to receive services from service providers with whom the designated provider does not have an arrangement;

(13) a statement regarding the availability of public funds for payment for residence or services; and

(14) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

(c) The contract must include a statement regarding:

(1) the ability of a resident to furnish and decorate the resident's unit within the terms of the lease;

(2) a resident's right to access food at any time;

(3) a resident's right to choose the resident's visitors and times of visits;

(4) a resident's right to choose a roommate if sharing a unit; and

(5) a resident's right to have and use a lockable door to the resident's unit. The designated setting must provide the locks on the unit. Only a staff member with a specific need to enter

the unit shall have keys, and advance notice must be given to the resident before entrance, when possible.

(d) A restriction of a resident's rights under this subdivision is allowed only if determined necessary for health and safety reasons identified by the home care provider's registered nurse in an initial assessment or reassessment, as defined under section 144A.4791, subdivision 8, and documented in the written service plan under section 144A.4791, subdivision 9. Any restrictions of those rights for people served under this chapter and section 256B.49 must be documented in the resident's coordinated service and support plan, as defined under sections 256B.49, subdivision 15, and 256S.10.

(e) The contract and related documents executed by each resident or resident's representative must be maintained by the designated provider in files from the date of execution until three years after the contract is terminated.

Subd. 4. **Training in dementia.** (a) If a designated provider has a special program or special care unit for residents with Alzheimer's disease or other dementias or advertises, markets, or otherwise promotes the provision of services for persons with Alzheimer's disease or other dementias, whether in a segregated or general unit, employees of the provider must meet the following training requirements:

(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;

(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b), or a supervisor meeting the requirements in clause (1), must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;

(3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at

least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and

(4) new employees may satisfy the initial training requirements under clauses (1) to (3) by producing written proof of previously completed required training within the past 18 months.

(b) Areas of required training include:

(1) an explanation of Alzheimer's disease and related disorders;

(2) assistance with activities of daily living;

(3) problem solving with challenging behaviors; and

(4) communication skills.

(c) The provider must provide to residents and prospective residents in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.

Subd. 5. **Restraints.** Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience.

Subd. 6. **Termination of contract.** A designated provider must include with notice of termination of contract information about how to contact the ombudsman for long-term care, including the address and telephone number, along with a statement of how to request problem-solving assistance.

Subd. 7. **Manager requirements.** (a) The person primarily responsible for oversight and management of the designated provider, as designated by the owner, must obtain at least 30 hours of continuing education every two years of employment as the manager in topics relevant to the operations of the facility and the needs of its tenants. Continuing education earned to maintain a professional license, such as a nursing home administrator license, nursing license, social worker license, or real estate license, can be used to complete this requirement.

(b) New managers may satisfy the initial dementia training requirements by producing written proof of previously completed required training within the past 18 months.

Subd. 8. **Emergency planning.** (a) Each designated provider must meet the following requirements:

(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in-place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;

(2) prominently post an emergency disaster plan;

(3) provide building emergency exit diagrams to all residents upon signing a contract;

(4) post emergency exit diagrams on each floor; and

(5) have a written policy and procedure regarding missing residents.

(b) Each designated provider must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training available to all residents annually. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.

(c) Each designated provider location must conduct and document a fire drill or other emergency drill at least once every six months. To the extent possible, drills must be coordinated with local fire departments or other community emergency resources.

Subd. 9. **Other laws.** Each designated provider must comply with chapter 504B, and must obtain and maintain all other licenses, permits, registrations, or other required governmental approvals. A designated provider is not required to obtain a lodging license under chapter 157 and related rules.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 34. Laws 2020, Fifth Special Session chapter 3, article 10, section 3, is amended to read:

Sec. 3. **TEMPORARY PERSONAL CARE ASSISTANCE COMPENSATION FOR SERVICES PROVIDED BY A PARENT OR SPOUSE.**

(a) Notwithstanding Minnesota Statutes, section 256B.0659, subdivisions 3, paragraph (a), clause (1); 11, paragraph (c); and 19, paragraph (b), clause (3), during a peacetime emergency declared by the governor under Minnesota Statutes, section 12.31, subdivision 2, for an outbreak of COVID-19, a parent, stepparent, or legal guardian of a minor who is a personal care assistance recipient or a spouse of a personal care assistance recipient may provide and be paid for providing personal care assistance services.

(b) This section expires ~~February 7, 2021~~ upon the expiration of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

EFFECTIVE DATE; REVIVAL AND REENACTMENT. This section is effective the day following final enactment, or upon federal approval, whichever is later, and Laws 2020, Fifth Special Session chapter 3, article 10, section 3, is revived and reenacted as of that date.

Sec. 35. **SELF-DIRECTED WORKER CONTRACT RATIFICATION.**

The labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota, submitted to the Legislative Coordinating Commission on March 1, 2021, is ratified.

Sec. 36. **DIRECTION TO THE COMMISSIONER; CUSTOMIZED LIVING REPORT.**

(a) By January 15, 2022, the commissioner of human services shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance. The report must include the commissioner's:

(1) assessment of the prevalence of customized living services provided under Minnesota Statutes, section 256B.49, supplanting the provision of residential services and supports licensed under Minnesota Statutes, chapter 245D, and provided in settings licensed under Minnesota Statutes, chapter 245A;

(2) recommendations regarding the continuation of the moratorium on home and community-based services customized living settings under Minnesota Statutes, section 256B.49, subdivision 28;

(3) other policy recommendations to ensure that customized living services are being provided in a manner consistent with the policy objectives of the foster care licensing moratorium under Minnesota Statutes, section 245A.03, subdivision 7; and

(4) recommendations for needed statutory changes to implement the transition from existing four-person or fewer customized living settings to corporate adult foster care or community residential settings.

(b) The commissioner of health shall provide the commissioner of human services with the required data to complete the report in paragraph (a) and implement the moratorium on home and community-based services customized living settings under Minnesota Statutes, section 256B.49, subdivision 28. The data must include, at a minimum, each registered housing with services establishment under Minnesota Statutes, chapter 144D, enrolled as a customized living setting to deliver customized living services as defined under the brain

injury or community access for disability inclusion waiver plans under Minnesota Statutes, section 256B.49.

Sec. 37. **DIRECTION TO COMMISSIONER; PROVIDER STANDARDS FOR CUSTOMIZED LIVING SERVICES IN DESIGNATED SETTINGS.**

The commissioner of human services shall review policies and provider standards for customized living services provided in settings identified in Minnesota Statutes, section 256S.20, subdivision 1, paragraph (a), clause (2), in consultation with stakeholders. The commissioner may provide recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over customized living services by February 15, 2022, regarding appropriate regulatory oversight and payment policies for customized living services delivered in these settings.

Sec. 38. **GOVERNOR'S COUNCIL ON AN AGE-FRIENDLY MINNESOTA.**

The Governor's Council on an Age-Friendly Minnesota, established in Executive Order 19-38, shall: (1) work to advance age-friendly policies; and (2) coordinate state, local, and private partners' collaborative work on emergency preparedness, with a focus on older adults, communities, and persons in zip codes most impacted by the COVID-19 pandemic. The Governor's Council on an Age-Friendly Minnesota is extended and expires October 1, 2022.

Sec. 39. **RATE INCREASE FOR DIRECT SUPPORT SERVICES WORKFORCE.**

(a) Effective October 1, 2021, or upon federal approval, whichever is later, if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved pursuant to Minnesota Statutes, section 3.855, the commissioner of human services shall increase:

(1) reimbursement rates, individual budgets, grants, or allocations by 4.14 percent for services under paragraph (b) provided on or after October 1, 2021, or upon federal approval, whichever is later, to implement the minimum hourly wage, holiday, and paid time off provisions of that agreement;

(2) reimbursement rates, individual budgets, grants, or allocations by 2.95 percent for services under paragraph (b) provided on or after July 1, 2022, or upon federal approval, whichever is later, to implement the minimum hourly wage, holiday, and paid time off provisions of that agreement;

(3) individual budgets, grants, or allocations by 1.58 percent for services under paragraph (c) provided on or after October 1, 2021, or upon federal approval, whichever is later, to implement the minimum hourly wage, holiday, and paid time off provisions of that agreement; and

(4) individual budgets, grants, or allocations by .81 percent for services under paragraph (c) provided on or after July 1, 2022, or upon federal approval, whichever is later, to implement the minimum hourly wage, holiday, and paid time off provisions of that agreement.

(b) The rate changes described in paragraph (a), clauses (1) and (2), apply to direct support services provided through a covered program, as defined in Minnesota Statutes, section 256B.0711, subdivision 1, with the exception of consumer-directed community supports available under programs established pursuant to home and community-based service waivers authorized under section 1915(c) of the federal Social Security Act and Minnesota Statutes, including but not limited to chapter 256S and sections 256B.092 and 256B.49, and under the alternative care program under Minnesota Statutes, section 256B.0913.

(c) The funding changes described in paragraph (a), clauses (3) and (4), apply to consumer-directed community supports available under programs established pursuant to home and community-based service waivers authorized under section 1915(c) of the federal Social Security Act, and Minnesota Statutes, including but not limited to chapter 256S and sections 256B.092 and 256B.49, and under the alternative care program under Minnesota Statutes, section 256B.0913.

Sec. 40. **WAIVER REIMAGINE PHASE II.**

(a) The commissioner of human services must implement a two-home and community-based services waiver program structure, as authorized under section 1915(c) of the federal Social Security Act, that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

(b) The commissioner of human services must implement an individualized budget methodology, as authorized under section 1915(c) of the federal Social Security Act, that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

(c) The commissioner of human services may seek all federal authority necessary to implement this section.

EFFECTIVE DATE. This section is effective September 1, 2024, or 90 days after federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 41. **REPEALER.**

(a) Minnesota Statutes 2020, section 256B.097, subdivisions 1, 2, 3, 4, 5, and 6, are repealed effective July 1, 2021.

(b) Minnesota Statutes 2020, sections 256B.0916, subdivisions 2, 3, 4, 5, 8, 11, and 12; and 256B.49, subdivisions 26 and 27, are repealed effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

(c) Minnesota Statutes 2020, section 256S.20, subdivision 2, is repealed effective August 1, 2021.

ARTICLE 15
COMMUNITY SUPPORTS POLICY

Section 1. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team must use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) Services must be age-appropriate and meet the specific needs of the client.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every six months or prior to discharge from the service, whichever comes first.

(e) The treatment team must complete an individual treatment plan for each client and the individual treatment plan must:

(1) be based on the information in the client's diagnostic assessment and baselines;

(2) identify goals and objectives of treatment, a treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;

(3) be developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;

(4) be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessments, and treatment planning;

(5) be reviewed at least once every six months and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment;

(6) be signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;

(7) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan;

(8) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports;

(ii) be reviewed at least once every 90 days and revised, if necessary;

(9) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and

(10) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.

(f) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(g) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(h) The treatment team shall provide interventions to promote positive interpersonal relationships.

Sec. 2. Minnesota Statutes 2020, section 256B.69, subdivision 5a, is amended to read:

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

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

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each

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

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

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's

membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

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

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

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

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

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

Sec. 3. Minnesota Statutes 2020, section 256B.85, subdivision 1, is amended to read:

Subdivision 1. **Basis and scope.** (a) Upon federal approval, the commissioner shall establish a state plan option for the provision of home and community-based personal assistance service and supports called "community first services and supports (CFSS)."

(b) CFSS is a participant-controlled method of selecting and providing services and supports that allows the participant maximum control of the services and supports. Participants may choose the degree to which they direct and manage their supports by choosing to have a significant and meaningful role in the management of services and

supports including by directly employing support workers with the necessary supports to perform that function.

(c) CFSS is available statewide to eligible people to assist with accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task; and to assist with acquiring, maintaining, and enhancing the skills necessary to accomplish ADLs, IADLs, and health-related procedures and tasks. CFSS allows payment for the participant for certain supports and goods such as environmental modifications and technology that are intended to replace or decrease the need for human assistance.

(d) Upon federal approval, CFSS will replace the personal care assistance program under sections 256.476, 256B.0625, subdivisions 19a and 19c, and 256B.0659.

(e) For the purposes of this section, notwithstanding the provisions of section 144A.43, subdivision 3, supports purchased under CFSS are not considered home care services.

Sec. 4. Minnesota Statutes 2020, section 256B.85, subdivision 2, is amended to read:

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

(b) "Activities of daily living" or "ADLs" means ~~eating, toileting, grooming, dressing, bathing, mobility, positioning, and transferring.~~:

(1) dressing, including assistance with choosing, applying, and changing clothing and applying special appliances, wraps, or clothing;

(2) grooming, including assistance with basic hair care, oral care, shaving, applying cosmetics and deodorant, and care of eyeglasses and hearing aids. Grooming includes nail care, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

(4) eating, including assistance with hand washing and applying orthotics required for eating, transfers, or feeding;

(5) transfers, including assistance with transferring the participant from one seating or reclining area to another;

(6) mobility, including assistance with ambulation and use of a wheelchair. Mobility does not include providing transportation for a participant;

(7) positioning, including assistance with positioning or turning a participant for necessary care and comfort; and

(8) toileting, including assistance with bowel or bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.

(c) "Agency-provider model" means a method of CFSS under which a qualified agency provides services and supports through the agency's own employees and policies. The agency must allow the participant to have a significant role in the selection and dismissal of support workers of their choice for the delivery of their specific services and supports.

(d) "Behavior" means a description of a need for services and supports used to determine the home care rating and additional service units. The presence of Level I behavior is used to determine the home care rating.

(e) "Budget model" means a service delivery method of CFSS that allows the use of a service budget and assistance from a financial management services (FMS) provider for a participant to directly employ support workers and purchase supports and goods.

(f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that has been ordered by a physician, advanced practice registered nurse, or physician's assistant and is specified in a community support plan, including:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0651;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician, advanced practice registered nurse, or physician's assistant and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(g) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task, or the purchase of goods as defined in subdivision 7, clause (3), that replace the need for human assistance.

(h) "Community first services and supports service delivery plan" or "CFSS service delivery plan" means a written document detailing the services and supports chosen by the

participant to meet assessed needs that are within the approved CFSS service authorization, as determined in subdivision 8. Services and supports are based on the coordinated service and support plan identified in ~~section~~ sections 256B.092, subdivision 1b, and 256S.10.

(i) "Consultation services" means a Minnesota health care program enrolled provider organization that provides assistance to the participant in making informed choices about CFSS services in general and self-directed tasks in particular, and in developing a person-centered CFSS service delivery plan to achieve quality service outcomes.

(j) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

(k) "Dependency" in activities of daily living means a person requires hands-on assistance or constant supervision and cueing to accomplish one or more of the activities of daily living every day or on the days during the week that the activity is performed; however, a child ~~may~~ must not be found to be dependent in an activity of daily living if, because of the child's age, an adult would either perform the activity for the child or assist the child with the activity and the assistance needed is the assistance appropriate for a typical child of the same age.

(l) "Extended CFSS" means CFSS services and supports provided under CFSS that are included in the CFSS service delivery plan through one of the home and community-based services waivers and as approved and authorized under chapter 256S and sections 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants. Extended CFSS excludes the purchase of goods.

(m) "Financial management services provider" or "FMS provider" means a qualified organization required for participants using the budget model under subdivision 13 that is an enrolled provider with the department to provide vendor fiscal/employer agent financial management services (FMS).

(n) "Health-related procedures and tasks" means procedures and tasks related to the specific assessed health needs of a participant that can be taught or assigned by a state-licensed health care or mental health professional and performed by a support worker.

(o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community.

(p) "Lead agency" has the meaning given in section 256B.0911, subdivision 1a, paragraph (e).

(q) "Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(r) "Level I behavior" means physical aggression towards self or others or destruction of property that requires the immediate response of another person.

(s) "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, and includes any of the following supports listed in clauses (1) to (3) and other types of assistance, except that a support worker ~~may~~ must not determine medication dose or time for medication or inject medications into veins, muscles, or skin:

(1) under the direction of the participant or the participant's representative, bringing medications to the participant including medications given through a nebulizer, opening a container of previously set-up medications, emptying the container into the participant's hand, opening and giving the medication in the original container to the participant, or bringing to the participant liquids or food to accompany the medication;

(2) organizing medications as directed by the participant or the participant's representative; and

(3) providing verbal or visual reminders to perform regularly scheduled medications.

(t) "Participant" means a person who is eligible for CFSS.

(u) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant or participant's legal representative, if any, to serve as a representative in connection with the provision of CFSS. ~~This authorization must be in writing or by another method that clearly indicates the participant's free choice and may be withdrawn at any time. The participant's representative must have no financial interest in the provision of any services included in the participant's CFSS service delivery plan and must be capable of providing the support necessary to assist the participant in the use of CFSS. If through the assessment process described in subdivision 5 a participant is determined to be in need of a participant's representative, one must be selected.~~ If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one. ~~Two persons may be designated as a participant's~~

~~representative for reasons such as divided households and court-ordered custodies. Duties of a participant's representatives may include:~~

~~(1) being available while services are provided in a method agreed upon by the participant or the participant's legal representative and documented in the participant's CFSS service delivery plan;~~

~~(2) monitoring CFSS services to ensure the participant's CFSS service delivery plan is being followed; and~~

~~(3) reviewing and signing CFSS time sheets after services are provided to provide verification of the CFSS services.~~

(v) "Person-centered planning process" means a process that is directed by the participant to plan for CFSS services and supports.

(w) "Service budget" means the authorized dollar amount used for the budget model or for the purchase of goods.

(x) "Shared services" means the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into ~~an~~ a written agreement to receive services at the same time ~~and~~, in the same setting ~~by~~, and through the same ~~employer~~ agency-provider or FMS provider.

(y) "Support worker" means a qualified and trained employee of the agency-provider as required by subdivision 11b or of the participant employer under the budget model as required by subdivision 14 who has direct contact with the participant and provides services as specified within the participant's CFSS service delivery plan.

(z) "Unit" means the increment of service based on hours or minutes identified in the service agreement.

(aa) "Vendor fiscal employer agent" means an agency that provides financial management services.

(bb) "Wages and benefits" means the hourly wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or other forms of employee compensation and benefits.

(cc) "Worker training and development" means services provided according to subdivision 18a for developing workers' skills as required by the participant's individual CFSS service

delivery plan that are arranged for or provided by the agency-provider or purchased by the participant employer. These services include training, education, direct observation and supervision, and evaluation and coaching of job skills and tasks, including supervision of health-related tasks or behavioral supports.

Sec. 5. Minnesota Statutes 2020, section 256B.85, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) CFSS is available to a person who ~~meets one of the following~~:

~~(1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056, or 256B.057, subdivisions 5 and 9;~~

(1) is determined eligible for medical assistance under this chapter, excluding those under section 256B.057, subdivisions 3, 3a, 3b, and 4;

(2) is a participant in the alternative care program under section 256B.0913;

(3) is a waiver participant as defined under chapter 256S or section 256B.092, 256B.093, or 256B.49; or

(4) has medical services identified in a person's individualized education program and is eligible for services as determined in section 256B.0625, subdivision 26.

(b) In addition to meeting the eligibility criteria in paragraph (a), a person must also meet all of the following:

(1) require assistance and be determined dependent in one activity of daily living or Level I behavior based on assessment under section 256B.0911; and

(2) is not a participant under a family support grant under section 252.32.

(c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as determined under section 256B.0911.

Sec. 6. Minnesota Statutes 2020, section 256B.85, subdivision 4, is amended to read:

Subd. 4. **Eligibility for other services.** Selection of CFSS by a participant must not restrict access to other medically necessary care and services furnished under the state plan benefit or other services available through the alternative care program.

Sec. 7. Minnesota Statutes 2020, section 256B.85, subdivision 5, is amended to read:

Subd. 5. **Assessment requirements.** (a) The assessment of functional need must:

(1) be conducted by a certified assessor according to the criteria established in section 256B.0911, subdivision 3a;

(2) be conducted face-to-face, initially and at least annually thereafter, or when there is a significant change in the participant's condition or a change in the need for services and supports, or at the request of the participant when the participant experiences a change in condition or needs a change in the services or supports; and

(3) be completed using the format established by the commissioner.

(b) The results of the assessment and any recommendations and authorizations for CFSS must be determined and communicated in writing by the lead agency's ~~certified~~ assessor as defined in section 256B.0911 to the participant ~~and the agency-provider or FMS provider chosen by the participant~~ or the participant's representative and chosen CFSS providers within ~~40 calendar~~ ten business days and must include the participant's right to appeal the assessment under section 256.045, subdivision 3.

(c) The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model. The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model without using the assessment process described in this subdivision. Authorization for a temporary level of CFSS services under the agency-provider model is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this paragraph shall have no bearing on a future authorization. ~~Participants approved for a temporary authorization shall access the consultation service~~ For CFSS services needed beyond the 45-day temporary authorization, the lead agency must conduct an assessment as described in this subdivision and participants must use consultation services to complete their orientation and selection of a service model.

Sec. 8. Minnesota Statutes 2020, section 256B.85, subdivision 6, is amended to read:

Subd. 6. **Community first services and supports service delivery plan.** (a) The CFSS service delivery plan must be developed and evaluated through a person-centered planning process by the participant, or the participant's representative or legal representative who may be assisted by a consultation services provider. The CFSS service delivery plan must reflect the services and supports that are important to the participant and for the participant to meet the needs assessed by the certified assessor and identified in the coordinated service and support plan identified in ~~section~~ sections 256B.092, subdivision 1b, and 256S.10. The CFSS service delivery plan must be reviewed by the participant, the consultation services provider, and the agency-provider or FMS provider prior to starting services and at least

annually upon reassessment, or when there is a significant change in the participant's condition, or a change in the need for services and supports.

(b) The commissioner shall establish the format and criteria for the CFSS service delivery plan.

(c) The CFSS service delivery plan must be person-centered and:

(1) specify the consultation services provider, agency-provider, or FMS provider selected by the participant;

(2) reflect the setting in which the participant resides that is chosen by the participant;

(3) reflect the participant's strengths and preferences;

(4) include the methods and supports used to address the needs as identified through an assessment of functional needs;

(5) include the participant's identified goals and desired outcomes;

(6) reflect the services and supports, paid and unpaid, that will assist the participant to achieve identified goals, including the costs of the services and supports, and the providers of those services and supports, including natural supports;

(7) identify the amount and frequency of face-to-face supports and amount and frequency of remote supports and technology that will be used;

(8) identify risk factors and measures in place to minimize them, including individualized backup plans;

(9) be understandable to the participant and the individuals providing support;

(10) identify the individual or entity responsible for monitoring the plan;

(11) be finalized and agreed to in writing by the participant and signed by ~~all~~ individuals and providers responsible for its implementation;

(12) be distributed to the participant and other people involved in the plan;

(13) prevent the provision of unnecessary or inappropriate care;

(14) include a detailed budget for expenditures for budget model participants or participants under the agency-provider model if purchasing goods; and

(15) include a plan for worker training and development provided according to subdivision 18a detailing what service components will be used, when the service components

will be used, how they will be provided, and how these service components relate to the participant's individual needs and CFSS support worker services.

(d) The CFSS service delivery plan must describe the units or dollar amount available to the participant. The total units of agency-provider services or the service budget amount for the budget model include both annual totals and a monthly average amount that cover the number of months of the service agreement. The amount used each month may vary, but additional funds must not be provided above the annual service authorization amount, determined according to subdivision 8, unless a change in condition is assessed and authorized by the certified assessor and documented in the coordinated service and support plan and CFSS service delivery plan.

(e) In assisting with the development or modification of the CFSS service delivery plan during the authorization time period, the consultation services provider shall:

(1) consult with the FMS provider on the spending budget when applicable; and

(2) consult with the participant or participant's representative, agency-provider, and case manager~~/~~ or care coordinator.

(f) The CFSS service delivery plan must be approved by the consultation services provider for participants without a case manager or care coordinator who is responsible for authorizing services. A case manager or care coordinator must approve the plan for a waiver or alternative care program participant.

Sec. 9. Minnesota Statutes 2020, section 256B.85, subdivision 7, is amended to read:

Subd. 7. **Community first services and supports; covered services.** Services and supports covered under CFSS include:

(1) assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task;

(2) assistance to acquire, maintain, or enhance the skills necessary for the participant to accomplish activities of daily living, instrumental activities of daily living, or health-related tasks;

(3) expenditures for items, services, supports, environmental modifications, or goods, including assistive technology. These expenditures must:

(i) relate to a need identified in a participant's CFSS service delivery plan; and

(ii) increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance for the participant's assessed needs;

(4) observation and redirection for behavior or symptoms where there is a need for assistance;

(5) back-up systems or mechanisms, such as the use of pagers or other electronic devices, to ensure continuity of the participant's services and supports;

(6) services provided by a consultation services provider as defined under subdivision 17, that is under contract with the department and enrolled as a Minnesota health care program provider;

(7) services provided by an FMS provider as defined under subdivision 13a, that is an enrolled provider with the department;

(8) CFSS services provided by a support worker who is a parent, stepparent, or legal guardian of a participant under age 18, or who is the participant's spouse. These support workers shall not:

(i) provide any medical assistance home and community-based services in excess of 40 hours per seven-day period regardless of the number of parents providing services, combination of parents and spouses providing services, or number of children who receive medical assistance services; and

(ii) have a wage that exceeds the current rate for a CFSS support worker including the wage, benefits, and payroll taxes; and

(9) worker training and development services as described in subdivision 18a.

Sec. 10. Minnesota Statutes 2020, section 256B.85, subdivision 8, is amended to read:

Subd. 8. **Determination of CFSS service authorization amount.** (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin. The authorization for CFSS must be completed as soon as possible following an assessment but no later than 40 calendar days from the date of the assessment.

(b) The amount of CFSS authorized must be based on the participant's home care rating described in paragraphs (d) and (e) and any additional service units for which the participant qualifies as described in paragraph (f).

(c) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for a participant:

(1) the total number of dependencies of activities of daily living;

(2) the presence of complex health-related needs; and

(3) the presence of Level I behavior.

(d) The methodology to determine the total service units for CFSS for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the PCA program.

(e) Each home care rating is designated by the letters P through Z and EN and has the following base number of service units assigned:

(1) P home care rating requires Level I behavior or one to three dependencies in ADLs and qualifies the person for five service units;

(2) Q home care rating requires Level I behavior and one to three dependencies in ADLs and qualifies the person for six service units;

(3) R home care rating requires a complex health-related need and one to three dependencies in ADLs and qualifies the person for seven service units;

(4) S home care rating requires four to six dependencies in ADLs and qualifies the person for ten service units;

(5) T home care rating requires four to six dependencies in ADLs and Level I behavior and qualifies the person for 11 service units;

(6) U home care rating requires four to six dependencies in ADLs and a complex health-related need and qualifies the person for 14 service units;

(7) V home care rating requires seven to eight dependencies in ADLs and qualifies the person for 17 service units;

(8) W home care rating requires seven to eight dependencies in ADLs and Level I behavior and qualifies the person for 20 service units;

(9) Z home care rating requires seven to eight dependencies in ADLs and a complex health-related need and qualifies the person for 30 service units; and

(10) EN home care rating includes ventilator dependency as defined in section 256B.0651, subdivision 1, paragraph (g). A person who meets the definition of ventilator-dependent

and the EN home care rating and utilize a combination of CFSS and home care nursing services is limited to a total of 96 service units per day for those services in combination. Additional units may be authorized when a person's assessment indicates a need for two staff to perform activities. Additional time is limited to 16 service units per day.

(f) Additional service units are provided through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living;

(2) 30 additional minutes per day for each complex health-related need; and

(3) 30 additional minutes per day ~~when the~~ for each behavior under this clause that requires assistance at least four times per week ~~for one or more of the following behaviors~~:

(i) level I behavior that requires the immediate response of another person;

(ii) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(iii) increased need for assistance for participants who are verbally aggressive or resistive to care so that the time needed to perform activities of daily living is increased.

(g) The service budget for budget model participants shall be based on:

(1) assessed units as determined by the home care rating; and

(2) an adjustment needed for administrative expenses.

Sec. 11. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision to read:

Subd. 8a. **Authorization; exceptions.** All CFSS services must be authorized by the commissioner or the commissioner's designee as described in subdivision 8 except when:

(1) the lead agency temporarily authorizes services in the agency-provider model as described in subdivision 5, paragraph (c);

(2) CFSS services in the agency-provider model were required to treat an emergency medical condition that if not immediately treated could cause a participant serious physical or mental disability, continuation of severe pain, or death. The CFSS agency provider must request retroactive authorization from the lead agency no later than five working days after providing the initial emergency service. The CFSS agency provider must be able to substantiate the emergency through documentation such as reports, notes, and admission

or discharge histories. A lead agency must follow the authorization process in subdivision 5 after the lead agency receives the request for authorization from the agency provider;

(3) the lead agency authorizes a temporary increase to the amount of services authorized in the agency or budget model to accommodate the participant's temporary higher need for services. Authorization for a temporary level of CFSS services is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this clause shall have no bearing on a future authorization;

(4) a participant's medical assistance eligibility has lapsed, is then retroactively reinstated, and an authorization for CFSS services is completed based on the date of a current assessment, eligibility, and request for authorization;

(5) a third-party payer for CFSS services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(6) the commissioner has determined that a lead agency or state human services agency has made an error; or

(7) a participant enrolled in managed care experiences a temporary disenrollment from a health plan, in which case the commissioner shall accept the current health plan authorization for CFSS services for up to 60 days. The request must be received within the first 30 days of the disenrollment. If the recipient's reenrollment in managed care is after the 60 days and before 90 days, the provider shall request an additional 30-day extension of the current health plan authorization, for a total limit of 90 days from the time of disenrollment.

Sec. 12. Minnesota Statutes 2020, section 256B.85, subdivision 9, is amended to read:

Subd. 9. **Noncovered services.** (a) Services or supports that are not eligible for payment under this section include those that:

(1) are not authorized by the certified assessor or included in the CFSS service delivery plan;

(2) are provided prior to the authorization of services and the approval of the CFSS service delivery plan;

(3) are duplicative of other paid services in the CFSS service delivery plan;

(4) supplant natural unpaid supports that appropriately meet a need in the CFSS service delivery plan, are provided voluntarily to the participant, and are selected by the participant in lieu of other services and supports;

(5) are not effective means to meet the participant's needs; and

(6) are available through other funding sources, including~~,~~ but not limited to~~,~~ funding through title IV-E of the Social Security Act.

(b) Additional services, goods, or supports that are not covered include:

(1) those that are not for the direct benefit of the participant, except that services for caregivers such as training to improve the ability to provide CFSS are considered to directly benefit the participant if chosen by the participant and approved in the support plan;

(2) any fees incurred by the participant, such as Minnesota health care programs fees and co-pays, legal fees, or costs related to advocate agencies;

(3) insurance, except for insurance costs related to employee coverage;

(4) room and board costs for the participant;

(5) services, supports, or goods that are not related to the assessed needs;

(6) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

(7) assistive technology devices and assistive technology services other than those for back-up systems or mechanisms to ensure continuity of service and supports listed in subdivision 7;

(8) medical supplies and equipment covered under medical assistance;

(9) environmental modifications, except as specified in subdivision 7;

(10) expenses for travel, lodging, or meals related to training the participant or the participant's representative or legal representative;

(11) experimental treatments;

(12) any service or good covered by other state plan services, including prescription and over-the-counter medications, compounds, and solutions and related fees, including premiums and co-payments;

(13) membership dues or costs, except when the service is necessary and appropriate to treat a health condition or to improve or maintain the adult participant's health condition.

The condition must be identified in the participant's CFSS service delivery plan and monitored by a Minnesota health care program enrolled physician, advanced practice registered nurse, or physician's assistant;

(14) vacation expenses other than the cost of direct services;

(15) vehicle maintenance or modifications not related to the disability, health condition, or physical need;

(16) tickets and related costs to attend sporting or other recreational or entertainment events;

(17) services provided and billed by a provider who is not an enrolled CFSS provider;

(18) CFSS provided by a participant's representative or paid legal guardian;

(19) services that are used solely as a child care or babysitting service;

(20) services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules;

(21) sterile procedures;

(22) giving of injections into veins, muscles, or skin;

(23) homemaker services that are not an integral part of the assessed CFSS service;

(24) home maintenance or chore services;

(25) home care services, including hospice services if elected by the participant, covered by Medicare or any other insurance held by the participant;

(26) services to other members of the participant's household;

(27) services not specified as covered under medical assistance as CFSS;

(28) application of restraints or implementation of deprivation procedures;

(29) assessments by CFSS provider organizations or by independently enrolled registered nurses;

(30) services provided in lieu of legally required staffing in a residential or child care setting; ~~and~~

(31) services provided by ~~the residential or program~~ a foster care license holder ~~in a residence for more than four participants.~~ except when the home of the person receiving services is the licensed foster care provider's primary residence;

(32) services that are the responsibility of the foster care provider under the terms of the foster care placement agreement, assessment under sections 256N.24 and 260C.4411, and administrative rules under sections 256N.24 and 260C.4411;

(33) services in a setting that has a licensed capacity greater than six, unless all conditions for a variance under section 245A.04, subdivision 9a, are satisfied for a sibling, as defined in section 260C.007, subdivision 32;

(34) services from a provider who owns or otherwise controls the living arrangement, except when the provider of services is related by blood, marriage, or adoption or when the provider is a licensed foster care provider who is not prohibited from providing services under clauses (31) to (33);

(35) instrumental activities of daily living for children younger than 18 years of age, except when immediate attention is needed for health or hygiene reasons integral to an assessed need for assistance with activities of daily living, health-related procedures, and tasks or behaviors; or

(36) services provided to a resident of a nursing facility, hospital, intermediate care facility, or health care facility licensed by the commissioner of health.

Sec. 13. Minnesota Statutes 2020, section 256B.85, subdivision 10, is amended to read:

Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a) Agency-providers identified in subdivision 11 and FMS providers identified in subdivision 13a shall:

(1) enroll as a medical assistance Minnesota health care programs provider and meet all applicable provider standards and requirements including completion of required provider training as determined by the commissioner;

(2) demonstrate compliance with federal and state laws and policies for CFSS as determined by the commissioner;

(3) comply with background study requirements under chapter 245C and maintain documentation of background study requests and results;

(4) verify and maintain records of all services and expenditures by the participant, including hours worked by support workers;

(5) not engage in any agency-initiated direct contact or marketing in person, by telephone, or other electronic means to potential participants, guardians, family members, or participants' representatives;

(6) directly provide services and not use a subcontractor or reporting agent;

(7) meet the financial requirements established by the commissioner for financial solvency;

(8) have never had a lead agency contract or provider agreement discontinued due to fraud, or have never had an owner, board member, or manager fail a state or FBI-based criminal background check while enrolled or seeking enrollment as a Minnesota health care programs provider; and

(9) have an office located in Minnesota.

(b) In conducting general duties, agency-providers and FMS providers shall:

(1) pay support workers based upon actual hours of services provided;

(2) pay for worker training and development services based upon actual hours of services provided or the unit cost of the training session purchased;

(3) withhold and pay all applicable federal and state payroll taxes;

(4) make arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(5) enter into a written agreement with the participant, participant's representative, or legal representative that assigns roles and responsibilities to be performed before services, supports, or goods are provided and that meets the requirements of subdivisions 20a, 20b, and 20c for agency-providers;

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

(7) comply with the labor market reporting requirements described in section 256B.4912, subdivision 1a;

(8) comply with any data requests from the department consistent with the Minnesota Government Data Practices Act under chapter 13; ~~and~~

(9) maintain documentation for the requirements under subdivision 16, paragraph (e), clause (2), to qualify for an enhanced rate under this section~~.~~; and

(10) request reassessments 60 days before the end of the current authorization for CFSS on forms provided by the commissioner.

Sec. 14. Minnesota Statutes 2020, section 256B.85, subdivision 11, is amended to read:

Subd. 11. **Agency-provider model.** (a) The agency-provider model includes services provided by support workers and staff providing worker training and development services who are employed by an agency-provider that meets the criteria established by the commissioner, including required training.

(b) The agency-provider shall allow the participant to have a significant role in the selection and dismissal of the support workers for the delivery of the services and supports specified in the participant's CFSS service delivery plan. The agency must make a reasonable effort to fulfill the participant's request for the participant's preferred worker.

(c) A participant may use authorized units of CFSS services as needed within a service agreement that is not greater than 12 months. Using authorized units in a flexible manner in either the agency-provider model or the budget model does not increase the total amount of services and supports authorized for a participant or included in the participant's CFSS service delivery plan.

(d) A participant may share CFSS services. Two or three CFSS participants may share services at the same time provided by the same support worker.

(e) The agency-provider must use a minimum of 72.5 percent of the revenue generated by the medical assistance payment for CFSS for support worker wages and benefits, except all of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. The agency-provider must document how this requirement is being met. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services must not be used in making this calculation.

(f) The agency-provider model must be used by ~~individuals~~ participants who are restricted by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

(g) Participants purchasing goods under this model, along with support worker services, must:

(1) specify the goods in the CFSS service delivery plan and detailed budget for expenditures that must be approved by the consultation services provider, case manager, or care coordinator; and

(2) use the FMS provider for the billing and payment of such goods.

Sec. 15. Minnesota Statutes 2020, section 256B.85, subdivision 11b, is amended to read:

Subd. 11b. **Agency-provider model; support worker competency.** (a) The agency-provider must ensure that support workers are competent to meet the participant's assessed needs, goals, and additional requirements as written in the CFSS service delivery plan. ~~Within 30 days of any support worker beginning to provide services for a participant,~~ The agency-provider must evaluate the competency of the worker through direct observation of the support worker's performance of the job functions in a setting where the participant is using CFSS~~.~~ within 30 days of:

(1) any support worker beginning to provide services for a participant; or

(2) any support worker beginning to provide shared services.

(b) The agency-provider must verify and maintain evidence of support worker competency, including documentation of the support worker's:

(1) education and experience relevant to the job responsibilities assigned to the support worker and the needs of the participant;

(2) relevant training received from sources other than the agency-provider;

(3) orientation and instruction to implement services and supports to participant needs and preferences as identified in the CFSS service delivery plan; ~~and~~

(4) orientation and instruction delivered by an individual competent to perform, teach, or assign the health-related tasks for tracheostomy suctioning and services to participants on ventilator support, including equipment operation and maintenance; and

~~(4)~~ (5) periodic performance reviews completed by the agency-provider at least annually, including any evaluations required under subdivision 11a, paragraph (a). If a support worker is a minor, all evaluations of worker competency must be completed in person and in a setting where the participant is using CFSS.

(c) The agency-provider must develop a worker training and development plan with the participant to ensure support worker competency. The worker training and development plan must be updated when:

(1) the support worker begins providing services;

(2) the support worker begins providing shared services;

~~(2)~~ (3) there is any change in condition or a modification to the CFSS service delivery plan; or

~~(3)~~ (4) a performance review indicates that additional training is needed.

Sec. 16. Minnesota Statutes 2020, section 256B.85, subdivision 12, is amended to read:

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

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

(2) proof of surety bond coverage. Upon new enrollment, or if the agency-provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the agency-provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the agency-provider must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

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

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

(8) ~~copies of all other forms~~ proof that the CFSS agency-provider ~~uses in the course of daily business including, but not limited to~~ has all of the following forms and documents:

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

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

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

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

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

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

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

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

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

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

~~(d) The commissioner shall send annual review notifications to agency-providers 30 days prior to renewal. The notification must:~~

~~(1) list the materials and information the agency-provider is required to submit;~~

~~(2) provide instructions on submitting information to the commissioner; and~~

~~(3) provide a due date by which the commissioner must receive the requested information.~~

~~Agency-providers shall submit all required documentation for annual review within 30 days of notification from the commissioner. If an agency-provider fails to submit all the required documentation, the commissioner may take action under subdivision 23a.~~

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

Sec. 17. Minnesota Statutes 2020, section 256B.85, subdivision 12b, is amended to read:

Subd. 12b. **CFSS agency-provider requirements; notice regarding termination of services.** (a) An agency-provider must provide written notice when it intends to terminate services with a participant at least ~~ten~~ 30 calendar days before the proposed service termination is to become effective, except in cases where:

(1) the participant engages in conduct that significantly alters the terms of the CFSS service delivery plan with the agency-provider;

(2) the participant or other persons at the setting where services are being provided engage in conduct that creates an imminent risk of harm to the support worker or other agency-provider staff; or

(3) an emergency or a significant change in the participant's condition occurs within a 24-hour period that results in the participant's service needs exceeding the participant's identified needs in the current CFSS service delivery plan so that the agency-provider cannot safely meet the participant's needs.

(b) When a participant initiates a request to terminate CFSS services with the agency-provider, the agency-provider must give the participant a written ~~acknowledgement~~ acknowledgment of the participant's service termination request that includes the date the request was received by the agency-provider and the requested date of termination.

(c) The agency-provider must participate in a coordinated transfer of the participant to a new agency-provider to ensure continuity of care.

Sec. 18. Minnesota Statutes 2020, section 256B.85, subdivision 13, is amended to read:

Subd. 13. **Budget model.** (a) Under the budget model participants exercise responsibility and control over the services and supports described and budgeted within the CFSS service delivery plan. Participants must use services specified in subdivision 13a provided by an FMS provider. Under this model, participants may use their approved service budget allocation to:

(1) directly employ support workers, and pay wages, federal and state payroll taxes, and premiums for workers' compensation, liability, and health insurance coverage; and

(2) obtain supports and goods as defined in subdivision 7.

(b) Participants who are unable to fulfill any of the functions listed in paragraph (a) may authorize a legal representative or participant's representative to do so on their behalf.

(c) If two or more participants using the budget model live in the same household and have the same worker, the participants must use the same FMS provider.

(d) If the FMS provider advises that there is a joint employer in the budget model, all participants associated with that joint employer must use the same FMS provider.

~~(c)~~ (e) The commissioner shall disenroll or exclude participants from the budget model and transfer them to the agency-provider model under, but not limited to, the following circumstances:

(1) when a participant has been restricted by the Minnesota restricted recipient program, in which case the participant may be excluded for a specified time period under Minnesota Rules, parts 9505.2160 to 9505.2245;

(2) when a participant exits the budget model during the participant's service plan year. Upon transfer, the participant shall not access the budget model for the remainder of that service plan year; or

(3) when the department determines that the participant or participant's representative or legal representative is unable to fulfill the responsibilities under the budget model, as specified in subdivision 14.

~~(d)~~ (f) A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision under paragraph ~~(c)~~ (e), clause (3), to disenroll or exclude the participant from the budget model.

Sec. 19. Minnesota Statutes 2020, section 256B.85, subdivision 13a, is amended to read:

Subd. 13a. **Financial management services.** (a) Services provided by an FMS provider include but are not limited to: filing and payment of federal and state payroll taxes on behalf of the participant; initiating and complying with background study requirements under chapter 245C and maintaining documentation of background study requests and results; billing for approved CFSS services with authorized funds; monitoring expenditures; accounting for and disbursing CFSS funds; providing assistance in obtaining and filing for liability, workers' compensation, and unemployment coverage; and providing participant instruction and technical assistance to the participant in fulfilling employer-related requirements in accordance with section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1.

(b) Agency-provider services shall not be provided by the FMS provider.

(c) The FMS provider shall provide service functions as determined by the commissioner for budget model participants that include but are not limited to:

(1) assistance with the development of the detailed budget for expenditures portion of the CFSS service delivery plan as requested by the consultation services provider or participant;

(2) data recording and reporting of participant spending;

(3) other duties established by the department, including with respect to providing assistance to the participant, participant's representative, or legal representative in performing employer responsibilities regarding support workers. The support worker shall not be considered the employee of the FMS provider; and

(4) billing, payment, and accounting of approved expenditures for goods.

(d) The FMS provider shall obtain an assurance statement from the participant employer agreeing to follow state and federal regulations and CFSS policies regarding employment of support workers.

(e) The FMS provider shall:

(1) not limit or restrict the participant's choice of service or support providers or service delivery models consistent with any applicable state and federal requirements;

(2) provide the participant, consultation services provider, and case manager or care coordinator, if applicable, with a monthly written summary of the spending for services and supports that were billed against the spending budget;

(3) be knowledgeable of state and federal employment regulations, including those under the Fair Labor Standards Act of 1938, and comply with the requirements under section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1, regarding agency employer tax liability for vendor fiscal/employer agent, and any requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

(4) have current and adequate liability insurance and bonding and sufficient cash flow as determined by the commissioner and have on staff or under contract a certified public accountant or an individual with a baccalaureate degree in accounting;

(5) assume fiscal accountability for state funds designated for the program and be held liable for any overpayments or violations of applicable statutes or rules, including but not limited to the Minnesota False Claims Act, chapter 15C; ~~and~~

(6) maintain documentation of receipts, invoices, and bills to track all services and supports expenditures for any goods purchased and maintain time records of support workers. The documentation and time records must be maintained for a minimum of five years from the claim date and be available for audit or review upon request by the commissioner. Claims submitted by the FMS provider to the commissioner for payment must correspond with services, amounts, and time periods as authorized in the participant's service budget and service plan and must contain specific identifying information as determined by the commissioner~~.~~; and

(7) provide written notice to the participant or the participant's representative at least 30 calendar days before a proposed service termination becomes effective.

(f) The commissioner ~~of human services~~ shall:

(1) establish rates and payment methodology for the FMS provider;

(2) identify a process to ensure quality and performance standards for the FMS provider and ensure statewide access to FMS providers; and

(3) establish a uniform protocol for delivering and administering CFSS services to be used by eligible FMS providers.

Sec. 20. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision to read:

Subd. 14a. **Participant's representative responsibilities.** (a) If a participant is unable to direct the participant's own care, the participant must use a participant's representative to receive CFSS services. A participant's representative is required if:

(1) the person is under 18 years of age;

(2) the person has a court-appointed guardian; or

(3) an assessment according to section 256B.0659, subdivision 3a, determines that the participant is in need of a participant's representative.

(b) A participant's representative must:

(1) be at least 18 years of age;

(2) actively participate in planning and directing CFSS services;

(3) have sufficient knowledge of the participant's circumstances to use CFSS services consistent with the participant's health and safety needs identified in the participant's service delivery plan;

(4) not have a financial interest in the provision of any services included in the participant's CFSS service delivery plan; and

(5) be capable of providing the support necessary to assist the participant in the use of CFSS services.

(c) A participant's representative must not be the:

(1) support worker;

(2) worker training and development service provider;

(3) agency-provider staff, unless related to the participant by blood, marriage, or adoption;

(4) consultation service provider, unless related to the participant by blood, marriage, or adoption;

(5) FMS staff, unless related to the participant by blood, marriage, or adoption;

(6) FMS owner or manager; or

(7) lead agency staff acting as part of employment.

(d) A licensed family foster parent who lives with the participant may be the participant's representative if the family foster parent meets the other participant's representative requirements.

(e) There may be two persons designated as the participant's representative, including instances of divided households and court-ordered custodies. Each person named as the participant's representative must meet the program criteria and responsibilities.

(f) The participant or the participant's legal representative shall appoint a participant's representative. The participant's representative must be identified at the time of assessment and listed on the participant's service agreement and CFSS service delivery plan.

(g) A participant's representative must enter into a written agreement with an agency-provider or FMS on a form determined by the commissioner and maintained in the participant's file, to:

(1) be available while care is provided using a method agreed upon by the participant or the participant's legal representative and documented in the participant's service delivery plan;

(2) monitor CFSS services to ensure the participant's service delivery plan is followed;

(3) review and sign support worker time sheets after services are provided to verify the provision of services;

(4) review and sign vendor paperwork to verify receipt of goods; and

(5) in the budget model, review and sign documentation to verify worker training and development expenditures.

(h) A participant's representative may delegate responsibility to another adult who is not the support worker during a temporary absence of at least 24 hours but not more than six months. To delegate responsibility, the participant's representative must:

(1) ensure that the delegate serving as the participant's representative satisfies the requirements of the participant's representative;

(2) ensure that the delegate performs the functions of the participant's representative;

(3) communicate to the CFSS agency-provider or FMS provider about the need for a delegate by updating the written agreement to include the name of the delegate and the delegate's contact information; and

(4) ensure that the delegate protects the participant's privacy according to federal and state data privacy laws.

(i) The designation of a participant's representative remains in place until:

(1) the participant revokes the designation;

(2) the participant's representative withdraws the designation or becomes unable to fulfill the duties;

(3) the legal authority to act as a participant's representative changes; or

(4) the participant's representative is disqualified.

(j) A lead agency may disqualify a participant's representative who engages in conduct that creates an imminent risk of harm to the participant, the support workers, or other staff. A participant's representative who fails to provide support required by the participant must be referred to the common entry point.

Sec. 21. Minnesota Statutes 2020, section 256B.85, subdivision 15, is amended to read:

Subd. 15. **Documentation of support services provided; time sheets.** (a) CFSS services provided to a participant by a support worker employed by either an agency-provider or the participant employer must be documented daily by each support worker, on a time sheet. Time sheets may be created, submitted, and maintained electronically. Time sheets must be submitted by the support worker at least once per month to the:

(1) agency-provider when the participant is using the agency-provider model. The agency-provider must maintain a record of the time sheet and provide a copy of the time sheet to the participant; or

(2) participant and the participant's FMS provider when the participant is using the budget model. The participant and the FMS provider must maintain a record of the time sheet.

(b) The documentation on the time sheet must correspond to the participant's assessed needs within the scope of CFSS covered services. The accuracy of the time sheets must be verified by the:

(1) agency-provider when the participant is using the agency-provider model; or

(2) participant employer and the participant's FMS provider when the participant is using the budget model.

(c) The time sheet must document the time the support worker provides services to the participant. The following elements must be included in the time sheet:

(1) the support worker's full name and individual provider number;

(2) the agency-provider's name and telephone numbers, when responsible for the CFSS service delivery plan;

(3) the participant's full name;

(4) the dates within the pay period established by the agency-provider or FMS provider, including month, day, and year, and arrival and departure times with a.m. or p.m. notations for days worked within the established pay period;

(5) the covered services provided to the participant on each date of service;

(6) ~~a~~ the signature ~~line for~~ of the participant or the participant's representative and a statement that the participant's or participant's representative's signature is verification of the time sheet's accuracy;

(7) the ~~personal~~ signature of the support worker;

(8) any shared care provided, if applicable;

(9) a statement that it is a federal crime to provide false information on CFSS billings for medical assistance payments; and

(10) dates and location of participant stays in a hospital, care facility, or incarceration occurring within the established pay period.

Sec. 22. Minnesota Statutes 2020, section 256B.85, subdivision 17a, is amended to read:

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

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

(2) are under contract with the department;

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

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

(5) have proof of surety bond coverage. Upon new enrollment, or if the consultation service provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the consultation service provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the consultation service provider must purchase a surety bond of $100,000. The surety bond

must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

~~(5)~~ (6) employ lead professional staff with a minimum of ~~three~~ two years of experience in providing services such as support planning, support broker, case management or care coordination, or consultation services and consumer education to participants using a self-directed program using FMS under medical assistance;

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

~~(6)~~ (8) comply with medical assistance provider requirements;

~~(7)~~ (9) understand the CFSS program and its policies;

~~(8)~~ (10) are knowledgeable about self-directed principles and the application of the person-centered planning process;

~~(9)~~ (11) have general knowledge of the FMS provider duties and the vendor fiscal/employer agent model, including all applicable federal, state, and local laws and regulations regarding tax, labor, employment, and liability and workers' compensation coverage for household workers; and

~~(10)~~ (12) have all employees, including lead professional staff, staff in management and supervisory positions, and owners of the agency who are active in the day-to-day management and operations of the agency, complete training as specified in the contract with the department.

Sec. 23. Minnesota Statutes 2020, section 256B.85, subdivision 18a, is amended to read:

Subd. 18a. **Worker training and development services.** (a) The commissioner shall develop the scope of tasks and functions, service standards, and service limits for worker training and development services.

(b) Worker training and development costs are in addition to the participant's assessed service units or service budget. Services provided according to this subdivision must:

(1) help support workers obtain and expand the skills and knowledge necessary to ensure competency in providing quality services as needed and defined in the participant's CFSS service delivery plan and as required under subdivisions 11b and 14;

(2) be provided or arranged for by the agency-provider under subdivision 11, or purchased by the participant employer under the budget model as identified in subdivision 13; ~~and~~

(3) be delivered by an individual competent to perform, teach, or assign the tasks, including health-related tasks, identified in the plan through education, training, and work experience relevant to the person's assessed needs; and

~~(3)~~ (4) be described in the participant's CFSS service delivery plan and documented in the participant's file.

(c) Services covered under worker training and development shall include:

(1) support worker training on the participant's individual assessed needs and condition, provided individually or in a group setting by a skilled and knowledgeable trainer beyond any training the participant or participant's representative provides;

(2) tuition for professional classes and workshops for the participant's support workers that relate to the participant's assessed needs and condition;

(3) direct observation, monitoring, coaching, and documentation of support worker job skills and tasks, beyond any training the participant or participant's representative provides, including supervision of health-related tasks or behavioral supports that is conducted by an appropriate professional based on the participant's assessed needs. These services must be provided at the start of services or the start of a new support worker except as provided in paragraph (d) and must be specified in the participant's CFSS service delivery plan; and

(4) the activities to evaluate CFSS services and ensure support worker competency described in subdivisions 11a and 11b.

(d) The services in paragraph (c), clause (3), are not required to be provided for a new support worker providing services for a participant due to staffing failures, unless the support worker is expected to provide ongoing backup staffing coverage.

(e) Worker training and development services shall not include:

(1) general agency training, worker orientation, or training on CFSS self-directed models;

(2) payment for preparation or development time for the trainer or presenter;

(3) payment of the support worker's salary or compensation during the training;

(4) training or supervision provided by the participant, the participant's support worker, or the participant's informal supports, including the participant's representative; or

(5) services in excess of ~~96 units~~ the rate set by the commissioner per annual service agreement, unless approved by the department.

Sec. 24. Minnesota Statutes 2020, section 256B.85, subdivision 20b, is amended to read:

Subd. 20b. **Service-related rights under an agency-provider.** A participant receiving CFSS from an agency-provider has service-related rights to:

(1) participate in and approve the initial development and ongoing modification and evaluation of CFSS services provided to the participant;

(2) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(3) before services are initiated, be told the limits to the services available from the agency-provider, including the agency-provider's knowledge, skill, and ability to meet the participant's needs identified in the CFSS service delivery plan;

(4) a coordinated transfer of services when there will be a change in the agency-provider;

(5) before services are initiated, be told what the agency-provider charges for the services;

(6) before services are initiated, be told to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the participant may be responsible for paying;

(7) receive services from an individual who is competent and trained, who has professional certification or licensure, as required, and who meets additional qualifications identified in the participant's CFSS service delivery plan;

(8) have the participant's preferences for support workers identified and documented, and have those preferences met when possible; and

(9) before services are initiated, be told the choices that are available from the agency-provider for meeting the participant's assessed needs identified in the CFSS service delivery plan, including but not limited to which support worker staff will be providing services ~~and~~, the proposed frequency and schedule of visits, and any agreements for shared services.

Sec. 25. Minnesota Statutes 2020, section 256B.85, subdivision 23, is amended to read:

Subd. 23. **Commissioner's access.** (a) When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the agency-provider, consultation services provider, or FMS provider's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. ~~Denying the commissioner access to records is cause for immediate suspension of payment and terminating~~ If the ~~agency-provider's~~

~~enrollment or~~ agency-provider, FMS ~~provider's enrollment~~ provider, or consultation services provider denies the commissioner access to records, the provider's payment may be immediately suspended or the provider's enrollment may be terminated according to section 256B.064 ~~or terminating the consultation services provider contract~~.

(b) The commissioner has the authority to request proof of compliance with laws, rules, and policies from agency-providers, consultation services providers, FMS providers, and participants.

(c) When relevant to an investigation conducted by the commissioner, the commissioner must be given access to the business office, documents, and records of the agency-provider, consultation services provider, or FMS provider, including records maintained in electronic format; participants served by the program; and staff during regular business hours. The commissioner must be given access without prior notice and as often as the commissioner considers necessary if the commissioner is investigating an alleged violation of applicable laws or rules. The commissioner may request and shall receive assistance from lead agencies and other state, county, and municipal agencies and departments. The commissioner's access includes being allowed to photocopy, photograph, and make audio and video recordings at the commissioner's expense.

Sec. 26. Minnesota Statutes 2020, section 256B.85, subdivision 23a, is amended to read:

Subd. 23a. **Sanctions; information for participants upon termination of services.** (a) The commissioner may withhold payment from the provider or suspend or terminate the provider enrollment number if the provider fails to comply fully with applicable laws or rules. The provider has the right to appeal the decision of the commissioner under section 256B.064.

(b) Notwithstanding subdivision 13, paragraph (c), if a participant employer fails to comply fully with applicable laws or rules, the commissioner may disenroll the participant from the budget model. A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision to disenroll the participant from the budget model.

(c) Agency-providers of CFSS services or FMS providers must provide each participant with a copy of participant protections in subdivision 20c at least 30 days prior to terminating services to a participant, if the termination results from sanctions under this subdivision or section 256B.064, such as a payment withhold or a suspension or termination of the provider enrollment number. If a CFSS agency-provider ~~or~~, FMS provider, or consultation services provider determines it is unable to continue providing services to a participant because of

an action under this subdivision or section 256B.064, the agency-provider ~~or~~, FMS provider, or consultation services provider must notify the participant, the participant's representative, and the commissioner 30 days prior to terminating services to the participant, and must assist the commissioner and lead agency in supporting the participant in transitioning to another CFSS agency-provider ~~or~~, FMS provider, or consultation services provider of the participant's choice.

(d) In the event the commissioner withholds payment from a CFSS agency-provider ~~or~~, FMS provider, or consultation services provider, or suspends or terminates a provider enrollment number of a CFSS agency-provider ~~or~~, FMS provider, or consultation services provider under this subdivision or section 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care and the lead agencies for all participants with active service agreements with the agency-provider ~~or~~, FMS provider, or consultation services provider. At the commissioner's request, the lead agencies must contact participants to ensure that the participants are continuing to receive needed care, and that the participants have been given free choice of agency-provider ~~or~~, FMS provider, or consultation services provider if they transfer to another CFSS agency-provider ~~or~~, FMS provider, or consultation services provider. In addition, the commissioner or the commissioner's delegate may directly notify participants who receive care from the agency-provider ~~or~~, FMS provider, or consultation services provider that payments have been or will be withheld or that the provider's participation in medical assistance has been or will be suspended or terminated, if the commissioner determines that the notification is necessary to protect the welfare of the participants.

ARTICLE 16
MISCELLANEOUS

Section 1. **[119B.195] RETAINING EARLY EDUCATORS THROUGH ATTAINING INCENTIVES NOW (REETAIN) GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The retaining early educators through attaining incentives now (REETAIN) grant program is established to provide competitive grants to incentivize well-trained child care professionals to remain in the workforce. The overall goal of the REETAIN grant program is to create more consistent care for children over time.

Subd. 2. **Administration.** The commissioner shall administer the REETAIN grant program through a grant to a nonprofit with the demonstrated ability to manage benefit programs for child care professionals. Up to ten percent of grant money may be used for administration of the grant program.

Subd. 3. **Application.** Applicants must apply for the REETAIN grant program using the forms and according to timelines established by the commissioner.

Subd. 4. **Eligibility.** (a) To be eligible for a grant, an applicant must:

(1) be licensed to provide child care or work for a licensed child care program;

(2) work directly with children at least 30 hours per week;

(3) have worked in the applicant's current position for at least 12 months;

(4) agree to work in the early childhood care and education field for at least 12 months upon receiving a grant under this section;

(5) have a career lattice step of five or higher;

(6) have a current membership with the Minnesota quality improvement and registry tool;

(7) not be a current teacher education and compensation helps scholarship recipient; and

(8) meet any other requirements determined by the commissioner.

(b) Grant recipients must sign a contract agreeing to remain in the early childhood care and education field for 12 months.

Subd. 5. **Grant awards.** Grant awards must be made annually and may be made up to an amount per recipient determined by the commissioner. Grant recipients may use grant money for program supplies, training, or personal expenses.

Subd. 6. **Report.** By January 1 each year, the commissioner must report to the legislative committees with jurisdiction over child care about the number of grants awarded to recipients and outcomes of the grant program since the last report.

Sec. 2. Minnesota Statutes 2020, section 136A.128, subdivision 2, is amended to read:

Subd. 2. **Program components.** (a) The nonprofit organization must use the grant for:

(1) tuition scholarships up to ~~$5,000~~ $10,000 per year for courses leading to the nationally recognized child development associate credential or college-level courses leading to an associate's degree or bachelor's degree in early childhood development and school-age care; and

(2) education incentives of a minimum of ~~$100~~ $250 to participants in the tuition scholarship program if they complete a year of working in the early care and education field.

(b) Applicants for the scholarship must be employed by a licensed early childhood or child care program and working directly with children, a licensed family child care provider, employed by a public prekindergarten program, or an employee in a school-age program exempt from licensing under section 245A.03, subdivision 2, paragraph (a), clause (12). Lower wage earners must be given priority in awarding the tuition scholarships. Scholarship recipients must contribute at least ten percent of the total scholarship and must be sponsored by their employers, who must also contribute ~~ten~~ at least five percent of the total scholarship. Scholarship recipients who are self-employed must contribute 20 percent of the total scholarship.

Sec. 3. Minnesota Statutes 2020, section 136A.128, subdivision 4, is amended to read:

Subd. 4. **Administration.** A nonprofit organization that receives a grant under this section may use ~~five~~ ten percent of the grant amount to administer the program.

Sec. 4. Minnesota Statutes 2020, section 256.041, is amended to read:

256.041 CULTURAL AND ETHNIC COMMUNITIES LEADERSHIP COUNCIL.

Subdivision 1. **Establishment; purpose.** (a) There is hereby established the Cultural and Ethnic Communities Leadership Council for the Department of Human Services. The purpose of the council is to advise the commissioner of human services on ~~reducing~~ implementing strategies to reduce inequities and disparities that particularly affect racial and ethnic groups in Minnesota.

(b) This council is comprised of racially and ethnically diverse community leaders including American Indians who are residents of Minnesota facing the compounded challenges of systemic inequities. Members include people who are refugees, immigrants, and LGBTQ+; people who have disabilities; and people who live in rural Minnesota.

Subd. 2. **Members.** (a) The council must consist of:

(1) the chairs and ranking minority members of the committees in the house of representatives and the senate with jurisdiction over human services; and

(2) no fewer than 15 and no more than 25 members appointed by and serving at the pleasure of the commissioner of human services, in consultation with county, tribal, cultural, and ethnic communities; diverse program participants; ~~and~~ parent representatives from these communities; and cultural and ethnic communities leadership council members.

(b) In making appointments under this section, the commissioner shall give priority consideration to public members of the legislative councils of color established under ~~chapter 3~~ section 15.0145.

(c) Members must be appointed to allow for representation of the following groups:

(1) racial and ethnic minority groups;

(2) the American Indian community, which must be represented by two members;

(3) culturally and linguistically specific advocacy groups and service providers;

(4) human services program participants;

(5) public and private institutions;

(6) parents of human services program participants;

(7) members of the faith community;

(8) Department of Human Services employees; and

(9) any other group the commissioner deems appropriate to facilitate the goals and duties of the council.

Subd. 3. **Guidelines.** The commissioner shall direct the development of guidelines defining the membership of the council; setting out definitions; and developing duties of the commissioner, the council, and council members regarding racial and ethnic disparities reduction. The guidelines must be developed in consultation with:

(1) the chairs of relevant committees; and

(2) county, tribal, and cultural communities and program participants from these communities.

Subd. 4. **Chair.** The commissioner shall accept recommendations from the council to appoint a chair or chairs.

~~Subd. 5. **Terms for first appointees.** The initial members appointed shall serve until January 15, 2016.~~

Subd. 6. **Terms.** A term shall be for two years and appointees may be reappointed to serve two additional terms. The commissioner shall make appointments to replace members vacating their positions ~~by January 15 of each year~~ in a timely manner, no more than three months after the council reviews panel recommendations.

Subd. 7. **Duties of commissioner.** (a) The commissioner of human services or the commissioner's designee shall:

(1) maintain and actively engage with the council established in this section;

(2) supervise and coordinate policies for persons from racial, ethnic, cultural, linguistic, and tribal communities who experience disparities in access and outcomes;

(3) identify human services rules or statutes affecting persons from racial, ethnic, cultural, linguistic, and tribal communities that may need to be revised;

(4) investigate and implement ~~cost-effective~~ equitable and culturally responsive models of service delivery ~~such as~~ including careful ~~adaptation~~ adoption of ~~clinically~~ proven services ~~that constitute one strategy for increasing~~ to increase the number of culturally relevant services available to currently underserved populations; ~~and~~

(5) based on recommendations of the council, review identified department policies that maintain racial, ethnic, cultural, linguistic, and tribal disparities~~, and~~; make adjustments to ensure those disparities are not perpetuated~~.~~; and advise the department on progress and accountability measures for addressing inequities;

(6) in partnership with the council, renew and implement equity policy with action plans and resources necessary to implement the action plans;

(7) support interagency collaboration to advance equity;

(8) address the council at least twice annually on the state of equity within the department; and

(9) support member participation in the council, including participation in educational and community engagement events across Minnesota that address equity in human services.

(b) The commissioner of human services or the commissioner's designee shall consult with the council and receive recommendations from the council when meeting the requirements in this subdivision.

Subd. 8. **Duties of council.** The council shall:

(1) recommend to the commissioner for review ~~identified policies in the~~ Department of Human Services policy, budgetary, and operational decisions and practices that ~~maintain~~ impact racial, ethnic, cultural, linguistic, and tribal disparities;

(2) with community input, advance legislative proposals to improve racial and health equity outcomes;

(3) identify issues regarding inequities and disparities by engaging diverse populations in human services programs;

~~(3)~~ (4) engage in mutual learning essential for achieving human services parity and optimal wellness for service recipients;

~~(4)~~ (5) raise awareness about human services disparities to the legislature and media;

~~(5)~~ (6) provide technical assistance and consultation support to counties, private nonprofit agencies, and other service providers to build their capacity to provide equitable human services for persons from racial, ethnic, cultural, linguistic, and tribal communities who experience disparities in access and outcomes;

~~(6)~~ (7) provide technical assistance to promote statewide development of culturally and linguistically appropriate, accessible, and cost-effective human services and related policies;

~~(7) provide~~ (8) recommend and monitor training and outreach to facilitate access to culturally and linguistically appropriate, accessible, and cost-effective human services to prevent disparities;

~~(8) facilitate culturally appropriate and culturally sensitive admissions, continued services, discharges, and utilization review for human services agencies and institutions;~~

(9) form work groups to help carry out the duties of the council that include, but are not limited to, persons who provide and receive services and representatives of advocacy groups, and provide the work groups with clear guidelines, standardized parameters, and tasks for the work groups to accomplish;

(10) promote information sharing in the human services community and statewide; and

(11) by February 15 ~~each year~~ in the second year of the biennium, prepare and submit to the chairs and ranking minority members of the committees in the house of representatives and the senate with jurisdiction over human services a report that summarizes the activities of the council, identifies the major problems and issues confronting racial and ethnic groups in accessing human services, makes recommendations to address issues, and lists the specific objectives that the council seeks to attain during the next biennium, and recommendations to strengthen equity, diversity, and inclusion within the department. The report must ~~also include a list of programs, groups, and grants used to reduce disparities, and statistically valid reports of outcomes on the reduction of the disparities.~~ identify racial and ethnic groups' difficulty in accessing human services and make recommendations to address the issues. The report must include any updated Department of Human Services equity policy, implementation plans, equity initiatives, and the council's progress.

Subd. 9. **Duties of council members.** The members of the council shall:

(1) with no more than three absences per year, attend and participate in scheduled meetings and be prepared by reviewing meeting notes;

(2) maintain open communication channels with respective constituencies;

(3) identify and communicate issues and risks that could impact the timely completion of tasks;

(4) collaborate on inequity and disparity reduction efforts;

(5) communicate updates of the council's work progress and status on the Department of Human Services website; ~~and~~

(6) participate in any activities the council or chair deems appropriate and necessary to facilitate the goals and duties of the council~~.~~; and

(7) participate in work groups to carry out council duties.

Subd. 10. **Expiration.** The council ~~expires on June 30, 2022~~ shall expire when racial and ethnic-based disparities no longer exist in the state of Minnesota.

Subd. 11. **Compensation.** Compensation for members of the council is governed by section 15.059, subdivision 3.

Sec. 5. **CHILDREN WITH DISABILITIES INCLUSIVE CHILD CARE ACCESS EXPANSION GRANT PROGRAM.**

Subdivision 1. **Establishment.** (a) The commissioner of human services shall establish a competitive grant program to expand access to licensed family child care providers or licensed child care centers for children with disabilities including medical complexities. The commissioner shall award grants to counties or Tribes, including at least one county from the seven-county metropolitan area and at least one county or Tribe outside the seven-county metropolitan area, and grant funds shall be used to enable child care providers to develop an inclusive child care setting and offer care to children with disabilities and children without disabilities. Grants shall be awarded to at least two applicants beginning no later than December 1, 2021.

(b) For purposes of this section, "child with a disability" means a child who has a substantial delay or has an identifiable physical, medical, emotional, or mental condition that hinders development.

(c) For purposes of this section, "inclusive child care setting" means child care provided in a manner that serves children with disabilities in the same setting as children without disabilities.

Subd. 2. **Commissioner's duties.** To administer the grant program, the commissioner shall:

(1) consult with relevant stakeholders to develop a request for proposals that at least requires grant applicants to identify the items or services and estimated accompanying costs, where possible, needed to expand access to inclusive child care settings for children with disabilities;

(2) develop procedures for data collection, qualitative and quantitative measurement of grant program outcomes, and reporting requirements for grant recipients;

(3) convene a working group of grant recipients, partner child care providers, and participating families to assess progress on grant activities, share best practices, and collect and review data on grant activities; and

(4) by February 1, 2023, provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over early childhood programs on the activities and outcomes of the grant program with legislative recommendations for implementing inclusive child care settings statewide. The report shall be made available to the public.

Subd. 3. **Grant activities.** Grant recipients shall use grant funds for the cost of facility modifications, resources, or services necessary to expand access to inclusive child care settings for children with disabilities, including:

(1) onetime needs to equip a child care setting to serve children with disabilities, including but not limited to environmental modifications; accessibility modifications; sensory adaptation; training materials and staff time for training, including for substitutes; or equipment purchases, including durable medical equipment;

(2) ongoing medical- or disability-related services for children with disabilities in inclusive child care settings, including but not limited to mental health supports; inclusion specialist services; home care nursing; behavioral supports; coaching or training for staff and substitutes; substitute teaching time; or additional child care staff, an enhanced rate, or another mechanism to increase staff-to-child ratio; and

(3) other expenses determined by the grant recipient and each partner child care provider to be necessary to establish an inclusive child care setting and serve children with disabilities at the provider's location.

Subd. 4. **Requirements for grant recipients.** Upon receipt of grant funds and throughout the grant period, grant recipients shall:

(1) partner with at least two but no more than five child care providers, each of which must meet one of the following criteria:

(i) serve 29 or fewer children, including at least two children with a disability who are not a family member of the child care provider if the participating child care provider is a family child care provider; or

(ii) serve more than 30 children, including at least three children with a disability;

(2) develop and follow a process to ensure that grant funding is used to support children with disabilities who, without the additional supports made available through the grant, would have difficulty accessing an inclusive child care setting;

(3) pursue funding for ongoing services needed for children with disabilities in inclusive child care settings, such as Medicaid or private health insurance coverage; additional grant funding; or other funding sources;

(4) explore and seek opportunities to use existing federal funds to provide ongoing support to family child care providers or child care centers serving children with disabilities. Grant recipients shall seek to minimize family financial obligations for child care for a child with disabilities beyond what child care would cost for a child without disabilities; and

(5) identify and utilize training resources for child care providers, where available and applicable, for at least one of the grant recipient's partner child care providers.

Subd. 5. **Reporting.** Grant recipients shall report to the commissioner every six months, in a manner specified by the commissioner, on the following:

(1) the number, type, and cost of additional supports needed to serve children with disabilities in inclusive child care settings;

(2) best practices for billing;

(3) availability and use of funding sources other than through the grant program;

(4) processes for identifying families of children with disabilities who could benefit from grant activities and connecting them with a child care provider interested in serving them;

(5) processes and eligibility criteria used to determine whether a child is a child with a disability and means of prioritizing grant funding to serve children with significant support needs associated with their disability; and

(6) any other information deemed relevant by the commissioner.

Sec. 6. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; FAMILY CHILD CARE SHARED SERVICES INNOVATION GRANTS.**

The commissioner of human services shall establish a grant program to test strategies by which family child care providers may share services and thereby achieve economies of scale. The commissioner shall report the results of the grant program to the legislative committees with jurisdiction over early care and education programs.

Sec. 7. **REPORT ON PARTICIPATION IN EARLY CHILDHOOD PROGRAMS BY CHILDREN IN FOSTER CARE.**

Subdivision 1. **Reporting requirement.** (a) The commissioner of human services shall report on the participation in early care and education programs by children under age six who have experienced foster care, as defined in Minnesota Statutes, section 260C.007, subdivision 18, at any time during the reporting period.

(b) For purposes of this section, "early care and education program" means Early Head Start and Head Start under the federal Improving Head Start for School Readiness Act of 2007; special education programs under Minnesota Statutes, chapter 125A; early learning scholarships under Minnesota Statutes, section 124D.165; school readiness under Minnesota Statutes, sections 124D.15 and 124D.16; school readiness plus under Laws 2017, First Special Session chapter 5, article 8, section 9; voluntary prekindergarten under Minnesota Statutes, section 124D.151; child care assistance under Minnesota Statutes, chapter 119B; and other programs as determined by the commissioner.

Subd. 2. **Report content.** (a) The report shall provide counts and rates of participation in the early care and education program by each child's race, ethnicity, age, and county of residence. The report shall use the most current administrative data and systems, including the Early Childhood Longitudinal Data System, and include recommendations for collecting any other administrative data listed in this paragraph that is not currently available.

(b) The report shall include recommendations to:

(1) provide the data described in paragraph (a) on an annual basis as part of the report required under Minnesota Statutes, section 257.0725;

(2) facilitate children's continued participation in early care and education programs after reunification, adoption, or transfer of permanent legal and physical custody; and

(3) regularly report measures of early childhood well-being for children who have experienced foster care. "Measures of early childhood well-being" include administrative data from developmental screenings, school readiness assessments, well-child medical visits, and other sources as determined by the commissioner, in consultation with the commissioners of health, education, and management and budget, county social service and public health agencies, and school districts.

(c) The report shall include an implementation plan to increase the rates of participation among children and their foster families in early care and education programs, including processes for referrals and follow-up. The plan shall be developed in collaboration with affected communities and families, incorporating their experiences and feedback. Representatives from county public health agencies; county social service agencies, including child protection services; early childhood care and education providers; the judiciary; and school districts must collaborate on the plan's development and implementation strategy.

(d) The report shall identify barriers to be addressed to ensure that early care and education programs are responsive to the cultural, logistical, and racial equity concerns and needs of children's foster families and families of origin and the report shall identify methods to ensure that the experiences and feedback from children's foster families and families of origin are included in the ongoing implementation of early care and education programs.

Subd. 3. **Submission to legislature.** By June 30, 2022, the commissioner shall submit an interim progress report, including identification of potential administrative data sources and barriers and a listing of plan development participants, and by December 1, 2022, the commissioner shall submit the final report required under this section to the legislative committees with jurisdiction over early care and education programs.

Sec. 8. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 136A.128, in Minnesota Statutes, chapter 119B. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

ARTICLE 17
MENTAL HEALTH UNIFORM SERVICE STANDARDS

Section 1. **[245I.01] PURPOSE AND CITATION.**

Subdivision 1. **Citation.** This chapter may be cited as the "Mental Health Uniform Service Standards Act."

Subd. 2. **Purpose.** In accordance with sections 245.461 and 245.487, the purpose of this chapter is to create a system of mental health care that is unified, accountable, and comprehensive, and to promote the recovery and resiliency of Minnesotans who have mental illnesses. The state's public policy is to support Minnesotans' access to quality outpatient and residential mental health services. Further, the state's public policy is to protect the health and safety, rights, and well-being of Minnesotans receiving mental health services.

Sec. 2. **[245I.011] APPLICABILITY.**

Subdivision 1. **License requirements.** A license holder under this chapter must comply with the requirements in chapters 245A, 245C, and 260E; section 626.557; and Minnesota Rules, chapter 9544.

Subd. 2. **Variances.** (a) The commissioner may grant a variance to an applicant, license holder, or certification holder as long as the variance does not affect the staff qualifications or the health or safety of any person in a licensed or certified program and the applicant, license holder, or certification holder meets the following conditions:

(1) an applicant, license holder, or certification holder must request the variance on a form approved by the commissioner and in a manner prescribed by the commissioner;

(2) the request for a variance must include the:

(i) reasons that the applicant, license holder, or certification holder cannot comply with a requirement as stated in the law; and

(ii) alternative equivalent measures that the applicant, license holder, or certification holder will follow to comply with the intent of the law; and

(3) the request for a variance must state the period of time when the variance is requested.

(b) The commissioner may grant a permanent variance when the conditions under which the applicant, license holder, or certification holder requested the variance do not affect the health or safety of any person whom the licensed or certified program serves, and when the conditions of the variance do not compromise the qualifications of staff who provide services to clients. A permanent variance expires when the conditions that warranted the variance change in any way. Any applicant, license holder, or certification holder must inform the commissioner of any changes to the conditions that warranted the permanent variance. If an applicant, license holder, or certification holder fails to advise the commissioner of changes to the conditions that warranted the variance, the commissioner must revoke the permanent variance and may impose other sanctions under sections 245A.06 and 245A.07.

(c) The commissioner's decision to grant or deny a variance request is final and not subject to appeal under the provisions of chapter 14.

Subd. 3. **Certification required.** (a) An individual, organization, or government entity that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause (19), and chooses to be identified as a certified mental health clinic must:

(1) be a mental health clinic that is certified under section 245I.20;

(2) comply with all of the responsibilities assigned to a license holder by this chapter except subdivision 1; and

(3) comply with all of the responsibilities assigned to a certification holder by chapter 245A.

(b) An individual, organization, or government entity described by this subdivision must obtain a criminal background study for each staff person or volunteer who provides direct contact services to clients.

Subd. 4. **License required.** An individual, organization, or government entity providing intensive residential treatment services or residential crisis stabilization to adults must be licensed under section 245I.23. An entity with an adult foster care license providing residential crisis stabilization is exempt from licensure under section 245I.23.

Subd. 5. **Programs certified under chapter 256B.** (a) An individual, organization, or government entity certified under the following sections must comply with all of the responsibilities assigned to a license holder under this chapter except subdivision 1:

(1) an assertive community treatment provider under section 256B.0622, subdivision 3a;

(2) an adult rehabilitative mental health services provider under section 256B.0623;

(3) a mobile crisis team under section 256B.0624;

(4) a children's therapeutic services and supports provider under section 256B.0943;

(5) an intensive treatment in foster care provider under section 256B.0946; and

(6) an intensive nonresidential rehabilitative mental health services provider under section 256B.0947.

(b) An individual, organization, or government entity certified under the sections listed in paragraph (a), clauses (1) to (6), must obtain a criminal background study for each staff person and volunteer providing direct contact services to a client.

Sec. 3. **[245I.02] DEFINITIONS.**

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

Subd. 2. **Approval.** "Approval" means the documented review of, opportunity to request changes to, and agreement with a treatment document. An individual may demonstrate approval with a written signature, secure electronic signature, or documented oral approval.

Subd. 3. **Behavioral sciences or related fields.** "Behavioral sciences or related fields" means an education from an accredited college or university in social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, nursing, and other similar fields approved by the commissioner.

Subd. 4. **Business day.** "Business day" means a weekday on which government offices are open for business. Business day does not include state or federal holidays, Saturdays, or Sundays.

Subd. 5. **Case manager.** "Case manager" means a client's case manager according to section 256B.0596; 256B.0621; 256B.0625, subdivision 20; 256B.092, subdivision 1a; 256B.0924; 256B.093, subdivision 3a; 256B.094; or 256B.49.

Subd. 6. **Certified rehabilitation specialist.** "Certified rehabilitation specialist" means a staff person who meets the qualifications of section 245I.04, subdivision 8.

Subd. 7. **Child.** "Child" means a client under the age of 18.

Subd. 8. **Client.** "Client" means a person who is seeking or receiving services regulated by this chapter. For the purpose of a client's consent to services, client includes a parent, guardian, or other individual legally authorized to consent on behalf of a client to services.

Subd. 9. **Clinical trainee.** "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

Subd. 10. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designee.

Subd. 11. **Co-occurring substance use disorder treatment.** "Co-occurring substance use disorder treatment" means the treatment of a person who has a co-occurring mental illness and substance use disorder. Co-occurring substance use disorder treatment is characterized by stage-wise comprehensive treatment, treatment goal setting, and flexibility for clients at each stage of treatment. Co-occurring substance use disorder treatment includes

assessing and tracking each client's stage of change readiness and treatment using a treatment approach based on a client's stage of change, such as motivational interviewing when working with a client at an earlier stage of change readiness and a cognitive behavioral approach and relapse prevention to work with a client at a later stage of change; and facilitating a client's access to community supports.

Subd. 12. **Crisis plan.** "Crisis plan" means a plan to prevent and de-escalate a client's future crisis situation, with the goal of preventing future crises for the client and the client's family and other natural supports. Crisis plan includes a crisis plan developed according to section 245.4871, subdivision 9a.

Subd. 13. **Critical incident.** "Critical incident" means an occurrence involving a client that requires a license holder to respond in a manner that is not part of the license holder's ordinary daily routine. Critical incident includes a client's suicide, attempted suicide, or homicide; a client's death; an injury to a client or other person that is life-threatening or requires medical treatment; a fire that requires a fire department's response; alleged maltreatment of a client; an assault of a client; an assault by a client; or other situation that requires a response by law enforcement, the fire department, an ambulance, or another emergency response provider.

Subd. 14. **Diagnostic assessment.** "Diagnostic assessment" means the evaluation and report of a client's potential diagnoses that a mental health professional or clinical trainee completes under section 245I.10, subdivisions 4 to 6.

Subd. 15. **Direct contact.** "Direct contact" has the meaning given in section 245C.02, subdivision 11.

Subd. 16. **Family and other natural supports.** "Family and other natural supports" means the people whom a client identifies as having a high degree of importance to the client. Family and other natural supports also means people that the client identifies as being important to the client's mental health treatment, regardless of whether the person is related to the client or lives in the same household as the client.

Subd. 17. **Functional assessment.** "Functional assessment" means the assessment of a client's current level of functioning relative to functioning that is appropriate for someone the client's age. For a client five years of age or younger, a functional assessment is the Early Childhood Service Intensity Instrument (ESCII). For a client six to 17 years of age, a functional assessment is the Child and Adolescent Service Intensity Instrument (CASII). For a client 18 years of age or older, a functional assessment is the functional assessment described in section 245I.10, subdivision 9.

Subd. 18. **Individual abuse prevention plan.** "Individual abuse prevention plan" means a plan according to section 245A.65, subdivision 2, paragraph (b), and section 626.557, subdivision 14.

Subd. 19. **Level of care assessment.** "Level of care assessment" means the level of care decision support tool appropriate to the client's age. For a client five years of age or younger, a level of care assessment is the Early Childhood Service Intensity Instrument (ESCII). For a client six to 17 years of age, a level of care assessment is the Child and Adolescent Service Intensity Instrument (CASII). For a client 18 years of age or older, a level of care assessment is the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS).

Subd. 20. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

Subd. 21. **License holder.** "License holder" has the meaning given in section 245A.02, subdivision 9.

Subd. 22. **Licensed prescriber.** "Licensed prescriber" means an individual who is authorized to prescribe legend drugs under section 151.37.

Subd. 23. **Mental health behavioral aide.** "Mental health behavioral aide" means a staff person who is qualified under section 245I.04, subdivision 16.

Subd. 24. **Mental health certified family peer specialist.** "Mental health certified family peer specialist" means a staff person who is qualified under section 245I.04, subdivision 12.

Subd. 25. **Mental health certified peer specialist.** "Mental health certified peer specialist" means a staff person who is qualified under section 245I.04, subdivision 10.

Subd. 26. **Mental health practitioner.** "Mental health practitioner" means a staff person who is qualified under section 245I.04, subdivision 4.

Subd. 27. **Mental health professional.** "Mental health professional" means a staff person who is qualified under section 245I.04, subdivision 2.

Subd. 28. **Mental health rehabilitation worker.** "Mental health rehabilitation worker" means a staff person who is qualified under section 245I.04, subdivision 14.

Subd. 29. **Mental illness.** "Mental illness" means any of the conditions included in the most recent editions of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three or the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Subd. 30. **Organization.** "Organization" has the meaning given in section 245A.02, subdivision 10c.

Subd. 31. **Personnel file.** "Personnel file" means a set of records under section 245I.07, paragraph (a). Personnel files excludes information related to a person's employment that is not included in section 245I.07.

Subd. 32. **Registered nurse.** "Registered nurse" means a staff person who is qualified under section 148.171, subdivision 20.

Subd. 33. **Rehabilitative mental health services.** "Rehabilitative mental health services" means mental health services provided to an adult client that enable the client to develop and achieve psychiatric stability, social competencies, personal and emotional adjustment, independent living skills, family roles, and community skills when symptoms of mental illness has impaired any of the client's abilities in these areas.

Subd. 34. **Residential program.** "Residential program" has the meaning given in section 245A.02, subdivision 14.

Subd. 35. **Signature.** "Signature" means a written signature or an electronic signature defined in section 325L.02, paragraph (h).

Subd. 36. **Staff person.** "Staff person" means an individual who works under a license holder's direction or under a contract with a license holder. Staff person includes an intern, consultant, contractor, individual who works part-time, and an individual who does not provide direct contact services to clients. Staff person includes a volunteer who provides treatment services to a client or a volunteer whom the license holder regards as a staff person for the purpose of meeting staffing or service delivery requirements. A staff person must be 18 years of age or older.

Subd. 37. **Strengths.** "Strengths" means a person's inner characteristics, virtues, external relationships, activities, and connections to resources that contribute to a client's resilience and core competencies. A person can build on strengths to support recovery.

Subd. 38. **Trauma.** "Trauma" means an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma includes group traumatic experiences. Group traumatic experiences are emotional or psychological harm that a group experiences. Group traumatic experiences can be transmitted across generations within a community and are

often associated with racial and ethnic population groups who suffer major intergenerational losses.

Subd. 39. **Treatment plan.** "Treatment plan" means services that a license holder formulates to respond to a client's needs and goals. A treatment plan includes individual treatment plans under section 245I.10, subdivisions 7 and 8; initial treatment plans under section 245I.23, subdivision 7; and crisis treatment plans under sections 245I.23, subdivision 8, and 256B.0624, subdivision 11.

Subd. 40. **Treatment supervision.** "Treatment supervision" means a mental health professional's or certified rehabilitation specialist's oversight, direction, and evaluation of a staff person providing services to a client according to section 245I.06.

Subd. 41. **Volunteer.** "Volunteer" means an individual who, under the direction of the license holder, provides services to or facilitates an activity for a client without compensation.

Sec. 4. **[245I.03] REQUIRED POLICIES AND PROCEDURES.**

Subdivision 1. **Generally.** A license holder must establish, enforce, and maintain policies and procedures to comply with the requirements of this chapter and chapters 245A, 245C, and 260E; sections 626.557 and 626.5572; and Minnesota Rules, chapter 9544. The license holder must make all policies and procedures available in writing to each staff person. The license holder must complete and document a review of policies and procedures every two years and update policies and procedures as necessary. Each policy and procedure must identify the date that it was initiated and the dates of all revisions. The license holder must clearly communicate any policy and procedural change to each staff person and provide necessary training to each staff person to implement any policy and procedural change.

Subd. 2. **Health and safety.** A license holder must have policies and procedures to ensure the health and safety of each staff person and client during the provision of services, including policies and procedures for services based in community settings.

Subd. 3. **Client rights.** A license holder must have policies and procedures to ensure that each staff person complies with the client rights and protections requirements in section 245I.12.

Subd. 4. **Behavioral emergencies.** (a) A license holder must have procedures that each staff person follows when responding to a client who exhibits behavior that threatens the immediate safety of the client or others. A license holder's behavioral emergency procedures must incorporate person-centered planning and trauma-informed care.

(b) A license holder's behavioral emergency procedures must include:

(1) a plan designed to prevent the client from inflicting self-harm and harming others;

(2) contact information for emergency resources that a staff person must use when the license holder's behavioral emergency procedures are unsuccessful in controlling a client's behavior;

(3) the types of behavioral emergency procedures that a staff person may use;

(4) the specific circumstances under which the program may use behavioral emergency procedures; and

(5) the staff persons whom the license holder authorizes to implement behavioral emergency procedures.

(c) The license holder's behavioral emergency procedures must not include secluding or restraining a client except as allowed under section 245.8261.

(d) Staff persons must not use behavioral emergency procedures to enforce program rules or for the convenience of staff persons. Behavioral emergency procedures must not be part of any client's treatment plan. A staff person may not use behavioral emergency procedures except in response to a client's current behavior that threatens the immediate safety of the client or others.

Subd. 5. **Health services and medications.** If a license holder is licensed as a residential program, stores or administers client medications, or observes clients self-administer medications, the license holder must ensure that a staff person who is a registered nurse or licensed prescriber reviews and approves of the license holder's policies and procedures to comply with the health services and medications requirements in section 245I.11, the training requirements in section 245I.05, subdivision 6, and the documentation requirements in section 245I.08, subdivision 5.

Subd. 6. **Reporting maltreatment.** A license holder must have policies and procedures for reporting a staff person's suspected maltreatment, abuse, or neglect of a client according to chapter 260E and section 626.557.

Subd. 7. **Critical incidents.** If a license holder is licensed as a residential program, the license holder must have policies and procedures for reporting and maintaining records of critical incidents according to section 245I.13.

Subd. 8. **Personnel.** A license holder must have personnel policies and procedures that:

(1) include a chart or description of the organizational structure of the program that indicates positions and lines of authority;

(2) ensure that it will not adversely affect a staff person's retention, promotion, job assignment, or pay when a staff person communicates in good faith with the Department of Human Services, the Office of Ombudsman for Mental Health and Developmental Disabilities, the Department of Health, a health-related licensing board, a law enforcement agency, or a local agency investigating a complaint regarding a client's rights, health, or safety;

(3) prohibit a staff person from having sexual contact with a client in violation of chapter 604, sections 609.344 or 609.345;

(4) prohibit a staff person from neglecting, abusing, or maltreating a client as described in chapter 260E and sections 626.557 and 626.5572;

(5) include the drug and alcohol policy described in section 245A.04, subdivision 1, paragraph (c);

(6) describe the process for disciplinary action, suspension, or dismissal of a staff person for violating a policy provision described in clauses (3) to (5);

(7) describe the license holder's response to a staff person who violates other program policies or who has a behavioral problem that interferes with providing treatment services to clients; and

(8) describe each staff person's position that includes the staff person's responsibilities, authority to execute the responsibilities, and qualifications for the position.

Subd. 9. **Volunteers.** A license holder must have policies and procedures for using volunteers, including when a license holder must submit a background study for a volunteer, and the specific tasks that a volunteer may perform.

Subd. 10. **Data privacy.** (a) A license holder must have policies and procedures that comply with all applicable state and federal law. A license holder's use of electronic record keeping or electronic signatures does not alter a license holder's obligations to comply with applicable state and federal law.

(b) A license holder must have policies and procedures for a staff person to promptly document a client's revocation of consent to disclose the client's health record. The license holder must verify that the license holder has permission to disclose a client's health record before releasing any client data.

Sec. 5. **[245I.04] PROVIDER QUALIFICATIONS AND SCOPE OF PRACTICE.**

Subdivision 1. **Tribal providers.** For purposes of this section, a tribal entity may credential an individual according to section 256B.02, subdivision 7, paragraphs (b) and (c).

Subd. 2. **Mental health professional qualifications.** The following individuals may provide services to a client as a mental health professional:

(1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a: (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and mental health nursing by a national certification organization; or (ii) nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization;

(2) a licensed independent clinical social worker as defined in section 148E.050, subdivision 5;

(3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;

(4) a physician licensed under chapter 147 if the physician is: (i) certified by the American Board of Psychiatry and Neurology; (ii) certified by the American Osteopathic Board of Neurology and Psychiatry; or (iii) eligible for board certification in psychiatry;

(5) a marriage and family therapist licensed under sections 148B.29 to 148B.392; or

(6) a licensed professional clinical counselor licensed under section 148B.5301.

Subd. 3. **Mental health professional scope of practice.** A mental health professional must maintain a valid license with the mental health professional's governing health-related licensing board and must only provide services to a client within the scope of practice determined by the applicable health-related licensing board.

Subd. 4. **Mental health practitioner qualifications.** (a) An individual who is qualified in at least one of the ways described in paragraph (b) to (d) may serve as a mental health practitioner.

(b) An individual is qualified as a mental health practitioner through relevant coursework if the individual completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:

(1) has at least 2,000 hours of experience providing services to individuals with:

(i) a mental illness or a substance use disorder; or

(ii) a traumatic brain injury or a developmental disability, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to a client;

(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the individual's clients belong, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to a client;

(3) is working in a day treatment program under section 256B.0671, subdivision 3, or 256B.0943; or

(4) has completed a practicum or internship that (i) required direct interaction with adult clients or child clients, and (ii) was focused on behavioral sciences or related fields.

(c) An individual is qualified as a mental health practitioner through work experience if the individual:

(1) has at least 4,000 hours of experience in the delivery of services to individuals with:

(i) a mental illness or a substance use disorder; or

(ii) a traumatic brain injury or a developmental disability, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to clients; or

(2) receives treatment supervision at least once per week until meeting the requirement in clause (1) of 4,000 hours of experience and has at least 2,000 hours of experience providing services to individuals with:

(i) a mental illness or a substance use disorder; or

(ii) a traumatic brain injury or a developmental disability, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to clients.

(d) An individual is qualified as a mental health practitioner if the individual has a master's or other graduate degree in behavioral sciences or related fields.

Subd. 5. **Mental health practitioner scope of practice.** (a) A mental health practitioner under the treatment supervision of a mental health professional or certified rehabilitation specialist may provide an adult client with client education, rehabilitative mental health services, functional assessments, level of care assessments, and treatment plans. A mental health practitioner under the treatment supervision of a mental health professional may

provide skill-building services to a child client and complete treatment plans for a child client.

(b) A mental health practitioner must not provide treatment supervision to other staff persons. A mental health practitioner may provide direction to mental health rehabilitation workers and mental health behavioral aides.

(c) A mental health practitioner who provides services to clients according to section 256B.0624 or 256B.0944 may perform crisis assessments and interventions for a client.

Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who: (1) is enrolled in an accredited graduate program of study to prepare the staff person for independent licensure as a mental health professional and who is participating in a practicum or internship with the license holder through the individual's graduate program; or (2) has completed an accredited graduate program of study to prepare the staff person for independent licensure as a mental health professional and who is in compliance with the requirements of the applicable health-related licensing board, including requirements for supervised practice.

(b) A clinical trainee is responsible for notifying and applying to a health-related licensing board to ensure that the trainee meets the requirements of the health-related licensing board. As permitted by a health-related licensing board, treatment supervision under this chapter may be integrated into a plan to meet the supervisory requirements of the health-related licensing board but does not supersede those requirements.

Subd. 7. **Clinical trainee scope of practice.** (a) A clinical trainee under the treatment supervision of a mental health professional may provide a client with psychotherapy, client education, rehabilitative mental health services, diagnostic assessments, functional assessments, level of care assessments, and treatment plans.

(b) A clinical trainee must not provide treatment supervision to other staff persons. A clinical trainee may provide direction to mental health behavioral aides and mental health rehabilitation workers.

(c) A psychological clinical trainee under the treatment supervision of a psychologist may perform psychological testing of clients.

(d) A clinical trainee must not provide services to clients that violate any practice act of a health-related licensing board, including failure to obtain licensure if licensure is required.

Subd. 8. **Certified rehabilitation specialist qualifications.** A certified rehabilitation specialist must have:

(1) a master's degree from an accredited college or university in behavioral sciences or related fields;

(2) at least 4,000 hours of post-master's supervised experience providing mental health services to clients; and

(3) a valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner.

Subd. 9. **Certified rehabilitation specialist scope of practice.** (a) A certified rehabilitation specialist may provide an adult client with client education, rehabilitative mental health services, functional assessments, level of care assessments, and treatment plans.

(b) A certified rehabilitation specialist may provide treatment supervision to a mental health certified peer specialist, mental health practitioner, and mental health rehabilitation worker.

Subd. 10. **Mental health certified peer specialist qualifications.** A mental health certified peer specialist must:

(1) have been diagnosed with a mental illness;

(2) be a current or former mental health services client; and

(3) have a valid certification as a mental health certified peer specialist under section 256B.0615.

Subd. 11. **Mental health certified peer specialist scope of practice.** A mental health certified peer specialist under the treatment supervision of a mental health professional or certified rehabilitation specialist must:

(1) provide individualized peer support to each client;

(2) promote a client's recovery goals, self-sufficiency, self-advocacy, and development of natural supports; and

(3) support a client's maintenance of skills that the client has learned from other services.

Subd. 12. **Mental health certified family peer specialist qualifications.** A mental health certified family peer specialist must:

(1) have raised or be currently raising a child with a mental illness;

(2) have experience navigating the children's mental health system; and

(3) have a valid certification as a mental health certified family peer specialist under section 256B.0616.

Subd. 13. **Mental health certified family peer specialist scope of practice.** A mental health certified family peer specialist under the treatment supervision of a mental health professional must provide services to increase the child's ability to function in the child's home, school, and community. The mental health certified family peer specialist must:

(1) provide family peer support to build on a client's family's strengths and help the family achieve desired outcomes;

(2) provide nonadversarial advocacy to a child client and the child's family that encourages partnership and promotes the child's positive change and growth;

(3) support families in advocating for culturally appropriate services for a child in each treatment setting;

(4) promote resiliency, self-advocacy, and development of natural supports;

(5) support maintenance of skills learned from other services;

(6) establish and lead parent support groups;

(7) assist parents in developing coping and problem-solving skills; and

(8) educate parents about mental illnesses and community resources, including resources that connect parents with similar experiences to one another.

Subd. 14. **Mental health rehabilitation worker qualifications.** (a) A mental health rehabilitation worker must:

(1) have a high school diploma or equivalent; and

(2) meet one of the following qualification requirements:

(i) be fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

(ii) have an associate of arts degree;

(iii) have two years of full-time postsecondary education or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields;

(iv) be a registered nurse;

(v) have, within the previous ten years, three years of personal life experience with mental illness;

(vi) have, within the previous ten years, three years of life experience as a primary caregiver to an adult with a mental illness, traumatic brain injury, substance use disorder, or developmental disability; or

(vii) have, within the previous ten years, 2,000 hours of work experience providing health and human services to individuals.

(b) A mental health rehabilitation worker who is scheduled as an overnight staff person and works alone is exempt from the additional qualification requirements in paragraph (a), clause (2).

Subd. 15. **Mental health rehabilitation worker scope of practice.** A mental health rehabilitation worker under the treatment supervision of a mental health professional or certified rehabilitation specialist may provide rehabilitative mental health services to an adult client according to the client's treatment plan.

Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health behavioral aide must have: (1) a high school diploma or equivalent; or (2) two years of experience as a primary caregiver to a child with mental illness within the previous ten years.

(b) A level 2 mental health behavioral aide must: (1) have an associate or bachelor's degree; or (2) be certified by a program under section 256B.0943, subdivision 8a.

Subd. 17. **Mental health behavioral aide scope of practice.** While under the treatment supervision of a mental health professional, a mental health behavioral aide may practice psychosocial skills with a child client according to the child's treatment plan and individual behavior plan that a mental health professional, clinical trainee, or mental health practitioner has previously taught to the child.

Sec. 6. **[245I.05] TRAINING REQUIRED.**

Subdivision 1. **Training plan.** A license holder must develop a training plan to ensure that staff persons receive ongoing training according to this section. The training plan must include:

(1) a formal process to evaluate the training needs of each staff person. An annual performance evaluation of a staff person satisfies this requirement;

(2) a description of how the license holder conducts ongoing training of each staff person, including whether ongoing training is based on a staff person's hire date or a specified annual cycle determined by the program;

(3) a description of how the license holder verifies and documents each staff person's previous training experience. A license holder may consider a staff person to have met a training requirement in subdivision 3, paragraph (d) or (e), if the staff person has received equivalent postsecondary education in the previous four years or training experience in the previous two years; and

(4) a description of how the license holder determines when a staff person needs additional training, including when the license holder will provide additional training.

Subd. 2. **Documentation of training.** (a) The license holder must provide training to each staff person according to the training plan and must document that the license holder provided the training to each staff person. The license holder must document the following information for each staff person's training:

(1) the topics of the training;

(2) the name of the trainee;

(3) the name and credentials of the trainer;

(4) the license holder's method of evaluating the trainee's competency upon completion of training;

(5) the date of the training; and

(6) the length of training in hours and minutes.

(b) Documentation of a staff person's continuing education credit accepted by the governing health-related licensing board is sufficient to document training for purposes of this subdivision.

Subd. 3. **Initial training.** (a) A staff person must receive training about:

(1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and

(2) the maltreatment of minor reporting requirements and definitions in chapter 260E within 72 hours of first providing direct contact services to a client.

(b) Before providing direct contact services to a client, a staff person must receive training about:

(1) client rights and protections under section 245I.12;

(2) the Minnesota Health Records Act, including client confidentiality, family engagement under section 144.294, and client privacy;

(3) emergency procedures that the staff person must follow when responding to a fire, inclement weather, a report of a missing person, and a behavioral or medical emergency;

(4) specific activities and job functions for which the staff person is responsible, including the license holder's program policies and procedures applicable to the staff person's position;

(5) professional boundaries that the staff person must maintain; and

(6) specific needs of each client to whom the staff person will be providing direct contact services, including each client's developmental status, cognitive functioning, physical and mental abilities.

(c) Before providing direct contact services to a client, a mental health rehabilitation worker, mental health behavioral aide, or mental health practitioner qualified under section 245I.04, subdivision 4, must receive 30 hours of training about:

(1) mental illnesses;

(2) client recovery and resiliency;

(3) mental health de-escalation techniques;

(4) co-occurring mental illness and substance use disorders; and

(5) psychotropic medications and medication side effects.

(d) Within 90 days of first providing direct contact services to an adult client, a clinical trainee, mental health practitioner, mental health certified peer specialist, or mental health rehabilitation worker must receive training about:

(1) trauma-informed care and secondary trauma;

(2) person-centered individual treatment plans, including seeking partnerships with family and other natural supports;

(3) co-occurring substance use disorders; and

(4) culturally responsive treatment practices.

(e) Within 90 days of first providing direct contact services to a child client, a clinical trainee, mental health practitioner, mental health certified family peer specialist, mental health certified peer specialist, or mental health behavioral aide must receive training about the topics in clauses (1) to (5). This training must address the developmental characteristics of each child served by the license holder and address the needs of each child in the context of the child's family, support system, and culture. Training topics must include:

(1) trauma-informed care and secondary trauma, including adverse childhood experiences (ACEs);

(2) family-centered treatment plan development, including seeking partnership with a child client's family and other natural supports;

(3) mental illness and co-occurring substance use disorders in family systems;

(4) culturally responsive treatment practices; and

(5) child development, including cognitive functioning, and physical and mental abilities.

(f) For a mental health behavioral aide, the training under paragraph (e) must include parent team training using a curriculum approved by the commissioner.

Subd. 4. **Ongoing training.** (a) A license holder must ensure that staff persons who provide direct contact services to clients receive annual training about the topics in subdivision 3, paragraphs (a) and (b), clauses (1) to (3).

(b) A license holder must ensure that each staff person who is qualified under section 245I.04 who is not a mental health professional receives 30 hours of training every two years. The training topics must be based on the program's needs and the staff person's areas of competency.

Subd. 5. **Additional training for medication administration.** (a) Prior to administering medications to a client under delegated authority or observing a client self-administer medications, a staff person who is not a licensed prescriber, registered nurse, or licensed practical nurse qualified under section 148.171, subdivision 8, must receive training about psychotropic medications, side effects, and medication management.

(b) Prior to administering medications to a client under delegated authority, a staff person must successfully complete a:

(1) medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution with completion of the course documented in writing and placed in the staff person's personnel file; or

(2) formalized training program taught by a registered nurse or licensed prescriber that is offered by the license holder. A staff person's successful completion of the formalized training program must include direct observation of the staff person to determine the staff person's areas of competency.

Sec. 7. **[245I.06] TREATMENT SUPERVISION.**

Subdivision 1. **Generally.** (a) A license holder must ensure that a mental health professional or certified rehabilitation specialist provides treatment supervision to each staff person who provides services to a client and who is not a mental health professional or certified rehabilitation specialist. When providing treatment supervision, a treatment supervisor must follow a staff person's written treatment supervision plan.

(b) Treatment supervision must focus on each client's treatment needs and the ability of the staff person under treatment supervision to provide services to each client, including the following topics related to the staff person's current caseload:

(1) a review and evaluation of the interventions that the staff person delivers to each client;

(2) instruction on alternative strategies if a client is not achieving treatment goals;

(3) a review and evaluation of each client's assessments, treatment plans, and progress notes for accuracy and appropriateness;

(4) instruction on the cultural norms or values of the clients and communities that the license holder serves and the impact that a client's culture has on providing treatment;

(5) evaluation of and feedback regarding a direct service staff person's areas of competency; and

(6) coaching, teaching, and practicing skills with a staff person.

(c) A treatment supervisor must provide treatment supervision to a staff person using methods that allow for immediate feedback, including in-person, telephone, and interactive video supervision.

(d) A treatment supervisor's responsibility for a staff person receiving treatment supervision is limited to the services provided by the associated license holder. If a staff person receiving treatment supervision is employed by multiple license holders, each license holder is responsible for providing treatment supervision related to the treatment of the license holder's clients.

Subd. 2. **Treatment supervision planning.** (a) A treatment supervisor and the staff person supervised by the treatment supervisor must develop a written treatment supervision plan. The license holder must ensure that a new staff person's treatment supervision plan is completed and implemented by a treatment supervisor and the new staff person within 30

days of the new staff person's first day of employment. The license holder must review and update each staff person's treatment supervision plan annually.

(b) Each staff person's treatment supervision plan must include:

(1) the name and qualifications of the staff person receiving treatment supervision;

(2) the names and licensures of the treatment supervisors who are supervising the staff person;

(3) how frequently the treatment supervisors must provide treatment supervision to the staff person; and

(4) the staff person's authorized scope of practice, including a description of the client population that the staff person serves, and a description of the treatment methods and modalities that the staff person may use to provide services to clients.

Subd. 3. **Treatment supervision and direct observation of mental health rehabilitation workers and mental health behavioral aides.** (a) A mental health behavioral aide or a mental health rehabilitation worker must receive direct observation from a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner while the mental health behavioral aide or mental health rehabilitation worker provides treatment services to clients, no less than twice per month for the first six months of employment and once per month thereafter. The staff person performing the direct observation must approve of the progress note for the observed treatment service.

(b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work must at a minimum consist of:

(1) monthly individual supervision; and

(2) direct observation twice per month.

Sec. 8. **[245I.07] PERSONNEL FILES.**

(a) For each staff person, a license holder must maintain a personnel file that includes:

(1) verification of the staff person's qualifications required for the position including training, education, practicum or internship agreement, licensure, and any other required qualifications;

(2) documentation related to the staff person's background study;

(3) the hiring date of the staff person;

(4) a description of the staff person's job responsibilities with the license holder;

(5) the date that the staff person's specific duties and responsibilities became effective, including the date that the staff person began having direct contact with clients;

(6) documentation of the staff person's training as required by section 245I.05, subdivision 2;

(7) a verification copy of license renewals that the staff person completed during the staff person's employment;

(8) annual job performance evaluations; and

(9) if applicable, the staff person's alleged and substantiated violations of the license holder's policies under section 245I.03, subdivision 8, clauses (3) to (7), and the license holder's response.

(b) The license holder must ensure that all personnel files are readily accessible for the commissioner's review. The license holder is not required to keep personnel files in a single location.

Sec. 9. **[245I.08] DOCUMENTATION STANDARDS.**

Subdivision 1. **Generally.** A license holder must ensure that all documentation required by this chapter complies with this section.

Subd. 2. **Documentation standards.** A license holder must ensure that all documentation required by this chapter:

(1) is legible;

(2) identifies the applicable client and staff person on each page; and

(3) is signed and dated by the staff persons who provided services to the client or completed the documentation, including the staff persons' credentials.

Subd. 3. **Documenting approval.** A license holder must ensure that all diagnostic assessments, functional assessments, level of care assessments, and treatment plans completed by a clinical trainee or mental health practitioner contain documentation of approval by a treatment supervisor within five business days of initial completion by the staff person under treatment supervision.

Subd. 4. **Progress notes.** A license holder must use a progress note to document each occurrence of a mental health service that a staff person provides to a client. A progress note must include the following:

(1) the type of service;

(2) the date of service;

(3) the start and stop time of the service unless the license holder is licensed as a residential program;

(4) the location of the service;

(5) the scope of the service, including: (i) the targeted goal and objective; (ii) the intervention that the staff person provided to the client and the methods that the staff person used; (iii) the client's response to the intervention; (iv) the staff person's plan to take future actions, including changes in treatment that the staff person will implement if the intervention was ineffective; and (v) the service modality;

(6) the signature, printed name, and credentials of the staff person who provided the service to the client;

(7) the mental health provider travel documentation required by section 256B.0625, if applicable; and

(8) significant observations by the staff person, if applicable, including: (i) the client's current risk factors; (ii) emergency interventions by staff persons; (iii) consultations with or referrals to other professionals, family, or significant others; and (iv) changes in the client's mental or physical symptoms.

Subd. 5. **Medication administration record.** If a license holder administers or observes a client self-administer medications, the license holder must maintain a medication administration record for each client that contains the following, as applicable:

(1) the client's date of birth;

(2) the client's allergies;

(3) all medication orders for the client, including client-specific orders for over-the-counter medications and approved condition-specific protocols;

(4) the name of each ordered medication, date of each medication's expiration, each medication's dosage frequency, method of administration, and time;

(5) the licensed prescriber's name and telephone number;

(6) the date of initiation;

(7) the signature, printed name, and credentials of the staff person who administered the medication or observed the client self-administer the medication; and

(8) the reason that the license holder did not administer the client's prescribed medication or observe the client self-administer the client's prescribed medication.

Sec. 10. **[245I.09] CLIENT FILES.**

Subdivision 1. **Generally.** (a) A license holder must maintain a file for each client that contains the client's current and accurate records. The license holder must store each client file on the premises where the license holder provides or coordinates services for the client. The license holder must ensure that all client files are readily accessible for the commissioner's review. The license holder is not required to keep client files in a single location.

(b) The license holder must protect client records against loss, tampering, or unauthorized disclosure of confidential client data according to the Minnesota Government Data Practices Act, chapter 13; the privacy provisions of the Minnesota health care programs provider agreement; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191; and the Minnesota Health Records Act, sections 144.291 to 144.298.

Subd. 2. **Record retention.** A license holder must retain client records of a discharged client for a minimum of five years from the date of the client's discharge. A license holder who ceases to provide treatment services to a client must retain the client's records for a minimum of five years from the date that the license holder stopped providing services to the client and must notify the commissioner of the location of the client records and the name of the individual responsible for storing and maintaining the client records.

Subd. 3. **Contents.** A license holder must retain a clear and complete record of the information that the license holder receives regarding a client, and of the services that the license holder provides to the client. If applicable, each client's file must include the following information:

(1) the client's screenings, assessments, and testing;

(2) the client's treatment plans and reviews of the client's treatment plan;

(3) the client's individual abuse prevention plans;

(4) the client's health care directive under section 145C.01, subdivision 5a, and the client's emergency contacts;

(5) the client's crisis plans;

(6) the client's consents for releases of information and documentation of the client's releases of information;

(7) the client's significant medical and health-related information;

(8) a record of each communication that a staff person has with the client's other mental health providers and persons interested in the client, including the client's case manager, family members, primary caregiver, legal representatives, court representatives, representatives from the correctional system, or school administration;

(9) written information by the client that the client requests to include in the client's file; and

(10) the date of the client's discharge from the license holder's program, the reason that the license holder discontinued services for the client, and the client's discharge summaries.

Sec. 11. **[245I.10] ASSESSMENT AND TREATMENT PLANNING.**

Subdivision 1. **Definitions.** (a) "Diagnostic formulation" means a written analysis and explanation of a client's clinical assessment to develop a hypothesis about the cause and nature of a client's presenting problems and to identify the most suitable approach for treating the client.

(b) "Responsivity factors" means the factors other than the diagnostic formulation that may modify a client's treatment needs. This includes a client's learning style, abilities, cognitive functioning, cultural background, and personal circumstances. When documenting a client's responsivity factors a mental health professional or clinical trainee must include an analysis of how a client's strengths are reflected in the license holder's plan to deliver services to the client.

Subd. 2. **Generally.** (a) A license holder must use a client's diagnostic assessment or crisis assessment to determine a client's eligibility for mental health services, except as provided in this section.

(b) Prior to completing a client's initial diagnostic assessment, a license holder may provide a client with the following services:

(1) an explanation of findings;

(2) neuropsychological testing, neuropsychological assessment, and psychological testing;

(3) any combination of psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed three sessions;

(4) crisis assessment services according to section 256B.0624; and

(5) ten days of intensive residential treatment services according to the assessment and treatment planning standards in section 245.23, subdivision 7.

(c) Based on the client's needs that a crisis assessment identifies under section 256B.0624, a license holder may provide a client with the following services:

(1) crisis intervention and stabilization services under section 245I.23 or 256B.0624; and

(2) any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization.

(d) Based on the client's needs in the client's brief diagnostic assessment, a license holder may provide a client with any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization for any new client or for an existing client who the license holder projects will need fewer than ten sessions during the next 12 months.

(e) Based on the client's needs that a hospital's medical history and presentation examination identifies, a license holder may provide a client with:

(1) any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization for any new client or for an existing client who the license holder projects will need fewer than ten sessions during the next 12 months; and

(2) up to five days of day treatment services or partial hospitalization.

(f) A license holder must complete a new standard diagnostic assessment of a client:

(1) when the client requires services of a greater number or intensity than the services that paragraphs (b) to (e) describe;

(2) at least annually following the client's initial diagnostic assessment if the client needs additional mental health services and the client does not meet the criteria for a brief assessment;

(3) when the client's mental health condition has changed markedly since the client's most recent diagnostic assessment; or

(4) when the client's current mental health condition does not meet the criteria of the client's current diagnosis.

(g) For an existing client, the license holder must ensure that a new standard diagnostic assessment includes a written update containing all significant new or changed information about the client, and an update regarding what information has not significantly changed, including a discussion with the client about changes in the client's life situation, functioning, presenting problems, and progress with achieving treatment goals since the client's last diagnostic assessment was completed.

Subd. 3. **Continuity of services.** (a) For any client with a diagnostic assessment completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before the effective date of this section, the diagnostic assessment is valid for authorizing the client's treatment and billing for one calendar year after the date that the assessment was completed.

(b) For any client with an individual treatment plan completed under section 256B.0622, 256B.0623, 256B.0943, 256B.0946, or 256B.0947 or Minnesota Rules, parts 9505.0370 to 9505.0372, the client's treatment plan is valid for authorizing treatment and billing until the treatment plan's expiration date.

(c) This subdivision expires July 1, 2023.

Subd. 4. **Diagnostic assessment.** A client's diagnostic assessment must: (1) identify at least one mental health diagnosis for which the client meets the diagnostic criteria and recommend mental health services to develop the client's mental health services and treatment plan; or (2) include a finding that the client does not meet the criteria for a mental health disorder.

Subd. 5. **Brief diagnostic assessment; required elements.** (a) Only a mental health professional or clinical trainee may complete a brief diagnostic assessment of a client. A license holder may only use a brief diagnostic assessment for a client who is six years of age or older.

(b) When conducting a brief diagnostic assessment of a client, the assessor must complete a face-to-face interview with the client and a written evaluation of the client. The assessor must gather and document initial components of the client's standard diagnostic assessment, including the client's:

(1) age;

(2) description of symptoms, including the reason for the client's referral;

(3) history of mental health treatment;

(4) cultural influences on the client; and

(5) mental status examination.

(c) Based on the initial components of the assessment, the assessor must develop a provisional diagnostic formulation about the client. The assessor may use the client's provisional diagnostic formulation to address the client's immediate needs and presenting problems.

(d) A mental health professional or clinical trainee may use treatment sessions with the client authorized by a brief diagnostic assessment to gather additional information about the client to complete the client's standard diagnostic assessment if the number of sessions will exceed the coverage limits in subdivision 2.

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a client and a written evaluation of the client. The assessor must complete a client's standard diagnostic assessment within the client's cultural context.

(b) When completing a standard diagnostic assessment of a client, the assessor must gather and document information about the client's current life situation, including the following information:

(1) the client's age;

(2) the client's current living situation, including the client's housing status and household members;

(3) the status of the client's basic needs;

(4) the client's education level and employment status;

(5) the client's current medications;

(6) any immediate risks to the client's health and safety;

(7) the client's perceptions of the client's condition;

(8) the client's description of the client's symptoms, including the reason for the client's referral;

(9) the client's history of mental health treatment; and

(10) cultural influences on the client.

(c) If the assessor cannot obtain the information that this subdivision requires without retraumatizing the client or harming the client's willingness to engage in treatment, the assessor must identify which topics will require further assessment during the course of the client's treatment. The assessor must gather and document information related to the following topics:

(1) the client's relationship with the client's family and other significant personal relationships, including the client's evaluation of the quality of each relationship;

(2) the client's strengths and resources, including the extent and quality of the client's social networks;

(3) important developmental incidents in the client's life;

(4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

(5) the client's history of or exposure to alcohol and drug usage and treatment; and

(6) the client's health history and the client's family health history, including the client's physical, chemical, and mental health history.

(d) When completing a standard diagnostic assessment of a client, an assessor must use a recognized diagnostic framework.

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

(2) When completing a standard diagnostic assessment of a client who is six years of age or older, the assessor must use the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(3) When completing a standard diagnostic assessment of a client who is five years of age or younger, an assessor must administer the Early Childhood Service Intensity Instrument (ECSII) to the client and include the results in the client's assessment.

(4) When completing a standard diagnostic assessment of a client who is six to 17 years of age, an assessor must administer the Child and Adolescent Service Intensity Instrument (CASII) to the client and include the results in the client's assessment.

(5) When completing a standard diagnostic assessment of a client who is 18 years of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders

published by the American Psychiatric Association to screen and assess the client for a substance use disorder.

(e) When completing a standard diagnostic assessment of a client, the assessor must include and document the following components of the assessment:

(1) the client's mental status examination;

(2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client information that supports the assessor's findings after applying a recognized diagnostic framework from paragraph (d); and any differential diagnosis of the client;

(3) an explanation of: (i) how the assessor diagnosed the client using the information from the client's interview, assessment, psychological testing, and collateral information about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths; and (v) the client's responsivity factors.

(f) When completing a standard diagnostic assessment of a client, the assessor must consult the client and the client's family about which services that the client and the family prefer to treat the client. The assessor must make referrals for the client as to services required by law.

Subd. 7. **Individual treatment plan.** A license holder must follow each client's written individual treatment plan when providing services to the client with the following exceptions:

(1) services that do not require that a license holder completes a standard diagnostic assessment of a client before providing services to the client;

(2) when developing a service plan; and

(3) when a client re-engages in services under subdivision 8, paragraph (b).

Subd. 8. **Individual treatment plan; required elements.** (a) After completing a client's diagnostic assessment and before providing services to the client, the license holder must complete the client's individual treatment plan. The license holder must:

(1) base the client's individual treatment plan on the client's diagnostic assessment and baseline measurements;

(2) for a child client, use a child-centered, family-driven, and culturally appropriate planning process that allows the child's parents and guardians to observe and participate in the child's individual and family treatment services, assessments, and treatment planning;

(3) for an adult client, use a person-centered, culturally appropriate planning process that allows the client's family and other natural supports to observe and participate in the client's treatment services, assessments, and treatment planning;

(4) identify the client's treatment goals, measureable treatment objectives, a schedule for accomplishing the client's treatment goals and objectives, a treatment strategy, and the individuals responsible for providing treatment services and supports to the client. The license holder must have a treatment strategy to engage the client in treatment if the client:

(i) has a history of not engaging in treatment; and

(ii) is ordered by a court to participate in treatment services or to take neuroleptic medications;

(5) identify the participants involved in the client's treatment planning. The client must be a participant in the client's treatment planning. If applicable, the license holder must document the reasons that the license holder did not involve the client's family or other natural supports in the client's treatment planning;

(6) review the client's individual treatment plan every 180 days and update the client's individual treatment plan with the client's treatment progress, new treatment objectives and goals or, if the client has not made treatment progress, changes in the license holder's approach to treatment; and

(7) ensure that the client approves of the client's individual treatment plan unless a court orders the client's treatment plan under chapter 253B.

(b) If the client disagrees with the client's treatment plan, the license holder must document in the client file the reasons why the client does not agree with the treatment plan. If the license holder cannot obtain the client's approval of the treatment plan, a mental health professional must make efforts to obtain approval from a person who is authorized to consent on the client's behalf within 30 days after the client's previous individual treatment plan expired. A license holder may not deny a client service during this time period solely because the license holder could not obtain the client's approval of the client's individual treatment plan. A license holder may continue to bill for the client's otherwise eligible services when the client re-engages in services.

Subd. 9. **Functional assessment; required elements.** When a license holder is completing a functional assessment for an adult client, the license holder must:

(1) complete a functional assessment of the client after completing the client's diagnostic assessment;

(2) use a collaborative process that allows the client and the client's family and other natural supports, the client's referral sources, and the client's providers to provide information about how the client's symptoms of mental illness impact the client's functioning;

(3) if applicable, document the reasons that the license holder did not contact the client's family and other natural supports;

(4) assess and document how the client's symptoms of mental illness impact the client's functioning in the following areas:

(i) the client's mental health symptoms;

(ii) the client's mental health service needs;

(iii) the client's substance use;

(iv) the client's vocational and educational functioning;

(v) the client's social functioning, including the use of leisure time;

(vi) the client's interpersonal functioning, including relationships with the client's family and other natural supports;

(vii) the client's ability to provide self-care and live independently;

(viii) the client's medical and dental health;

(ix) the client's financial assistance needs; and

(x) the client's housing and transportation needs;

(5) include a narrative summarizing the client's strengths, resources, and all areas of functional impairment;

(6) complete the client's functional assessment before the client's initial individual treatment plan unless a service specifies otherwise; and

(7) update the client's functional assessment with the client's current functioning whenever there is a significant change in the client's functioning or at least every 180 days, unless a service specifies otherwise.

Sec. 12. **[245I.11] HEALTH SERVICES AND MEDICATIONS.**

Subdivision 1. **Generally.** If a license holder is licensed as a residential program, stores or administers client medications, or observes clients self-administer medications, the license holder must ensure that a staff person who is a registered nurse or licensed prescriber is responsible for overseeing storage and administration of client medications and observing

as a client self-administers medications, including training according to section 245I.05, subdivision 6, and documenting the occurrence according to section 245I.08, subdivision 5.

Subd. 2. **Health services.** If a license holder is licensed as a residential program, the license holder must:

(1) ensure that a client is screened for health issues within 72 hours of the client's admission;

(2) monitor the physical health needs of each client on an ongoing basis;

(3) offer referrals to clients and coordinate each client's care with psychiatric and medical services;

(4) identify circumstances in which a staff person must notify a registered nurse or licensed prescriber of any of a client's health concerns and the process for providing notification of client health concerns; and

(5) identify the circumstances in which the license holder must obtain medical care for a client and the process for obtaining medical care for a client.

Subd. 3. **Storing and accounting for medications.** (a) If a license holder stores client medications, the license holder must:

(1) store client medications in original containers in a locked location;

(2) store refrigerated client medications in special trays or containers that are separate from food;

(3) store client medications marked "for external use only" in a compartment that is separate from other client medications;

(4) store Schedule II to IV drugs listed in section 152.02, subdivisions 3 to 5, in a compartment that is locked separately from other medications;

(5) ensure that only authorized staff persons have access to stored client medications;

(6) follow a documentation procedure on each shift to account for all scheduled drugs; and

(7) record each incident when a staff person accepts a supply of client medications and destroy discontinued, outdated, or deteriorated client medications.

(b) If a license holder is licensed as a residential program, the license holder must allow clients who self-administer medications to keep a private medication supply. The license

holder must ensure that the client stores all private medication in a locked container in the client's private living area, unless the private medication supply poses a health and safety risk to any clients. A client must not maintain a private medication supply of a prescription medication without a written medication order from a licensed prescriber and a prescription label that includes the client's name.

Subd. 4. **Medication orders.** (a) If a license holder stores, prescribes, or administers medications or observes a client self-administer medications, the license holder must:

(1) ensure that a licensed prescriber writes all orders to accept, administer, or discontinue client medications;

(2) accept nonwritten orders to administer client medications in emergency circumstances only;

(3) establish a timeline and process for obtaining a written order with the licensed prescriber's signature when the license holder accepts a nonwritten order to administer client medications;

(4) obtain prescription medication renewals from a licensed prescriber for each client every 90 days for psychotropic medications and annually for all other medications; and

(5) maintain the client's right to privacy and dignity.

(b) If a license holder employs a licensed prescriber, the license holder must inform the client about potential medication effects and side effects and obtain and document the client's informed consent before the licensed prescriber prescribes a medication.

Subd. 5. **Medication administration.** If a license holder is licensed as a residential program, the license holder must:

(1) assess and document each client's ability to self-administer medication. In the assessment, the license holder must evaluate the client's ability to: (i) comply with prescribed medication regimens; and (ii) store the client's medications safely and in a manner that protects other individuals in the facility. Through the assessment process, the license holder must assist the client in developing the skills necessary to safely self-administer medication;

(2) monitor the effectiveness of medications, side effects of medications, and adverse reactions to medications for each client. The license holder must address and document any concerns about a client's medications;

(3) ensure that no staff person or client gives a legend drug supply for one client to another client;

(4) have policies and procedures for: (i) keeping a record of each client's medication orders; (ii) keeping a record of any incident of deferring a client's medications; (iii) documenting any incident when a client's medication is omitted; and (iv) documenting when a client refuses to take medications as prescribed; and

(5) document and track medication errors, document whether the license holder notified anyone about the medication error, determine if the license holder must take any follow-up actions, and identify the staff persons who are responsible for taking follow-up actions.

Sec. 13. **[245I.12] CLIENT RIGHTS AND PROTECTIONS.**

Subdivision 1. **Client rights.** A license holder must ensure that all clients have the following rights:

(1) the rights listed in the health care bill of rights in section 144.651;

(2) the right to be free from discrimination based on age, race, color, creed, religion, national origin, gender, marital status, disability, sexual orientation, and status with regard to public assistance. The license holder must follow all applicable state and federal laws including the Minnesota Human Rights Act, chapter 363A; and

(3) the right to be informed prior to a photograph or audio or video recording being made of the client. The client has the right to refuse to allow any recording or photograph of the client that is not for the purposes of identification or supervision by the license holder.

Subd. 2. **Restrictions to client rights.** If the license holder restricts a client's right, the license holder must document in the client file a mental health professional's approval of the restriction and the reasons for the restriction.

Subd. 3. **Notice of rights.** The license holder must give a copy of the client's rights according to this section to each client on the day of the client's admission. The license holder must document that the license holder gave a copy of the client's rights to each client on the day of the client's admission according to this section. The license holder must post a copy of the client rights in an area visible or accessible to all clients. The license holder must include the client rights in Minnesota Rules, chapter 9544, for applicable clients.

Subd. 4. **Client property.** (a) The license holder must meet the requirements of section 245A.04, subdivision 13.

(b) If the license holder is unable to obtain a client's signature acknowledging the receipt or disbursement of the client's funds or property required by section 245A.04, subdivision 13, paragraph (c), clause (1), two staff persons must sign documentation acknowledging

that the staff persons witnessed the client's receipt or disbursement of the client's funds or property.

(c) The license holder must return all of the client's funds and other property to the client except for the following items:

(1) illicit drugs, drug paraphernalia, and drug containers that are subject to forfeiture under section 609.5316. The license holder must give illicit drugs, drug paraphernalia, and drug containers to a local law enforcement agency or destroy the items; and

(2) weapons, explosives, and other property that may cause serious harm to the client or others. The license holder may give a client's weapons and explosives to a local law enforcement agency. The license holder must notify the client that a local law enforcement agency has the client's property and that the client has the right to reclaim the property if the client has a legal right to possess the item.

(d) If a client leaves the license holder's program but abandons the client's funds or property, the license holder must retain and store the client's funds or property, including medications, for a minimum of 30 days after the client's discharge from the program.

Subd. 5. **Client grievances.** (a) The license holder must have a grievance procedure that:

(1) describes to clients how the license holder will meet the requirements in this subdivision; and

(2) contains the current public contact information of the Department of Human Services, Licensing Division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Department of Health, Office of Health Facilities Complaints; and all applicable health-related licensing boards.

(b) On the day of each client's admission, the license holder must explain the grievance procedure to the client.

(c) The license holder must:

(1) post the grievance procedure in a place visible to clients and provide a copy of the grievance procedure upon request;

(2) allow clients, former clients, and their authorized representatives to submit a grievance to the license holder;

(3) within three business days of receiving a client's grievance, acknowledge in writing that the license holder received the client's grievance. If applicable, the license holder must

include a notice of the client's separate appeal rights for a managed care organization's reduction, termination, or denial of a covered service;

(4) within 15 business days of receiving a client's grievance, provide a written final response to the client's grievance containing the license holder's official response to the grievance; and

(5) allow the client to bring a grievance to the person with the highest level of authority in the program.

Sec. 14. **[245I.13] CRITICAL INCIDENTS.**

If a license holder is licensed as a residential program, the license holder must report all critical incidents to the commissioner within ten days of learning of the incident on a form approved by the commissioner. The license holder must keep a record of critical incidents in a central location that is readily accessible to the commissioner for review upon the commissioner's request for a minimum of two licensing periods.

Sec. 15. **[245I.20] MENTAL HEALTH CLINIC.**

Subdivision 1. **Purpose.** Certified mental health clinics provide clinical services for the treatment of mental illnesses with a treatment team that reflects multiple disciplines and areas of expertise.

Subd. 2. **Definitions.** (a) "Clinical services" means services provided to a client to diagnose, describe, predict, and explain the client's status relative to a condition or problem as described in the: (1) current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or (2) current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three. Where necessary, clinical services includes services to treat a client to reduce the client's impairment due to the client's condition. Clinical services also includes individual treatment planning, case review, record-keeping required for a client's treatment, and treatment supervision. For the purposes of this section, clinical services excludes services delivered to a client under a separate license and services listed under section 245I.011, subdivision 5.

(b) "Competent" means having professional education, training, continuing education, consultation, supervision, experience, or a combination thereof necessary to demonstrate sufficient knowledge of and proficiency in a specific clinical service.

(c) "Discipline" means a branch of professional knowledge or skill acquired through a specific course of study, training, and supervised practice. Discipline is usually documented by a specific educational degree, licensure, or certification of proficiency. Examples of the mental health disciplines include but are not limited to psychiatry, psychology, clinical social work, marriage and family therapy, clinical counseling, and psychiatric nursing.

(d) "Treatment team" means the mental health professionals, mental health practitioners, and clinical trainees who provide clinical services to clients.

Subd. 3. **Organizational structure.** (a) A mental health clinic location must be an entire facility or a clearly identified unit within a facility that is administratively and clinically separate from the rest of the facility. The mental health clinic location may provide services other than clinical services to clients, including medical services, substance use disorder services, social services, training, and education.

(b) The certification holder must notify the commissioner of all mental health clinic locations. If there is more than one mental health clinic location, the certification holder must designate one location as the main location and all of the other locations as satellite locations. The main location as a unit and the clinic as a whole must comply with the minimum staffing standards in subdivision 4.

(c) The certification holder must ensure that each satellite location:

(1) adheres to the same policies and procedures as the main location;

(2) provides treatment team members with face-to-face or telephone access to a mental health professional for the purposes of supervision whenever the satellite location is open. The certification holder must maintain a schedule of the mental health professionals who will be available and the contact information for each available mental health professional. The schedule must be current and readily available to treatment team members; and

(3) enables clients to access all of the mental health clinic's clinical services and treatment team members, as needed.

Subd. 4. **Minimum staffing standards.** (a) A certification holder's treatment team must consist of at least four mental health professionals. At least two of the mental health professionals must be employed by or under contract with the mental health clinic for a minimum of 35 hours per week each. Each of the two mental health professionals must specialize in a different mental health discipline.

(b) The treatment team must include:

(1) a physician qualified as a mental health professional according to section 245I.04, subdivision 2, clause (4), or a nurse qualified as a mental health professional according to section 245I.04, subdivision 2, clause (1); and

(2) a psychologist qualified as a mental health professional according to section 245I.04, subdivision 2, clause (3).

(c) The staff persons fulfilling the requirement in paragraph (b) must provide clinical services at least:

(1) eight hours every two weeks if the mental health clinic has over 25.0 full-time equivalent treatment team members;

(2) eight hours each month if the mental health clinic has 15.1 to 25.0 full-time equivalent treatment team members;

(3) four hours each month if the mental health clinic has 5.1 to 15.0 full-time equivalent treatment team members; or

(4) two hours each month if the mental health clinic has 2.0 to 5.0 full-time equivalent treatment team members or only provides in-home services to clients.

(d) The certification holder must maintain a record that demonstrates compliance with this subdivision.

Subd. 5. **Treatment supervision specified.** (a) A mental health professional must remain responsible for each client's case. The certification holder must document the name of the mental health professional responsible for each case and the dates that the mental health professional is responsible for the client's case from beginning date to end date. The certification holder must assign each client's case for assessment, diagnosis, and treatment services to a treatment team member who is competent in the assigned clinical service, the recommended treatment strategy, and in treating the client's characteristics.

(b) Treatment supervision of mental health practitioners and clinical trainees required by section 245I.06 must include case reviews as described in this paragraph. Every two months, a mental health professional must complete a case review of each client assigned to the mental health professional when the client is receiving clinical services from a mental health practitioner or clinical trainee. The case review must include a consultation process that thoroughly examines the client's condition and treatment, including: (1) a review of the client's reason for seeking treatment, diagnoses and assessments, and the individual treatment plan; (2) a review of the appropriateness, duration, and outcome of treatment provided to the client; and (3) treatment recommendations.

Subd. 6. **Additional policy and procedure requirements.** (a) In addition to the policies and procedures required by section 245I.03, the certification holder must establish, enforce, and maintain the policies and procedures required by this subdivision.

(b) The certification holder must have a clinical evaluation procedure to identify and document each treatment team member's areas of competence.

(c) The certification holder must have policies and procedures for client intake and case assignment that:

(1) outline the client intake process;

(2) describe how the mental health clinic determines the appropriateness of accepting a client into treatment by reviewing the client's condition and need for treatment, the clinical services that the mental health clinic offers to clients, and other available resources; and

(3) contain a process for assigning a client's case to a mental health professional who is responsible for the client's case and other treatment team members.

Subd. 7. **Referrals.** If necessary treatment for a client or treatment desired by a client is not available at the mental health clinic, the certification holder must facilitate appropriate referrals for the client. When making a referral for a client, the treatment team member must document a discussion with the client that includes: (1) the reason for the client's referral; (2) potential treatment resources for the client; and (3) the client's response to receiving a referral.

Subd. 8. **Emergency service.** For the certification holder's telephone numbers that clients regularly access, the certification holder must include the contact information for the area's mental health crisis services as part of the certification holder's message when a live operator is not available to answer clients' calls.

Subd. 9. **Quality assurance and improvement plan.** (a) At a minimum, a certification holder must develop a written quality assurance and improvement plan that includes a plan for:

(1) encouraging ongoing consultation among members of the treatment team;

(2) obtaining and evaluating feedback about services from clients, family and other natural supports, referral sources, and staff persons;

(3) measuring and evaluating client outcomes;

(4) reviewing client suicide deaths and suicide attempts;

(5) examining the quality of clinical service delivery to clients; and

(6) self-monitoring of compliance with this chapter.

(b) At least annually, the certification holder must review, evaluate, and update the quality assurance and improvement plan. The review must: (1) include documentation of the actions that the certification holder will take as a result of information obtained from monitoring activities in the plan; and (2) establish goals for improved service delivery to clients for the next year.

Subd. 10. **Application procedures.** (a) The applicant for certification must submit any documents that the commissioner requires on forms approved by the commissioner.

(b) Upon submitting an application for certification, an applicant must pay the application fee required by section 245A.10, subdivision 3.

(c) The commissioner must act on an application within 90 working days of receiving a completed application.

(d) When the commissioner receives an application for initial certification that is incomplete because the applicant failed to submit required documents or is deficient because the submitted documents do not meet certification requirements, the commissioner must provide the applicant with written notice that the application is incomplete or deficient. In the notice, the commissioner must identify the particular documents that are missing or deficient and give the applicant 45 days to submit a second application that is complete. An applicant's failure to submit a complete application within 45 days after receiving notice from the commissioner is a basis for certification denial.

(e) The commissioner must give notice of a denial to an applicant when the commissioner has made the decision to deny the certification application. In the notice of denial, the commissioner must state the reasons for the denial in plain language. The commissioner must send or deliver the notice of denial to an applicant by certified mail or personal service. In the notice of denial, the commissioner must state the reasons that the commissioner denied the application and must inform the applicant of the applicant's right to request a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an applicant delivers an appeal by personal service, the commissioner must receive the appeal within 20 calendar days after the applicant received the notice of denial.

Subd. 11. **Commissioner's right of access.** (a) When the commissioner is exercising the powers conferred to the commissioner by this chapter, if the mental health clinic is in

operation and the information is relevant to the commissioner's inspection or investigation, the certification holder must provide the commissioner access to:

(1) the physical facility and grounds where the program is located;

(2) documentation and records, including electronically maintained records;

(3) clients served by the mental health clinic;

(4) staff persons of the mental health clinic; and

(5) personnel records of current and former staff of the mental health clinic.

(b) The certification holder must provide the commissioner with access to the facility and grounds, documentation and records, clients, and staff without prior notice and as often as the commissioner considers necessary if the commissioner is investigating alleged maltreatment or a violation of a law or rule, or conducting an inspection. When conducting an inspection, the commissioner may request and must receive assistance from other state, county, and municipal governmental agencies and departments. The applicant or certification holder must allow the commissioner, at the commissioner's expense, to photocopy, photograph, and make audio and video recordings during an inspection.

Subd. 12. **Monitoring and inspections.** (a) The commissioner may conduct a certification review of the certified mental health clinic every two years to determine the certification holder's compliance with applicable rules and statutes.

(b) The commissioner must offer the certification holder a choice of dates for an announced certification review. A certification review must occur during the clinic's normal working hours.

(c) The commissioner must make the results of certification reviews and investigations publicly available on the department's website.

Subd. 13. **Correction orders.** (a) If the applicant or certification holder fails to comply with a law or rule, the commissioner may issue a correction order. The correction order must state:

(1) the condition that constitutes a violation of the law or rule;

(2) the specific law or rule that the applicant or certification holder has violated; and

(3) the time that the applicant or certification holder is allowed to correct each violation.

(b) If the applicant or certification holder believes that the commissioner's correction order is erroneous, the applicant or certification holder may ask the commissioner to

reconsider the part of the correction order that is allegedly erroneous. An applicant or certification holder must make a request for reconsideration in writing. The request must be postmarked and sent to the commissioner within 20 calendar days after the applicant or certification holder received the correction order; and the request must:

(1) specify the part of the correction order that is allegedly erroneous;

(2) explain why the specified part is erroneous; and

(3) include documentation to support the allegation of error.

(c) A request for reconsideration does not stay any provision or requirement of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal.

(d) If the commissioner finds that the applicant or certification holder failed to correct the violation specified in the correction order, the commissioner may decertify the certified mental health clinic according to subdivision 14.

(e) Nothing in this subdivision prohibits the commissioner from decertifying a mental health clinic according to subdivision 14.

Subd. 14. **Decertification.** (a) The commissioner may decertify a mental health clinic if a certification holder:

(1) failed to comply with an applicable law or rule; or

(2) knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for certification, during an investigation, or regarding compliance with applicable laws or rules.

(b) When considering decertification of a mental health clinic, the commissioner must consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of clients.

(c) If the commissioner decertifies a mental health clinic, the order of decertification must inform the certification holder of the right to have a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The certification holder may appeal the decertification. The certification holder must appeal a decertification in writing and send or deliver the appeal to the commissioner by certified mail or personal service. If the certification holder mails the appeal, the appeal must be postmarked and sent to the commissioner within ten calendar days after the certification holder receives the order of decertification. If the certification holder delivers an appeal by personal service, the

commissioner must receive the appeal within ten calendar days after the certification holder received the order. If a certification holder submits a timely appeal of an order of decertification, the certification holder may continue to operate the program until the commissioner issues a final order on the decertification.

(d) If the commissioner decertifies a mental health clinic pursuant to paragraph (a), clause (1), based on a determination that the mental health clinic was responsible for maltreatment, and if the certification holder appeals the decertification according to paragraph (c), and appeals the maltreatment determination under section 260E.33, the final decertification determination is stayed until the commissioner issues a final decision regarding the maltreatment appeal.

Subd. 15. **Transfer prohibited.** A certification issued under this section is only valid for the premises and the individual, organization, or government entity identified by the commissioner on the certification. A certification is not transferable or assignable.

Subd. 16. **Notifications required and noncompliance.** (a) A certification holder must notify the commissioner, in a manner prescribed by the commissioner, and obtain the commissioner's approval before making any change to the name of the certification holder or the location of the mental health clinic.

(b) Changes in mental health clinic organization, staffing, treatment, or quality assurance procedures that affect the ability of the certification holder to comply with the minimum standards of this section must be reported in writing by the certification holder to the commissioner within 15 days of the occurrence. Review of the change must be conducted by the commissioner. A certification holder with changes resulting in noncompliance in minimum standards must receive written notice and may have up to 180 days to correct the areas of noncompliance before being decertified. Interim procedures to resolve the noncompliance on a temporary basis must be developed and submitted in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. Not reporting an occurrence of a change that results in noncompliance within 15 days, failure to develop an approved interim procedure within 30 days of the determination of the noncompliance, or nonresolution of the noncompliance within 180 days will result in immediate decertification.

(c) The mental health clinic may be required to submit written information to the department to document that the mental health clinic has maintained compliance with this section and mental health clinic procedures.

Sec. 16. **[245I.23] INTENSIVE RESIDENTIAL TREATMENT SERVICES AND RESIDENTIAL CRISIS STABILIZATION.**

Subdivision 1. **Purpose.** (a) Intensive residential treatment services is a community-based medically monitored level of care for an adult client that uses established rehabilitative principles to promote a client's recovery and to develop and achieve psychiatric stability, personal and emotional adjustment, self-sufficiency, and other skills that help a client transition to a more independent setting.

(b) Residential crisis stabilization provides structure and support to an adult client in a community living environment when a client has experienced a mental health crisis and needs short-term services to ensure that the client can safely return to the client's home or precrisis living environment with additional services and supports identified in the client's crisis assessment.

Subd. 2. **Definitions.** (a) "Program location" means a set of rooms that are each physically self-contained and have defining walls extending from floor to ceiling. Program location includes bedrooms, living rooms or lounge areas, bathrooms, and connecting areas.

(b) "Treatment team" means a group of staff persons who provide intensive residential treatment services or residential crisis stabilization to clients. The treatment team includes mental health professionals, mental health practitioners, clinical trainees, certified rehabilitation specialists, mental health rehabilitation workers, and mental health certified peer specialists.

Subd. 3. **Treatment services description.** The license holder must describe in writing all treatment services that the license holder provides. The license holder must have the description readily available for the commissioner upon the commissioner's request.

Subd. 4. **Required intensive residential treatment services.** (a) On a daily basis, the license holder must follow a client's treatment plan to provide intensive residential treatment services to the client to improve the client's functioning.

(b) The license holder must offer and have the capacity to directly provide the following treatment services to each client:

(1) rehabilitative mental health services;

(2) crisis prevention planning to assist a client with:

(i) identifying and addressing patterns in the client's history and experience of the client's mental illness; and

(ii) developing crisis prevention strategies that include de-escalation strategies that have been effective for the client in the past;

(3) health services and administering medication;

(4) co-occurring substance use disorder treatment;

(5) engaging the client's family and other natural supports in the client's treatment and educating the client's family and other natural supports to strengthen the client's social and family relationships; and

(6) making referrals for the client to other service providers in the community and supporting the client's transition from intensive residential treatment services to another setting.

(c) The license holder must include Illness Management and Recovery (IMR), Enhanced Illness Management and Recovery (E-IMR), or other similar interventions in the license holder's programming as approved by the commissioner.

Subd. 5. **Required residential crisis stabilization services.** (a) On a daily basis, the license holder must follow a client's individual crisis treatment plan to provide services to the client in residential crisis stabilization to improve the client's functioning.

(b) The license holder must offer and have the capacity to directly provide the following treatment services to the client:

(1) crisis stabilization services as described in section 256B.0624, subdivision 7;

(2) rehabilitative mental health services;

(3) health services and administering the client's medications; and

(4) making referrals for the client to other service providers in the community and supporting the client's transition from residential crisis stabilization to another setting.

Subd. 6. **Optional treatment services.** (a) If the license holder offers additional treatment services to a client, the treatment service must be:

(1) approved by the commissioner; and

(2)(i) a mental health evidence-based practice that the federal Department of Health and Human Services Substance Abuse and Mental Health Service Administration has adopted;

(ii) a nationally recognized mental health service that substantial research has validated as effective in helping individuals with serious mental illness achieve treatment goals; or

(iii) developed under state-sponsored research of publicly funded mental health programs and validated to be effective for individuals, families, and communities.

(b) Before providing an optional treatment service to a client, the license holder must provide adequate training to a staff person about providing the optional treatment service to a client.

Subd. 7. **Intensive residential treatment services assessment and treatment planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate and document the client's immediate needs, including the client's:

(1) health and safety, including the client's need for crisis assistance;

(2) responsibilities for children, family and other natural supports, and employers; and

(3) housing and legal issues.

(b) Within 24 hours of the client's admission, the license holder must complete an initial treatment plan for the client. The license holder must:

(1) base the client's initial treatment plan on the client's referral information and an assessment of the client's immediate needs;

(2) consider crisis assistance strategies that have been effective for the client in the past;

(3) identify the client's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the client engage in treatment;

(4) identify the participants involved in the client's treatment planning. The client must be a participant; and

(5) ensure that a treatment supervisor approves of the client's initial treatment plan if a mental health practitioner or clinical trainee completes the client's treatment plan, notwithstanding section 245I.08, subdivision 3.

(c) According to section 245A.65, subdivision 2, paragraph (b), the license holder must complete an individual abuse prevention plan as part of a client's initial treatment plan.

(d) Within five days of the client's admission and again within 60 days after the client's admission, the license holder must complete a level of care assessment of the client. If the license holder determines that a client does not need a medically monitored level of service, a treatment supervisor must document how the client's admission to and continued services in intensive residential treatment services are medically necessary for the client.

(e) Within ten days of a client's admission, the license holder must complete or review and update the client's standard diagnostic assessment.

(f) Within ten days of a client's admission, the license holder must complete the client's individual treatment plan, notwithstanding section 245I.10, subdivision 8. Within 40 days after the client's admission and again within 70 days after the client's admission, the license holder must update the client's individual treatment plan. The license holder must focus the client's treatment planning on preparing the client for a successful transition from intensive residential treatment services to another setting. In addition to the required elements of an individual treatment plan under section 245I.10, subdivision 8, the license holder must identify the following information in the client's individual treatment plan: (1) the client's referrals and resources for the client's health and safety; and (2) the staff persons who are responsible for following up with the client's referrals and resources. If the client does not receive a referral or resource that the client needs, the license holder must document the reason that the license holder did not make the referral or did not connect the client to a particular resource. The license holder is responsible for determining whether additional follow-up is required on behalf of the client.

(g) Within 30 days of the client's admission, the license holder must complete a functional assessment of the client. Within 60 days after the client's admission, the license holder must update the client's functional assessment to include any changes in the client's functioning and symptoms.

(h) For a client with a current substance use disorder diagnosis and for a client whose substance use disorder screening in the client's standard diagnostic assessment indicates the possibility that the client has a substance use disorder, the license holder must complete a written assessment of the client's substance use within 30 days of the client's admission. In the substance use assessment, the license holder must: (1) evaluate the client's history of substance use, relapses, and hospitalizations related to substance use; (2) assess the effects of the client's substance use on the client's relationships including with family member and others; (3) identify financial problems, health issues, housing instability, and unemployment; (4) assess the client's legal problems, past and pending incarceration, violence, and victimization; and (5) evaluate the client's suicide attempts, noncompliance with taking prescribed medications, and noncompliance with psychosocial treatment.

(i) On a weekly basis, a mental health professional or certified rehabilitation specialist must review each client's treatment plan and individual abuse prevention plan. The license holder must document in the client's file each weekly review of the client's treatment plan and individual abuse prevention plan.

Subd. 8. **Residential crisis stabilization assessment and treatment planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate the client and document the client's immediate needs, including the client's:

(1) health and safety, including the client's need for crisis assistance;

(2) responsibilities for children, family and other natural supports, and employers; and

(3) housing and legal issues.

(b) Within 24 hours of a client's admission, the license holder must complete a crisis treatment plan for the client under section 256B.0624, subdivision 11. The license holder must base the client's crisis treatment plan on the client's referral information and an assessment of the client's immediate needs.

(c) Section 245A.65, subdivision 2, paragraph (b), requires the license holder to complete an individual abuse prevention plan for a client as part of the client's crisis treatment plan.

Subd. 9. **Key staff positions.** (a) The license holder must have a staff person assigned to each of the following key staff positions at all times:

(1) a program director who qualifies as a mental health practitioner. The license holder must designate the program director as responsible for all aspects of the operation of the program and the program's compliance with all applicable requirements. The program director must know and understand the implications of this chapter; chapters 245A, 245C, and 260E; sections 626.557 and 626.5572; Minnesota Rules, chapter 9544; and all other applicable requirements. The license holder must document in the program director's personnel file how the program director demonstrates knowledge of these requirements. The program director may also serve as the treatment director of the program, if qualified;

(2) a treatment director who qualifies as a mental health professional. The treatment director must be responsible for overseeing treatment services for clients and the treatment supervision of all staff persons; and

(3) a registered nurse who qualifies as a mental health practitioner. The registered nurse must:

(i) work at the program location a minimum of eight hours per week;

(ii) provide monitoring and supervision of staff persons as defined in section 148.171, subdivisions 8a and 23;

(iii) be responsible for the review and approval of health service and medication policies and procedures under section 245I.03, subdivision 5; and

(iv) oversee the license holder's provision of health services to clients, medication storage, and medication administration to clients.

(b) Within five business days of a change in a key staff position, the license holder must notify the commissioner of the staffing change. The license holder must notify the commissioner of the staffing change on a form approved by the commissioner and include the name of the staff person now assigned to the key staff position and the staff person's qualifications.

Subd. 10. **Minimum treatment team staffing levels and ratios.** (a) The license holder must maintain a treatment team staffing level sufficient to:

(1) provide continuous daily coverage of all shifts;

(2) follow each client's treatment plan and meet each client's needs as identified in the client's treatment plan;

(3) implement program requirements; and

(4) safely monitor and guide the activities of each client, taking into account the client's level of behavioral and psychiatric stability, cultural needs, and vulnerabilities.

(b) The license holder must ensure that treatment team members:

(1) remain awake during all work hours; and

(2) are available to monitor and guide the activities of each client whenever clients are present in the program.

(c) On each shift, the license holder must maintain a treatment team staffing ratio of at least one treatment team member to nine clients. If the license holder is serving nine or fewer clients, at least one treatment team member on the day shift must be a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner. If the license holder is serving more than nine clients, at least one of the treatment team members working during both the day and evening shifts must be a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.

(d) If the license holder provides residential crisis stabilization to clients and is serving at least one client in residential crisis stabilization and more than four clients in residential crisis stabilization and intensive residential treatment services, the license holder must maintain a treatment team staffing ratio on each shift of at least two treatment team members during the client's first 48 hours in residential crisis stabilization.

Subd. 11. **Shift exchange.** A license holder must ensure that treatment team members working on different shifts exchange information about a client as necessary to effectively care for the client and to follow and update a client's treatment plan and individual abuse prevention plan.

Subd. 12. **Daily documentation.** (a) For each day that a client is present in the program, the license holder must provide a daily summary in the client's file that includes observations about the client's behavior and symptoms, including any critical incidents in which the client was involved.

(b) For each day that a client is not present in the program, the license holder must document the reason for a client's absence in the client's file.

Subd. 13. **Access to a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.** Treatment team members must have access in person or by telephone to a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner within 30 minutes. The license holder must maintain a schedule of mental health professionals, clinical trainees, certified rehabilitation specialists, or mental health practitioners who will be available and contact information to reach them. The license holder must keep the schedule current and make the schedule readily available to treatment team members.

Subd. 14. **Weekly team meetings.** (a) The license holder must hold weekly team meetings and ancillary meetings according to this subdivision.

(b) A mental health professional or certified rehabilitation specialist must hold at least one team meeting each calendar week and be physically present at the team meeting. All treatment team members, including treatment team members who work on a part-time or intermittent basis, must participate in a minimum of one team meeting during each calendar week when the treatment team member is working for the license holder. The license holder must document all weekly team meetings, including the names of meeting attendees.

(c) If a treatment team member cannot participate in a weekly team meeting, the treatment team member must participate in an ancillary meeting. A mental health professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner who participated in the most recent weekly team meeting may lead the ancillary meeting. During the ancillary meeting, the treatment team member leading the ancillary meeting must review the information that was shared at the most recent weekly team meeting, including revisions to client treatment plans and other information that the treatment supervisors exchanged

with treatment team members. The license holder must document all ancillary meetings, including the names of meeting attendees.

Subd. 15. **Intensive residential treatment services admission criteria.** (a) An eligible client for intensive residential treatment services is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a mental illness;

(3) because of a mental illness, has a substantial disability and functional impairment in three or more areas listed in section 245I.10, subdivision 9, clause (4), that markedly reduce the individual's self-sufficiency;

(4) has one or more of the following: a history of recurring or prolonged inpatient hospitalizations during the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services with poor outcomes for the individual; and

(5) in the written opinion of a mental health professional, needs mental health services that available community-based services cannot provide, or is likely to experience a mental health crisis or require a more restrictive setting if the individual does not receive intensive rehabilitative mental health services.

(b) The license holder must not limit or restrict intensive residential treatment services to a client based solely on:

(1) the client's substance use;

(2) the county in which the client resides; or

(3) whether the client elects to receive other services for which the client may be eligible, including case management services.

(c) This subdivision does not prohibit the license holder from restricting admissions of individuals who present an imminent risk of harm or danger to themselves or others.

Subd. 16. **Residential crisis stabilization services admission criteria.** An eligible client for residential crisis stabilization is an individual who is age 18 or older and meets the eligibility criteria in section 256B.0624, subdivision 3.

Subd. 17. **Admissions referrals and determinations.** (a) The license holder must identify the information that the license holder needs to make a determination about a person's admission referral.

(b) The license holder must:

(1) always be available to receive referral information about a person seeking admission to the license holder's program;

(2) respond to the referral source within eight hours of receiving a referral and, within eight hours, communicate with the referral source about what information the license holder needs to make a determination concerning the person's admission;

(3) consider the license holder's staffing ratio and the areas of treatment team members' competency when determining whether the license holder is able to meet the needs of a person seeking admission; and

(4) determine whether to admit a person within 72 hours of receiving all necessary information from the referral source.

Subd. 18. **Discharge standards.** (a) When a license holder discharges a client from a program, the license holder must categorize the discharge as a successful discharge, program-initiated discharge, or non-program-initiated discharge according to the criteria in this subdivision. The license holder must meet the standards associated with the type of discharge according to this subdivision.

(b) To successfully discharge a client from a program, the license holder must ensure that the following criteria are met:

(1) the client must substantially meet the client's documented treatment plan goals and objectives;

(2) the client must complete discharge planning with the treatment team; and

(3) the client and treatment team must arrange for the client to receive continuing care at a less intensive level of care after discharge.

(c) Prior to successfully discharging a client from a program, the license holder must complete the client's discharge summary and provide the client with a copy of the client's discharge summary in plain language that includes:

(1) a brief review of the client's problems and strengths during the period that the license holder provided services to the client;

(2) the client's response to the client's treatment plan;

(3) the goals and objectives that the license holder recommends that the client addresses during the first three months following the client's discharge from the program;

(4) the recommended actions, supports, and services that will assist the client with a successful transition from the program to another setting;

(5) the client's crisis plan; and

(6) the client's forwarding address and telephone number.

(d) For a non-program-initiated discharge of a client from a program, the following criteria must be met:

(1)(i) the client has withdrawn the client's consent for treatment; (ii) the license holder has determined that the client has the capacity to make an informed decision; and (iii) the client does not meet the criteria for an emergency hold under section 253B.051, subdivision 2;

(2) the client has left the program against staff person advice;

(3) an entity with legal authority to remove the client has decided to remove the client from the program; or

(4) a source of payment for the services is no longer available.

(e) Within ten days of a non-program-initiated discharge of a client from a program, the license holder must complete the client's discharge summary in plain language that includes:

(1) the reasons for the client's discharge;

(2) a description of attempts by staff persons to enable the client to continue treatment or to consent to treatment; and

(3) recommended actions, supports, and services that will assist the client with a successful transition from the program to another setting.

(f) For a program-initiated discharge of a client from a program, the following criteria must be met:

(1) the client is competent but has not participated in treatment or has not followed the program rules and regulations and the client has not participated to such a degree that the program's level of care is ineffective or unsafe for the client, despite multiple, documented attempts that the license holder has made to address the client's lack of participation in treatment;

(2) the client has not made progress toward the client's treatment goals and objectives despite the license holder's persistent efforts to engage the client in treatment, and the license holder has no reasonable expectation that the client will make progress at the program's

level of care nor does the client require the program's level of care to maintain the current level of functioning;

(3) a court order or the client's legal status requires the client to participate in the program but the client has left the program against staff person advice; or

(4) the client meets criteria for a more intensive level of care and a more intensive level of care is available to the client.

(g) Prior to a program-initiated discharge of a client from a program, the license holder must consult the client, the client's family and other natural supports, and the client's case manager, if applicable, to review the issues involved in the program's decision to discharge the client from the program. During the discharge review process, which must not exceed five working days, the license holder must determine whether the license holder, treatment team, and any interested persons can develop additional strategies to resolve the issues leading to the client's discharge and to permit the client to have an opportunity to continue receiving services from the license holder. The license holder may temporarily remove a client from the program facility during the five-day discharge review period. The license holder must document the client's discharge review in the client's file.

(h) Prior to a program-initiated discharge of a client from the program, the license holder must complete the client's discharge summary and provide the client with a copy of the discharge summary in plain language that includes:

(1) the reasons for the client's discharge;

(2) the alternatives to discharge that the license holder considered or attempted to implement;

(3) the names of each individual who is involved in the decision to discharge the client and a description of each individual's involvement; and

(4) recommended actions, supports, and services that will assist the client with a successful transition from the program to another setting.

Subd. 19. **Program facility.** (a) The license holder must be licensed or certified as a board and lodging facility, supervised living facility, or a boarding care home by the Department of Health.

(b) The license holder must have a capacity of five to 16 beds and the program must not be declared as an institution for mental disease.

(c) The license holder must furnish each program location to meet the psychological, emotional, and developmental needs of clients.

(d) The license holder must provide one living room or lounge area per program location. There must be space available to provide services according to each client's treatment plan, such as an area for learning recreation time skills and areas for learning independent living skills, such as laundering clothes and preparing meals.

(e) The license holder must ensure that each program location allows each client to have privacy. Each client must have privacy during assessment interviews and counseling sessions. Each client must have a space designated for the client to see outside visitors at the program facility.

Subd. 20. **Physical separation of services.** If the license holder offers services to individuals who are not receiving intensive residential treatment services or residential stabilization at the program location, the license holder must inform the commissioner and submit a plan for approval to the commissioner about how and when the license holder will provide services. The license holder must only provide services to clients who are not receiving intensive residential treatment services or residential crisis stabilization in an area that is physically separated from the area in which the license holder provides clients with intensive residential treatment services or residential crisis stabilization.

Subd. 21. **Dividing staff time between locations.** A license holder must obtain approval from the commissioner prior to providing intensive residential treatment services or residential crisis stabilization to clients in more than one program location under one license and dividing one staff person's time between program locations during the same work period.

Subd. 22. **Additional policy and procedure requirements.** (a) In addition to the policies and procedures in section 245I.03, the license holder must establish, enforce, and maintain the policies and procedures in this subdivision.

(b) The license holder must have policies and procedures for receiving referrals and making admissions determinations about referred persons under subdivisions 14 to 16.

(c) The license holder must have policies and procedures for discharging clients under subdivision 17. In the policies and procedures, the license holder must identify the staff persons who are authorized to discharge clients from the program.

Subd. 23. **Quality assurance and improvement plan.** (a) A license holder must develop a written quality assurance and improvement plan that includes a plan to:

(1) encourage ongoing consultation between members of the treatment team;

(2) obtain and evaluate feedback about services from clients, family and other natural supports, referral sources, and staff persons;

(3) measure and evaluate client outcomes in the program;

(4) review critical incidents in the program;

(5) examine the quality of clinical services in the program; and

(6) self-monitor the license holder's compliance with this chapter.

(b) At least annually, the license holder must review, evaluate, and update the license holder's quality assurance and improvement plan. The license holder's review must:

(1) document the actions that the license holder will take in response to the information that the license holder obtains from the monitoring activities in the plan; and

(2) establish goals for improving the license holder's services to clients during the next year.

Subd. 24. **Application.** When an applicant requests licensure to provide intensive residential treatment services, residential crisis stabilization, or both to clients, the applicant must submit, on forms that the commissioner provides, any documents that the commissioner requires.

Sec. 17. **[256B.0671] COVERED MENTAL HEALTH SERVICES.**

Subdivision 1. **Definitions.** (a) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(b) "Mental health practitioner" means a staff person who is qualified under section 245I.04, subdivision 4.

(c) "Mental health professional" means a staff person who is qualified under section 245I.04, subdivision 2.

Subd. 2. **Generally.** (a) An individual, organization, or government entity providing mental health services to a client under this section must obtain a criminal background study of each staff person or volunteer who is providing direct contact services to a client.

(b) An individual, organization, or government entity providing mental health services to a client under this section must comply with all responsibilities that chapter 245I assigns to a license holder, except section 245I.011, subdivision 1, unless all of the individual's, organization's, or government entity's treatment staff are qualified as mental health professionals.

(c) An individual, organization, or government entity providing mental health services to a client under this section must comply with the following requirements if all of the license holder's treatment staff are qualified as mental health professionals:

(1) provider qualifications and scopes of practice under section 245I.04;

(2) maintaining and updating personnel files under section 245I.07;

(3) documenting under section 245I.08;

(4) maintaining and updating client files under section 245I.09;

(5) completing client assessments and treatment planning under section 245I.10;

(6) providing clients with health services and medications under section 245I.11; and

(7) respecting and enforcing client rights under section 245I.12.

Subd. 3. **Adult day treatment services.** (a) Subject to federal approval, medical assistance covers adult day treatment (ADT) services that are provided under contract with the county board. Adult day treatment payment is subject to the conditions in paragraphs (b) to (e). The provider must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments, protocols, and forms approved by the commissioner.

(b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve the effects of mental illness on a client to enable the client to benefit from a lower level of care and to live and function more independently in the community. Adult day treatment services must be provided to a client to stabilize the client's mental health and to improve the client's independent living and socialization skills. Adult day treatment must consist of at least one hour of group psychotherapy and must include group time focused on rehabilitative interventions or other therapeutic services that a multidisciplinary team provides to each client. Adult day treatment services are not a part of inpatient or residential treatment services. The following providers may apply to become adult day treatment providers:

(1) a hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 256B.0625, subdivision 5; or

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475.

(c) An adult day treatment (ADT) services provider must:

(1) ensure that the commissioner has approved of the organization as an adult day treatment provider organization;

(2) ensure that a multidisciplinary team provides ADT services to a group of clients. A mental health professional must supervise each multidisciplinary staff person who provides ADT services;

(3) make ADT services available to the client at least two days a week for at least three consecutive hours per day. ADT services may be longer than three hours per day, but medical assistance may not reimburse a provider for more than 15 hours per week;

(4) provide ADT services to each client that includes group psychotherapy by a mental health professional or clinical trainee and daily rehabilitative interventions by a mental health professional, clinical trainee, or mental health practitioner; and

(5) include ADT services in the client's individual treatment plan, when appropriate. The adult day treatment provider must:

(i) complete a functional assessment of each client under section 245I.10, subdivision 9;

(ii) notwithstanding section 245I.10, subdivision 8, review the client's progress and update the individual treatment plan at least every 90 days until the client is discharged from the program; and

(iii) include a discharge plan for the client in the client's individual treatment plan.

(d) To be eligible for adult day treatment, a client must:

(1) be 18 years of age or older;

(2) not reside in a nursing facility, hospital, institute of mental disease, or state-operated treatment center unless the client has an active discharge plan that indicates a move to an independent living setting within 180 days;

(3) have the capacity to engage in rehabilitative programming, skills activities, and psychotherapy in the structured, therapeutic setting of an adult day treatment program and demonstrate measurable improvements in functioning resulting from participation in the adult day treatment program;

(4) have a level of care assessment under section 245I.02, subdivision 19, recommending that the client participate in services with the level of intensity and duration of an adult day treatment program; and

(5) have the recommendation of a mental health professional for adult day treatment services. The mental health professional must find that adult day treatment services are medically necessary for the client.

(e) Medical assistance does not cover the following services as adult day treatment services:

(1) services that are primarily recreational or that are provided in a setting that is not under medical supervision, including sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) social or educational services that do not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultations with other providers or service agency staff persons about the care or progress of a client;

(4) prevention or education programs that are provided to the community;

(5) day treatment for clients with a primary diagnosis of a substance use disorder;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours per day; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Subd. 4. **Explanation of findings.** (a) Subject to federal approval, medical assistance covers an explanation of findings that a mental health professional or clinical trainee provides when the provider has obtained the authorization from the client or the client's representative to release the information.

(b) A mental health professional or clinical trainee provides an explanation of findings to assist the client or related parties in understanding the results of the client's testing or diagnostic assessment and the client's mental illness, and provides professional insight that the client or related parties need to carry out a client's treatment plan. Related parties may include the client's family and other natural supports and other service providers working with the client.

(c) An explanation of findings is not paid for separately when a mental health professional or clinical trainee explains the results of psychological testing or a diagnostic assessment to the client or the client's representative as part of the client's psychological testing or a diagnostic assessment.

Subd. 5. **Family psychoeducation services.** (a) Subject to federal approval, medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a mental health professional or a clinical trainee who has determined it medically necessary to involve family members in the child's care.

(b) "Family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Subd. 6. **Dialectical behavior therapy.** (a) Subject to federal approval, medical assistance covers intensive mental health outpatient treatment for dialectical behavior therapy for adults. A dialectical behavior therapy provider must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments and protocols that are approved by the commissioner.

(b) "Dialectical behavior therapy" means an evidence-based treatment approach that a mental health professional or clinical trainee provides to a client or a group of clients in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program involves: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

(c) To be eligible for dialectical behavior therapy, a client must:

(1) be 18 years of age or older;

(2) have mental health needs that available community-based services cannot meet or that the client must receive concurrently with other community-based services;

(3) have either:

(i) a diagnosis of borderline personality disorder; or

(ii) multiple mental health diagnoses, exhibit behaviors characterized by impulsivity or intentional self-harm, and be at significant risk of death, morbidity, disability, or severe dysfunction in multiple areas of the client's life;

(4) be cognitively capable of participating in dialectical behavior therapy as an intensive therapy program and be able and willing to follow program policies and rules to ensure the safety of the client and others; and

(5) be at significant risk of one or more of the following if the client does not receive dialectical behavior therapy:

(i) having a mental health crisis;

(ii) requiring a more restrictive setting such as hospitalization;

(iii) decompensating; or

(iv) engaging in intentional self-harm behavior.

(d) Individual dialectical behavior therapy combines individualized rehabilitative and psychotherapeutic interventions to treat a client's suicidal and other dysfunctional behaviors and to reinforce a client's use of adaptive skillful behaviors. A mental health professional or clinical trainee must provide individual dialectical behavior therapy to a client. A mental health professional or clinical trainee providing dialectical behavior therapy to a client must:

(1) identify, prioritize, and sequence the client's behavioral targets;

(2) treat the client's behavioral targets;

(3) assist the client in applying dialectical behavior therapy skills to the client's natural environment through telephone coaching outside of treatment sessions;

(4) measure the client's progress toward dialectical behavior therapy targets;

(5) help the client manage mental health crises and life-threatening behaviors; and

(6) help the client learn and apply effective behaviors when working with other treatment providers.

(e) Group skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group setting to reduce the client's suicidal and other dysfunctional coping behaviors and restore function. Group skills training must teach the client adaptive skills in the following areas: (1) mindfulness; (2) interpersonal effectiveness; (3) emotional regulation; and (4) distress tolerance.

(f) Group skills training must be provided by two mental health professionals or by a mental health professional co-facilitating with a clinical trainee or a mental health practitioner. Individual skills training must be provided by a mental health professional, a clinical trainee, or a mental health practitioner.

(g) Before a program provides dialectical behavior therapy to a client, the commissioner must certify the program as a dialectical behavior therapy provider. To qualify for certification as a dialectical behavior therapy provider, a provider must:

(1) allow the commissioner to inspect the provider's program;

(2) provide evidence to the commissioner that the program's policies, procedures, and practices meet the requirements of this subdivision and chapter 245I;

(3) be enrolled as a MHCP provider; and

(4) have a manual that outlines the program's policies, procedures, and practices that meet the requirements of this subdivision.

Subd. 7. **Mental health clinical care consultation.** (a) Subject to federal approval, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a mental health professional or a clinical trainee.

(b) "Clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the treatment supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings and to direct and coordinate clinical service components provided to the client and family.

Subd. 8. **Neuropsychological assessment.** (a) Subject to federal approval, medical assistance covers a client's neuropsychological assessment.

(b) Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist. A neuropsychological assessment must include a face-to-face interview with the client, interpretation of the test results, and preparation and completion of a report.

(c) A client is eligible for a neuropsychological assessment if the client meets at least one of the following criteria:

(1) the client has a known or strongly suspected brain disorder based on the client's medical history or the client's prior neurological evaluation, including a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorder, significant exposure to neurotoxins, central nervous system infection, metabolic

or toxic encephalopathy, fetal alcohol syndrome, or congenital malformation of the brain; or

(2) the client has cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology or suspected neuropsychological impairment in addition to functional psychopathology. The client's symptoms may include:

(i) having a poor memory or impaired problem solving;

(ii) experiencing change in mental status evidenced by lethargy, confusion, or disorientation;

(iii) experiencing a deteriorating level of functioning;

(iv) displaying a marked change in behavior or personality;

(v) in a child or an adolescent, having significant delays in acquiring academic skill or poor attention relative to peers;

(vi) in a child or an adolescent, having reached a significant plateau in expected development of cognitive, social, emotional, or physical functioning relative to peers; and

(vii) in a child or an adolescent, significant inability to develop expected knowledge, skills, or abilities to adapt to new or changing cognitive, social, emotional, or physical demands.

(d) The neuropsychological assessment must be completed by a neuropsychologist who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program and:

(i) completed an internship or its equivalent in a clinically relevant area of professional psychology;

(ii) completed the equivalent of two full-time years of experience and specialized training, at least one of which is at the postdoctoral level, supervised by a clinical neuropsychologist in the study and practice of clinical neuropsychology and related neurosciences; and

(iii) holds a current license to practice psychology independently according to sections 144.88 to 144.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in clause (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessments prior to December 31, 2010.

Subd. 9. **Neuropsychological testing.** (a) Subject to federal approval, medical assistance covers neuropsychological testing for clients.

(b) "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn, and recall information and use problem solving and judgment.

(c) Medical assistance covers neuropsychological testing of a client when the client:

(1) has a significant mental status change that is not a result of a metabolic disorder and that has failed to respond to treatment;

(2) is a child or adolescent with a significant plateau in expected development of cognitive, social, emotional, or physical function relative to peers;

(3) is a child or adolescent with a significant inability to develop expected knowledge, skills, or abilities to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) has a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(i) traumatic brain injury;

(ii) stroke;

(iii) brain tumor;

(iv) substance use disorder;

(v) cerebral anoxic or hypoxic episode;

(vi) central nervous system infection or other infectious disease;

(vii) neoplasms or vascular injury of the central nervous system;

(viii) neurodegenerative disorders;

(ix) demyelinating disease;

(x) extrapyramidal disease;

(xi) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(xii) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders, including lupus, erythematosus, or celiac disease;

(xiii) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, including phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(xiv) severe or prolonged nutrition or malabsorption syndromes; or

(xv) a condition presenting in a manner difficult for a clinician to distinguish between the neurocognitive effects of a neurogenic syndrome, including dementia or encephalopathy; and a major depressive disorder when adequate treatment for major depressive disorder has not improved the client's neurocognitive functioning; or another disorder, including autism, selective mutism, anxiety disorder, or reactive attachment disorder.

(d) Neuropsychological testing must be administered or clinically supervised by a qualified neuropsychologist under subdivision 8, paragraph (c).

(e) Medical assistance does not cover neuropsychological testing of a client when the testing is:

(1) primarily for educational purposes;

(2) primarily for vocational counseling or training;

(3) for personnel or employment testing;

(4) a routine battery of psychological tests given to the client at the client's inpatient admission or during a client's continued inpatient stay; or

(5) for legal or forensic purposes.

Subd. 10. **Psychological testing.** (a) Subject to federal approval, medical assistance covers psychological testing of a client.

(b) "Psychological testing" means the use of tests or other psychometric instruments to determine the status of a client's mental, intellectual, and emotional functioning.

(c) The psychological testing must:

(1) be administered or supervised by a licensed psychologist qualified under section 245I.04, subdivision 2, clause (3), who is competent in the area of psychological testing; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a clinical trainee in psychology under the treatment supervision of a licensed psychologist under section 245I.06.

(d) A licensed psychologist must supervise the administration, scoring, and interpretation of a client's psychological tests when a clinical psychology trainee, technician, psychometrist, or psychological assistant or a computer-assisted psychological testing program completes the psychological testing of the client. The report resulting from the psychological testing must be signed by the licensed psychologist who conducts the face-to-face interview with the client. The licensed psychologist or a staff person who is under treatment supervision must place the client's psychological testing report in the client's record and release one copy of the report to the client and additional copies to individuals authorized by the client to receive the report.

Subd. 11. **Psychotherapy.** (a) Subject to federal approval, medical assistance covers psychotherapy for a client.

(b) "Psychotherapy" means treatment of a client with mental illness that applies to the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client. Medical assistance covers psychotherapy if a mental health professional or a clinical trainee provides psychotherapy to a client.

(c) "Individual psychotherapy" means psychotherapy that a mental health professional or clinical trainee designs for a client.

(d) "Family psychotherapy" means psychotherapy that a mental health professional or clinical trainee designs for a client and one or more of the client's family members or primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance for medical assistance to cover family psychotherapy. For purposes of this paragraph, "primary caregiver whose participation is necessary to accomplish the client's treatment goals" excludes shift or facility staff persons who work at the client's residence. Medical assistance payments for family psychotherapy are limited to face-to-face sessions during which the client is present throughout the session, unless the mental health professional or clinical trainee believes that the client's exclusion from the family

psychotherapy session is necessary to meet the goals of the client's individual treatment plan. If the client is excluded from a family psychotherapy session, a mental health professional or clinical trainee must document the reason for the client's exclusion and the length of time that the client is excluded. The mental health professional must also document any reason that a member of the client's family is excluded from a psychotherapy session.

(e) Group psychotherapy is appropriate for a client who, because of the nature of the client's emotional, behavioral, or social dysfunctions, can benefit from treatment in a group setting. For a group of three to eight clients, at least one mental health professional or clinical trainee must provide psychotherapy to the group. For a group of nine to 12 clients, a team of at least two mental health professionals or two clinical trainees or one mental health professional and one clinical trainee must provide psychotherapy to the group. Medical assistance will cover group psychotherapy for a group of no more than 12 persons.

(f) A multiple-family group psychotherapy session is eligible for medical assistance if a mental health professional or clinical trainee designs the psychotherapy session for at least two but not more than five families. A mental health professional or clinical trainee must design multiple-family group psychotherapy sessions to meet the treatment needs of each client. If the client is excluded from a psychotherapy session, the mental health professional or clinical trainee must document the reason for the client's exclusion and the length of time that the client was excluded. The mental health professional or clinical trainee must document any reason that a member of the client's family was excluded from a psychotherapy session.

Subd. 12. **Partial hospitalization.** (a) Subject to federal approval, medical assistance covers a client's partial hospitalization.

(b) "Partial hospitalization" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x(ff), that a multidisciplinary staff person provides in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services to a client.

(c) Partial hospitalization is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness who meets the criteria for an inpatient hospital admission under Minnesota Rules, part 9505.0520, subpart 1, and who has family and community resources that support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services for a client that a multidisciplinary staff person provides to a client to treat the client's mental illness.

Subd. 13. **Diagnostic assessments.** Subject to federal approval, medical assistance covers a client's diagnostic assessments that a mental health professional or clinical trainee completes under section 245I.10.

Sec. 18. **DIRECTION TO COMMISSIONER; SINGLE COMPREHENSIVE LICENSE STRUCTURE.**

The commissioner of human services, in consultation with stakeholders including counties, tribes, managed care organizations, provider organizations, advocacy groups, and clients and clients' families, shall develop recommendations to develop a single comprehensive licensing structure for mental health service programs, including outpatient and residential services for adults and children. The recommendations must prioritize program integrity, the welfare of clients and clients' families, improved integration of mental health and substance use disorder services, and the reduction of administrative burden on providers.

Sec. 19. **EFFECTIVE DATE.**

This article is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 18
CRISIS RESPONSE SERVICES

Section 1. Minnesota Statutes 2020, section 245.469, subdivision 1, is amended to read:

Subdivision 1. **Availability of emergency services.** ~~By July 1, 1988,~~ (a) County boards must provide or contract for enough emergency services within the county to meet the needs of adults, children, and families in the county who are experiencing an emotional crisis or mental illness. ~~Clients may be required to pay a fee according to section 245.481.~~ Emergency service providers must not delay the timely provision of emergency services to a client because of the unwillingness or inability of the client to pay for services. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of ~~adults with mental illness or emotional crises~~ each client;

(2) minimize further deterioration of ~~adults with mental illness or emotional crises~~ each client;

(3) help ~~adults with mental illness or emotional crises~~ each client to obtain ongoing care and treatment; ~~and~~

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs~~.~~; and

(5) provide support, psychoeducation, and referrals to each client's family members, service providers, and other third parties on behalf of the client in need of emergency services.

(b) If a county provides engagement services under section 253B.041, the county's emergency service providers must refer clients to engagement services when the client meets the criteria for engagement services.

Sec. 2. Minnesota Statutes 2020, section 245.469, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to adults with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, ~~a~~ a clinical trainee, or mental health practitioner~~, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional~~.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional, clinical trainee, or mental health practitioner ~~after January 1, 1991,~~ if the county documents that:

(1) mental health professionals, clinical trainees, or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives ~~clinical~~ treatment supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services ~~reviewed by the state advisory council on mental health and then~~ approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services ~~reviewed by the state advisory council on mental health and then~~ approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Sec. 3. Minnesota Statutes 2020, section 245.4879, subdivision 1, is amended to read:

Subdivision 1. **Availability of emergency services.** County boards must provide or contract for ~~enough~~ mental health emergency services ~~within the county to meet the needs of children, and children's families when clinically appropriate, in the county who are experiencing an emotional crisis or emotional disturbance. The county board shall ensure that parents, providers, and county residents are informed about when and how to access emergency mental health services for children. A child or the child's parent may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the parent to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:~~ according to section 245.469.

~~(1) promote the safety and emotional stability of children with emotional disturbances or emotional crises;~~

~~(2) minimize further deterioration of the child with emotional disturbance or emotional crisis;~~

~~(3) help each child with an emotional disturbance or emotional crisis to obtain ongoing care and treatment; and~~

~~(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs.~~

Sec. 4. Minnesota Statutes 2020, section 256B.0624, is amended to read:

256B.0624 ~~ADULT~~ CRISIS RESPONSE SERVICES COVERED.

Subdivision 1. **Scope.** ~~Medical assistance covers adult mental health crisis response services as defined in subdivision 2, paragraphs (c) to (e),~~ (a) Subject to federal approval, ~~if provided to a recipient as defined in subdivision 3 and provided by a qualified provider entity as defined in this section and by a qualified individual provider working within the provider's scope of practice and as defined in this subdivision and identified in the recipient's individual crisis treatment plan as defined in subdivision 11 and if determined to be medically necessary~~ medical assistance covers medically necessary crisis response services when the services are provided according to the standards in this section.

(b) Subject to federal approval, medical assistance covers medically necessary residential crisis stabilization for adults when the services are provided by an entity licensed under and meeting the standards in section 245I.23 or an entity with an adult foster care license meeting the standards in this section.

(c) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments and protocols approved by the commissioner.

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

~~(a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization.~~

~~(b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with section 62Q.55.~~

~~A mental health crisis or emergency is determined for medical assistance service reimbursement by a physician, a mental health professional, or crisis mental health practitioner with input from the recipient whenever possible.~~

(a) "Certified rehabilitation specialist" means a staff person who is qualified under section 245I.04, subdivision 8.

(b) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(c) "~~Mental health~~ Crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or ~~mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation. It includes, when feasible, assessing whether the person might be willing to voluntarily accept treatment, determining whether the person has an advance directive, and obtaining information and history from involved family members or caretakers~~ a qualified member of a crisis team, as described in subdivision 6a.

(d) "~~Mental health mobile~~ Crisis intervention ~~services~~" means face-to-face, short-term intensive mental health services initiated during a mental health crisis ~~or mental health emergency~~ to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning. ~~The services, including screening and treatment plan recommendations, must be culturally and linguistically appropriate.~~

~~(1) This service is provided on site by a mobile crisis intervention team outside of an inpatient hospital setting. Mental health mobile crisis intervention services must be available 24 hours a day, seven days a week.~~

~~(2) The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances.~~

~~(3) The mobile crisis intervention team must be available to meet promptly face-to-face with a person in mental health crisis or emergency in a community setting or hospital emergency room.~~

~~(4) The intervention must consist of a mental health crisis assessment and a crisis treatment plan.~~

~~(5) The team must be available to individuals who are experiencing a co-occurring substance use disorder, who do not need the level of care provided in a detoxification facility.~~

~~(6) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient, including engagement in treatment planning and family psychoeducation.~~

(e) "Crisis screening" means a screening of a client's potential mental health crisis situation under subdivision 6.

~~(e)~~ (f) "~~Mental health~~ Crisis stabilization ~~services~~" means individualized mental health services provided to a recipient ~~following crisis intervention services~~ which are designed to restore the recipient to the recipient's prior functional level. ~~Mental health~~ Crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, ~~or~~ a short-term supervised, licensed residential program, or an emergency department. ~~Mental health crisis stabilization does not include partial hospitalization or day treatment. Mental health~~ Crisis stabilization services includes family psychoeducation.

(g) "Crisis team" means the staff of a provider entity who are supervised and prepared to provide mobile crisis services to a client in a potential mental health crisis situation.

(h) "Mental health certified family peer specialist" means a staff person who is qualified under section 245I.04, subdivision 12.

(i) "Mental health certified peer specialist" means a staff person who is qualified under section 245I.04, subdivision 10.

(j) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without the provision of crisis response services, would likely result in significantly reducing the recipient's levels of functioning in primary activities of daily living, in an emergency situation under section 62Q.55, or in the placement of the recipient in a more restrictive setting, including but not limited to inpatient hospitalization.

(k) "Mental health practitioner" means a staff person who is qualified under section 245I.04, subdivision 4.

(l) "Mental health professional" means a staff person who is qualified under section 245I.04, subdivision 2.

(m) "Mental health rehabilitation worker" means a staff person who is qualified under section 245I.04, subdivision 14.

(n) "Mobile crisis services" means screening, assessment, intervention, and community based stabilization, excluding residential crisis stabilization, that is provided to a recipient.

Subd. 3. **Eligibility.** ~~An eligible recipient is an individual who:~~

~~(1) is age 18 or older;~~

~~(2) is screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed; and~~

~~(3) is assessed as experiencing a mental health crisis or emergency, and mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.~~

(a) A recipient is eligible for crisis assessment services when the recipient has screened positive for a potential mental health crisis during a crisis screening.

(b) A recipient is eligible for crisis intervention services and crisis stabilization services when the recipient has been assessed during a crisis assessment to be experiencing a mental health crisis.

Subd. 4. **Provider entity standards.** (a) A ~~provider entity is an entity that meets the standards listed in paragraph (c) and~~ mobile crisis provider must be:

(1) ~~is~~ a county board operated entity; ~~or~~

(2) an Indian health services facility or facility owned and operated by a tribe or tribal organization operating under United States Code, title 325, section 450f; or

~~(2) is~~ (3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

(b) A mobile crisis provider must meet the following standards:

(1) must ensure that crisis screenings, crisis assessments, and crisis intervention services are available to a recipient 24 hours a day, seven days a week;

(2) must be able to respond to a call for services in a designated service area or according to a written agreement with the local mental health authority for an adjacent area;

(3) must have at least one mental health professional on staff at all times and at least one additional staff member capable of leading a crisis response in the community; and

(4) must provide the commissioner with information about the number of requests for service, the number of people that the provider serves face-to-face, outcomes, and the protocols that the provider uses when deciding when to respond in the community.

~~(b)~~ (c) A provider entity that provides crisis stabilization services in a residential setting under subdivision 7 is not required to meet the requirements of ~~paragraph~~ paragraphs (a)~~,~~ ~~clauses (1) and (2)~~ to (b), but must meet all other requirements of this subdivision.

~~(c) The adult mental health~~ (d) A crisis ~~response~~ services provider ~~entity~~ must have the capacity to meet and carry out the standards in section 245I.011, subdivision 5, and the following standards:

(1) ~~has the capacity to recruit, hire, and manage and train mental health professionals, practitioners, and rehabilitation workers~~ ensures that staff persons provide support for a recipient's family and natural supports, by enabling the recipient's family and natural supports to observe and participate in the recipient's treatment, assessments, and planning services;

(2) has adequate administrative ability to ensure availability of services;

~~(3) is able to ensure adequate preservice and in-service training;~~

~~(4)~~ (3) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;

~~(5)~~ (4) is able to ensure that staff are ~~capable of~~ implementing culturally specific treatment identified in the ~~individual~~ crisis treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;

~~(6)~~ (5) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient or family member during the service partnership between the recipient and providers;

~~(7)~~ (6) is able to ensure that ~~mental health professionals and mental health practitioners~~ staff have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;

~~(8)~~ (7) is able to coordinate these services with county emergency services, community hospitals, ambulance, transportation services, social services, law enforcement, engagement services, and mental health crisis services through regularly scheduled interagency meetings;

~~(9) is able to ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;~~

~~(10)~~ (8) is able to ensure that services are coordinated with other ~~mental~~ behavioral health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the ~~adult~~ recipient or parent or guardian. Services must also be coordinated with the recipient's case manager if the ~~adult~~ recipient is receiving case management services;

~~(11)~~ (9) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486 and 245.487 to 245.4879;

~~(12) is able to submit information as required by the state;~~

~~(13) maintains staff training and personnel files;~~

(10) is able to coordinate detoxification services for the recipient according to Minnesota Rules, parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F;

~~(14)~~ (11) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction; and

~~(15) is able to keep records as required by applicable laws;~~

~~(16) is able to comply with all applicable laws and statutes;~~

~~(17)~~ (12) is an enrolled medical assistance provider~~; and~~.

~~(18) develops and maintains written policies and procedures regarding service provision and administration of the provider entity, including safety of staff and recipients in high-risk situations.~~

Subd. 4a. **Alternative provider standards.** If a county or tribe demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services according to the standards in subdivision 4, paragraph ~~(c), clause (9)~~ (b), the commissioner may approve ~~a crisis response provider based on~~ an alternative plan proposed by a county or ~~group of counties~~ tribe. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of mobile crisis services;

(2) provide mobile crisis services outside of the usual nine-to-five office hours and on weekends and holidays; and

(3) comply with standards for emergency mental health services in section 245.469.

Subd. 5. **~~Mobile~~ Crisis assessment and intervention staff qualifications.** ~~For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two people with at least one member providing on-site crisis intervention services when needed.~~ (a) Qualified individual staff of a qualified provider entity must provide crisis assessment and intervention services to a recipient. A staff member providing crisis assessment and intervention services to a recipient must be qualified as a:

(1) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health certified peer specialist.

(b) When crisis assessment and intervention services are provided to a recipient in the community, a mental health professional, clinical trainee, or mental health practitioner must lead the response.

(c) The 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce the recipient's risk of suicide and self-injurious behavior.

(d) Team members must be experienced in ~~mental health~~ crisis assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources. ~~The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.~~

Subd. 6. **Crisis ~~assessment and mobile intervention treatment planning~~ screening.** (a) ~~Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted.~~ The crisis screening may use the resources of ~~crisis assistance and~~ emergency services as defined in ~~sections 245.462, subdivision 6, and~~ section 245.469,

subdivisions 1 and 2. The crisis screening must gather information, determine whether a mental health crisis situation exists, identify parties involved, and determine an appropriate response.

(b) When conducting the crisis screening of a recipient, a provider must:

(1) employ evidence-based practices to reduce the recipient's risk of suicide and self-injurious behavior;

(2) work with the recipient to establish a plan and time frame for responding to the recipient's mental health crisis, including responding to the recipient's immediate need for support by telephone or text message until the provider can respond to the recipient face-to-face;

(3) document significant factors in determining whether the recipient is experiencing a mental health crisis, including prior requests for crisis services, a recipient's recent presentation at an emergency department, known calls to 911 or law enforcement, or information from third parties with knowledge of a recipient's history or current needs;

(4) accept calls from interested third parties and consider the additional needs or potential mental health crises that the third parties may be experiencing;

(5) provide psychoeducation, including means reduction, to relevant third parties including family members or other persons living with the recipient; and

(6) consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(c) For the purposes of this section, the following situations indicate a positive screen for a potential mental health crisis and the provider must prioritize providing a face-to-face crisis assessment of the recipient, unless a provider documents specific evidence to show why this was not possible, including insufficient staffing resources, concerns for staff or recipient safety, or other clinical factors:

(1) the recipient presents at an emergency department or urgent care setting and the health care team at that location requested crisis services; or

(2) a peace officer requested crisis services for a recipient who is potentially subject to transportation under section 253B.051.

(d) A provider is not required to have direct contact with the recipient to determine that the recipient is experiencing a potential mental health crisis. A mobile crisis provider may

gather relevant information about the recipient from a third party to establish the recipient's need for services and potential safety factors.

Subd. 6a. **Crisis assessment.** ~~(b)~~ (a) If a ~~crisis exists~~ recipient screens positive for potential mental health crisis, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which ~~emergency~~ services are needed and, as time permits, the recipient's current life situation, health information, including current medications, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, current functioning, and the recipient's preferences as communicated directly by the recipient, or as communicated in a health care directive as described in chapters 145C and 253B, the crisis treatment plan described under ~~paragraph (d)~~ subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

(b) A provider must conduct a crisis assessment at the recipient's location whenever possible.

(c) Whenever possible, the assessor must attempt to include input from the recipient and the recipient's family and other natural supports to assess whether a crisis exists.

(d) A crisis assessment includes determining: (1) whether the recipient is willing to voluntarily engage in treatment or (2) has an advance directive and (3) gathering the recipient's information and history from involved family or other natural supports.

(e) A crisis assessment must include coordinated response with other health care providers if the assessment indicates that a recipient needs detoxification, withdrawal management, or medical stabilization in addition to crisis response services. If the recipient does not need an acute level of care, a team must serve an otherwise eligible recipient who has a co-occurring substance use disorder.

(f) If, after completing a crisis assessment of a recipient, a provider refers a recipient to an intensive setting, including an emergency department, inpatient hospitalization, or residential crisis stabilization, one of the crisis team members who completed or conferred about the recipient's crisis assessment must immediately contact the referral entity and consult with the triage nurse or other staff responsible for intake at the referral entity. During the consultation, the crisis team member must convey key findings or concerns that led to the recipient's referral. Following the immediate consultation, the provider must also send written documentation upon completion. The provider must document if these releases occurred with authorization by the recipient, the recipient's legal guardian, or as allowed by section 144.293, subdivision 5.

Subd. 6b. **Crisis intervention services.** ~~(c)~~ (a) If the crisis assessment determines mobile crisis intervention services are needed, the crisis intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the crisis assessment, crisis treatment plan, and actions taken and needed. At least one of the team members must be ~~on site~~ providing face-to-face crisis intervention services. If providing ~~on-site~~ crisis intervention services, a clinical trainee or mental health practitioner must seek ~~clinical~~ treatment supervision as required in subdivision 9.

(b) If a provider delivers crisis intervention services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

~~(d)~~ (c) The mobile crisis intervention team must develop ~~an initial, brief~~ a crisis treatment plan ~~as soon as appropriate but no later than 24 hours after the initial face-to-face intervention~~ according to subdivision 11. ~~The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.~~

~~(e)~~ (d) The mobile crisis intervention team must document which ~~short-term goals~~ crisis treatment plan goals and objectives have been met and when no further crisis intervention services are required.

~~(f)~~ (e) If the recipient's mental health crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

~~(g)~~ (f) If the recipient's mental health crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis ~~stabilization~~ treatment plan must be developed ~~which~~ that meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; ~~and~~

(3) crisis stabilization services must be delivered according to the crisis treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis ~~stabilization~~ treatment plan, ~~supportive counseling,~~ skills training, and collaboration with other service providers in the community~~.~~; and

(4) if a provider delivers crisis stabilization services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

~~(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.~~

~~(c)~~ (b) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization ~~services~~, the residential staff must include, for at least eight hours per day, at least one ~~individual who meets the qualifications in subdivision 8, paragraph (a), clause (1) or (2)~~ mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.

~~(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.~~

Subd. 8. **~~Adult~~ Crisis stabilization staff qualifications.** (a) ~~Adult~~ Mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. ~~Individual provider staff must have the following qualifications~~ A staff member providing crisis stabilization services to a recipient must be qualified as a:

(1) ~~be a~~ mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~;

(2) ~~be a~~ certified rehabilitation specialist;

(3) clinical trainee;

(4) mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional~~;

(5) mental health certified family peer specialist;

~~(3) be a~~ (6) mental health certified peer specialist ~~under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional~~; or

~~(4) be a~~ (7) mental health rehabilitation worker ~~who meets the criteria in section 256B.0623, subdivision 5, paragraph (a), clause (4); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional~~.

(b) ~~Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.~~ The 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce a recipient's risk of suicide and self-injurious behavior.

Subd. 9. **Supervision.** Clinical trainees and mental health practitioners may provide crisis assessment and ~~mobile~~ crisis intervention services if the following ~~clinical~~ treatment supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity~~, who is an employee or under contract with the provider entity,~~ must be immediately available by phone or in person for ~~clinical~~ treatment supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a clinical trainee or mental health practitioner provides ~~on-site service~~ crisis assessment or crisis intervention services; and

(4) the mental health professional must:

(i) review and approve, as defined in section 245I.02, subdivision 2, of the tentative crisis assessment and crisis treatment plan within 24 hours of first providing services to the recipient, notwithstanding section 245I.08, subdivision 3; and

(ii) document the consultation required in clause (3).~~; and~~

~~(iii) sign the crisis assessment and treatment plan within the next business day;~~

~~(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and~~

~~(6) the on-site observation must be documented in the recipient's record and signed by the mental health professional.~~

~~Subd. 10.~~ **~~Recipient file.~~** ~~Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:~~

~~(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;~~

~~(2) signed release forms;~~

~~(3) recipient health information and current medications;~~

~~(4) emergency contacts for the recipient;~~

~~(5) case records which document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;~~

~~(6) required clinical supervision by mental health professionals;~~

~~(7) summary of the recipient's case reviews by staff;~~

~~(8) any written information by the recipient that the recipient wants in the file; and~~

~~(9) an advance directive, if there is one available.~~

~~Documentation in the file must comply with all requirements of the commissioner.~~

Subd. 11. **Crisis treatment plan.** ~~The individual crisis stabilization treatment plan must include, at a minimum:~~

~~(1) a list of problems identified in the assessment;~~

~~(2) a list of the recipient's strengths and resources;~~

~~(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;~~

~~(4) specific objectives directed toward the achievement of each one of the goals;~~

~~(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;~~

~~(6) planned frequency and type of services initiated;~~

~~(7) a crisis response action plan if a crisis should occur;~~

~~(8) clear progress notes on outcome of goals;~~

~~(9) a written plan must be completed within 24 hours of beginning services with the recipient; and~~

~~(10) a treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.~~

(a) Within 24 hours of the recipient's admission, the provider entity must complete the recipient's crisis treatment plan. The provider entity must:

(1) base the recipient's crisis treatment plan on the recipient's crisis assessment;

(2) consider crisis assistance strategies that have been effective for the recipient in the past;

(3) for a child recipient, use a child-centered, family-driven, and culturally appropriate planning process that allows the recipient's parents and guardians to observe or participate in the recipient's individual and family treatment services, assessment, and treatment planning;

(4) for an adult recipient, use a person-centered, culturally appropriate planning process that allows the recipient's family and other natural supports to observe or participate in treatment services, assessment, and treatment planning;

(5) identify the participants involved in the recipient's treatment planning. The recipient, if possible, must be a participant;

(6) identify the recipient's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the recipient engage in treatment;

(7) include documentation of referral to and scheduling of services, including specific providers where applicable;

(8) ensure that the recipient or the recipient's legal guardian approves under section 245I.02, subdivision 2, of the recipient's crisis treatment plan unless a court orders the recipient's treatment plan under chapter 253B. If the recipient or the recipient's legal guardian disagrees with the crisis treatment plan, the license holder must document in the client file the reasons why the recipient disagrees with the crisis treatment plan; and

(9) ensure that a treatment supervisor approves under section 245I.02, subdivision 2, of the recipient's treatment plan within 24 hours of the recipient's admission if a mental health practitioner or clinical trainee completes the crisis treatment plan, notwithstanding section 245I.08, subdivision 3.

(b) The provider entity must provide the recipient and the recipient's legal guardian with a copy of the recipient's crisis treatment plan.

Subd. 12. **Excluded services.** The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) recipient transportation costs may be covered under other medical assistance provisions, but transportation services are not an adult mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide adult mental health crisis response services;

(5) services performed by volunteers;

(6) direct billing of time spent "on call" when not delivering services to a recipient;

(7) provider service time included in case management reimbursement. When a provider is eligible to provide more than one type of medical assistance service, the recipient must have a choice of provider for each service, unless otherwise provided for by law;

(8) outreach services to potential recipients; ~~and~~

(9) a mental health service that is not medically necessary~~.~~;

(10) services that a residential treatment center licensed under Minnesota Rules, chapter 2960, provides to a client;

(11) partial hospitalization or day treatment; and

(12) a crisis assessment that a residential provider completes when a daily rate is paid for the recipient's crisis stabilization.

Sec. 5. **EFFECTIVE DATE.**

This article is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 19

MENTAL HEALTH UNIFORM SERVICE STANDARDS; CONFORMING CHANGES

Section 1. Minnesota Statutes 2020, section 62A.152, subdivision 3, is amended to read:

Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber contracts that provide benefits for mental or nervous disorder treatments in a hospital must provide direct reimbursement for those services if performed by a mental health professional~~,~~ ~~as defined in sections 245.462, subdivision 18, clauses (1) to (5); and 245.4871, subdivision 27, clauses (1) to (5)~~ qualified according to section 245I.04, subdivision 2, to the extent that the services and treatment are within the scope of mental health professional licensure.

This subdivision is intended to provide payment of benefits for mental or nervous disorder treatments performed by a licensed mental health professional in a hospital and is not intended to change or add benefits for those services provided in policies or contracts to which this subdivision applies.

Sec. 2. Minnesota Statutes 2020, section 62A.3094, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in paragraphs (b) to (d) have the meanings given.

(b) "Autism spectrum disorders" means the conditions as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(c) "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing and preventative services. Medically necessary care must be consistent with generally accepted practice parameters as determined by physicians and licensed psychologists who typically manage patients who have autism spectrum disorders.

(d) "Mental health professional" means a mental health professional ~~as defined in section 245.4871, subdivision 27~~ who is qualified according to section 245I.04, subdivision 2,

clause (1), (2), (3), (4), or (6), who has training and expertise in autism spectrum disorder and child development.

Sec. 3. Minnesota Statutes 2020, section 62Q.096, is amended to read:

62Q.096 CREDENTIALING OF PROVIDERS.

If a health plan company has initially credentialed, as providers in its provider network, individual providers employed by or under contract with an entity that:

(1) is authorized to bill under section 256B.0625, subdivision 5;

(2) ~~meets the requirements of Minnesota Rules, parts 9520.0750 to 9520.0870~~ is a mental health clinic certified under section 245I.20;

(3) is designated an essential community provider under section 62Q.19; and

(4) is under contract with the health plan company to provide mental health services,

the health plan company must continue to credential at least the same number of providers from that entity, as long as those providers meet the health plan company's credentialing standards.

A health plan company shall not refuse to credential these providers on the grounds that their provider network has a sufficient number of providers of that type.

Sec. 4. Minnesota Statutes 2020, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a

supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under chapter 245G or 245I, or Minnesota Rules, parts 9530.6510 to 9530.6590.

Sec. 5. Minnesota Statutes 2020, section 144D.01, subdivision 4, is amended to read:

Subd. 4. **Housing with services establishment or establishment.** (a) "Housing with services establishment" or "establishment" means:

(1) an establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment; or

(2) an establishment that registers under section 144D.025.

(b) Housing with services establishment does not include:

(1) a nursing home licensed under chapter 144A;

(2) a hospital, certified boarding care home, or supervised living facility licensed under sections 144.50 to 144.56;

(3) a board and lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D ~~or~~, 245G, or 245I;

(4) a board and lodging establishment which serves as a shelter for battered women or other similar purpose;

(5) a family adult foster care home licensed by the Department of Human Services;

(6) private homes in which the residents are related by kinship, law, or affinity with the providers of services;

(7) residential settings for persons with developmental disabilities in which the services are licensed under chapter 245D;

(8) a home-sharing arrangement such as when an elderly or disabled person or single-parent family makes lodging in a private residence available to another person in exchange for services or rent, or both;

(9) a duly organized condominium, cooperative, common interest community, or owners' association of the foregoing where at least 80 percent of the units that comprise the

condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(10) services for persons with developmental disabilities that are provided under a license under chapter 245D; or

(11) a temporary family health care dwelling as defined in sections 394.307 and 462.3593.

Sec. 6. Minnesota Statutes 2020, section 144G.08, subdivision 7, as amended by Laws 2020, Seventh Special Session chapter 1, article 6, section 5, is amended to read:

Subd. 7. **Assisted living facility.** "Assisted living facility" means a facility that provides sleeping accommodations and assisted living services to one or more adults. Assisted living facility includes assisted living facility with dementia care, and does not include:

(1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361;

(2) a nursing home licensed under chapter 144A;

(3) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56;

(4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D ~~or~~, 245G, or 245I;

(5) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D;

(6) a private home in which the residents are related by kinship, law, or affinity with the provider of services;

(7) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593;

(9) a setting offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing;

(10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services;

(11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q;

(12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56;

(13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011;

(14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b); or

(15) any establishment that exclusively or primarily serves as a shelter or temporary shelter for victims of domestic or any other form of violence.

Sec. 7. Minnesota Statutes 2020, section 148B.5301, subdivision 2, is amended to read:

Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed 4,000 hours of post-master's degree supervised professional practice in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders in both children and adults. The supervised practice shall be conducted according to the requirements in paragraphs (b) to (e).

(b) The supervision must have been received under a contract that defines clinical practice and supervision from a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~ who is qualified according to section 245I.04, subdivision 2, or by a board-approved supervisor, who has at least two years of postlicensure experience in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders. All supervisors must meet the supervisor requirements in Minnesota Rules, part 2150.5010.

(c) The supervision must be obtained at the rate of two hours of supervision per 40 hours of professional practice. The supervision must be evenly distributed over the course of the supervised professional practice. At least 75 percent of the required supervision hours must be received in person. The remaining 25 percent of the required hours may be received by

telephone or by audio or audiovisual electronic device. At least 50 percent of the required hours of supervision must be received on an individual basis. The remaining 50 percent may be received in a group setting.

(d) The supervised practice must include at least 1,800 hours of clinical client contact.

(e) The supervised practice must be clinical practice. Supervision includes the observation by the supervisor of the successful application of professional counseling knowledge, skills, and values in the differential diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders.

Sec. 8. Minnesota Statutes 2020, section 148E.120, subdivision 2, is amended to read:

Subd. 2. **Alternate supervisors.** (a) The board may approve an alternate supervisor as determined in this subdivision. The board shall approve up to 25 percent of the required supervision hours by a ~~licensed~~ mental health professional who is competent and qualified to provide supervision according to the mental health professional's respective licensing board, as established by section ~~245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

(b) The board shall approve up to 100 percent of the required supervision hours by an alternate supervisor if the board determines that:

(1) there are five or fewer supervisors in the county where the licensee practices social work who meet the applicable licensure requirements in subdivision 1;

(2) the supervisor is an unlicensed social worker who is employed in, and provides the supervision in, a setting exempt from licensure by section 148E.065, and who has qualifications equivalent to the applicable requirements specified in sections 148E.100 to 148E.115;

(3) the supervisor is a social worker engaged in authorized social work practice in Iowa, Manitoba, North Dakota, Ontario, South Dakota, or Wisconsin, and has the qualifications equivalent to the applicable requirements in sections 148E.100 to 148E.115; or

(4) the applicant or licensee is engaged in nonclinical authorized social work practice outside of Minnesota and the supervisor meets the qualifications equivalent to the applicable requirements in sections 148E.100 to 148E.115, or the supervisor is an equivalent mental health professional, as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency; or

(5) the applicant or licensee is engaged in clinical authorized social work practice outside of Minnesota and the supervisor meets qualifications equivalent to the applicable requirements in section 148E.115, or the supervisor is an equivalent mental health professional as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency.

(c) In order for the board to consider an alternate supervisor under this section, the licensee must:

(1) request in the supervision plan and verification submitted according to section 148E.125 that an alternate supervisor conduct the supervision; and

(2) describe the proposed supervision and the name and qualifications of the proposed alternate supervisor. The board may audit the information provided to determine compliance with the requirements of this section.

Sec. 9. Minnesota Statutes 2020, section 148F.11, subdivision 1, is amended to read:

Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes, but is not limited to: licensed physicians; registered nurses; licensed practical nurses; licensed psychologists and licensed psychological practitioners; members of the clergy provided such services are provided within the scope of regular ministries; American Indian medicine men and women; licensed attorneys; probation officers; licensed marriage and family therapists; licensed social workers; social workers employed by city, county, or state agencies; licensed professional counselors; licensed professional clinical counselors; licensed school counselors; registered occupational therapists or occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders (UMICAD) certified counselors when providing services to Native American people; city, county, or state employees when providing assessments or case management under Minnesota Rules, chapter 9530; and individuals defined in section 256B.0623, subdivision 5, paragraph (a), clauses (1) ~~and (2)~~ to (6), providing ~~integrated dual diagnosis~~ co-occurring substance use disorder treatment in adult mental health rehabilitative programs certified or licensed by the Department of Human Services under section 245I.23, 256B.0622, or 256B.0623.

(b) Nothing in this chapter prohibits technicians and resident managers in programs licensed by the Department of Human Services from discharging their duties as provided in Minnesota Rules, chapter 9530.

(c) Any person who is exempt from licensure under this section must not use a title incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug counselor" or otherwise hold himself or herself out to the public by any title or description stating or implying that he or she is engaged in the practice of alcohol and drug counseling, or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the use of one of the titles in paragraph (a).

Sec. 10. Minnesota Statutes 2020, section 245.462, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** The definitions in this section apply to sections 245.461 to ~~245.486~~ 245.4863.

Sec. 11. Minnesota Statutes 2020, section 245.462, subdivision 6, is amended to read:

Subd. 6. **Community support services program.** "Community support services program" means services, other than inpatient or residential treatment services, provided or coordinated by an identified program and staff under the ~~clinical~~ treatment supervision of a mental health professional designed to help adults with serious and persistent mental illness to function and remain in the community. A community support services program includes:

(1) client outreach,

(2) medication monitoring,

(3) assistance in independent living skills,

(4) development of employability and work-related opportunities,

(5) crisis assistance,

(6) psychosocial rehabilitation,

(7) help in applying for government benefits, and

(8) housing support services.

The community support services program must be coordinated with the case management services specified in section 245.4711.

Sec. 12. Minnesota Statutes 2020, section 245.462, subdivision 8, is amended to read:

Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means ~~a structured program of treatment and care provided to an adult~~

~~in or by: (1) a hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (2) a community mental health center under section 245.62; or (3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least two days a week by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as part of the treatment process. The services are aimed at stabilizing the adult's mental health status, providing mental health services, and developing and improving the adult's independent living and socialization skills. The goal of day treatment is to reduce or relieve mental illness and to enable the adult to live in the community. Day treatment services are not a part of inpatient or residential treatment services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. The commissioner may limit medical assistance reimbursement for day treatment to 15 hours per week per person~~ the treatment services described by section 256B.0671, subdivision 3.

Sec. 13. Minnesota Statutes 2020, section 245.462, subdivision 9, is amended to read:

Subd. 9. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update~~ section 245I.10, subdivisions 4 to 6.

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~

~~(2) description of symptoms, including reason for referral;~~

~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~

~~(5) mental status examination.~~

~~(c) On the basis of the initial components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

~~(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3), unit (a), a brief diagnostic assessment may be used for a client's family who requires a language interpreter to participate in the assessment.~~

Sec. 14. Minnesota Statutes 2020, section 245.462, subdivision 14, is amended to read:

Subd. 14. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan of intervention, treatment, and services for an adult with mental illness that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsible for providing treatment to the adult with mental illness~~ the formulation of planned services that are responsive to the needs and goals of a client. An individual treatment plan must be completed according to section 245I.10, subdivisions 7 and 8.

Sec. 15. Minnesota Statutes 2020, section 245.462, subdivision 16, is amended to read:

Subd. 16. **Mental health funds.** "Mental health funds" are funds expended under sections 245.73 and 256E.12, federal mental health block grant funds, and funds expended under section 256D.06 to facilities licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670.

Sec. 16. Minnesota Statutes 2020, section 245.462, subdivision 17, is amended to read:

Subd. 17. **Mental health practitioner.** ~~(a)~~ "Mental health practitioner" means a staff person ~~providing services to adults with mental illness or children with emotional disturbance who is qualified in at least one of the ways described in paragraphs (b) to (g). A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults~~ qualified according to section 245I.04, subdivision 4.

~~(b) For purposes of this subdivision, a practitioner is qualified through relevant coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:~~

~~(1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects;~~

~~(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to adults with mental illness or children with emotional disturbance, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;~~

~~(3) is working in a day treatment program under section 245.4712, subdivision 2; or~~

~~(4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(c) For purposes of this subdivision, a practitioner is qualified through work experience if the person:~~

~~(1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; or~~

~~(2) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, emotional disturbance, or substance use disorder, and receives clinical supervision as required by applicable statutes and rules from a mental health professional at least once a week until the requirement of 4,000 hours of supervised experience is met; or~~

~~(ii) traumatic brain injury or developmental disabilities; completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; and receives clinical supervision as required by applicable statutes and rules at least once a week from a mental health professional until the requirement of 4,000 hours of supervised experience is met.~~

~~(d) For purposes of this subdivision, a practitioner is qualified through a graduate student internship if the practitioner is a graduate student in behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training.~~

~~(e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's degree if the practitioner:~~

~~(1) holds a master's or other graduate degree in behavioral sciences or related fields; or~~

~~(2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical care if the practitioner meets the definition of vendor of medical care in section 256B.02, subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.~~

~~(g) For purposes of medical assistance coverage of diagnostic assessments, explanations of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health practitioner working as a clinical trainee means that the practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of direct practice, treatment team collaboration, continued professional learning, and job management. The practitioner must also:~~

~~(1) comply with requirements for licensure or board certification as a mental health professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or~~

~~(2) be a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.~~

~~(h) For purposes of this subdivision, "behavioral sciences or related fields" has the meaning given in section 256B.0623, subdivision 5, paragraph (d).~~

~~(i) Notwithstanding the licensing requirements established by a health-related licensing board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other statute or rule.~~

Sec. 17. Minnesota Statutes 2020, section 245.462, subdivision 18, is amended to read:

Subd. 18. **Mental health professional.** "Mental health professional" means a staff person ~~providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:~~ who is qualified according to section 245I.04, subdivision 2.

~~(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285; and:~~

~~(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization; or~~

~~(ii) who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(2) in clinical social work: a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(3) in psychology: an individual licensed by the Board of Psychology under sections 148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;~~

~~(4) in psychiatry: a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

~~(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; or~~

~~(7) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.~~

Sec. 18. Minnesota Statutes 2020, section 245.462, subdivision 21, is amended to read:

Subd. 21. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the ~~clinical~~ treatment supervision of a mental health professional to adults with mental illness who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 19. Minnesota Statutes 2020, section 245.462, subdivision 23, is amended to read:

Subd. 23. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the ~~clinical~~ treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for adults with mental illness under chapter 245I, Minnesota Rules, parts 9520.0500 to 9520.0670, or other rules adopted by the commissioner.

Sec. 20. Minnesota Statutes 2020, section 245.462, is amended by adding a subdivision to read:

Subd. 27. **Treatment supervision.** "Treatment supervision" means the treatment supervision described by section 245I.06.

Sec. 21. Minnesota Statutes 2020, section 245.4661, subdivision 5, is amended to read:

Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with the exception of the placement of a Minnesota specialty treatment facility as defined in paragraph (c), must be developed under the direction of the county board, or multiple county boards acting jointly, as the local mental health authority. The planning process for each pilot shall include, but not be limited to, mental health consumers, families, advocates, local mental health advisory councils, local and state providers, representatives of state and local public employee bargaining units, and the department of human services. As part of the planning process, the county board or boards shall designate a managing entity responsible for receipt of funds and management of the pilot project.

(b) For Minnesota specialty treatment facilities, the commissioner shall issue a request for proposal for regions in which a need has been identified for services.

(c) For purposes of this section, "Minnesota specialty treatment facility" is defined as an intensive residential treatment service licensed under ~~section 256B.0622, subdivision 2, paragraph (b)~~ chapter 245I.

Sec. 22. Minnesota Statutes 2020, section 245.4662, subdivision 1, is amended to read:

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

(b) "Community partnership" means a project involving the collaboration of two or more eligible applicants.

(c) "Eligible applicant" means an eligible county, Indian tribe, mental health service provider, hospital, or community partnership. Eligible applicant does not include a state-operated direct care and treatment facility or program under chapter 246.

(d) "Intensive residential treatment services" has the meaning given in section 256B.0622~~, subdivision 2~~.

(e) "Metropolitan area" means the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

Sec. 23. Minnesota Statutes 2020, section 245.467, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~All providers of residential, acute care hospital inpatient, and regional treatment centers must complete a diagnostic assessment for each of their clients within five days of admission. Providers of day treatment services must complete a diagnostic assessment within five days after the adult's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within three years preceding admission, only an adult diagnostic assessment update is necessary. An "adult diagnostic assessment update" means a written summary by a mental health professional of the adult's current mental health status and service needs and includes a face-to-face interview with the adult. If the adult's mental health status has changed markedly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.~~ Providers of services governed by this section must complete a diagnostic assessment according to the standards of section 245I.10, subdivisions 4 to 6.

Sec. 24. Minnesota Statutes 2020, section 245.467, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment services, residential treatment, acute care hospital inpatient treatment, and all regional treatment centers must develop an individual treatment plan for each of their adult clients. The individual treatment plan must be based on a diagnostic assessment. To the extent possible, the adult client shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment and acute care hospital inpatient treatment, and all regional treatment centers must develop the individual treatment plan within ten days of client intake and must review the individual treatment plan every 90 days after intake. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Outpatient and day treatment services providers must review the individual treatment plan every 90 days after intake.~~ Providers of services governed by this section must complete an individual treatment plan according to the standards of section 245I.10, subdivisions 7 and 8.

Sec. 25. Minnesota Statutes 2020, section 245.470, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of adults with mental illness residing in the county. Services may be provided directly by the county through county-operated ~~mental health centers or~~ mental health clinics ~~approved by the commissioner under section 245.69, subdivision 2~~ meeting the standards of chapter 245I; by contract with privately operated ~~mental health centers or~~ mental health clinics ~~approved by the commissioner under section 245.69, subdivision 2~~ meeting the standards of chapter 245I; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a ~~licensed~~ mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~. Clients may be required to pay a fee according to section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating an adult's mental health needs through therapy;

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication; and

(7) preventing placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the client can best be served outside the county.

Sec. 26. Minnesota Statutes 2020, section 245.4712, subdivision 2, is amended to read:

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be developed as a part of the community support services available to adults with serious and persistent mental illness residing in the county. Adults may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client need;

(4) coordinate with or be offered in conjunction with a local education agency's special education program; and

(5) operate on a continuous basis throughout the year.

(b) ~~For purposes of complying with medical assistance requirements, an adult day treatment program must comply with the method of clinical supervision specified in Minnesota Rules, part 9505.0371, subpart 4. The clinical supervision must be performed by a qualified supervisor who satisfies the requirements of Minnesota Rules, part 9505.0371, subpart 5.~~ An adult day treatment program must comply with medical assistance requirements in section 256B.0671, subdivision 3.

~~A day treatment program must demonstrate compliance with this clinical supervision requirement by the commissioner's review and approval of the program according to Minnesota Rules, part 9505.0372, subpart 8.~~

(c) County boards may request a waiver from including day treatment services if they can document that:

(1) an alternative plan of care exists through the county's community support services for clients who would otherwise need day treatment services;

(2) day treatment, if included, would be duplicative of other components of the community support services; and

(3) county demographics and geography make the provision of day treatment services cost ineffective and infeasible.

Sec. 27. Minnesota Statutes 2020, section 245.472, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** Providers of residential services must be licensed under chapter 245I or applicable rules adopted by the commissioner ~~and must be clinically supervised by a mental health professional. Persons employed in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, in the capacity of program director as of July 1, 1987, in accordance with Minnesota Rules, parts 9520.0500 to 9520.0670, may be allowed to continue providing clinical supervision within a facility, provided they continue to be employed as a program director in a facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670~~. Residential services must be provided under treatment supervision.

Sec. 28. Minnesota Statutes 2020, section 245.4863, is amended to read:

245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.

(a) The commissioner shall require individuals who perform chemical dependency assessments to screen clients for co-occurring mental health disorders, and staff who perform mental health diagnostic assessments to screen for co-occurring substance use disorders. Screening tools must be approved by the commissioner. If a client screens positive for a co-occurring mental health or substance use disorder, the individual performing the screening must document what actions will be taken in response to the results and whether further assessments must be performed.

(b) Notwithstanding paragraph (a), screening is not required when:

(1) the presence of co-occurring disorders was documented for the client in the past 12 months;

(2) the client is currently receiving co-occurring disorders treatment;

(3) the client is being referred for co-occurring disorders treatment; or

(4) a mental health professional~~, as defined in Minnesota Rules, part 9505.0370, subpart 18,~~ who is competent to perform diagnostic assessments of co-occurring disorders is performing a diagnostic assessment ~~that meets the requirements in Minnesota Rules, part 9533.0090, subpart 5,~~ to identify whether the client may have co-occurring mental health and chemical dependency disorders. If an individual is identified to have co-occurring mental health and substance use disorders, the assessing mental health professional must document what actions will be taken to address the client's co-occurring disorders.

(c) The commissioner shall adopt rules as necessary to implement this section. The commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing a certification process for integrated dual disorder treatment providers and a system through which individuals receive integrated dual diagnosis treatment if assessed as having both a substance use disorder and either a serious mental illness or emotional disturbance.

(d) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of integrated dual diagnosis treatment to persons with co-occurring disorders.

Sec. 29. Minnesota Statutes 2020, section 245.4871, subdivision 9a, is amended to read:

Subd. 9a. **Crisis ~~assistance~~ planning.** "Crisis ~~assistance~~ planning" means ~~assistance to the child, the child's family, and all providers of services to the child to: recognize factors~~

~~precipitating a mental health crisis, identify behaviors related to the crisis, and be informed of available resources to resolve the crisis. Crisis assistance requires the development of a plan which addresses prevention and intervention strategies to be used in a potential crisis. Other interventions include: (1) arranging for admission to acute care hospital inpatient treatment~~ the development of a written plan to assist a child and the child's family in preventing and addressing a potential crisis and is distinct from mobile crisis services defined in section 256B.0624. The plan must address prevention, deescalation, and intervention strategies to be used in a crisis. The plan identifies factors that might precipitate a crisis, behaviors or symptoms related to the emergence of a crisis, and the resources available to resolve a crisis. The plan must address the following potential needs: (1) acute care; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis. When appropriate for the child's needs, the plan must include strategies to reduce the child's risk of suicide and self-injurious behavior. Crisis ~~assistance~~ planning does not include services designed to secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.

Sec. 30. Minnesota Statutes 2020, section 245.4871, subdivision 10, is amended to read:

Subd. 10. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to a child in:

(1) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 245.62;

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475; ~~or~~

(4) an entity that operates a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract with an entity that is under contract with a county board~~.~~; or

(5) a program certified under section 256B.0943.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum two-hour time block by a multidisciplinary staff under the ~~clinical~~ treatment supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as an extension of the

treatment process. The services are aimed at stabilizing the child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. Day treatment services are not a part of inpatient hospital or residential treatment services.

A day treatment service must be available to a child up to 15 hours a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

Sec. 31. Minnesota Statutes 2020, section 245.4871, subdivision 11a, is amended to read:

Subd. 11a. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update~~ section 245I.10, subdivisions 4 to 6.

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~

~~(2) description of symptoms, including reason for referral;~~

~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~

~~(5) mental status examination.~~

~~(c) On the basis of the brief components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

Sec. 32. Minnesota Statutes 2020, section 245.4871, subdivision 17, is amended to read:

Subd. 17. **Family community support services.** "Family community support services" means services provided under the ~~clinical~~ treatment supervision of a mental health professional and designed to help each child with severe emotional disturbance to function and remain with the child's family in the community. Family community support services do not include acute care hospital inpatient treatment, residential treatment services, or regional treatment center services. Family community support services include:

(1) client outreach to each child with severe emotional disturbance and the child's family;

(2) medication monitoring where necessary;

(3) assistance in developing independent living skills;

(4) assistance in developing parenting skills necessary to address the needs of the child with severe emotional disturbance;

(5) assistance with leisure and recreational activities;

(6) crisis ~~assistance~~ planning, including crisis placement and respite care;

(7) professional home-based family treatment;

(8) foster care with therapeutic supports;

(9) day treatment;

(10) assistance in locating respite care and special needs day care; and

(11) assistance in obtaining potential financial resources, including those benefits listed in section 245.4884, subdivision 5.

Sec. 33. Minnesota Statutes 2020, section 245.4871, subdivision 21, is amended to read:

Subd. 21. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan of intervention, treatment, and services for a child with an emotional disturbance that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. An individual treatment plan for a child must be developed in conjunction with the family unless clinically inappropriate. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment to the child with an emotional disturbance~~ the formulation of planned services that are responsive to the needs and goals of a client. An individual treatment plan must be completed according to section 245I.10, subdivisions 7 and 8.

Sec. 34. Minnesota Statutes 2020, section 245.4871, subdivision 26, is amended to read:

Subd. 26. **Mental health practitioner.** "Mental health practitioner" ~~has the meaning given in section 245.462, subdivision 17~~ means a staff person who is qualified according to section 245I.04, subdivision 4.

Sec. 35. Minnesota Statutes 2020, section 245.4871, subdivision 27, is amended to read:

Subd. 27. **Mental health professional.** "Mental health professional" means a staff person ~~providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:~~ who is qualified according to section 245I.04, subdivision 2.

~~(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of~~

~~post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;~~

~~(3) in psychology, the mental health professional must be an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;~~

~~(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

~~(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances;~~

~~(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or~~

~~(7) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.~~

Sec. 36. Minnesota Statutes 2020, section 245.4871, subdivision 29, is amended to read:

Subd. 29. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the ~~clinical~~ treatment supervision of a mental health professional to children with emotional disturbances who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 37. Minnesota Statutes 2020, section 245.4871, subdivision 31, is amended to read:

Subd. 31. **Professional home-based family treatment.** "Professional home-based family treatment" means intensive mental health services provided to children because of an

emotional disturbance (1) who are at risk of out-of-home placement; (2) who are in out-of-home placement; or (3) who are returning from out-of-home placement. Services are provided to the child and the child's family primarily in the child's home environment. Services may also be provided in the child's school, child care setting, or other community setting appropriate to the child. Services must be provided on an individual family basis, must be child-oriented and family-oriented, and must be designed using information from diagnostic and functional assessments to meet the specific mental health needs of the child and the child's family. Examples of services are: (1) individual therapy; (2) family therapy; (3) client outreach; (4) assistance in developing individual living skills; (5) assistance in developing parenting skills necessary to address the needs of the child; (6) assistance with leisure and recreational services; (7) crisis ~~assistance~~ planning, including crisis respite care and arranging for crisis placement; and (8) assistance in locating respite and child care. Services must be coordinated with other services provided to the child and family.

Sec. 38. Minnesota Statutes 2020, section 245.4871, subdivision 32, is amended to read:

Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the ~~clinical~~ treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for children with emotional disturbances under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted by the commissioner.

Sec. 39. Minnesota Statutes 2020, section 245.4871, subdivision 34, is amended to read:

Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care" means the mental health training and mental health support services and ~~clinical~~ treatment supervision provided by a mental health professional to foster families caring for children with severe emotional disturbance to provide a therapeutic family environment and support for the child's improved functioning. Therapeutic support of foster care includes services provided under section 256B.0946.

Sec. 40. Minnesota Statutes 2020, section 245.4871, is amended by adding a subdivision to read:

Subd. 36. **Treatment supervision.** "Treatment supervision" means the treatment supervision described by section 245I.06.

Sec. 41. Minnesota Statutes 2020, section 245.4876, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~All residential treatment facilities and acute care hospital inpatient treatment facilities that provide mental health services for children must complete a diagnostic assessment for each of their child clients within five working days of admission. Providers of day treatment services for children must complete a diagnostic assessment within five days after the child's second visit or 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within 180 days preceding admission, only updating is necessary. "Updating" means a written summary by a mental health professional of the child's current mental health status and service needs. If the child's mental health status has changed markedly since the child's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.~~ Providers of services governed by this section shall complete a diagnostic assessment according to the standards of section 245I.10, subdivisions 4 to 6.

Sec. 42. Minnesota Statutes 2020, section 245.4876, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment services, professional home-based family treatment, residential treatment, and acute care hospital inpatient treatment, and all regional treatment centers that provide mental health services for children must develop an individual treatment plan for each child client. The individual treatment plan must be based on a diagnostic assessment. To the extent appropriate, the child and the child's family shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment, professional home-based family treatment, and acute care hospital inpatient treatment, and regional treatment centers must develop the individual treatment plan within ten working days of client intake or admission and must review the individual treatment plan every 90 days after intake, except that the administrative review of the treatment plan of a child placed in a residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Providers of outpatient and day treatment services must review the~~

~~individual treatment plan every 90 days after intake.~~ Providers of services governed by this section shall complete an individual treatment plan according to the standards of section 245I.10, subdivisions 7 and 8.

Sec. 43. Minnesota Statutes 2020, section 245.488, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of each child with emotional disturbance residing in the county and the child's family. Services may be provided directly by the county through county-operated ~~mental health centers or~~ mental health clinics ~~approved by the commissioner under section 245.69, subdivision 2~~ meeting the standards of chapter 245I; by contract with privately operated ~~mental health centers or~~ mental health clinics ~~approved by the commissioner under section 245.69, subdivision 2~~ meeting the standards of chapter 245I; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a ~~licensed~~ mental health professional ~~as defined in section 245.4871, subdivision 27, clauses (1) to (6)~~. A child or a child's parent may be required to pay a fee based in accordance with section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating the child's mental health needs through therapy; and

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the child requires necessary and appropriate services that are only available outside the county.

(c) Outpatient services offered by the county board to prevent placement must be at the level of treatment appropriate to the child's diagnostic assessment.

Sec. 44. Minnesota Statutes 2020, section 245.4901, subdivision 2, is amended to read:

Subd. 2. **Eligible applicants.** An eligible applicant for school-linked mental health grants is an entity that is:

(1) a mental health clinic certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a tribe or tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943; or

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals qualified according to section ~~245I.16~~ 245I.04, subdivision 2, or two alcohol and drug counselors licensed or exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families.

Sec. 45. Minnesota Statutes 2020, section 245.62, subdivision 2, is amended to read:

Subd. 2. **Definition.** A community mental health center is a private nonprofit corporation or public agency approved under the ~~rules promulgated by the commissioner pursuant to subdivision 4~~ standards of section 256B.0625, subdivision 5.

Sec. 46. Minnesota Statutes 2020, section 245A.04, subdivision 5, is amended to read:

Subd. 5. **Commissioner's right of access.** (a) When the commissioner is exercising the powers conferred by this chapter, ~~sections 245.69 and~~ section 626.557, and chapter 260E, the commissioner must be given access to:

(1) the physical plant and grounds where the program is provided;

(2) documents and records, including records maintained in electronic format;

(3) persons served by the program; and

(4) staff and personnel records of current and former staff whenever the program is in operation and the information is relevant to inspections or investigations conducted by the commissioner. Upon request, the license holder must provide the commissioner verification of documentation of staff work experience, training, or educational requirements.

The commissioner must be given access without prior notice and as often as the commissioner considers necessary if the commissioner is investigating alleged maltreatment, conducting a licensing inspection, or investigating an alleged violation of applicable laws or rules. In conducting inspections, the commissioner may request and shall receive assistance

from other state, county, and municipal governmental agencies and departments. The applicant or license holder shall allow the commissioner to photocopy, photograph, and make audio and video tape recordings during the inspection of the program at the commissioner's expense. The commissioner shall obtain a court order or the consent of the subject of the records or the parents or legal guardian of the subject before photocopying hospital medical records.

(b) Persons served by the program have the right to refuse to consent to be interviewed, photographed, or audio or videotaped. Failure or refusal of an applicant or license holder to fully comply with this subdivision is reasonable cause for the commissioner to deny the application or immediately suspend or revoke the license.

Sec. 47. Minnesota Statutes 2020, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600
125 to 149 persons	$700
150 to 174 persons	$800
175 to 199 persons	$900
200 to 224 persons	$1,000
225 or more persons	$1,100

(b)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee based on revenues derived from the provision of services that would require licensure under chapter 245D during the calendar year immediately preceding the year in which the license fee is paid, according to the following schedule:

License Holder Annual Revenue	License Fee
less than or equal to $10,000	$200
greater than $10,000 but less than or equal to $25,000	$300

greater than $25,000 but less than or equal to $50,000	$400
greater than $50,000 but less than or equal to $100,000	$500
greater than $100,000 but less than or equal to $150,000	$600
greater than $150,000 but less than or equal to $200,000	$800
greater than $200,000 but less than or equal to $250,000	$1,000
greater than $250,000 but less than or equal to $300,000	$1,200
greater than $300,000 but less than or equal to $350,000	$1,400
greater than $350,000 but less than or equal to $400,000	$1,600
greater than $400,000 but less than or equal to $450,000	$1,800
greater than $450,000 but less than or equal to $500,000	$2,000
greater than $500,000 but less than or equal to $600,000	$2,250
greater than $600,000 but less than or equal to $700,000	$2,500
greater than $700,000 but less than or equal to $800,000	$2,750
greater than $800,000 but less than or equal to $900,000	$3,000
greater than $900,000 but less than or equal to $1,000,000	$3,250
greater than $1,000,000 but less than or equal to $1,250,000	$3,500
greater than $1,250,000 but less than or equal to $1,500,000	$3,750
greater than $1,500,000 but less than or equal to $1,750,000	$4,000
greater than $1,750,000 but less than or equal to $2,000,000	$4,250
greater than $2,000,000 but less than or equal to $2,500,000	$4,500
greater than $2,500,000 but less than or equal to $3,000,000	$4,750
greater than $3,000,000 but less than or equal to $3,500,000	$5,000
greater than $3,500,000 but less than or equal to $4,000,000	$5,500

greater than $4,000,000 but less than or equal to $4,500,000	$6,000
greater than $4,500,000 but less than or equal to $5,000,000	$6,500
greater than $5,000,000 but less than or equal to $7,500,000	$7,000
greater than $7,500,000 but less than or equal to $10,000,000	$8,500
greater than $10,000,000 but less than or equal to $12,500,000	$10,000
greater than $12,500,000 but less than or equal to $15,000,000	$14,000
greater than $15,000,000	$18,000

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(5) Notwithstanding clause (1), a license holder providing services under one or more licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license holder for all licenses held under chapter 245B for calendar year 2013. For calendar year 2017 and thereafter, the license holder shall pay an annual license fee according to clause (1).

(c) A chemical dependency treatment program licensed under chapter 245G, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

(d) A chemical dependency program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

(e) Except for child foster care, a residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

(f) A residential facility licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

(g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(h) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of $1,500.

(i) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

(j) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900
75 to 99 persons	$1,100
100 or more persons	$1,300

(k) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(l) A ~~mental health center or~~ mental health clinic ~~requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870~~ certified under section 245I.20, shall pay ~~a~~ an annual nonrefundable certification fee of $1,550 ~~per year~~. If the ~~mental health center or~~ mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

Sec. 48. Minnesota Statutes 2020, section 245A.65, subdivision 2, is amended to read:

Subd. 2. **Abuse prevention plans.** All license holders shall establish and enforce ongoing written program abuse prevention plans and individual abuse prevention plans as required under section 626.557, subdivision 14.

(a) The scope of the program abuse prevention plan is limited to the population, physical plant, and environment within the control of the license holder and the location where licensed services are provided. In addition to the requirements in section 626.557, subdivision 14, the program abuse prevention plan shall meet the requirements in clauses (1) to (5).

(1) The assessment of the population shall include an evaluation of the following factors: age, gender, mental functioning, physical and emotional health or behavior of the client; the need for specialized programs of care for clients; the need for training of staff to meet identified individual needs; and the knowledge a license holder may have regarding previous abuse that is relevant to minimizing risk of abuse for clients.

(2) The assessment of the physical plant where the licensed services are provided shall include an evaluation of the following factors: the condition and design of the building as it relates to the safety of the clients; and the existence of areas in the building which are difficult to supervise.

(3) The assessment of the environment for each facility and for each site when living arrangements are provided by the agency shall include an evaluation of the following factors: the location of the program in a particular neighborhood or community; the type of grounds and terrain surrounding the building; the type of internal programming; and the program's staffing patterns.

(4) The license holder shall provide an orientation to the program abuse prevention plan for clients receiving services. If applicable, the client's legal representative must be notified of the orientation. The license holder shall provide this orientation for each new person within 24 hours of admission, or for persons who would benefit more from a later orientation, the orientation may take place within 72 hours.

(5) The license holder's governing body or the governing body's delegated representative shall review the plan at least annually using the assessment factors in the plan and any substantiated maltreatment findings that occurred since the last review. The governing body or the governing body's delegated representative shall revise the plan, if necessary, to reflect the review results.

(6) A copy of the program abuse prevention plan shall be posted in a prominent location in the program and be available upon request to mandated reporters, persons receiving services, and legal representatives.

(b) In addition to the requirements in section 626.557, subdivision 14, the individual abuse prevention plan shall meet the requirements in clauses (1) and (2).

(1) The plan shall include a statement of measures that will be taken to minimize the risk of abuse to the vulnerable adult when the individual assessment required in section 626.557, subdivision 14, paragraph (b), indicates the need for measures in addition to the specific measures identified in the program abuse prevention plan. The measures shall include the specific actions the program will take to minimize the risk of abuse within the scope of the licensed services, and will identify referrals made when the vulnerable adult is susceptible to abuse outside the scope or control of the licensed services. When the assessment indicates that the vulnerable adult does not need specific risk reduction measures in addition to those identified in the program abuse prevention plan, the individual abuse prevention plan shall document this determination.

(2) An individual abuse prevention plan shall be developed for each new person as part of the initial individual program plan or service plan required under the applicable licensing rule or statute. The review and evaluation of the individual abuse prevention plan shall be done as part of the review of the program plan ~~or,~~ service plan, or treatment plan. The person receiving services shall participate in the development of the individual abuse prevention plan to the full extent of the person's abilities. If applicable, the person's legal representative shall be given the opportunity to participate with or for the person in the development of the plan. The interdisciplinary team shall document the review of all abuse prevention plans at least annually, using the individual assessment and any reports of abuse relating to the person. The plan shall be revised to reflect the results of this review.

Sec. 49. Minnesota Statutes 2020, section 245D.02, subdivision 20, is amended to read:

Subd. 20. **Mental health crisis intervention team.** "Mental health crisis intervention team" means a mental health crisis response provider as identified in section 256B.0624~~, subdivision 2, paragraph (d), for adults, and in section 256B.0944, subdivision 1, paragraph (d), for children~~.

Sec. 50. Minnesota Statutes 2020, section 256B.0615, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist services, as established in subdivision 2, subject to federal approval, if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and are provided by a mental health certified peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 10.

Sec. 51. Minnesota Statutes 2020, section 256B.0615, subdivision 5, is amended to read:

Subd. 5. **Certified peer specialist training and certification.** The commissioner of human services shall develop a training and certification process for certified peer specialists~~, who must be at least 21 years of age~~. The candidates must have had a primary diagnosis of mental illness, be a current or former consumer of mental health services, and must demonstrate leadership and advocacy skills and a strong dedication to recovery. The training curriculum must teach participating consumers specific skills relevant to providing peer support to other consumers. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to peer support counseling.

Sec. 52. Minnesota Statutes 2020, section 256B.0616, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services, as established in subdivision 2, subject to federal approval, if provided to recipients who have an emotional disturbance or severe emotional disturbance under chapter 245, and are provided by a mental health certified family peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 12. A family peer specialist cannot provide services to the peer specialist's family.

Sec. 53. Minnesota Statutes 2020, section 256B.0616, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** Family peer support services may be ~~located in~~ provided to recipients of inpatient hospitalization, partial hospitalization, residential treatment, intensive treatment in foster care, day treatment, children's therapeutic services and supports, or crisis services.

Sec. 54. Minnesota Statutes 2020, section 256B.0616, subdivision 5, is amended to read:

Subd. 5. **Certified family peer specialist training and certification.** The commissioner shall develop a training and certification process for certified family peer specialists ~~who must be at least 21 years of age~~. The candidates must have raised or be currently raising a child with a mental illness, have had experience navigating the children's mental health system, and must demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach participating family peer specialists specific skills relevant to providing peer support to other parents. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support counseling.

Sec. 55. Minnesota Statutes 2020, section 256B.0622, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically necessary, assertive community treatment ~~for clients as defined in subdivision 2a and intensive residential treatment services for clients as defined in subdivision 3,~~ when the services are provided by an entity certified under and meeting the standards in this section.

(b) Subject to federal approval, medical assistance covers medically necessary, intensive residential treatment services when the services are provided by an entity licensed under and meeting the standards in section 245I.23.

(c) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Sec. 56. Minnesota Statutes 2020, section 256B.0622, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "ACT team" means the group of interdisciplinary mental health staff who work as a team to provide assertive community treatment.

(c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per day, seven days per week, in a community-based setting.

(d) "Individual treatment plan" means ~~the document that results from a person-centered planning process of determining real-life outcomes with clients and developing strategies to achieve those outcomes~~ a plan described by section 245I.10, subdivisions 7 and 8.

~~(e) "Assertive engagement" means the use of collaborative strategies to engage clients to receive services.~~

~~(f) "Benefits and finance support" means assisting clients in capably managing financial affairs. Services include, but are not limited to, assisting clients in applying for benefits; assisting with redetermination of benefits; providing financial crisis management; teaching and supporting budgeting skills and asset development; and coordinating with a client's representative payee, if applicable.~~

~~(g) "Co-occurring disorder treatment" means the treatment of co-occurring mental illness and substance use disorders and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment. Services include, but are not limited to, assessing and tracking clients' stages of change readiness and treatment; applying the appropriate treatment based on stages of change, such as outreach and motivational interviewing techniques to work with clients in earlier stages of change readiness and cognitive behavioral approaches and relapse prevention to work with clients in later stages of change; and facilitating access to community supports.~~

~~(h)~~ (e) "Crisis assessment and intervention" means mental health crisis response services as defined in section 256B.0624, subdivision 2~~, paragraphs (c) to (e)~~.

~~(i) "Employment services" means assisting clients to work at jobs of their choosing. Services must follow the principles of the individual placement and support (IPS) employment model, including focusing on competitive employment; emphasizing individual client preferences and strengths; ensuring employment services are integrated with mental health services; conducting rapid job searches and systematic job development according to client preferences and choices; providing benefits counseling; and offering all services in an individualized and time-unlimited manner. Services shall also include educating clients about opportunities and benefits of work and school and assisting the client in learning job skills, navigating the work place, and managing work relationships.~~

~~(j) "Family psychoeducation and support" means services provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include, but are not limited to, individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent.~~

~~(k) "Housing access support" means assisting clients to find, obtain, retain, and move to safe and adequate housing of their choice. Housing access support includes, but is not limited to, locating housing options with a focus on integrated independent settings; applying for housing subsidies, programs, or resources; assisting the client in developing relationships with local landlords; providing tenancy support and advocacy for the individual's tenancy rights at the client's home; and assisting with relocation.~~

~~(l)~~ (f) "Individual treatment team" means a minimum of three members of the ACT team who are responsible for consistently carrying out most of a client's assertive community treatment services.

~~(m) "Intensive residential treatment services treatment team" means all staff who provide intensive residential treatment services under this section to clients. At a minimum, this includes the clinical supervisor; mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462,~~

~~subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision 5, paragraph (a), clause (4); and mental health certified peer specialists under section 256B.0615.~~

~~(n) "Intensive residential treatment services" means short-term, time-limited services provided in a residential setting to clients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes.~~

~~(o) "Medication assistance and support" means assisting clients in accessing medication, developing the ability to take medications with greater independence, and providing medication setup. This includes the prescription, administration, and order of medication by appropriate medical staff.~~

~~(p) "Medication education" means educating clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications.~~

~~(q) "Overnight staff" means a member of the intensive residential treatment services team who is responsible during hours when clients are typically asleep.~~

~~(r) "Mental health certified peer specialist services" has the meaning given in section 256B.0615.~~

~~(s) "Physical health services" means any service or treatment to meet the physical health needs of the client to support the client's mental health recovery. Services include, but are not limited to, education on primary health issues, including wellness education; medication administration and monitoring; providing and coordinating medical screening and follow-up; scheduling routine and acute medical and dental care visits; tobacco cessation strategies; assisting clients in attending appointments; communicating with other providers; and integrating all physical and mental health treatment.~~

~~(t)~~ (g) "Primary team member" means the person who leads and coordinates the activities of the individual treatment team and is the individual treatment team member who has primary responsibility for establishing and maintaining a therapeutic relationship with the client on a continuing basis.

~~(u) "Rehabilitative mental health services" means mental health services that are rehabilitative and enable the client to develop and enhance psychiatric stability, social~~

~~competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness.~~

~~(v) "Symptom management" means supporting clients in identifying and targeting the symptoms and occurrence patterns of their mental illness and developing strategies to reduce the impact of those symptoms.~~

~~(w) "Therapeutic interventions" means empirically supported techniques to address specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms. Interventions include empirically supported psychotherapies including, but not limited to, cognitive behavioral therapy, exposure therapy, acceptance and commitment therapy, interpersonal therapy, and motivational interviewing.~~

~~(x) "Wellness self-management and prevention" means a combination of approaches to working with the client to build and apply skills related to recovery, and to support the client in participating in leisure and recreational activities, civic participation, and meaningful structure.~~

(h) "Certified rehabilitation specialist" means a staff person who is qualified according to section 245I.04, subdivision 8.

(i) "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

(j) "Mental health certified peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 10.

(k) "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

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

(m) "Mental health rehabilitation worker" means a staff person who is qualified according to section 245I.04, subdivision 14.

Sec. 57. Minnesota Statutes 2020, section 256B.0622, subdivision 3a, is amended to read:

Subd. 3a. **Provider certification and contract requirements for assertive community treatment.** (a) The assertive community treatment provider must:

(1) have a contract with the host county to provide assertive community treatment services; and

(2) have each ACT team be certified by the state following the certification process and procedures developed by the commissioner. The certification process determines whether the ACT team meets the standards for assertive community treatment under this section ~~as well as~~, the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum program fidelity standards as measured by a nationally recognized fidelity tool approved by the commissioner. Recertification must occur at least every three years.

(b) An ACT team certified under this subdivision must meet the following standards:

(1) have capacity to recruit, hire, manage, and train required ACT team members;

(2) have adequate administrative ability to ensure availability of services;

~~(3) ensure adequate preservice and ongoing training for staff;~~

~~(4) ensure that staff is capable of implementing culturally specific services that are culturally responsive and appropriate as determined by the client's culture, beliefs, values, and language as identified in the individual treatment plan;~~

~~(5)~~ (3) ensure flexibility in service delivery to respond to the changing and intermittent care needs of a client as identified by the client and the individual treatment plan;

~~(6) develop and maintain client files, individual treatment plans, and contact charting;~~

~~(7) develop and maintain staff training and personnel files;~~

~~(8) submit information as required by the state;~~

~~(9)~~ (4) keep all necessary records required by law;

~~(10) comply with all applicable laws;~~

~~(11)~~ (5) be an enrolled Medicaid provider; and

~~(12)~~ (6) establish and maintain a quality assurance plan to determine specific service outcomes and the client's satisfaction with services~~; and~~.

~~(13) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.~~

(c) The commissioner may intervene at any time and decertify an ACT team with cause. The commissioner shall establish a process for decertification of an ACT team and shall require corrective action, medical assistance repayment, or decertification of an ACT team that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process. The decertification is subject to appeal to the state.

Sec. 58. Minnesota Statutes 2020, section 256B.0622, subdivision 4, is amended to read:

Subd. 4. **Provider entity licensure and contract requirements for intensive residential treatment services.** ~~(a) The intensive residential treatment services provider entity must:~~

~~(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;~~

~~(2) not exceed 16 beds per site; and~~

~~(3) comply with the additional standards in this section.~~

~~(b)~~ (a) The commissioner shall develop procedures for counties and providers to submit other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

~~(c)~~ (b) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

~~(d)~~ (c) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and tribal authority that serves as a local mental health authority in the proposed service area. The statement of need must specify if the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within 60 days of the receipt of the request, the commissioner shall determine the need for the program based on the documentation submitted by the provider entity.

Sec. 59. Minnesota Statutes 2020, section 256B.0622, subdivision 7, is amended to read:

Subd. 7. **Assertive community treatment service standards.** (a) ACT teams must offer and have the capacity to directly provide the following services:

(1) assertive engagement using collaborative strategies to encourage clients to receive services;

(2) benefits and finance support that assists clients to capably manage financial affairs. Services include but are not limited to assisting clients in applying for benefits, assisting with redetermination of benefits, providing financial crisis management, teaching and supporting budgeting skills and asset development, and coordinating with a client's representative payee, if applicable;

(3) co-occurring substance use disorder treatment as defined in section 245I.02, subdivision 11;

(4) crisis assessment and intervention;

(5) employment services that assist clients to work at jobs of the clients' choosing. Services must follow the principles of the individual placement and support employment model, including focusing on competitive employment, emphasizing individual client preferences and strengths, ensuring employment services are integrated with mental health services, conducting rapid job searches and systematic job development according to client preferences and choices, providing benefits counseling, and offering all services in an individualized and time-unlimited manner. Services must also include educating clients about opportunities and benefits of work and school and assisting the client in learning job skills, navigating the workplace, workplace accommodations, and managing work relationships;

(6) family psychoeducation and support provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include but are not limited to individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent;

(7) housing access support that assists clients to find, obtain, retain, and move to safe and adequate housing of their choice. Housing access support includes but is not limited to locating housing options with a focus on integrated independent settings; applying for housing subsidies, programs, or resources; assisting the client in developing relationships with local landlords; providing tenancy support and advocacy for the individual's tenancy rights at the client's home; and assisting with relocation;

(8) medication assistance and support that assists clients in accessing medication, developing the ability to take medications with greater independence, and providing

medication setup. Medication assistance and support includes assisting the client with the prescription, administration, and ordering of medication by appropriate medical staff;

(9) medication education that educates clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications;

(10) mental health certified peer specialists services according to section 256B.0615;

(11) physical health services to meet the physical health needs of the client to support the client's mental health recovery. Services include but are not limited to education on primary health and wellness issues, medication administration and monitoring, providing and coordinating medical screening and follow-up, scheduling routine and acute medical and dental care visits, tobacco cessation strategies, assisting clients in attending appointments, communicating with other providers, and integrating all physical and mental health treatment;

(12) rehabilitative mental health services as defined in section 245I.02, subdivision 33;

(13) symptom management that supports clients in identifying and targeting the symptoms and occurrence patterns of their mental illness and developing strategies to reduce the impact of those symptoms;

(14) therapeutic interventions to address specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms. Interventions include empirically supported psychotherapies including but not limited to cognitive behavioral therapy, exposure therapy, acceptance and commitment therapy, interpersonal therapy, and motivational interviewing;

(15) wellness self-management and prevention that includes a combination of approaches to working with the client to build and apply skills related to recovery, and to support the client in participating in leisure and recreational activities, civic participation, and meaningful structure; and

(16) other services based on client needs as identified in a client's assertive community treatment individual treatment plan.

(b) ACT teams must ensure the provision of all services necessary to meet a client's needs as identified in the client's individual treatment plan.

Sec. 60. Minnesota Statutes 2020, section 256B.0622, subdivision 7a, is amended to read:

Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

(i) shall be a ~~licensed~~ mental health professional ~~who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role but must obtain full licensure within 24 months of assuming the role of team leader;

(ii) must be an active member of the ACT team and provide some direct services to clients;

(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team, providing ~~clinical oversight~~ treatment supervision of services in conjunction with the psychiatrist or psychiatric care provider, and supervising team members to ensure delivery of best and ethical practices; and

(iv) must be available to provide overall ~~clinical oversight~~ treatment supervision to the ACT team after regular business hours and on weekends and holidays. The team leader may delegate this duty to another qualified member of the ACT team;

(2) the psychiatric care provider:

(i) must be a ~~licensed psychiatrist certified by the American Board of Psychiatry and Neurology or eligible for board certification or certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~ mental health professional permitted to prescribe psychiatric medications as part of the mental health professional's scope of practice. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness;

(ii) shall collaborate with the team leader in sharing overall clinical responsibility for screening and admitting clients; monitoring clients' treatment and team member service delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects, and health-related conditions; actively collaborating with nurses; and helping provide ~~clinical~~ treatment supervision to the team;

(iii) shall fulfill the following functions for assertive community treatment clients: provide assessment and treatment of clients' symptoms and response to medications, including side effects; provide brief therapy to clients; provide diagnostic and medication education to clients, with medication decisions based on shared decision making; monitor clients' nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and community visits;

(iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized for mental health treatment and shall communicate directly with the client's inpatient psychiatric care providers to ensure continuity of care;

(v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per 50 clients. Part-time psychiatric care providers shall have designated hours to work on the team, with sufficient blocks of time on consistent days to carry out the provider's clinical, supervisory, and administrative responsibilities. No more than two psychiatric care providers may share this role;

(vi) may not provide specific roles and responsibilities by telemedicine unless approved by the commissioner; and

(vii) shall provide psychiatric backup to the program after regular business hours and on weekends and holidays. The psychiatric care provider may delegate this duty to another qualified psychiatric provider;

(3) the nursing staff:

(i) shall consist of one to three registered nurses or advanced practice registered nurses, of whom at least one has a minimum of one-year experience working with adults with serious mental illness and a working knowledge of psychiatric medications. No more than two individuals can share a full-time equivalent position;

(ii) are responsible for managing medication, administering and documenting medication treatment, and managing a secure medication room; and

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

(i) shall be a full-time equivalent co-occurring disorder specialist who has received specific training on co-occurring disorders that is consistent with national evidence-based practices. The training must include practical knowledge of common substances and how they affect mental illnesses, the ability to assess substance use disorders and the client's stage of treatment, motivational interviewing, and skills necessary to provide counseling to clients at all different stages of change and treatment. The co-occurring disorder specialist

may also be an individual who is a licensed alcohol and drug counselor as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience, and other requirements in section 245G.11, subdivision 5. No more than two co-occurring disorder specialists may occupy this role; and

(ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients. The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT team members on co-occurring disorders;

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services to individuals with mental illness. An individual who does not meet these qualifications may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

(ii) shall provide or facilitate the provision of vocational services to clients. The vocational specialist serves as a consultant and educator to fellow ACT team members on these services; and

(iii) ~~should~~ must not refer individuals to receive any type of vocational services or linkage by providers outside of the ACT team;

(6) the mental health certified peer specialist:

(i) shall be a full-time equivalent ~~mental health certified peer specialist as defined in section 256B.0615~~. No more than two individuals can share this position. The mental health certified peer specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of clients. This requirement may be waived due to workforce shortages upon approval of the commissioner;

(ii) must provide coaching, mentoring, and consultation to the clients to promote recovery, self-advocacy, and self-direction, promote wellness management strategies, and assist clients in developing advance directives; and

(iii) must model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience, provide consultation to team members, promote a culture where the clients' points of view and preferences are recognized, understood, respected, and integrated into treatment, and serve in a manner equivalent to other team members;

(7) the program administrative assistant shall be a full-time office-based program administrative assistant position assigned to solely work with the ACT team, providing a range of supports to the team, clients, and families; and

(8) additional staff:

(i) shall be based on team size. Additional treatment team staff may include ~~licensed~~ mental health professionals ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A~~; clinical trainees; certified rehabilitation specialists; mental health practitioners ~~as defined in section 245.462, subdivision 17; a mental health practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C~~; or mental health rehabilitation workers ~~as defined in section 256B.0623, subdivision 5, paragraph (a), clause (4)~~. These individuals shall have the knowledge, skills, and abilities required by the population served to carry out rehabilitation and support functions; and

(ii) shall be selected based on specific program needs or the population served.

(b) Each ACT team must clearly document schedules for all ACT team members.

(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.

(d) Members of the ACT team must have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of rehabilitation services. Each staff member shall be proficient in their respective discipline and be able to work collaboratively as a member of a multidisciplinary team to deliver the majority of the treatment, rehabilitation, and support services clients require to fully benefit from receiving assertive community treatment.

(e) Each ACT team member must fulfill training requirements established by the commissioner.

Sec. 61. Minnesota Statutes 2020, section 256B.0622, subdivision 7b, is amended to read:

Subd. 7b. **Assertive community treatment program size and opportunities.** (a) Each ACT team shall maintain an annual average caseload that does not exceed 100 clients. Staff-to-client ratios shall be based on team size as follows:

(1) a small ACT team must:

(i) employ at least six but no more than seven full-time treatment team staff, excluding the program assistant and the psychiatric care provider;

(ii) serve an annual average maximum of no more than 50 clients;

(iii) ensure at least one full-time equivalent position for every eight clients served;

(iv) schedule ACT team staff for at least eight-hour shift coverage on weekdays and on-call duty to provide crisis services and deliver services after hours when staff are not working;

(v) provide crisis services during business hours if the small ACT team does not have sufficient staff numbers to operate an after-hours on-call system. During all other hours, the ACT team may arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider;

(vi) adjust schedules and provide staff to carry out the needed service activities in the evenings or on weekend days or holidays, when necessary;

(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team's psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must be arranged and a mechanism of timely communication and coordination established in writing; and

(viii) be composed of, at minimum, one full-time team leader, at least 16 hours each week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time equivalent nursing, one full-time ~~substance abuse~~ co-occurring disorder specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least one additional full-time ACT team member who has mental health professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner status; and

(2) a midsize ACT team shall:

(i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry time for 51 clients, with an additional two hours for every six clients added to the team, 1.5 to two full-time equivalent nursing staff, one full-time ~~substance abuse~~ co-occurring disorder

specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT members, with at least one dedicated full-time staff member with mental health professional status. Remaining team members may have mental health professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner status;

(ii) employ seven or more treatment team full-time equivalents, excluding the program assistant and the psychiatric care provider;

(iii) serve an annual average maximum caseload of 51 to 74 clients;

(iv) ensure at least one full-time equivalent position for every nine clients served;

(v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays and six- to eight-hour shift coverage on weekends and holidays. In addition to these minimum specifications, staff are regularly scheduled to provide the necessary services on a client-by-client basis in the evenings and on weekends and holidays;

(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working;

(vii) have the authority to arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider; and

(viii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must be arranged and a mechanism of timely communication and coordination established in writing;

(3) a large ACT team must:

(i) be composed of, at minimum, one full-time team leader, at least 32 hours each week per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff, one full-time ~~substance abuse~~ co-occurring disorder specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least two additional full-time equivalent ACT team members, with at least one dedicated full-time staff member with mental health professional status.

Remaining team members may have mental health professional or mental health practitioner status;

(ii) employ nine or more treatment team full-time equivalents, excluding the program assistant and psychiatric care provider;

(iii) serve an annual average maximum caseload of 75 to 100 clients;

(iv) ensure at least one full-time equivalent position for every nine individuals served;

(v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the second shift providing services at least 12 hours per day weekdays. For weekends and holidays, the team must operate and schedule ACT team staff to work one eight-hour shift, with a minimum of two staff each weekend day and every holiday;

(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working; and

(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team psychiatric care provider during all hours is not feasible, alternative psychiatric backup must be arranged and a mechanism of timely communication and coordination established in writing.

(b) An ACT team of any size may have a staff-to-client ratio that is lower than the requirements described in paragraph (a) upon approval by the commissioner, but may not exceed a one-to-ten staff-to-client ratio.

Sec. 62. Minnesota Statutes 2020, section 256B.0622, subdivision 7d, is amended to read:

Subd. 7d. **Assertive community treatment assessment and individual treatment plan.** (a) An initial assessment~~, including a diagnostic assessment that meets the requirements of Minnesota Rules, part 9505.0372, subpart 1, and a 30-day treatment plan~~ shall be completed the day of the client's admission to assertive community treatment by the ACT team leader or the psychiatric care provider, with participation by designated ACT team members and the client. The initial assessment must include obtaining or completing a standard diagnostic assessment according to section 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader, psychiatric care provider, or other mental health professional designated by the team leader or psychiatric care provider, must update the client's diagnostic assessment at least annually.

(b) ~~An initial~~ A functional assessment must be completed ~~within ten days of intake and updated every six months for assertive community treatment, or prior to discharge from the service, whichever comes first~~ according to section 245I.10, subdivision 9.

~~(c) Within 30 days of the client's assertive community treatment admission, the ACT team shall complete an in-depth assessment of the domains listed under section 245.462, subdivision 11a.~~

~~(d)~~ Each part of the ~~in-depth~~ functional assessment areas shall be completed by each respective team specialist or an ACT team member with skill and knowledge in the area being assessed. ~~The assessments are based upon all available information, including that from client interview family and identified natural supports, and written summaries from other agencies, including police, courts, county social service agencies, outpatient facilities, and inpatient facilities, where applicable.~~

~~(e)~~ (c) Between 30 and 45 days after the client's admission to assertive community treatment, the entire ACT team must hold a comprehensive case conference, where all team members, including the psychiatric provider, present information discovered from the completed ~~in-depth~~ assessments and provide treatment recommendations. The conference must serve as the basis for the first ~~six-month~~ individual treatment plan, which must be written by the primary team member.

~~(f)~~ (d) The client's psychiatric care provider, primary team member, and individual treatment team members shall assume responsibility for preparing the written narrative of the results from the psychiatric and social functioning history timeline and the comprehensive assessment.

~~(g)~~ (e) The primary team member and individual treatment team members shall be assigned by the team leader in collaboration with the psychiatric care provider by the time of the first treatment planning meeting or 30 days after admission, whichever occurs first.

~~(h)~~ (f) Individual treatment plans must be developed through the following treatment planning process:

(1) The individual treatment plan shall be developed in collaboration with the client and the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT team shall evaluate, together with each client, the client's needs, strengths, and preferences and develop the individual treatment plan collaboratively. The ACT team shall make every effort to ensure that the client and the client's family and natural supports, with the client's consent, are in attendance at the treatment planning meeting, are involved in ongoing

meetings related to treatment, and have the necessary supports to fully participate. The client's participation in the development of the individual treatment plan shall be documented.

(2) The client and the ACT team shall work together to formulate and prioritize the issues, set goals, research approaches and interventions, and establish the plan. The plan is individually tailored so that the treatment, rehabilitation, and support approaches and interventions achieve optimum symptom reduction, help fulfill the personal needs and aspirations of the client, take into account the cultural beliefs and realities of the individual, and improve all the aspects of psychosocial functioning that are important to the client. The process supports strengths, rehabilitation, and recovery.

(3) Each client's individual treatment plan shall identify service needs, strengths and capacities, and barriers, and set specific and measurable short- and long-term goals for each service need. The individual treatment plan must clearly specify the approaches and interventions necessary for the client to achieve the individual goals, when the interventions shall happen, and identify which ACT team member shall carry out the approaches and interventions.

(4) The primary team member and the individual treatment team, together with the client and the client's family and natural supports with the client's consent, are responsible for reviewing and rewriting the treatment goals and individual treatment plan whenever there is a major decision point in the client's course of treatment or at least every six months.

(5) The primary team member shall prepare a summary that thoroughly describes in writing the client's and the individual treatment team's evaluation of the client's progress and goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last individual treatment plan. The client's most recent diagnostic assessment must be included with the treatment plan summary.

(6) The individual treatment plan and review must be ~~signed~~ approved or acknowledged by the client, the primary team member, the team leader, the psychiatric care provider, and all individual treatment team members. A copy of the ~~signed~~ approved individual treatment plan ~~is~~ must be made available to the client.

Sec. 63. Minnesota Statutes 2020, section 256B.0623, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers medically necessary adult rehabilitative mental health services ~~as defined in subdivision 2, subject to federal approval, if provided to recipients as defined in subdivision 3 and provided by a qualified provider entity meeting the standards in this section and by a qualified individual~~

~~provider working within the provider's scope of practice and identified in the recipient's individual treatment plan as defined in section 245.462, subdivision 14, and if determined to be medically necessary according to section 62Q.53~~ when the services are provided by an entity meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Sec. 64. Minnesota Statutes 2020, section 256B.0623, subdivision 2, is amended to read:

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

(a) "Adult rehabilitative mental health services" means ~~mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services~~ the services described in section 245I.02, subdivision 33.

~~(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.~~

~~(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.~~

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program ~~under Minnesota Rules, chapter 9505~~, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Sec. 65. Minnesota Statutes 2020, section 256B.0623, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section ~~245.462, subdivision 11a~~ 245I.10, subdivision 9, clause (4), so that self-sufficiency is markedly reduced; and

(4) has had a recent standard diagnostic assessment ~~or an adult diagnostic assessment update~~ by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

Sec. 66. Minnesota Statutes 2020, section 256B.0623, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the state following the certification process and procedures developed by the commissioner.

(b) The certification process is a determination as to whether the entity meets the standards in this ~~subdivision~~ section and chapter 245I, as required in section 245I.011, subdivision 5. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) A noncounty provider entity must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate its services with the other services available in that county. A county-operated entity must obtain this additional certification from any other county in which it will provide services.

(d) State-level recertification must occur at least every three years.

(e) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(f) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train ~~mental health professionals, mental health practitioners, and mental health rehabilitation workers~~ qualified staff;

(2) have adequate administrative ability to ensure availability of services;

~~(3) ensure adequate preservice and inservice and ongoing training for staff;~~

~~(4)~~ (3) ensure that ~~mental health professionals, mental health practitioners, and mental health rehabilitation workers~~ staff are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

~~(5) ensure that staff is capable of implementing culturally specific services that are culturally competent and appropriate as determined by the recipient's culture, beliefs, values, and language as identified in the individual treatment plan;~~

~~(6)~~ (4) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

~~(7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan;~~

~~(8)~~ (5) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

~~(9)~~ (6) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

~~(10) develop and maintain recipient files, individual treatment plans, and contact charting;~~

~~(11) develop and maintain staff training and personnel files;~~

~~(12) submit information as required by the state;~~

~~(13) establish and maintain a quality assurance plan to evaluate the outcome of services provided;~~

~~(14)~~ (7) keep all necessary records required by law;

~~(15)~~ (8) deliver services as required by section 245.461;

~~(16) comply with all applicable laws;~~

~~(17)~~ (9) be an enrolled Medicaid provider; and

~~(18)~~ (10) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services~~; and~~.

~~(19) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.~~

Sec. 67. Minnesota Statutes 2020, section 256B.0623, subdivision 5, is amended to read:

Subd. 5. **Qualifications of provider staff.** ~~(a)~~ Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified ~~under one of the following criteria~~ as:

(1) a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending receipt of adult mental health rehabilitative services, the definition of mental health professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (7), and who holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner~~ who is qualified according to section 245I.04, subdivision 2;

(2) a certified rehabilitation specialist who is qualified according to section 245I.04, subdivision 8;

(3) a clinical trainee who is qualified according to section 245I.04, subdivision 6;

(4) a mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional~~ qualified according to section 245I.04, subdivision 4;

~~(3)~~ (5) a mental health certified peer specialist ~~under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional~~ who is qualified according to section 245I.04, subdivision 10; or

~~(4)~~ (6) a mental health rehabilitation worker who is qualified according to section 245I.04, subdivision 14. ~~A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who:~~

~~(i) is at least 21 years of age;~~

~~(ii) has a high school diploma or equivalent;~~

~~(iii) has successfully completed 30 hours of training during the two years immediately prior to the date of hire, or before provision of direct services, in all of the following areas: recovery from mental illness, mental health de-escalation techniques, recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and~~

~~(iv) meets the qualifications in paragraph (b).~~

~~(b) In addition to the requirements in paragraph (a), a mental health rehabilitation worker must also meet the qualifications in clause (1), (2), or (3):~~

~~(1) has an associates of arts degree, two years of full-time postsecondary education, or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields; is a registered nurse; or within the previous ten years has:~~

~~(i) three years of personal life experience with serious mental illness;~~

~~(ii) three years of life experience as a primary caregiver to an adult with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability; or~~

~~(iii) 2,000 hours of supervised work experience in the delivery of mental health services to adults with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability;~~

~~(2)(i) is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;~~

~~(ii) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;~~

~~(iii) has 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;~~

~~(iv) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or mental health practitioner; and~~

~~(v) has 15 hours of additional continuing education on mental health topics during the first year of employment and 15 hours during every additional year of employment; or~~

~~(3) for providers of crisis residential services, intensive residential treatment services, partial hospitalization, and day treatment services:~~

~~(i) satisfies clause (2), items (ii) to (iv); and~~

~~(ii) has 40 hours of additional continuing education on mental health topics during the first year of employment.~~

~~(c) A mental health rehabilitation worker who solely acts and is scheduled as overnight staff is not required to comply with paragraph (a), clause (4), item (iv).~~

~~(d) For purposes of this subdivision, "behavioral sciences or related fields" means an education from an accredited college or university and includes but is not limited to social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, and other fields as approved by the commissioner.~~

Sec. 68. Minnesota Statutes 2020, section 256B.0623, subdivision 6, is amended to read:

Subd. 6. **Required ~~training and~~ supervision.** ~~(a) Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d).~~

~~(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).~~

~~(c) Clinical supervision may be provided by a full- or part-time qualified professional employed by or under contract with the provider entity. Clinical supervision may be provided~~

~~by interactive videoconferencing according to procedures developed by the commissioner. A mental health professional providing clinical supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:~~

~~(1) review the information in the recipient's file;~~

~~(2) review and approve initial and updates of individual treatment plans;~~

(a) A treatment supervisor providing treatment supervision required by section 245I.06 must:

~~(3)~~ (1) meet with ~~mental health rehabilitation workers and practitioners, individually or in small groups,~~ staff receiving treatment supervision at least monthly to discuss treatment topics of interest ~~to the workers and practitioners;~~

~~(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss~~ and treatment plans of recipients~~, and approve by signature and document in the recipient's file any resulting plan updates~~; and

~~(5)~~ (2) meet at least monthly with the directing clinical trainee or mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing clinical trainee or mental health practitioner~~; and~~.

~~(6) be available for urgent consultation as the individual recipient needs or the situation necessitates.~~

~~(d)~~ (b) An adult rehabilitative mental health services provider entity must have a treatment director who is a ~~mental health practitioner or~~ mental health professional clinical trainee, certified rehabilitation specialist, or mental health practitioner. The treatment director must ~~ensure the following~~:

(1) ~~while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by a mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works~~ ensure the direct observation of mental health rehabilitation workers required by section 245I.06, subdivision 3, is provided;

~~(2) the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;~~

~~(3) progress notes are reviewed from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the individual treatment plan and goals;~~

~~(4)~~ (2) ensure immediate availability by phone or in person for consultation by a mental health professional, certified rehabilitation specialist, clinical trainee, or a mental health practitioner to the mental health rehabilitation ~~services~~ worker during service provision;

~~(5) oversee the identification of changes in individual recipient treatment strategies, revise the plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;~~

~~(6)~~ (3) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;

~~(7)~~ (4) ensure that clinical trainees, mental health practitioners, and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers; and

~~(8)~~ (5) oversee the record of the results of ~~on-site~~ direct observation ~~and charting~~, progress note evaluation, and corrective actions taken to modify the work of the clinical trainees, mental health practitioners, and mental health rehabilitation workers.

~~(c)~~ (c) A clinical trainee or mental health practitioner who is providing treatment direction for a provider entity must receive treatment supervision at least monthly ~~from a mental health professional~~ to:

(1) identify and plan for general needs of the recipient population served;

(2) identify and plan to address provider entity program needs and effectiveness;

(3) identify and plan provider entity staff training and personnel needs and issues; and

(4) plan, implement, and evaluate provider entity quality improvement programs.

Sec. 69. Minnesota Statutes 2020, section 256B.0623, subdivision 9, is amended to read:

Subd. 9. **Functional assessment.** (a) Providers of adult rehabilitative mental health services must complete a written functional assessment ~~as defined in section 245.462, subdivision 11a~~ according to section 245I.10, subdivision 9, for each recipient. ~~The functional assessment must be completed within 30 days of intake, and reviewed and updated at least every six months after it is developed, unless there is a significant change in the functioning of the recipient. If there is a significant change in functioning, the assessment must be~~

~~updated. A single functional assessment can meet case management and adult rehabilitative mental health services requirements if agreed to by the recipient. Unless the recipient refuses, the recipient must have significant participation in the development of the functional assessment.~~

(b) When a provider of adult rehabilitative mental health services completes a written functional assessment, the provider must also complete a level of care assessment as defined in section 245I.02, subdivision 19, for the recipient.

Sec. 70. Minnesota Statutes 2020, section 256B.0623, subdivision 12, is amended to read:

Subd. 12. **Additional requirements.** (a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.

(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community. Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or section 245I.23, or an acute care hospital.

(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and individual treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's individual treatment plan. No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

(d) Adult rehabilitative mental health services are appropriate if provided to enable a recipient to retain stability and functioning, when the recipient is at risk of significant functional decompensation or requiring more restrictive service settings without these services.

(e) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas including: interpersonal communication skills, community resource utilization and integration skills, crisis planning, relapse prevention skills, health care directives, budgeting

and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.

(f) Community intervention, including consultation with relatives, guardians, friends, employers, treatment providers, and other significant individuals, is appropriate when directed exclusively to the treatment of the client.

Sec. 71. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week, except as provided in paragraph (f). Telemedicine services shall be paid at the full allowable rate.

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

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

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

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

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

(5) has an established quality assurance process related to telemedicine services.

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

(1) the type of service provided by telemedicine;

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

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

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

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

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

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

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6, a community paramedic as defined under section 144E.001, subdivision 5f, ~~or~~ a clinical trainee who is qualified according to section 245I.04, subdivision 6, a mental health practitioner ~~defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional~~ qualified according to section 245I.04, subdivision 4, and a community health worker who meets the criteria under subdivision 49, paragraph (a); "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

(f) The limit on coverage of three telemedicine services per enrollee per calendar week does not apply if:

(1) the telemedicine services provided by the licensed health care provider are for the treatment and control of tuberculosis; and

(2) the services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the commissioner of health.

Sec. 72. Minnesota Statutes 2020, section 256B.0625, subdivision 5, is amended to read:

Subd. 5. **Community mental health center services.** Medical assistance covers community mental health center services provided by a community mental health center that meets the requirements in paragraphs (a) to (j).

(a) The provider ~~is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870~~ must be certified as a mental health clinic under section 245I.20.

(b) ~~The provider provides mental health services under the clinical supervision of a mental health professional who is licensed for independent practice at the doctoral level or by a board-certified psychiatrist~~ In addition to the policies and procedures required by section 245I.03, the provider must establish, enforce, and maintain the policies and procedures for oversight of clinical services by a doctoral level psychologist or a board certified or board eligible psychiatrist ~~who is eligible for board certification~~. ~~Clinical supervision has the meaning given in Minnesota Rules, part 9505.0370, subpart 6.~~ These policies and procedures must be developed with the involvement of a doctoral level psychologist and a board certified or board eligible psychiatrist, and must include:

(1) requirements for when to seek clinical consultation by doctoral level psychologist or a board certified or board eligible psychiatrist;

(2) requirements for the involvement of a doctoral level psychologist or a board certified or board eligible psychiatrist in the direction of clinical services; and

(3) involvement of a doctoral level psychologist or a board certified or board eligible psychiatrist in quality improvement initiatives and review as part of a multidisciplinary care team.

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in section 245.481, and agree to serve within the limits of its capacity all individuals residing in its service delivery area.

(e) At a minimum, the provider must provide the following outpatient mental health services: diagnostic assessment; explanation of findings; family, group, and individual

psychotherapy, including crisis intervention psychotherapy services, ~~multiple family group psychotherapy~~, psychological testing, and medication management. In addition, the provider must provide or be capable of providing upon request of the local mental health authority day treatment services, multiple family group psychotherapy, and professional home-based mental health services. The provider must have the capacity to provide such services to specialized populations such as the elderly, families with children, persons who are seriously and persistently mentally ill, and children who are seriously emotionally disturbed.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are ~~diagnosed with both~~ dually diagnosed with mental illness or emotional disturbance, and ~~chemical dependency~~ substance use disorder, and to individuals who are dually diagnosed with a mental illness or emotional disturbance and developmental disability.

(g) The provider must provide 24-hour emergency care services or demonstrate the capacity to assist recipients in need of such services to access such services on a 24-hour basis.

(h) The provider must have a contract with the local mental health authority to provide one or more of the services specified in paragraph (e).

(i) The provider must agree, upon request of the local mental health authority, to enter into a contract with the county to provide mental health services not reimbursable under the medical assistance program.

(j) The provider may not be enrolled with the medical assistance program as both a hospital and a community mental health center. The community mental health center's administrative, organizational, and financial structure must be separate and distinct from that of the hospital.

(k) The commissioner may require the provider to annually attest that the provider meets the requirements in this subdivision using a form that the commissioner provides.

EFFECTIVE DATE. Paragraphs (e), (f), and (k) are effective the day following final enactment.

Sec. 73. Minnesota Statutes 2020, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~; a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148E.010 and 148E.055, or a qualified designated coordinator under section 245D.081, subdivision 2. The qualified professional shall perform the duties required in section 256B.0659.

Sec. 74. Minnesota Statutes 2020, section 256B.0625, subdivision 28a, is amended to read:

Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers services performed by a licensed physician assistant if the service is otherwise covered under this chapter as a physician service and if the service is within the scope of practice of a licensed physician assistant as defined in section 147A.09.

(b) Licensed physician assistants, who are supervised by a physician certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, may bill for medication management and evaluation and management services provided to medical assistance enrollees in inpatient hospital settings, and in outpatient settings after the licensed physician assistant completes 2,000 hours of clinical experience in the evaluation and treatment of mental health, consistent with their authorized scope of practice, as defined in section 147A.09, with the exception of performing psychotherapy or diagnostic assessments or providing ~~clinical~~ treatment supervision.

Sec. 75. Minnesota Statutes 2020, section 256B.0625, subdivision 42, is amended to read:

Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part 9505.0175, subpart 28, the definition of a mental health professional ~~shall include a person who is~~ qualified ~~as specified in~~ according to section ~~245.462, subdivision 18, clauses (1) to (6); or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2, for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Sec. 76. Minnesota Statutes 2020, section 256B.0625, subdivision 48, is amended to read:

Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance covers consultation provided by a ~~psychiatrist, a psychologist, an advanced practice registered nurse certified in psychiatric mental health, a licensed independent clinical social worker, as defined in section 245.462, subdivision 18, clause (2), or a licensed marriage and family therapist, as defined in section 245.462, subdivision 18, clause (5)~~ mental health professional

who is qualified according to section 245I.04, subdivision 2, except a licensed professional clinical counselor licensed under section 148B.5301, via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Sec. 77. Minnesota Statutes 2020, section 256B.0625, subdivision 49, is amended to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has~~:~~

~~(1)~~ received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum~~; or~~.

~~(2) at least five years of supervised experience with an enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.~~

~~Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.~~

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5)~~, or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Sec. 78. Minnesota Statutes 2020, section 256B.0625, subdivision 56a, is amended to read:

Subd. 56a. **Officer-involved community-based care coordination.** (a) Medical assistance covers officer-involved community-based care coordination for an individual who:

(1) has screened positive for benefiting from treatment for a mental illness or substance use disorder using a tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in officer-involved community-based care coordination.

(b) Officer-involved community-based care coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) Officer-involved community-based care coordination must be provided by an individual who is an employee of or is under contract with a county, or is an employee of or under contract with an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility to provide officer-involved community-based care coordination and is qualified under one of the following criteria:

(1) a ~~licensed~~ mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~;

(2) a clinical trainee who is qualified according to section 245I.04, subdivision 6, working under the treatment supervision of a mental health professional according to section 245I.06;

(3) a mental health practitioner ~~as defined in section 245.462, subdivision 17~~ who is qualified according to section 245I.04, subdivision 4, working under the ~~clinical~~ treatment supervision of a mental health professional according to section 245I.06;

~~(3)~~ (4) a mental health certified peer specialist ~~under section 256B.0615~~ who is qualified according to section 245I.04, subdivision 10, working under the ~~clinical~~ treatment supervision of a mental health professional according to section 245I.06;

(4) an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5; or

(5) a recovery peer qualified under section 245G.11, subdivision 8, working under the supervision of an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of officer-involved community-based care coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure that services and payments provided under officer-involved community-based care coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for officer-involved community-based care coordination services shall be provided by the county providing the services, from sources other than federal funds or funds used to match other federal funds.

Sec. 79. Minnesota Statutes 2020, section 256B.0757, subdivision 4c, is amended to read:

Subd. 4c. **Behavioral health home services staff qualifications.** (a) A behavioral health home services provider must maintain staff with required professional qualifications appropriate to the setting.

(b) If behavioral health home services are offered in a mental health setting, the integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice Act, sections 148.171 to 148.285.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be a mental health professional ~~as defined in~~ who is qualified according to section ~~245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

(d) If behavioral health home services are offered in either a primary care setting or mental health setting, the systems navigator must be a mental health practitioner ~~as defined in~~ who is qualified according to section ~~245.462, subdivision 17~~ 245I.04, subdivision 4, or a community health worker as defined in section 256B.0625, subdivision 49.

(e) If behavioral health home services are offered in either a primary care setting or mental health setting, the qualified health home specialist must be one of the following:

(1) a mental health certified peer ~~support~~ specialist ~~as defined in~~ who is qualified according to section ~~256B.0615~~ 245I.04, subdivision 10;

(2) a mental health certified family peer ~~support~~ specialist ~~as defined in~~ who is qualified according to section ~~256B.0616~~ 245I.04, subdivision 12;

(3) a case management associate as defined in section 245.462, subdivision 4, paragraph (g), or 245.4871, subdivision 4, paragraph (j);

(4) a mental health rehabilitation worker ~~as defined in~~ who is qualified according to section ~~256B.0623, subdivision 5, clause (4)~~ 245I.04, subdivision 14;

(5) a community paramedic as defined in section 144E.28, subdivision 9;

(6) a peer recovery specialist as defined in section 245G.07, subdivision 1, clause (5); or

(7) a community health worker as defined in section 256B.0625, subdivision 49.

Sec. 80. Minnesota Statutes 2020, section 256B.0941, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, services are determined to be medically necessary according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for

one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) was referred for treatment in a psychiatric residential treatment facility by a ~~qualified~~ mental health professional ~~licensed as defined in~~ who is qualified according to section ~~245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

(b) The commissioner shall provide oversight and review the use of referrals for clients admitted to psychiatric residential treatment facilities to ensure that eligibility criteria, clinical services, and treatment planning reflect clinical, state, and federal standards for psychiatric residential treatment facility level of care. The commissioner shall coordinate the production of a statewide list of children and youth who meet the medical necessity criteria for psychiatric residential treatment facility level of care and who are awaiting admission. The commissioner and any recipient of the list shall not use the statewide list to direct admission of children and youth to specific facilities.

Sec. 81. Minnesota Statutes 2020, section 256B.0943, subdivision 1, is amended to read:

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

(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed emotional disturbance, as defined in section 245.4871, subdivision 15, or a diagnosed mental illness, as defined in section 245.462, subdivision 20. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

~~(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility~~

~~for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.~~

~~(c)~~ (b) "Clinical trainee" means a ~~mental health practitioner who meets the qualifications specified in Minnesota Rules, part 9505.0371, subpart 5, item C~~ staff person who is qualified according to section 245I.04, subdivision 6.

~~(d)~~ (c) "Crisis ~~assistance~~ planning" has the meaning given in section 245.4871, subdivision 9a. ~~Crisis assistance entails the development of a written plan to assist a child's family to contend with a potential crisis and is distinct from the immediate provision of crisis intervention services.~~

~~(e)~~ (d) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

~~(f)~~ (e) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for three or more individuals and individual or group skills training provided by a ~~multidisciplinary~~ team, under the ~~clinical~~ treatment supervision of a mental health professional.

~~(g)~~ (f) "Standard diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0372, subpart 1~~ means the assessment described in 245I.10, subdivision 6.

~~(h)~~ (g) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered telemedicine services. Direct service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

~~(i)~~ (h) "Direction of mental health behavioral aide" means the activities of a mental health professional, clinical trainee, or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's ~~individualized~~ individual treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

~~(j)~~ (i) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.

~~(k)~~ (j) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or a clinical trainee or mental health practitioner~~,~~ under the ~~clinical~~ treatment supervision of a mental health professional, to guide the work of the mental health behavioral aide. The individual behavioral plan may be incorporated into the child's individual treatment plan so long as the behavioral plan is separately communicable to the mental health behavioral aide.

~~(l)~~ (k) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part 9505.0371, subpart 7~~ means the plan described in section 245I.10, subdivisions 7 and 8.

~~(m)~~ (l) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a ~~trained paraprofessional qualified as provided in subdivision 7, paragraph (b), clause (3)~~ mental health behavioral aide qualified according to section 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(m) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

(n) "Mental health practitioner" ~~has the meaning given in section 245.462, subdivision 17, except that a practitioner working in a day treatment setting may qualify as a mental health practitioner if the practitioner holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university, and: (1) has at least 2,000 hours of clinically supervised experience in the delivery of mental health services to clients with mental illness; (2) is fluent in the language, other than English, of the cultural group that makes up at least 50 percent of the practitioner's clients, completes 40 hours of training on the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once per week until meeting the required 2,000 hours of supervised experience; or (3) receives 40 hours of training on the delivery of services to clients with mental illness within six months of employment, and clinical supervision from a mental health professional at least once per week until meeting the required 2,000 hours of supervised experience~~ means a staff person who is qualified according to section 245I.04, subdivision 4.

(o) "Mental health professional" means ~~an individual as defined in Minnesota Rules, part 9505.0370, subpart 18~~ a staff person who is qualified according to section 245I.04, subdivision 2.

(p) "Mental health service plan development" includes:

(1) the development, review, and revision of a child's individual treatment plan, ~~as provided in Minnesota Rules, part 9505.0371, subpart 7,~~ including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) administering and reporting the standardized outcome ~~measurement instruments, determined and updated by the commissioner~~ measurements in section 245I.10, subdivision 6, paragraph (d), clauses (3) and (4), and other standardized outcome measurements approved by the commissioner, as periodically needed to evaluate the effectiveness of treatment ~~for children receiving clinical services and reporting outcome measures, as required by the commissioner~~.

(q) "Mental illness," for persons at least age 18 but under age 21, has the meaning given in section 245.462, subdivision 20, paragraph (a).

(r) "Psychotherapy" means the treatment ~~of mental or emotional disorders or maladjustment by psychological means. Psychotherapy may be provided in many modalities in accordance with Minnesota Rules, part 9505.0372, subpart 6, including patient and/or family psychotherapy; family psychotherapy; psychotherapy for crisis; group psychotherapy; or multiple-family psychotherapy. Beginning with the American Medical Association's Current Procedural Terminology, standard edition, 2014, the procedure "individual psychotherapy" is replaced with "patient and/or family psychotherapy," a substantive change that permits the therapist to work with the client's family without the client present to obtain information about the client or to explain the client's treatment plan to the family. Psychotherapy is appropriate for crisis response when a child has become dysregulated or experienced new trauma since the diagnostic assessment was completed and needs psychotherapy to address issues not currently included in the child's individual treatment plan~~ described in section 256B.0671, subdivision 11.

(s) "Rehabilitative services" or "psychiatric rehabilitation services" means ~~a series or multidisciplinary combination of psychiatric and psychosocial~~ interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with,

counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement. ~~Continuing progress toward goals is expected, and rehabilitative potential ceases when successive improvement is not observable over a period of time.~~

(t) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

(u) "Treatment supervision" means the supervision described in section 245I.06.

Sec. 82. Minnesota Statutes 2020, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports ~~as defined in this section that~~ when the services are provided by an eligible provider entity certified under ~~subdivision 4 provides to a client eligible under subdivision 3~~ and meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) The service components of children's therapeutic services and supports are:

(1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional, clinical trainee, or mental health practitioner;

(3) crisis ~~assistance~~ planning;

(4) mental health behavioral aide services;

(5) direction of a mental health behavioral aide;

(6) mental health service plan development; and

(7) children's day treatment.

Sec. 83. Minnesota Statutes 2020, section 256B.0943, subdivision 3, is amended to read:

Subd. 3. **Determination of client eligibility.** (a) A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a standard diagnostic assessment by a mental health professional or a ~~mental health practitioner who meets the requirements of a clinical trainee as defined in Minnesota Rules, part 9505.0371, subpart 5, item C,~~ clinical trainee that is performed within one year before the initial start of service. The standard diagnostic assessment must ~~meet the requirements for a standard or extended diagnostic assessment as defined in Minnesota Rules, part 9505.0372, subpart 1, items B and C, and~~:

~~(1) include current diagnoses, including any differential diagnosis, in accordance with all criteria for a complete diagnosis and diagnostic profile as specified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, or, for children under age five, as specified in the current edition of the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood;~~

~~(2)~~ (1) determine whether a child under age 18 has a diagnosis of emotional disturbance or, if the person is between the ages of 18 and 21, whether the person has a mental illness;

~~(3)~~ (2) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals; and

~~(4)~~ (3) be used in the development of the ~~individualized~~ individual treatment plan~~; and~~.

~~(5) be completed annually until age 18. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means an adult diagnostic update as defined in Minnesota Rules, part 9505.0371, subpart 2, item E.~~

(b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to five days of day treatment under this section based on a hospital's medical history and presentation examination of the client.

Sec. 84. Minnesota Statutes 2020, section 256B.0943, subdivision 4, is amended to read:

Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial provider entity application and certification process and recertification process to determine

whether a provider entity has an administrative and clinical infrastructure that meets the requirements in subdivisions 5 and 6. A provider entity must be certified for the three core rehabilitation services of psychotherapy, skills training, and crisis ~~assistance~~ planning. The commissioner shall recertify a provider entity at least every three years. The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process.

(b) For purposes of this section, a provider entity must meet the standards in this section and chapter 245I, as required by section 245I.011, subdivision 5, and be:

(1) an Indian health services facility or a facility owned and operated by a tribe or tribal organization operating as a 638 facility under Public Law 93-638 certified by the state;

(2) a county-operated entity certified by the state; or

(3) a noncounty entity certified by the state.

Sec. 85. Minnesota Statutes 2020, section 256B.0943, subdivision 5, is amended to read:

Subd. 5. **Provider entity administrative infrastructure requirements.** (a) ~~To be an eligible provider entity under this section, a provider entity must have an administrative infrastructure that establishes authority and accountability for decision making and oversight of functions, including finance, personnel, system management, clinical practice, and individual treatment outcomes measurement.~~ An eligible provider entity shall demonstrate the availability, by means of employment or contract, of at least one backup mental health professional in the event of the primary mental health professional's absence. ~~The provider must have written policies and procedures that it reviews and updates every three years and distributes to staff initially and upon each subsequent update.~~

(b) ~~The administrative infrastructure written~~ In addition to the policies and procedures required in section 245I.03, the policies and procedures must include:

~~(1) personnel procedures, including a process for: (i) recruiting, hiring, training, and retention of culturally and linguistically competent providers; (ii) conducting a criminal background check on all direct service providers and volunteers; (iii) investigating, reporting, and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting on violations of data privacy policies that are compliant with federal and state laws; (v) utilizing volunteers, including screening applicants, training and supervising volunteers,~~

~~and providing liability coverage for volunteers; and (vi) documenting that each mental health professional, mental health practitioner, or mental health behavioral aide meets the applicable provider qualification criteria, training criteria under subdivision 8, and clinical supervision or direction of a mental health behavioral aide requirements under subdivision 6;~~

~~(2)~~ (1) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws; and

~~(3)~~ (2) a client-specific treatment outcomes measurement system, including baseline measures, to measure a client's progress toward achieving mental health rehabilitation goals. ~~Effective July 1, 2017, to be eligible for medical assistance payment, a provider entity must report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner; and~~

~~(4) a process to establish and maintain individual client records. The client's records must include:~~

~~(i) the client's personal information;~~

~~(ii) forms applicable to data privacy;~~

~~(iii) the client's diagnostic assessment, updates, results of tests, individual treatment plan, and individual behavior plan, if necessary;~~

~~(iv) documentation of service delivery as specified under subdivision 6;~~

~~(v) telephone contacts;~~

~~(vi) discharge plan; and~~

~~(vii) if applicable, insurance information.~~

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

Sec. 86. Minnesota Statutes 2020, section 256B.0943, subdivision 5a, is amended to read:

Subd. 5a. **Background studies.** The requirements for background studies under ~~this~~ section 245I.011, subdivision 4, paragraph (d), may be met by a children's therapeutic services and supports services agency through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 7, and 245C.10, subdivision 8.

Sec. 87. Minnesota Statutes 2020, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, ~~individualized~~ individual treatment plans, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review, and update as necessary, the clinical policies and procedures every three years, must distribute the policies and procedures to staff initially and upon each subsequent update, and must train staff accordingly.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for meeting the requirements in this subdivision:

(1) providing or obtaining a client's standard diagnostic assessment, including a standard diagnostic assessment ~~performed by an outside or independent clinician, that identifies acute and chronic clinical disorders, co-occurring medical conditions, and sources of psychological and environmental problems, including baselines, and a functional assessment. The functional assessment component must clearly summarize the client's individual strengths and needs.~~ When required components of the standard diagnostic assessment~~, such as baseline measures,~~ are not provided in an outside or independent assessment or ~~when baseline measures~~ cannot be attained ~~in a one-session standard diagnostic assessment~~ immediately, the provider entity must determine the missing information within 30 days and amend the child's standard diagnostic assessment or incorporate the ~~baselines~~ information into the child's individual treatment plan;

(2) developing an individual treatment plan ~~that:~~;

~~(i) is based on the information in the client's diagnostic assessment and baselines;~~

~~(ii) identified goals and objectives of treatment, treatment strategy, schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;~~

~~(iii) is developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;~~

~~(iv) is developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessment, and treatment planning;~~

~~(v) is reviewed at least once every 90 days and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment; and~~

~~(vi) is signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;~~

(3) developing an individual behavior plan that documents ~~treatment strategies~~ and describes interventions to be provided by the mental health behavioral aide. The individual behavior plan must include:

(i) detailed instructions on the ~~treatment strategies to be provided~~ psychosocial skills to be practiced;

(ii) time allocated to each ~~treatment strategy~~ intervention;

(iii) methods of documenting the child's behavior;

(iv) methods of monitoring the child's progress in reaching objectives; and

(v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) providing ~~clinical~~ treatment supervision plans for ~~mental health practitioners and mental health behavioral aides. A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. The clinical supervisor also shall document supervisee-specific supervision in the supervisee's personnel file. Clinical~~ staff according to section 245I.06. Treatment supervision does not include the authority to make or terminate court-ordered placements of the child. A ~~clinical~~ treatment supervisor must be available for urgent consultation as required by the individual client's needs or the situation~~. Clinical supervision may occur individually or in a small group to discuss treatment and review progress toward goals. The focus of clinical supervision must be the client's treatment needs and progress and the mental health practitioner's or behavioral aide's ability to provide services~~;

(4a) meeting day treatment program conditions in items (i) ~~to (iii)~~ and (ii):

(i) the ~~clinical~~ treatment supervisor must be present and available on the premises more than 50 percent of the time in a provider's standard working week during which the supervisee is providing a mental health service; and

~~(ii) the diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan must be made by or reviewed, approved, and signed by the clinical supervisor; and~~

~~(iii)~~ (ii) every 30 days, the ~~clinical~~ treatment supervisor must review and sign the record indicating the supervisor has reviewed the client's care for all activities in the preceding 30-day period;

(4b) meeting the ~~clinical~~ treatment supervision standards in items (i) ~~to (iv)~~ and (ii) for all other services provided under CTSS:

~~(i) medical assistance shall reimburse for services provided by a mental health practitioner who is delivering services that fall within the scope of the practitioner's practice and who is supervised by a mental health professional who accepts full professional responsibility;~~

~~(ii) medical assistance shall reimburse for services provided by a mental health behavioral aide who is delivering services that fall within the scope of the aide's practice and who is supervised by a mental health professional who accepts full professional responsibility and has an approved plan for clinical supervision of the behavioral aide. Plans must be developed in accordance with supervision standards defined in Minnesota Rules, part 9505.0371, subpart 4, items A to D;~~

~~(iii)~~ (i) the mental health professional is required to be present at the site of service delivery for observation as clinically appropriate when the clinical trainee, mental health practitioner, or mental health behavioral aide is providing CTSS services; and

~~(iv)~~ (ii) when conducted, the on-site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the ~~clinical~~ treatment supervisor must be employed by the provider entity or other provider certified to provide mental health behavioral aide services to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The ~~mental health professional or mental health practitioner~~ staff giving direction must begin with the goals on the ~~individualized~~ individual treatment plan, and instruct the mental health behavioral aide on how to implement therapeutic activities and interventions that will lead to goal attainment. The ~~professional or practitioner~~ staff giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client

and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain or demonstrate the activities the aide is doing with the client and the activities' relationship to treatment goals. Direction is more didactic than is supervision and requires the ~~professional or practitioner~~ staff providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the ~~individualized~~ individual treatment plan and the ~~individualized~~ individual behavior plan. When providing direction, the ~~professional or practitioner~~ staff must:

(i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the ~~professional or practitioner~~ staff must approve and sign the progress notes;

(ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(iii) demonstrate family-friendly behaviors that support healthy collaboration among the child, the child's family, and providers as treatment is planned and implemented;

(iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; ~~and~~

(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide; and

(vi) ensure the immediate accessibility of a mental health professional, clinical trainee, or mental health practitioner to the behavioral aide during service delivery;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met each of the goals and objectives in the treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. ~~Revision of the individual treatment plan does not require a new diagnostic assessment unless the client's mental health status has changed markedly. The updated treatment plan must be signed by the clinical supervisor and by the client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.~~

Sec. 88. Minnesota Statutes 2020, section 256B.0943, subdivision 7, is amended to read:

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as a:

(1) ~~a~~ mental health professional ~~as defined in subdivision 1, paragraph (o);~~ ~~or~~

(2) ~~a~~ clinical trainee;

(3) mental health practitioner ~~or clinical trainee. The mental health practitioner or clinical trainee must work under the clinical supervision of a mental health professional~~; ~~or~~

(4) mental health certified family peer specialist; or

~~(3) a~~ (5) mental health behavioral aide ~~working under the clinical supervision of a mental health professional to implement the rehabilitative mental health services previously introduced by a mental health professional or practitioner and identified in the client's individual treatment plan and individual behavior plan.~~

~~(A) A level I mental health behavioral aide must:~~

~~(i) be at least 18 years old;~~

~~(ii) have a high school diploma or commissioner of education-selected high school equivalency certification or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and~~

~~(iii) meet preservice and continuing education requirements under subdivision 8.~~

~~(B) A level II mental health behavioral aide must:~~

~~(i) be at least 18 years old;~~

~~(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents or complete a certificate program established under subdivision 8a; and~~

~~(iii) meet preservice and continuing education requirements in subdivision 8.~~

(c) A day treatment ~~multidisciplinary~~ team must include at least one mental health professional or clinical trainee and one mental health practitioner.

Sec. 89. Minnesota Statutes 2020, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) ~~each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs.~~ the provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a ~~multidisciplinary~~ team under the ~~clinical~~ treatment supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available year-round at least three to five days per week, two or three hours per day, unless the normal five-day school week is shortened by a holiday, weather-related cancellation, or other districtwide reduction in a school week. A child transitioning into or out of day treatment must receive a minimum treatment of one day a week for a two-hour time block. The two-hour time block must include at least one hour of patient and/or family or group psychotherapy. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally

required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) To be eligible for medical assistance payment, a provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) ~~patient and/or family, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0372, subpart 6.~~ psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it. When a provider delivering other services to a child under this section deems it not medically necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider entity must document the medical reasons why psychotherapy is not necessary. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training ~~must be provided by a mental health professional or a mental health practitioner who is delivering services that fall within the scope of the provider's practice and is supervised by a mental health professional who accepts full professional responsibility for the training. Skills training~~ is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) the mental health professional delivering or supervising the delivery of skills training must document any underlying psychiatric condition and must document how skills training is being used in conjunction with psychotherapy to address the underlying condition;

(iv) skills training delivered to the child's family must teach skills needed by parents to enhance the child's skill development, to help the child utilize daily life skills taught by a mental health professional, clinical trainee, or mental health practitioner, and to develop or maintain a home environment that supports the child's progressive use of skills;

(v) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(A) one mental health professional ~~or one~~, clinical trainee, or mental health practitioner ~~under supervision of a licensed mental health professional~~ must work with a group of three to eight clients; or

(B) any combination of two mental health professionals, ~~two~~ clinical trainees, or mental health practitioners ~~under supervision of a licensed mental health professional, or one mental health professional or clinical trainee and one mental health practitioner~~ must work with a group of nine to 12 clients;

(vi) a mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client; and

(vii) for group skills training, when a skills group that meets the minimum group size requirement temporarily falls below the minimum group size because of a group member's temporary absence, the provider may conduct the session for the group members in attendance;

(3) crisis ~~assistance~~ planning to a child and family must include development of a written plan that anticipates the particular factors specific to the child that may precipitate a psychiatric crisis for the child in the near future. The written plan must document actions that the family should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for direct intervention and support services to the child and the child's family. Crisis ~~assistance~~ planning must include preparing resources designed to address abrupt or substantial changes in the functioning of the child or the child's family when sudden change in behavior or a loss of usual coping mechanisms is observed, or the child begins to present a danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan and individual behavior plan, ~~which are performed minimally by a paraprofessional qualified according to subdivision 7, paragraph (b), clause (3),~~ and which are designed to improve the functioning of the child in the progressive use of developmentally appropriate psychosocial skills. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (t), as previously taught by a mental health professional, clinical trainee, or mental health practitioner including:

(i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions so that the child progressively recognizes and responds to the cues independently;

(ii) performing as a practice partner or role-play partner;

(iii) reinforcing the child's accomplishments;

(iv) generalizing skill-building activities in the child's multiple natural settings;

(v) assigning further practice activities; and

(vi) intervening as necessary to redirect the child's target behavior and to de-escalate behavior that puts the child or other person at risk of injury.

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with an emotional disturbance or a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must implement treatment strategies in the individual treatment plan and the individual behavior plan as developed by the mental health professional, clinical trainee, or mental health practitioner providing direction for the mental health behavioral aide. The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies; and

~~(5) direction of a mental health behavioral aide must include the following:~~

~~(i) ongoing face-to-face observation of the mental health behavioral aide delivering services to a child by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and~~

~~(ii) immediate accessibility of the mental health professional, clinical trainee, or mental health practitioner to the mental health behavioral aide during service provision;~~

~~(6)~~ (5) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to ~~review, revise, and sign~~ approve the individual treatment plan. ~~Notwithstanding Minnesota Rules, part 9505.0371, subpart 7,~~ Medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If

upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development~~; and~~.

~~(7) to be eligible for payment, a diagnostic assessment must be complete with regard to all required components, including multiple assessment appointments required for an extended diagnostic assessment and the written report. Dates of the multiple assessment appointments must be noted in the client's clinical record.~~

Sec. 90. Minnesota Statutes 2020, section 256B.0943, subdivision 11, is amended to read:

Subd. 11. **Documentation and billing.** ~~(a)~~ A provider entity must document the services it provides under this section. The provider entity must ensure that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. Billing for covered service components under subdivision 2, paragraph (b), must not include anything other than direct service time.

~~(b) An individual mental health provider must promptly document the following in a client's record after providing services to the client:~~

~~(1) each occurrence of the client's mental health service, including the date, type, start and stop times, scope of the service as described in the child's individual treatment plan, and outcome of the service compared to baselines and objectives;~~

~~(2) the name, dated signature, and credentials of the person who delivered the service;~~

~~(3) contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools. The provider must document the name and date of each contact;~~

~~(4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative, if applicable;~~

~~(5) required clinical supervision directly related to the identified client's services and needs, as appropriate, with co-signatures of the supervisor and supervisee; and~~

~~(6) the date when services are discontinued and reasons for discontinuation of services.~~

Sec. 91. Minnesota Statutes 2020, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) ~~Effective May 23, 2013, and~~ Subject to federal approval, medical assistance covers medically necessary intensive

treatment services ~~described under paragraph (b) that~~ when the services are provided by a provider entity ~~eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the regulations established by a federally recognized Minnesota tribe~~ certified under and meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) Intensive treatment services to children with mental illness residing in foster family settings that comprise specific required service components provided in clauses (1) to (5) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~;

(2) crisis ~~assistance provided according to standards for children's therapeutic services and supports in section 256B.0943~~ planning;

(3) individual, family, and group psychoeducation services~~, defined in subdivision 1a, paragraph (q),~~ provided by a mental health professional or a clinical trainee;

(4) clinical care consultation~~, as defined in subdivision 1a, and~~ provided by a mental health professional or a clinical trainee; and

(5) service delivery payment requirements as provided under subdivision 4.

Sec. 92. Minnesota Statutes 2020, section 256B.0946, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the meanings given them.

(a) "Clinical care consultation" means communication from a treating clinician to other providers working with the same client to inform, inquire, and instruct regarding the client's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, including but not limited to the client's school, social services, day care, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the client and family.

~~(b) "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for~~

~~the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.~~

~~(c) "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.~~

~~(d)~~ (b) "Clinical trainee" ~~has the meaning given in Minnesota Rules, part 9505.0371, subpart 5, item C;~~ means a staff person who is qualified according to section 245I.04, subdivision 6.

~~(e)~~ (c) "Crisis ~~assistance~~ planning" has the meaning given in section 245.4871, subdivision 9a~~, including the development of a plan that addresses prevention and intervention strategies to be used in a potential crisis, but does not include actual crisis intervention~~.

~~(f)~~ (d) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences~~, as defined in Minnesota Rules, part 9505.0370, subpart 9,~~ into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

~~(g)~~ (e) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

~~(h)~~ (f) "Standard diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 11~~ means the assessment described in section 245I.10, subdivision 6.

~~(i)~~ (g) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

~~(j)~~ (h) "Foster care" has the meaning given in section 260C.007, subdivision 18.

~~(k)~~ (i) "Foster family setting" means the foster home in which the license holder resides.

~~(l)~~ (j) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 15~~ means the plan described in section 245I.10, subdivisions 7 and 8.

~~(m) "Mental health practitioner" has the meaning given in section 245.462, subdivision 17, and a mental health practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C.~~

(k) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

~~(n)~~ (l) "Mental health professional" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 18~~ means a staff person who is qualified according to section 245I.04, subdivision 2.

~~(o)~~ (m) "Mental illness" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 20~~ section 245I.02, subdivision 29.

~~(p)~~ (n) "Parent" has the meaning given in section 260C.007, subdivision 25.

~~(q)~~ (o) "Psychoeducation services" means information or demonstration provided to an individual, family, or group to explain, educate, and support the individual, family, or group in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

~~(r)~~ (p) "Psychotherapy" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 27~~ means the treatment described in section 256B.0671, subdivision 11.

~~(s)~~ (q) "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

(r) "Trauma" has the meaning given in section 245I.02, subdivision 38.

(s) "Treatment supervision" means the supervision described under section 245I.06.

Sec. 93. Minnesota Statutes 2020, section 256B.0946, subdivision 2, is amended to read:

Subd. 2. **Determination of client eligibility.** An eligible recipient is an individual, from birth through age 20, who is currently placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the regulations established by a federally recognized Minnesota tribe, and has received: (1) a

standard diagnostic assessment ~~and an evaluation of level of care needed, as defined in paragraphs (a) and (b).~~ within 180 days before the start of service that documents that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments; and (2) a level of care assessment as defined in section 245I.02, subdivision 19, that demonstrates that the individual requires intensive intervention without 24-hour medical monitoring, and a functional assessment as defined in section 245I.02, subdivision 17. The level of care assessment and the functional assessment must include information gathered from the placing county, tribe, or case manager.

~~(a) The diagnostic assessment must:~~

~~(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be conducted by a mental health professional or a clinical trainee;~~

~~(2) determine whether or not a child meets the criteria for mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20;~~

~~(3) document that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments;~~

~~(4) be performed within 180 days before the start of service; and~~

~~(5) be completed as either a standard or extended diagnostic assessment annually to determine continued eligibility for the service.~~

~~(b) The evaluation of level of care must be conducted by the placing county, tribe, or case manager in conjunction with the diagnostic assessment as described by Minnesota Rules, part 9505.0372, subpart 1, item B, using a validated tool approved by the commissioner of human services and not subject to the rulemaking process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates that the child requires intensive intervention without 24-hour medical monitoring. The commissioner shall update the list of approved level of care tools annually and publish on the department's website.~~

Sec. 94. Minnesota Statutes 2020, section 256B.0946, subdivision 3, is amended to read:

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive children's mental health services in a foster family setting must be certified by the state and have a service provision contract with a county board or a reservation tribal council and must be able to demonstrate the ability to provide all of the services required in this section and meet the standards in chapter 245I, as required in section 245I.011, subdivision 5.

(b) For purposes of this section, a provider agency must be:

(1) a county-operated entity certified by the state;

(2) an Indian Health Services facility operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

(3) a noncounty entity.

(c) Certified providers that do not meet the service delivery standards required in this section shall be subject to a decertification process.

(d) For the purposes of this section, all services delivered to a client must be provided by a mental health professional or a clinical trainee.

Sec. 95. Minnesota Statutes 2020, section 256B.0946, subdivision 4, is amended to read:

Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under this section, a provider must develop and practice written policies and procedures for intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply with the following requirements in paragraphs (b) to ~~(n)~~ (l).

~~(b) A qualified clinical supervisor, as defined in and performing in compliance with Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and provision of services described in this section.~~

~~(c) Each client receiving treatment services must receive an extended diagnostic assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30 days of enrollment in this service unless the client has a previous extended diagnostic assessment that the client, parent, and mental health professional agree still accurately describes the client's current mental health functioning.~~

~~(d)~~ (b) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received. This information must be reviewed and incorporated into the standard diagnostic assessment and team consultation and treatment planning review process.

~~(e)~~ (c) Each client receiving treatment must be assessed for a trauma history, and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

(d) The level of care assessment as defined in section 245I.02, subdivision 19, and functional assessment as defined in section 245I.02, subdivision 17, must be updated at least every 90 days or prior to discharge from the service, whichever comes first.

~~(f)~~ (e) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and ~~signed~~ approved every 90 days using the team consultation and treatment planning process~~, as defined in subdivision 1a, paragraph (s)~~.

~~(g)~~ (f) Clinical care consultation~~, as defined in subdivision 1a, paragraph (a),~~ must be provided in accordance with the client's individual treatment plan.

~~(h)~~ (g) Each client must have a crisis ~~assistance~~ plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.

~~(i)~~ (h) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week, unless reduced units of service are specified on the treatment plan as part of transition or on a discharge plan to another service or level of care. ~~Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.~~

~~(j)~~ (i) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

~~(k)~~ (j) Treatment must be developmentally and culturally appropriate for the client.

~~(l)~~ (k) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects.

~~(m)~~ (l) Parents, siblings, foster parents, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

~~(n)~~ (m) Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

Sec. 96. Minnesota Statutes 2020, section 256B.0946, subdivision 6, is amended to read:

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of intensive treatment in foster care services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section ~~256B.0944~~ 256B.0624; ~~and~~

(7) transportation~~.~~; and

(8) mental health certified family peer specialist services under section 256B.0616.

(b) Children receiving intensive treatment in foster care services are not eligible for medical assistance reimbursement for the following services while receiving intensive treatment in foster care:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section ~~256B.0625, subdivision 35b~~ 256B.0943;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph ~~(m)~~ (l);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) room and board costs as defined in section 256I.03, subdivision 6.

Sec. 97. Minnesota Statutes 2020, section 256B.0947, subdivision 1, is amended to read:

Subdivision 1. **Scope.** ~~Effective November 1, 2011, and~~ Subject to federal approval, medical assistance covers medically necessary, intensive nonresidential rehabilitative mental health services ~~as defined in subdivision 2, for recipients as defined in subdivision 3,~~ when the services are provided by an entity meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Sec. 98. Minnesota Statutes 2020, section 256B.0947, subdivision 2, is amended to read:

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

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, as adapted for youth, and are directed to recipients ~~ages 16, 17, 18, 19, or 20 with a serious mental illness or co-occurring mental illness and substance abuse addiction~~ who require intensive services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

(b) "Co-occurring mental illness and substance ~~abuse addiction~~ use disorder" means a dual diagnosis of at least one form of mental illness and at least one substance use disorder. Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine use.

(c) "Standard diagnostic assessment" ~~has the meaning given to it in Minnesota Rules, part 9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota Rules, part 9505.0372, subpart 1, and for this section must incorporate a determination of the youth's necessary level of care using a standardized functional assessment instrument approved and periodically updated by the commissioner~~ means the assessment described in section 245I.10, subdivision 6.

~~(d) "Education specialist" means an individual with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities.~~

~~(e) "Housing access support" means an ancillary activity to help an individual find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.~~

~~(f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring mental illness and substance use disorders by a team of cross-trained clinicians within the same program, and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment.~~

~~(g)~~ (d) "Medication education services" means services provided individually or in groups, which focus on:

(1) educating the client and client's family or significant nonfamilial supporters about mental illness and symptoms;

(2) the role and effects of medications in treating symptoms of mental illness; and

(3) the side effects of medications.

Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses with certification in psychiatric and mental health care.

~~(h) "Peer specialist" means an employed team member who is a mental health certified peer specialist according to section 256B.0615 and also a former children's mental health consumer who:~~

~~(1) provides direct services to clients including social, emotional, and instrumental support and outreach;~~

~~(2) assists younger peers to identify and achieve specific life goals;~~

~~(3) works directly with clients to promote the client's self-determination, personal responsibility, and empowerment;~~

~~(4) assists youth with mental illness to regain control over their lives and their developmental process in order to move effectively into adulthood;~~

~~(5) provides training and education to other team members, consumer advocacy organizations, and clients on resiliency and peer support; and~~

~~(6) meets the following criteria:~~

~~(i) is at least 22 years of age;~~

~~(ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20, or co-occurring mental illness and substance abuse addiction;~~

~~(iii) is a former consumer of child and adolescent mental health services, or a former or current consumer of adult mental health services for a period of at least two years;~~

~~(iv) has at least a high school diploma or equivalent;~~

~~(v) has successfully completed training requirements determined and periodically updated by the commissioner;~~

~~(vi) is willing to disclose the individual's own mental health history to team members and clients; and~~

~~(vii) must be free of substance use problems for at least one year.~~

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

~~(i)~~ (f) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.

~~(j)~~ (g) "Substance use disorders" means one or more of the disorders defined in the diagnostic and statistical manual of mental disorders, current edition.

~~(k)~~ (h) "Transition services" means:

(1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the client to establish provider relationships;

(2) providing the client with knowledge and skills needed posttransition;

(3) establishing communication between sending and receiving entities;

(4) supporting a client's request for service authorization and enrollment; and

(5) establishing and enforcing procedures and schedules.

A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.

~~(l)~~ (i) "Treatment team" means all staff who provide services to recipients under this section.

~~(m)~~ (j) "Family peer specialist" means a staff person who is qualified under section 256B.0616.

Sec. 99. Minnesota Statutes 2020, section 256B.0947, subdivision 3, is amended to read:

Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

(1) is age 16, 17, 18, 19, or 20; and

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance ~~abuse addiction~~ use disorder, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a ~~level-of-care determination, using an instrument approved by the commissioner~~ level of care assessment as defined in section 245I.02, subdivision 19, that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers;

(4) has received a functional assessment as defined in section 245I.02, subdivision 17, that indicates functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system within the next two years; and

(5) has had a recent standard diagnostic assessment~~, as provided in Minnesota Rules, part 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A,~~ that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

Sec. 100. Minnesota Statutes 2020, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** ~~(a) Subject to federal approval, medical assistance covers all medically necessary intensive nonresidential rehabilitative mental health services and supports, as defined in this section, under a single daily rate per client. Services and supports must be delivered by an eligible provider under subdivision 5 to an eligible client under subdivision 3.~~

~~(b)~~ (a) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities are covered by ~~the~~ a single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

(2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph (t);

(3) crisis ~~assistance~~ planning as defined in section 245.4871, subdivision 9a~~, which includes recognition of factors precipitating a mental health crisis, identification of behaviors related to the crisis, and the development of a plan to address prevention, intervention, and follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental health crisis; crisis assistance does not mean crisis response services or crisis intervention services provided in section 256B.0944~~;

(4) medication management provided by a physician or an advanced practice registered nurse with certification in psychiatric and mental health care;

(5) mental health case management as provided in section 256B.0625, subdivision 20;

(6) medication education services as defined in this section;

(7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;

(8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;

(9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

(10) coordination with, or performance of, crisis intervention and stabilization services as defined in section ~~256B.0944~~ 256B.0624;

~~(11) assessment of a client's treatment progress and effectiveness of services using standardized outcome measures published by the commissioner;~~

~~(12)~~ (11) transition services ~~as defined in this section~~;

~~(13) integrated dual disorders treatment as defined in this section~~ (12) co-occurring substance use disorder treatment as defined in section 245I.02, subdivision 11; and

~~(14)~~ (13) housing access support that assists clients to find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

~~(c)~~ (b) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity:

~~(1)~~ client access to crisis intervention services, as defined in section ~~256B.0944~~ 256B.0624, and available 24 hours per day and seven days per week~~;~~.

~~(2) completion of an extended diagnostic assessment, as defined in Minnesota Rules, part 9505.0372, subpart 1, item C; and~~

~~(3) determination of the client's needed level of care using an instrument approved and periodically updated by the commissioner.~~

Sec. 101. Minnesota Statutes 2020, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must ~~be provided by a provider entity as provided in subdivision 4~~ meet the standards in this section and chapter 245I as required in section 245I.011, subdivision 5.

(b) The treatment team for intensive nonresidential rehabilitative mental health services comprises both permanently employed core team members and client-specific team members as follows:

(1) ~~The core treatment team is an entity that operates under the direction of an independently licensed mental health professional, who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility for clients.~~ Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must minimally include~~, but is not limited to~~:

(i) ~~an independently licensed~~ a mental health professional~~, qualified under Minnesota Rules, part 9505.0371, subpart 5, item A,~~ who serves as team leader to provide administrative direction and ~~clinical~~ treatment supervision to the team;

(ii) an advanced-practice registered nurse with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist, either of which must be credentialed to prescribe medications;

(iii) a licensed alcohol and drug counselor who is also trained in mental health interventions; and

(iv) a mental health certified peer specialist ~~as defined in subdivision 2, paragraph (h)~~ who is qualified according to section 245I.04, subdivision 10, and is also a former children's mental health consumer.

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist with knowledge and experience working with youth on special education requirements and goals, special education plans, and coordination of educational activities with health care activities;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a clinical trainee who is qualified according to section 245I.04, subdivision 6;

(vi) a mental health practitioner~~, as defined in section 245.4871, subdivision 26~~ qualified according to section 245I.04, subdivision 4;

~~(vi)~~ (vii) a case management service provider, as defined in section 245.4871, subdivision 4;

~~(vii)~~ (viii) a housing access specialist; and

~~(viii)~~ (ix) a family peer specialist as defined in subdivision 2, paragraph (m).

(3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc members not employed by the team who consult on a specific client and who must accept overall clinical direction from the treatment team for the duration of the client's placement with the treatment team and must be paid by the provider agency at the rate for a typical session by that provider with that client or at a rate negotiated with the client-specific member. Client-specific treatment team members may include:

(i) the mental health professional treating the client prior to placement with the treatment team;

(ii) the client's current substance ~~abuse~~ use counselor, if applicable;

(iii) a lead member of the client's individualized education program team or school-based mental health provider, if applicable;

(iv) a representative from the client's health care home or primary care clinic, as needed to ensure integration of medical and behavioral health care;

(v) the client's probation officer or other juvenile justice representative, if applicable; and

(vi) the client's current vocational or employment counselor, if applicable.

(c) The ~~clinical~~ treatment supervisor shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team shall meet with the ~~clinical~~ treatment supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting must include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the individual client's treatment record.

(d) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

(e) The treatment team shall serve no more than 80 clients at any one time. Should local demand exceed the team's capacity, an additional team must be established rather than exceed this limit.

(f) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner, clinical trainee, or mental health professional. The provider shall have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(g) The intensive nonresidential rehabilitative mental health services provider shall participate in evaluation of the assertive community treatment for youth (Youth ACT) model as conducted by the commissioner, including the collection and reporting of data and the reporting of performance measures as specified by contract with the commissioner.

(h) A regional treatment team may serve multiple counties.

Sec. 102. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team must use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) Services must be age-appropriate and meet the specific needs of the client.

(d) The ~~initial functional assessment must be completed within ten days of intake and~~ level of care assessment as defined in section 245I.02, subdivision 19, and functional assessment as defined in section 245I.02, subdivision 17, must be updated at least every ~~six months~~ 90 days or prior to discharge from the service, whichever comes first.

(e) The treatment team must complete an individual treatment plan ~~must~~ for each client, according to section 245I.10, subdivisions 7 and 8, and the individual treatment plan must:

~~(1) be based on the information in the client's diagnostic assessment and baselines;~~

~~(2) identify goals and objectives of treatment, a treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;~~

~~(3) be developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;~~

~~(4) be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessments, and treatment planning;~~

~~(5) be reviewed at least once every six months and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment;~~

~~(6) be signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;~~

~~(7)~~ (1) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan;

~~(8)~~ (2) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment;

(ii) develop a schedule for accomplishing substance use disorder treatment goals and objectives; and

(iii) identify the individuals responsible for providing substance use disorder treatment services and supports;

~~(ii) be reviewed at least once every 90 days and revised, if necessary;~~

~~(9) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and~~

~~(10)~~ (3) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services~~.~~; and

(4) notwithstanding section 245I.10, subdivision 8, be reviewed at least every 90 days and revised to document treatment progress or, if progress is not documented, to document changes in treatment.

(f) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(g) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(h) The treatment team shall provide interventions to promote positive interpersonal relationships.

Sec. 103. Minnesota Statutes 2020, section 256B.0947, subdivision 7, is amended to read:

Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this section must be based on one daily encounter rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services, supports, and ancillary activities under this section, staff travel time to provide rehabilitative services under this section, and crisis response services under section ~~256B.0944~~ 256B.0624.

(b) Payment must not be made to more than one entity for each client for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team shall determine how to distribute the payment among the members.

(c) The commissioner shall establish regional cost-based rates for entities that will bill medical assistance for nonresidential intensive rehabilitative mental health services. In developing these rates, the commissioner shall consider:

(1) the cost for similar services in the health care trade area;

(2) actual costs incurred by entities providing the services;

(3) the intensity and frequency of services to be provided to each client;

(4) the degree to which clients will receive services other than services under this section; and

(5) the costs of other services that will be separately reimbursed.

(d) The rate for a provider must not exceed the rate charged by that provider for the same service to other payers.

Sec. 104. Minnesota Statutes 2020, section 256B.0949, subdivision 2, is amended to read:

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

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

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

(1) is severe and chronic;

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

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

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

(i) behavioral challenges and self-regulation;

(ii) cognition;

(iii) learning and play;

(iv) self-care; or

(v) safety.

(d) "Person" means a person under 21 years of age.

(e) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including individual treatment planning, staff supervision, individual treatment plan progress monitoring, and treatment review for each person. Clinical supervision is provided by a qualified supervising professional (QSP) who takes full professional responsibility for the service provided by each supervisee.

(f) "Commissioner" means the commissioner of human services, unless otherwise specified.

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

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

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

(j) "Generalizable goals" means results or gains that are observed during a variety of activities over time with different people, such as providers, family members, other adults, and people, and in different environments including, but not limited to, clinics, homes, schools, and the community.

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

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

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

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

(l) "Individual treatment plan" or "ITP" means the person-centered, individualized written plan of care that integrates and coordinates person and family information from the CMDE

for a person who meets medical necessity for the EIDBI benefit. An individual treatment plan must meet the standards in subdivision 6.

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

(n) "Mental health professional" ~~has the meaning given in~~ means a staff person who is qualified according to section ~~245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

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

(p) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or level III treatment provider.

Sec. 105. Minnesota Statutes 2020, section 256B.0949, subdivision 4, is amended to read:

Subd. 4. **Diagnosis.** (a) A diagnosis of ASD or a related condition must:

(1) be based upon current DSM criteria including direct observations of the person and information from the person's legal representative or primary caregivers;

(2) be completed by either (i) a licensed physician or advanced practice registered nurse or (ii) a mental health professional; and

(3) meet the requirements of ~~Minnesota Rules, part 9505.0372, subpart 1, items B and C~~ a standard diagnostic assessment according to section 245I.10, subdivision 6.

(b) Additional assessment information may be considered to complete a diagnostic assessment including specialized tests administered through special education evaluations and licensed school personnel, and from professionals licensed in the fields of medicine, speech and language, psychology, occupational therapy, and physical therapy. A diagnostic assessment may include treatment recommendations.

Sec. 106. Minnesota Statutes 2020, section 256B.0949, subdivision 5a, is amended to read:

Subd. 5a. **Comprehensive multidisciplinary evaluation provider qualification.** A CMDE provider must:

(1) be a licensed physician, advanced practice registered nurse, a mental health professional, or a ~~mental health practitioner who meets the requirements of a~~ clinical trainee ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~ who is qualified according to section 245I.04, subdivision 6;

(2) have at least 2,000 hours of clinical experience in the evaluation and treatment of people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in the following content areas: ASD or a related condition diagnosis, ASD or a related condition treatment strategies, and child development; and

(3) be able to diagnose, evaluate, or provide treatment within the provider's scope of practice and professional license.

Sec. 107. Minnesota Statutes 2020, section 256B.25, subdivision 3, is amended to read:

Subd. 3. **Payment exceptions.** The limitation in subdivision 2 shall not apply to:

(1) payment of Minnesota supplemental assistance funds to recipients who reside in facilities which are involved in litigation contesting their designation as an institution for treatment of mental disease;

(2) payment or grants to a boarding care home or supervised living facility licensed by the Department of Human Services under Minnesota Rules, parts 2960.0130 to 2960.0220 ~~or~~, 2960.0580 to 2960.0700, or 9520.0500 to 9520.0670, or under chapter 245G or 245I, or payment to recipients who reside in these facilities;

(3) payments or grants to a boarding care home or supervised living facility which are ineligible for certification under United States Code, title 42, sections 1396-1396p;

(4) payments or grants otherwise specifically authorized by statute or rule.

Sec. 108. Minnesota Statutes 2020, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall

be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

~~(c) The commissioner shall establish three levels of payment for mental health diagnostic assessment, based on three levels of complexity. The aggregate payment under the tiered rates must not exceed the projected aggregate payments for mental health diagnostic assessment under the previous single rate. The new rate structure is effective January 1, 2011, or upon federal approval, whichever is later.~~

~~(d)~~ (c) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

~~(e)~~ (d) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

Sec. 109. Minnesota Statutes 2020, section 256B.763, is amended to read:

256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.

(a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

(2) community mental health centers under section 256B.0625, subdivision 5; and

(3) mental health clinics ~~and centers~~ certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20, or hospital outpatient psychiatric departments that are designated as essential community providers under section 62Q.19.

(b) This increase applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

(c) This increase does not apply to rates that are governed by section 256B.0625, subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

(d) The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in paragraphs (a), (e), and (f). The prepaid health plan must pass this rate increase to the providers identified in paragraphs (a), (e), (f), and (g).

(e) Payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007, for:

(1) medication education services provided on or after January 1, 2008, by adult rehabilitative mental health services providers certified under section 256B.0623; and

(2) mental health behavioral aide services provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943 and not already included in paragraph (a), payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007.

(g) Payment rates shall be increased by 2.3 percent over the rates in effect on December 31, 2007, for individual and family skills training provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(h) For services described in paragraphs (b), (e), and (g) and rendered on or after July 1, 2017, payment rates for mental health clinics ~~and centers~~ certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20, that are not designated as essential community providers under section 62Q.19 shall be equal to payment rates for mental health clinics ~~and centers~~ certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20,

that are designated as essential community providers under section 62Q.19. In order to receive increased payment rates under this paragraph, a provider must demonstrate a commitment to serve low-income and underserved populations by:

(1) charging for services on a sliding-fee schedule based on current poverty income guidelines; and

(2) not restricting access or services because of a client's financial limitation.

Sec. 110. Minnesota Statutes 2020, section 256P.01, subdivision 6a, is amended to read:

Subd. 6a. **Qualified professional.** (a) For illness, injury, or incapacity, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse, physical therapist, occupational therapist, or licensed chiropractor, according to their scope of practice.

(b) For developmental disability, learning disability, and intelligence testing, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse, licensed independent clinical social worker, licensed psychologist, certified school psychologist, or certified psychometrist working under the supervision of a licensed psychologist.

(c) For mental health, a "qualified professional" means a licensed physician, advanced practice registered nurse, or qualified mental health professional under section ~~245.462, subdivision 18, clauses (1) to (6)~~ 245I.04, subdivision 2.

(d) For substance use disorder, a "qualified professional" means a licensed physician, a qualified mental health professional under section 245.462, subdivision 18, clauses (1) to (6), or an individual as defined in section 245G.11, subdivision 3, 4, or 5.

Sec. 111. Minnesota Statutes 2020, section 295.50, subdivision 9b, is amended to read:

Subd. 9b. **Patient services.** (a) "Patient services" means inpatient and outpatient services and other goods and services provided by hospitals, surgical centers, or health care providers. They include the following health care goods and services provided to a patient or consumer:

(1) bed and board;

(2) nursing services and other related services;

(3) use of hospitals, surgical centers, or health care provider facilities;

(4) medical social services;

(5) drugs, biologicals, supplies, appliances, and equipment;

(6) other diagnostic or therapeutic items or services;

(7) medical or surgical services;

(8) items and services furnished to ambulatory patients not requiring emergency care; and

(9) emergency services.

(b) "Patient services" does not include:

(1) services provided to nursing homes licensed under chapter 144A;

(2) examinations for purposes of utilization reviews, insurance claims or eligibility, litigation, and employment, including reviews of medical records for those purposes;

(3) services provided to and by community residential mental health facilities licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, and to and by residential treatment programs for children with severe emotional disturbance licensed or certified under chapter 245A;

(4) services provided under the following programs: day treatment services as defined in section 245.462, subdivision 8; assertive community treatment as described in section 256B.0622; adult rehabilitative mental health services as described in section 256B.0623; ~~adult~~ crisis response services as described in section 256B.0624; and children's therapeutic services and supports as described in section 256B.0943; ~~and children's mental health crisis response services as described in section 256B.0944;~~

(5) services provided to and by community mental health centers as defined in section 245.62, subdivision 2;

(6) services provided to and by assisted living programs and congregate housing programs;

(7) hospice care services;

(8) home and community-based waivered services under chapter 256S and sections 256B.49 and 256B.501;

(9) targeted case management services under sections 256B.0621; 256B.0625, subdivisions 20, 20a, 33, and 44; and 256B.094; and

(10) services provided to the following: supervised living facilities for persons with developmental disabilities licensed under Minnesota Rules, parts 4665.0100 to 4665.9900;

housing with services establishments required to be registered under chapter 144D; board and lodging establishments providing only custodial services that are licensed under chapter 157 and registered under section 157.17 to provide supportive services or health supervision services; adult foster homes as defined in Minnesota Rules, part 9555.5105; day training and habilitation services for adults with developmental disabilities as defined in section 252.41, subdivision 3; boarding care homes as defined in Minnesota Rules, part 4655.0100; adult day care services as defined in section 245A.02, subdivision 2a; and home health agencies as defined in Minnesota Rules, part 9505.0175, subpart 15, or licensed under chapter 144A.

Sec. 112. Minnesota Statutes 2020, section 325F.721, subdivision 1, is amended to read:

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

(b) "Covered setting" means an unlicensed setting providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, supportive services. For the purposes of this section, covered setting does not mean:

(1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361;

(2) a nursing home licensed under chapter 144A;

(3) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56;

(4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D ~~or~~, 245G, or 245I;

(5) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D;

(6) private homes in which the residents are related by kinship, law, or affinity with the providers of services;

(7) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(8) temporary family health care dwellings as defined in sections 394.307 and 462.3593;

(9) settings offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing;

(10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services;

(11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q;

(12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56;

(13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011; or

(14) an assisted living facility licensed under chapter 144G.

(c) "'I'm okay' check services" means providing a service to, by any means, check on the safety of a resident.

(d) "Resident" means a person entering into written contract for housing and services with a covered setting.

(e) "Supportive services" means:

(1) assistance with laundry, shopping, and household chores;

(2) housekeeping services;

(3) provision of meals or assistance with meals or food preparation;

(4) help with arranging, or arranging transportation to, medical, social, recreational, personal, or social services appointments; or

(5) provision of social or recreational services.

Arranging for services does not include making referrals or contacting a service provider in an emergency.

Sec. 113. **REPEALER.**

(a) Minnesota Statutes 2020, sections 245.462, subdivision 4a; 245.4879, subdivision 2; 245.62, subdivisions 3 and 4; 245.69, subdivision 2; 256B.0615, subdivision 2; 256B.0616, subdivision 2; 256B.0622, subdivisions 3 and 5a; 256B.0623, subdivisions 7, 8, 10, and 11; 256B.0625, subdivisions 5l, 35a, 35b, 61, 62, and 65; 256B.0943, subdivisions 8 and 10; 256B.0944; and 256B.0946, subdivision 5, are repealed.

(b) Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020; 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090; 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160; 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; 9520.0230; 9520.0750; 9520.0760; 9520.0770; 9520.0780; 9520.0790; 9520.0800; 9520.0810; 9520.0820; 9520.0830; 9520.0840; 9520.0850; 9520.0860; and 9520.0870, are repealed.

Sec. 114. **EFFECTIVE DATE.**

Unless otherwise stated, this article is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 20
FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2019, First Special Session chapter 9, article 14, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2021" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2021.

	APPROPRIATIONS Available for the Year Ending June 30 2021
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	
Subdivision 1. **Total Appropriation**	**$ (816,996,000)**

Appropriations by Fund

2021

General (745,266,000)

Health Care Access (36,893,000)

Federal TANF (34,837,000)

Subd. 2. **Forecasted Programs**

(a) **Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP)**

Appropriations by Fund

2021

General 59,004,000

Federal TANF (34,843,000)

(b) **MFIP Child Care Assistance** (54,158,000)

(c) **General Assistance** 3,925,000

(d) **Minnesota Supplemental Aid** 3,849,000

(e) **Housing Support** 3,022,000

(f) **Northstar Care for Children** (8,639,000)

(g) **MinnesotaCare** (36,893,000)

This appropriation is from the health care access fund.

(h) **Medical Assistance**

Appropriations by Fund

2021

General (694,938,000)

Health Care Access -0-

(i) **Alternative Care** 247,000

(j) **Consolidated Chemical Dependency Treatment Fund (CCDTF) Entitlement** (57,578,000)

Subd. 3. **Technical Activities** 6,000

This appropriation is from the federal TANF fund.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 21

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2022" and "2023" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2022, or June 30, 2023, respectively. "The first year" is fiscal year 2022. "The second year" is fiscal year 2023. "The biennium" is fiscal years 2022 and 2023.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2022	**2023**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	**$**	**9,104,404,000**	**$** **9,590,575,000**

Appropriations by Fund

	2022	2023
General	7,945,812,000	8,456,923,000
State Government Special Revenue	4,299,000	4,299,000
Health Care Access	867,214,000	845,520,000
Federal TANF	282,623,000	278,803,000
Lottery Prize	1,896,000	1,896,000
Opiate Epidemic Response	2,560,000	2,560,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **TANF Maintenance of Effort**

(a) **Nonfederal Expenditures.** The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF/MOE requirements, the commissioner may report as TANF/MOE expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) **Nonfederal Expenditures; Reporting.** For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) **Certain Expenditures Required.** The commissioner shall ensure that the MOE used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) **Limitation; Exceptions.** The commissioner must not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section

264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43(a)(2).

(e) **Supplemental Expenditures.** For the purposes of paragraph (d), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(f) **Reduction of Appropriations; Exception.** The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(g) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(h) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

(i) **Federal SNAP Education and Training Grants.** Federal funds available during fiscal years 2022 and 2023 for Supplemental Nutrition Assistance Program Education and Training and SNAP Quality Control Performance Bonus grants are appropriated to the commissioner of human services for the purposes allowable under the terms of the federal award. This paragraph is effective the day following final enactment.

Subd. 3. **Information Technology**

(a) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the

service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(b) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

Subd. 4. **Central Office; Operations**

	Appropriations by Fund	
General	175,025,000	168,967,000
State Government Special Revenue	4,174,000	4,174,000
Health Care Access	16,966,000	16,966,000
Federal TANF	100,000	100,000

(a) **Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Background Studies.** (1) $2,074,000 in fiscal year 2022 is from the general fund to provide a credit to providers who paid for emergency background studies in NETStudy 2.0.

(2) $2,061,000 in fiscal year 2022 is from the general fund to cover the costs of reprocessing emergency studies conducted under interagency agreements with other agencies.

(c) **Personal Care Assistance Compensation for Services Provided by a Parent or Spouse.** $349,000 in fiscal year 2022 is from the general fund for compensation for personal care assistance services provided by a parent or spouse under Laws 2020, Fifth Special Session chapter 3, article 10, section 3, as amended.

(d) **Family Foster Setting Background Studies.** $338,000 in fiscal year 2022 and $349,000 in fiscal year 2023 are from the general fund for costs related to implementing

and administering licensed family foster setting background study requirements.

(e) **Cultural and Ethnic Communities Leadership Council.** $18,000 in fiscal year 2022 and $62,000 in fiscal year 2023 are from the general fund for the Cultural and Ethnic Communities Leadership Council.

(f) **Ombudsperson for Child Care Providers.** $120,000 in fiscal year 2022 and $126,000 in fiscal year 2023 are for an ombudsperson for child care providers under Minnesota Statutes, section 119B.27.

(g) **Base Level Adjustment.** The general fund base is $163,421,000 in fiscal year 2024 and $162,260,000 in fiscal year 2025.

Subd. 5. **Central Office; Children and Families**

	Appropriations by Fund	
General	18,382,000	18,407,000
Federal TANF	2,582,000	2,582,000

(a) **Financial Institution Data Match and Payment of Fees.** The commissioner is authorized to allocate up to $310,000 in fiscal year 2022 and $310,000 in fiscal year 2023 from the systems special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

(b) **Base Level Adjustment.** The general fund base is $18,677,000 in fiscal year 2024 and $18,677,000 in fiscal year 2025.

Subd. 6. **Central Office; Health Care**

	Appropriations by Fund	
General	26,005,000	23,992,000
Health Care Access	28,168,000	28,168,000

(a) **Case Management Benefit Study for American Indians.** $200,000 in fiscal year 2022 is from the general fund for a contract to conduct fiscal analysis and development of standards for a targeted case management benefit for American Indians. The commissioner of human services must consult the Minnesota Indian Affairs Council in the development of any request for proposal and in the evaluation of responses. This is a onetime appropriation. Any unencumbered balance remaining from the first year does not cancel and is available for the second year of the biennium.

(b) **Integrated Care for High-Risk Pregnant Women Grant Program.** $106,000 in fiscal year 2022 and $122,000 in fiscal year 2023 are from the general fund for administration of the integrated care for high-risk pregnant women grant program under Minnesota Statutes, section 256B.79.

(c) **Studies on Health Care Delivery.** $700,000 in fiscal year 2022 and $300,000 in fiscal year 2023 are from the general fund for the commissioner of human services to develop a legislative proposal for a public option program and to compare and report to the legislature on delivery and payment system models to deliver services to MinnesotaCare enrollees and certain medical assistance enrollees.

(d) **Base Level Adjustment.** The general fund base is $24,036,000 in fiscal year 2024 and $24,034,000 in fiscal year 2025.

Subd. 7. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	18,873,000	18,900,000
State Government Special Revenue	125,000	125,000

(a) **Assisted Living Survey.** $2,593,000 in fiscal year 2022 and $2,593,000 in fiscal year 2023 are from the general fund for development and administration of a resident experience survey and family survey for all assisted living facilities according to Minnesota Statutes, section 256B.439, subdivision 3c. These appropriations are available in either year of the biennium.

(b) **Base Level Adjustment.** The general fund base is $18,859,000 in fiscal year 2024 and $18,900,000 in fiscal year 2025.

Subd. 8. **Central Office; Community Supports**

	Appropriations by Fund	
General	35,294,000	35,846,000
Lottery Prize	163,000	163,000
Opioid Epidemic Response	60,000	60,000

(a) **Study of Self Directed Tiered Wage Structure.** $25,000 in fiscal year 2022 is from the general fund for a study of the feasibility of a tiered wage structure for individual providers. This is a onetime appropriation. This appropriation is available only if the labor agreement between the state of Minnesota and the Service Employees International Union

Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

(b) **Substance Use Disorder Treatment Paperwork Reduction.** $234,000 in fiscal year 2022 and $201,000 in fiscal year 2023 are from the general fund for a contract with a vendor to develop, assess, and recommend systems improvements to minimize regulatory paperwork and improve systems for licensed substance use disorder programs. This is a onetime appropriation.

(c) **Case Management and Substance Use Disorder Treatment Rate Methodology Analysis.** $500,000 in fiscal year 2022 and $200,000 in fiscal year 2023 are from the general fund for the fiscal analysis needed to establish federally compliant payment methodologies for all medical assistance-funded case management services, including substance use disorder treatment rates. This is a onetime appropriation.

(d) **Substance Use Disorder Community of Practice.** $250,000 in fiscal year 2022 and $250,000 in fiscal year 2023 are from the general fund for the commissioner of human services to establish and administer the substance use disorder community of practice, including providing compensation for community of practice participants.

(e) **Sober Housing Program Recommendations Development.** $90,000 in fiscal year 2022 is from the general fund for developing recommendations related to sober housing programs and completing and

submitting a report on the recommendations to the legislature.

(f) **Base Level Adjustment.** The general fund base is $34,257,000 in fiscal year 2024 and $34,289,000 in fiscal year 2025. The opiate epidemic response fund base is $60,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 9. **Forecasted Programs; MFIP/DWP**

	Appropriations by Fund	
General	92,588,000	91,668,000
Federal TANF	104,285,000	104,410,000

Subd. 10. **Forecasted Programs; MFIP Child Care Assistance.**	103,347,000	110,788,000
Subd. 11. **Forecasted Programs; General Assistance.**	53,574,000	52,835,000

(a) **General Assistance Standard.** The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

(b) **Emergency General Assistance Limit.** The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2022 and $6,729,812 in fiscal year 2023. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

Subd. 12. **Forecasted Programs; Minnesota Supplemental Aid**	51,779,000	52,486,000

Subd. 13. **Forecasted Programs; Housing Support** 184,005,000 191,966,000

Subd. 14. **Forecasted Programs; Northstar Care for Children** 110,583,000 121,246,000

Subd. 15. **Forecasted Programs; MinnesotaCare** 207,437,000 184,822,000

Generally. This appropriation is from the health care access fund.

Subd. 16. **Forecasted Programs; Medical Assistance**

Appropriations by Fund		
General	6,058,256,000	6,577,278,000
Health Care Access	611,178,000	612,099,000

Behavioral Health Services. $1,000,000 in fiscal year 2022 and $1,000,000 in fiscal year 2023 are for behavioral health services provided by hospitals identified under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (a), clause (4). The increase in payments shall be made by increasing the adjustment under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (e), clause (2).

Subd. 17. **Forecasted Programs; Alternative Care** 45,669,000 45,656,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 18. **Forecasted Programs; Behavioral Health Fund** 132,377,000 116,706,000

(a) **Grants to Tribal Governments.** $28,873,377 in fiscal year 2022 is from the general fund to satisfy the value of overpayments owed by the Leech Lake Band

of Ojibwe and White Earth Band of Chippewa to repay overpayments for medication-assisted treatment services between fiscal year 2014 and fiscal year 2019. The grant to the Leech Lake Band of Ojibwe shall be $14,666,122 and the grant to the White Earth Band of Chippewa shall be $14,207,215. This is a onetime appropriation.

(b) **Institutions for Mental Disease Payments.** $8,328,000 in fiscal year 2022 is from the general fund for the commissioner of human services to reimburse counties for the amount identified by the commissioner for the statewide county share of costs for which federal funds were claimed, but were not eligible for federal funding for substance use disorder services provided in institutions for mental disease, for claims paid between January 1, 2014, and June 30, 2019. The commissioner of human services shall allocate this appropriation between counties in the amount identified by the department that is owed by each county. Prior to a county receiving reimbursement, the county must pay in full any unpaid consolidated chemical dependency treatment fund invoiced county share. This is a onetime appropriation.

Subd. 19. **Grant Programs; Support Services Grants**

	Appropriations by Fund	
General	8,715,000	8,715,000
Federal TANF	96,312,000	96,311,000

Subd. 20. **Grant Programs; BSF Child Care Grants.** 53,350,000 53,362,000

Base Level Adjustment. The general fund base is $53,366,000 in fiscal year 2024 and $53,366,000 in fiscal year 2025.

Subd. 21. **Grant Programs; Child Care Development Grants.** 2,317,000 2,257,000

(a) **TEACH Grant Program.** $500,000 in fiscal year 2022 and $500,000 in fiscal year 2023 are for TEACH program grants under Minnesota Statutes, section 136A.128.

(b) **Peer Mentoring Program for Licensed Family Child Care Providers.** $30,000 in fiscal year 2022 and $20,000 in fiscal year 2023 are for a grant to the Minnesota Child Care Provider Information Network for establishing a peer mentoring program for licensed family child care providers in the state. The grant money must be used to revise and update peer mentoring program curricula, recruit and train mentors and program participants, and support mentors and active mentoring. The Minnesota Child Care Provider Information Network must submit to the commissioner an initial report describing the program's implementation progress and financial accounting by September 1, 2022, and a final report must be submitted by June 30, 2023. Any unexpended balance in the first year does not cancel and is available in the second year. This is a onetime appropriation.

(c) **Report on Foster Children Participation in Early Childhood Programs.** $50,000 in fiscal year 2022 is for interim and final reports

on foster children's participation in early childhood programs. This is a onetime appropriation and is available until June 30, 2023.

(d) **Child Care Center Regulation Modernization.** $577,000 in fiscal year 2022 and $741,000 in fiscal year 2023 are for the child care center regulation modernization project. This is a onetime appropriation and remains available until June 30, 2024.

(e) **Family Child Care Regulation Modernization.** $478,000 in fiscal year 2022 and $642,000 in fiscal year 2023 are for the family child care regulation modernization project. This is a onetime appropriation and remains available until June 30, 2024.

(f) **Base Level Adjustment.** The general fund base is $2,237,000 in fiscal year 2024 and $2,237,000 in fiscal year 2025.

Subd. 22. **Grant Programs; Child Support Enforcement Grants** 50,000 50,000

Subd. 23. **Grant Programs; Children's Services Grants**

	Appropriations by Fund	
General	52,133,000	51,848,000
Federal TANF	140,000	140,000

(a) **Title IV-E Adoption Assistance.** The commissioner shall allocate funds from the Title IV-E reimbursement to the state from the Fostering Connections to Success and Increasing Adoptions Act for adoptive, foster, and kinship families as required in Minnesota Statutes, section 256N.261.

(b) **Indian Child Welfare Training.** $1,012,000 in fiscal year 2022 and $993,000 in fiscal year 2023 are from the general fund for the establishment and operation of the Tribal Training and Certification Partnership at the University of Minnesota-Duluth to provide training, establish federal Indian Child Welfare Act and Minnesota Family Preservation Act training requirements for county child welfare workers, and develop indigenous child welfare training for American Indian Tribes. The base for this appropriation is $1,053,000 in fiscal year 2024 and $1,053,000 in fiscal year 2025.

(c) **Parent Support for Better Outcomes Grants.** $150,000 in fiscal year 2022 and $150,000 in fiscal year 2023 are from the general fund for grants to Minnesota One-Stop for Communities to provide mentoring, guidance, and support services to parents navigating the child welfare system in Minnesota, in order to promote the development of safe, stable, and healthy families. Grant money may be used for parent mentoring, peer-to-peer support groups, housing support services, training, staffing, and administrative costs.

Subd. 24. **Grant Programs; Children and Community Service Grants**	60,251,000	60,856,000
Subd. 25. **Grant Programs; Children and Economic Support Grants**	34,240,000	34,240,000

(a) **Minnesota Food Assistance Program.** Unexpended funds for the Minnesota food assistance program for fiscal year 2022 do not cancel but are available for this purpose in fiscal year 2023.

(b) **Emergency Shelters.** $2,500,000 in fiscal year 2022 and $2,500,000 in fiscal year 2023 are for short-term housing facilities to increase the supply and improve the condition of shelters for individuals and families without a permanent residence. The commissioner shall ensure that a portion of the funds are expended to provide for short-term housing facilities for tribes and shall ensure equitable geographic distribution of funds. This appropriation is available until June 30, 2026.

(c) **Emergency Services Grants.** $9,000,000 in fiscal year 2022 and $9,000,000 in fiscal year 2023 are to provide emergency services grants under Minnesota Statutes, section 256E.36.

Subd. 26. **Grant Programs; Health Care Grants**

	Appropriations by Fund	
General	4,811,000	4,811,000
Health Care Access	3,465,000	3,465,000

Integrated Care for High Risk Pregnancies Initiative. $1,100,000 in fiscal year 2022 and $1,100,000 in fiscal year 2023 are from the general fund for the commissioner of human services to enter into a contract with the Integrated Care for High Risk Pregnancies (ICHRP) initiative to provide support to the integrated care for high-risk pregnant women grant program under Minnesota Statutes, section 256B.79.

Subd. 27. **Grant Programs; Other Long-Term Care Grants**	1,925,000	1,925,000
Subd. 28. **Grant Programs; Aging and Adult Services Grants**	32,495,000	32,495,000

Subd. 29. **Grant Programs; Deaf and Hard-of-Hearing Grants** 2,886,000 2,886,000

Subd. 30. **Grant Programs; Disabilities Grants** 20,251,000 18,863,000

Training Stipends for Direct Support Services Providers. $1,000,000 in fiscal year 2022 is from the general fund for stipends for individual providers of direct support services as defined in Minnesota Statutes, section 256B.0711, subdivision 1. These stipends are available to individual providers who have completed designated voluntary trainings made available through the State-Provider Cooperation Committee formed by the State of Minnesota and the Service Employees International Union Healthcare Minnesota. Any unspent appropriation in fiscal year 2022 is available in fiscal year 2023. This is a onetime appropriation. This appropriation is available only if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

Subd. 31. **Grant Programs; Housing Support Grants** 11,364,000 11,364,000

Long-Term Homeless Supportive Services. $1,000,000 in fiscal year 2022 and $1,000,000 in fiscal year 2023 are for long-term homeless supportive services under Minnesota Statutes, section 256K.26.

Subd. 32. **Grant Programs; Adult Mental Health Grants**

	Appropriations by Fund	
General	84,073,000	84,074,000
Opiate Epidemic Response	2,000,000	2,000,000

(a) **Culturally and Linguistically Appropriate Services Implementation Grants.** $750,000 in fiscal year 2022 and $750,000 in fiscal year 2023 are from the general fund for grants to substance use disorder treatment providers to implement culturally and linguistically appropriate services standards, according to the implementation and transition plan developed by the commissioner. This is a onetime appropriation.

(b) **Base Level Adjustment.** The general fund base is $83,324,000 in fiscal year 2024 and $83,324,000 in fiscal year 2025. The opiate epidemic response fund base is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 33. **Grant Programs; Child Mental Health Grants** 28,703,000 28,703,000

(a) **Children's Residential Facilities.** $3,000,000 in fiscal year 2022 and $3,000,000 in fiscal year 2023 are to reimburse counties and Tribal governments for a portion of the costs of treatment in children's residential facilities. The commissioner shall distribute the appropriation on an annual basis to counties and Tribal governments proportionally based on a methodology developed by the commissioner. Of this appropriation, $100,000 in fiscal year 2022 and $100,000 in fiscal year 2023 are available to the commissioner for administrative expenses and $70,000 in fiscal year 2022 is

available to the commissioner for the children's mental health residential treatment work group.

(b) **Base Level Adjustment.** The general fund base is $28,726,000 in fiscal year 2024 and $28,726,000 in fiscal year 2025.

Subd. 34. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	2,846,000	2,845,000
Lottery Prize	1,733,000	1,733,000
Opiate Epidemic Response	500,000	500,000

(a) **Problem Gambling.** $225,000 in fiscal year 2022 and $225,000 in fiscal year 2023 are from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

(b) **Recovery Community Organization Grants.** $573,000 in fiscal year 2022 and $571,000 in fiscal year 2023 are from the general fund for grants to recovery community organizations, as defined in Minnesota Statutes, section 254B.01, subdivision 8, to provide for costs and community-based peer recovery support services that are not otherwise eligible for reimbursement under Minnesota Statutes, section 254B.05, as part

of the continuum of care for substance use disorders.

(c) **Base Level Adjustment.** The general fund base is $2,636,000 in fiscal year 2024 and $2,636,000 in fiscal year 2025. The opiate epidemic response fund base is $500,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 35. **Direct Care and Treatment - Generally**

Transfer Authority. Money appropriated to budget activities under this subdivision and subdivisions 36 to 40 may be transferred between budget activities and between years of the biennium with the approval of the commissioner of management and budget.

Subd. 36. **Direct Care and Treatment - Mental Health and Substance Abuse**	139,946,000	144,103,000

(a) **Transfer Authority.** Money appropriated to support the continued operations of the Community Addiction Recovery Enterprise (C.A.R.E.) program may be transferred to the enterprise fund for C.A.R.E.

(b) **Operating Adjustment.** $2,307,000 in fiscal year 2022 and $2,453,000 in fiscal year 2023 are for the Community Addiction Recovery Enterprise program. The commissioner may transfer $2,307,000 in fiscal year 2022 and $2,453,000 in fiscal year 2023 to the enterprise fund for Community Addiction Recovery Enterprise.

Subd. 37. **Direct Care and Treatment - Community-Based Services**	18,771,000	19,752,000

(a) **Transfer Authority.** Money appropriated to support the continued operations of the Minnesota State Operated Community

Services (MSOCS) program may be transferred to the enterprise fund for MSOCS.

(b) **Operating Adjustment.** $1,519,000 in fiscal year 2022 and $2,541,000 in fiscal year 2023 are for the Minnesota State Operated Community Services program. The commissioner may transfer $1,519,000 in fiscal year 2022 and $2,541,000 in fiscal year 2023 to the enterprise fund for Minnesota State Operated Community Services.

Subd. 38. **Direct Care and Treatment - Forensic Services**	119,854,000	122,206,000
Subd. 39. **Direct Care and Treatment - Sex Offender Program**	97,570,000	99,917,000

Transfer Authority. Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

Subd. 40. **Direct Care and Treatment - Operations**	63,504,000	65,910,000
Subd. 41. **Technical Activities**	79,204,000	78,260,000

(a) **Generally.** This appropriation is from the federal TANF fund.

(b) **Base Level Adjustment.** The TANF fund base is $71,493,000 in fiscal year 2024 and $71,493,000 in fiscal year 2025.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation**	**$ 259,373,000**	**$ 251,881,000**

Appropriations by Fund

	2022	2023
General	156,337,000	150,554,000
State Government Special Revenue	54,465,000	53,356,000

Health Care Access	36,858,000	36,258,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund		
General	113,697,000	112,692,000
State Government Special Revenue	9,103,000	7,777,000
Health Care Access	36,858,000	36,258,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 in fiscal year 2022 and $3,579,000 in fiscal year 2023 are from the TANF fund for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2022 and $4,978,000 in fiscal year 2023 are from the TANF fund for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding in each fiscal year must be distributed to community health boards according to Minnesota Statutes, section 145A.131,

subdivision 1. $978,000 of the funding in each fiscal year must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 in fiscal year 2022 and $1,156,000 in fiscal year 2023 are from the TANF fund for family planning grants under Minnesota Statutes, section 145.925; and

(5) the commissioner may use up to 6.23 percent of the funds appropriated from the TANF fund each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(b) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

(c) **Maternal Morbidity and Death Studies.** $198,000 in fiscal year 2022 and $198,000 in fiscal year 2023 are from the general fund to be used to conduct maternal morbidity studies and maternal death studies under Minnesota Statutes, sections 145.901 and 145.9013.

(d) **Comprehensive Advanced Life Support Educational Program.** $100,000 in fiscal year 2022 and $100,000 in fiscal year 2023 are from the general fund for the comprehensive advanced life support educational program under Minnesota Statutes, section 144.6062. This is a onetime appropriation.

(e) **Local Public Health Grants.** $2,978,000 in fiscal year 2022 and $2,978,000 in fiscal year 2023 are from the general fund for local public health grants under Minnesota Statutes, section 145A.131. The base for this appropriation is $2,500,000 in fiscal year 2024 and $2,500,000 in fiscal year 2025.

(f) **Public Health Infrastructure and Health Equity and Outreach.** $5,000,000 in fiscal year 2022 and $5,000,000 in fiscal year 2023 are from the general fund for purposes of Minnesota Statutes, sections 144.0661 to 144.0663, and to build public health infrastructure at the state and local levels to address current and future public health emergencies, conduct outreach to underserved communities in the state experiencing health disparities, and build systems at the state and local levels with the goals of reducing and eliminating health disparities in these communities. A community health board or local unit of government must use any funds provided under this paragraph to supplement and not supplant local funds being used for public health purposes.

(g) **Mental Health Cultural Community Continuing Education.** $500,000 in fiscal year 2022 and $500,000 in fiscal year 2023 are from the general fund for the mental health cultural community continuing education grant program.

(h) **Health Professional Education Loan Forgiveness Program.** $3,000,000 in fiscal year 2022 and $3,000,000 in fiscal year 2023 are from the general fund for loan forgiveness

under the health professional education loan forgiveness program under Minnesota Statutes, section 144.1501, for individuals who: (1) are eligible alcohol and drug counselors or eligible mental health professionals, as defined in Minnesota Statutes, section 144.1501, subdivision 1; and (2) are Black, indigenous, or people of color, or members of an underrepresented community as defined in Minnesota Statutes, section 148E.010, subdivision 20. Loan forgiveness shall be provided according to this paragraph notwithstanding the priorities and distribution requirements for loan forgiveness in Minnesota Statutes, section 144.1501.

(i) **Birth Records; Homeless Youth.** $72,000 in fiscal year 2022 and $32,000 in fiscal year 2023 are from the general fund for administration and issuance of certified birth records and statements of no vital record found to homeless youth under Minnesota Statutes, section 144.2255.

(j) **Trauma-Informed Gun Violence Reduction Pilot Program.** $100,000 in fiscal year 2022 is from the general fund for the trauma-informed gun violence reduction pilot program.

(k) **Home Visiting for Pregnant Women and Families with Young Children.** $2,500,000 in fiscal year 2022 and $2,500,000 in fiscal year 2023 are from the general fund for grants for home visiting services under Minnesota Statutes, section 145.87.

(l) **Supporting Healthy Development of Babies During Pregnancy and Postpartum.**

$279,000 in fiscal year 2022 and $279,000 in fiscal year 2023 are from the general fund for a grant to the Amherst H. Wilder Foundation for the African American Babies Coalition initiative for community-driven training and education on best practices to support healthy development of babies during pregnancy and postpartum. Grant funds must be used to build capacity in, train, educate, or improve practices among individuals, from youth to elders, serving families with members who are Black, indigenous, or people of color, during pregnancy and postpartum. Of this appropriation, $19,000 in fiscal year 2022 and $19,000 in fiscal year 2023 are for the commissioner to use for administration. This is a onetime appropriation. Any unexpended balance in the first year of the biennium does not cancel and is available in the second year of the biennium.

(m) **Dignity in Pregnancy and Childbirth.** $1,695,000 in fiscal year 2022 and $908,000 in fiscal year 2023 are from the general fund for purposes of Minnesota Statutes, section 144.1461. Of this appropriation, $845,000 in fiscal year 2022 is for a grant to the University of Minnesota School of Public Health's Center for Antiracism Research for Health Equity, to develop a model curriculum on anti-racism and implicit bias for use by hospitals with obstetric care and birth centers to provide continuing education to staff caring for pregnant or postpartum women. The model curriculum must be evidence-based and must meet the criteria in Minnesota Statutes, section 144.1461, subdivision 2, paragraph (a). The

base for this appropriation is $907,000 in fiscal year 2024 and $860,000 in fiscal year 2025.

(n) **Recommendations to Expand Access to Data from the All-Payer Claims Database.** $55,000 in fiscal year 2022 is from the general fund for the commissioner to develop recommendations to expand access to data from the all-payer claims database under Minnesota Statutes, section 62U.04, to additional outside entities for public health or research purposes.

(o) **Base Level Adjustments.** The general fund base is $110,762,000 in fiscal year 2024 and $111,787,000 in fiscal year 2025. The state government special revenue fund base is $7,777,000 in fiscal year 2024 and $7,777,000 in fiscal year 2025. The health care access fund base is $36,858,000 in fiscal year 2024 and $36,258,000 in fiscal year 2025.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	31,070,000	26,283,000
State Government Special Revenue	45,362,000	45,579,000

(a) **Lead Risk Assessments and Lead Orders.** $1,530,000 in fiscal year 2022 and $1,314,000 in fiscal year 2023 are from the general fund for implementation of the requirements for conducting lead risk assessments under Minnesota Statutes, section 144.9504, subdivision 2, and for issuance of lead orders under Minnesota Statutes, section 144.9504, subdivision 5.

(b) **Hospital Closure or Curtailment of Operations.** $10,000 in fiscal year 2022 and

$1,000 in fiscal year 2023 are from the general fund for purposes of Minnesota Statutes, section 144.555, subdivisions 1a, 1b, and 2.

(c) **Transfer; Public Health Response Contingency Account.** The commissioner shall transfer $4,343,000 in fiscal year 2022 from the general fund to the public health response contingency account established in Minnesota Statutes, section 144.4199. This is a onetime transfer.

(d) **Skin Lightening Products Public Awareness and Education Grant Program.** $100,000 in fiscal year 2022 and $100,000 in fiscal year 2023 are from the general fund for a skin lightening products public awareness and education grant program. This is a onetime appropriation.

(e) **Base Level Adjustments.** The general fund base is $26,183,000 in fiscal year 2024 and $26,183,000 in fiscal year 2025. The state government special revenue fund base is $45,579,000 in fiscal year 2024 and $45,579,000 in fiscal year 2025.

Subd. 4. **Health Operations** 11,570,000 11,579,000

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation** **$ 27,535,000 $ 26,960,000**

Appropriations by Fund

State Government Special Revenue	27,459,000	26,884,000
Health Care Access	76,000	76,000

This appropriation is from the state government special revenue fund unless specified otherwise. The amounts that may be

spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Behavioral Health and Therapy**	877,000	875,000
Subd. 3. **Board of Chiropractic Examiners**	666,000	666,000
Subd. 4. **Board of Dentistry**	4,228,000	3,753,000

(a) **Administrative Services Unit - Operating Costs.** Of this appropriation, $2,738,000 in fiscal year 2022 and $2,263,000 in fiscal year 2023 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services it performs for other agencies.

(b) **Administrative Services Unit - Volunteer Health Care Provider Program.** Of this appropriation, $150,000 in fiscal year 2022 and $150,000 in fiscal year 2023 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative Services Unit - Retirement Costs.** Of this appropriation, $475,000 in fiscal year 2022 is a onetime appropriation to the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative services unit. These funds are available either year of the biennium.

(d) **Administrative Services Unit - Contested Cases and Other Legal Proceedings.** Of this appropriation, $200,000 in fiscal year 2022 and $200,000 in fiscal year 2023 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification by a health-related board to the administrative services unit that costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance for an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

Subd. 5. **Board of Dietetics and Nutrition Practice**	164,000	164,000
Subd. 6. **Board of Executives for Long Term Services and Supports**	693,000	635,000
Subd. 7. **Board of Marriage and Family Therapy**	413,000	410,000
Subd. 8. **Board of Medical Practice**	5,912,000	5,868,000

Health Professional Services Program. This appropriation includes $1,002,000 in fiscal year 2022 and $1,002,000 in fiscal year 2023 for the health professional services program.

Subd. 9. **Board of Nursing**	5,345,000	5,355,000

Subd. 10. **Board of Occupational Therapy Practice** 456,000 456,000

Subd. 11. **Board of Optometry** 238,000 238,000

Subd. 12. **Board of Pharmacy** 4,479,000 4,479,000

Appropriations by Fund

State Government Special Revenue	4,403,000	4,403,000
Health Care Access	76,000	76,000

Base Level Adjustment. The health care access fund base is $76,000 in fiscal year 2024, $38,000 in fiscal year 2025, and $0 in fiscal year 2026.

Subd. 13. **Board of Physical Therapy** 564,000 564,000

Subd. 14. **Board of Podiatric Medicine** 214,000 214,000

Subd. 15. **Board of Psychology** 1,362,000 1,360,000

Subd. 16. **Board of Social Work** 1,561,000 1,560,000

Subd. 17. **Board of Veterinary Medicine** 363,000 363,000

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD** **$ 4,453,000 $ 3,829,000**

(a) **Cooper/Sams Volunteer Ambulance Program.** $950,000 in fiscal year 2022 and $950,000 in fiscal year 2023 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(1) Of this amount, $861,000 in fiscal year 2022 and $861,000 in fiscal year 2023 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(2) Of this amount, $89,000 in fiscal year 2022 and $89,000 in fiscal year 2023 are for the operations of the ambulance service personnel

longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) **EMSRB Operations.** $1,880,000 in fiscal year 2022 and $1,880,000 in fiscal year 2023 are for board operations.

(c) **Regional Grants.** $1,235,000 in fiscal year 2022 and $585,000 in fiscal year 2023 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions under Minnesota Statutes, section 144E.52.

(d) **Ambulance Training Grants.** $361,000 in fiscal year 2022 and $361,000 in fiscal year 2023 are for training grants under Minnesota Statutes, section 144E.35.

Sec. 6. **COUNCIL ON DISABILITY** **$ 1,022,000 $ 1,038,000**

Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,487,000 $ 2,536,000**

Department of Psychiatry Monitoring. $100,000 in fiscal year 2022 and $100,000 in fiscal year 2023 are for monitoring the Department of Psychiatry at the University of Minnesota.

Sec. 8. **OMBUDSPERSONS FOR FAMILIES** **$ 733,000 $ 744,000**

Sec. 9. **ATTORNEY GENERAL** **$ 200,000 $ 200,000**

Excessive Drug Price Increases. This appropriation is for costs of expert witnesses and investigations under Minnesota Statutes, section 62J.844. This is a onetime appropriation.

Sec. 10. Laws 2019, First Special Session chapter 9, article 14, section 3, as amended by Laws 2019, First Special Session chapter 12, section 6, is amended to read:

Sec. 3. **COMMISSIONER OF HEALTH**

			~~**236,188,000**~~
Subdivision 1. **Total Appropriation**	**$**	**231,829,000**	**$** **233,584,000**

Appropriations by Fund

	2020	2021
		~~126,276,000~~
General	124,381,000	125,881,000
State Government		~~61,367,000~~
Special Revenue	58,450,000	59,158,000
Health Care Access	37,285,000	36,832,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund

		~~96,117,000~~
General	94,980,000	95,722,000
State Government		~~7,558,000~~
Special Revenue	7,614,000	6,924,000
Health Care Access	37,285,000	36,832,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 in fiscal year 2020 and $3,579,000 in fiscal year 2021 are from the TANF fund for home visiting and nutritional services under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2020 and $2,000,000 in fiscal year 2021 are from the TANF fund for decreasing racial and ethnic

disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2020 and $4,978,000 in fiscal year 2021 are from the TANF fund for the family home visiting grant program under Minnesota Statutes, section 145A.17. $4,000,000 of the funding in each fiscal year must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding in each fiscal year must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 in fiscal year 2020 and $1,156,000 in fiscal year 2021 are from the TANF fund for family planning grants under Minnesota Statutes, section 145.925; and

(5) The commissioner may use up to 6.23 percent of the amounts appropriated from the TANF fund each year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(b) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

(c) **Comprehensive Suicide Prevention.** $2,730,000 in fiscal year 2020 and $2,730,000 in fiscal year 2021 are from the general fund

for a comprehensive, community-based suicide prevention strategy. The funds are allocated as follows:

(1) $955,000 in fiscal year 2020 and $955,000 in fiscal year 2021 are for community-based suicide prevention grants authorized in Minnesota Statutes, section 145.56, subdivision 2. Specific emphasis must be placed on those communities with the greatest disparities. The base for this appropriation is $1,291,000 in fiscal year 2022 and $1,291,000 in fiscal year 2023;

(2) $683,000 in fiscal year 2020 and $683,000 in fiscal year 2021 are to support evidence-based training for educators and school staff and purchase suicide prevention curriculum for student use statewide, as authorized in Minnesota Statutes, section 145.56, subdivision 2. The base for this appropriation is $913,000 in fiscal year 2022 and $913,000 in fiscal year 2023;

(3) $137,000 in fiscal year 2020 and $137,000 in fiscal year 2021 are to implement the Zero Suicide framework with up to 20 behavioral and health care organizations each year to treat individuals at risk for suicide and support those individuals across systems of care upon discharge. The base for this appropriation is $205,000 in fiscal year 2022 and $205,000 in fiscal year 2023;

(4) $955,000 in fiscal year 2020 and $955,000 in fiscal year 2021 are to develop and fund a Minnesota-based network of National Suicide Prevention Lifeline, providing statewide coverage. The base for this appropriation is

$1,321,000 in fiscal year 2022 and $1,321,000 in fiscal year 2023; and

(5) the commissioner may retain up to 18.23 percent of the appropriation under this paragraph to administer the comprehensive suicide prevention strategy.

(d) **Statewide Tobacco Cessation.** $1,598,000 in fiscal year 2020 and $2,748,000 in fiscal year 2021 are from the general fund for statewide tobacco cessation services under Minnesota Statutes, section 144.397. The base for this appropriation is $2,878,000 in fiscal year 2022 and $2,878,000 in fiscal year 2023.

(e) **Health Care Access Survey.** $225,000 in fiscal year 2020 and $225,000 in fiscal year 2021 are from the health care access fund to continue and improve the Minnesota Health Care Access Survey. These appropriations may be used in either year of the biennium.

(f) **Community Solutions for Healthy Child Development Grant Program.** $1,000,000 in fiscal year 2020 and $1,000,000 in fiscal year 2021 are for the community solutions for healthy child development grant program to promote health and racial equity for young children and their families under article 11, section 107. The commissioner may use up to 23.5 percent of the total appropriation for administration. The base for this appropriation is $1,000,000 in fiscal year 2022, $1,000,000 in fiscal year 2023, and $0 in fiscal year 2024.

(g) **Domestic Violence and Sexual Assault Prevention Program.** $375,000 in fiscal year 2020 and $375,000 in fiscal year 2021 are

from the general fund for the domestic violence and sexual assault prevention program under article 11, section 108. This is a onetime appropriation.

(h) **Skin Lightening Products Public Awareness Grant Program.** $100,000 in fiscal year 2020 and $100,000 in fiscal year 2021 are from the general fund for a skin lightening products public awareness and education grant program. This is a onetime appropriation.

(i) **Cannabinoid Products Workgroup.** $8,000 in fiscal year 2020 is from the state government special revenue fund for the cannabinoid products workgroup. This is a onetime appropriation.

(j) **Base Level Adjustments.** The general fund base is $96,742,000 in fiscal year 2022 and $96,742,000 in fiscal year 2023. The health care access fund base is $37,432,000 in fiscal year 2022 and $36,832,000 in fiscal year 2023.

Subd. 3. **Health Protection**

Appropriations by Fund		
General	18,803,000	19,774,000
State Government		~~53,809,000~~
Special Revenue	50,836,000	52,234,000

(a) **Public Health Laboratory Equipment.** $840,000 in fiscal year 2020 and $655,000 in fiscal year 2021 are from the general fund for equipment for the public health laboratory. This is a onetime appropriation and is available until June 30, 2023.

(b) **Base Level Adjustment.** The general fund base is $19,119,000 in fiscal year 2022 and

$19,119,000 in fiscal year 2023. The state government special revenue fund base is $53,782,000 in fiscal year 2022 and $53,782,000 in fiscal year 2023.

Subd. 4. **Health Operations** 10,598,000 10,385,000

Base Level Adjustment. The general fund base is $10,912,000 in fiscal year 2022 and $10,912,000 in fiscal year 2023.

EFFECTIVE DATE. This section is effective the day following final enactment and the reductions in subdivisions 1 to 3 are onetime reductions.

Sec. 11. **APPROPRIATION; MINNESOTA FAMILY INVESTMENT PROGRAM SUPPLEMENTAL PAYMENT.**

$24,235,000 in fiscal year 2021 is appropriated from the TANF fund to the commissioner of human services to provide a onetime cash benefit of up to $750 for each household enrolled in the Minnesota family investment program or diversionary work program under Minnesota Statutes, chapter 256J, at the time that the cash benefit is distributed. The commissioner shall distribute these funds through existing systems and in a manner that minimizes the burden to families. This is a onetime appropriation.

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

Sec. 12. **APPROPRIATION; REFINANCING OF EMERGENCY CHILD CARE GRANTS; CANCELLATION.**

$26,622,626 in fiscal year 2021 is appropriated from the coronavirus relief federal fund to the commissioner of human services for fiscal year 2020 to replace a portion of the general fund appropriation in Laws 2020, chapter 71, article 1, section 2, subdivision 9. The general fund appropriation that is replaced by coronavirus relief funds under this section is canceled to the general fund. This is a onetime appropriation.

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

Sec. 13. **CANCELLATION; TRANSFER FROM STATE GOVERNMENT SPECIAL REVENUE FUND TO GENERAL FUND.**

The $77,000 transfer each year from the state government special revenue fund to the general fund under Laws 2008, chapter 364, section 17, paragraph (b), is canceled. This section does not expire.

EFFECTIVE DATE. This section is effective June 30, 2021.

Sec. 14. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATION.**

(a) The commissioner of human services shall allocate $212,400,000 from the child care and development block grant amount in the federal fund as follows:

(1) $1,435,000 for the quality rating and improvement system's evaluation and equity report under Minnesota Statutes, section 124D.142, subdivisions 3 and 4; and

(2) the remaining amount to reprioritize the basic sliding fee program waiting list under Minnesota Statutes, section 119B.03, to increase child care assistance rates for legal, nonlicensed family child care providers under Minnesota Statutes, section 119B.13, subdivision 1a, and to increase child care assistance rates under Minnesota Statutes, section 119B.13, subdivision 1, paragraph (a), to the 50th percentile of the most recent market rate survey. The commissioner may not increase the rate differential percentage established under Minnesota Statutes, section 119B.13, subdivision 3a or 3b.

(b) Each year, an amount equal to at least 88 percent of the federal discretionary funding in the Child Care and Development Block Grant of 2014, Public Law 113-186, in federal fiscal year 2018 above the amounts authorized in federal fiscal year 2017, not to exceed the cost of rate adjustments, shall be allocated to pay the cost of rate adjustments based on the most recent market survey.

(c) When increased federal discretionary child care and development block grant funding is used to pay for the rate increase under paragraph (a), the commissioner, in consultation with the commissioner of management and budget, may adjust the amount of working family credit expenditures as needed to meet the state's maintenance of effort requirements for the TANF block grant.

Sec. 15. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; CHILD CARE STABILIZATION.**

The commissioner shall allocate $325,000,000 from the child care and development block grant amount in the federal fund for the following purposes:

(1) $1,500,000 for the Children's Cabinet to conduct an evaluation of the use of federal money on early care and learning programs;

(2) $500,000 to award grants to community-based organizations working with family, friend, and neighbor caregivers, with a particular emphasis on such caregivers serving children from low-income families, families of color, Tribal communities, or families with limited English language proficiency, to promote healthy development, social-emotional learning, early literacy, and school readiness;

(3) $100,000 for a grant program to test strategies by which family child care providers could share services;

(4) $500,000 for competitive grants to expand access to child care for children with disabilities;

(5) $5,000,000 for child care improvement grants under Minnesota Statutes, section 119B.25;

(6) $5,000,000 for administering the monthly grants under clause (7); and

(7) the remaining amount to award monthly grants, between July 1, 2021, and June 30, 2023, to providers of early care and education to support the stability of the sector with providers required to direct 75 percent of such grants to employees or other individuals providing early care and education services.

Sec. 16. **FEDERAL FUNDS FOR VACCINE ACTIVITIES; APPROPRIATION.**

Federal funds made available to the commissioner of health for vaccine activities are appropriated to the commissioner for that purpose and shall be used to support work under Minnesota Statutes, sections 144.067 to 144.069.

Sec. 17. **FEDERAL FUNDS REPLACEMENT; APPROPRIATION.**

Notwithstanding any law to the contrary, the commissioner of management and budget must determine whether the expenditures authorized under this act are eligible uses of federal funding received under the Coronavirus State Fiscal Recovery Fund or any other federal funds received by the state under the American Rescue Plan Act, Public Law 117-2. If the

commissioner of management and budget determines an expenditure is eligible for funding under Public Law 117-2, the amount of the eligible expenditure is appropriated from the account where those amounts have been deposited and the corresponding general fund amounts appropriated under this act are canceled to the general fund.

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

Sec. 18. **TRANSFERS; HUMAN SERVICES.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2023, within fiscal years among the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid program, group residential housing program, the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health Finance and Policy Committee and Human Services Finance and Policy Committee quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health Finance and Policy Committee and Human Services Finance and Policy Committee quarterly about transfers made under this subdivision.

Sec. 19. **TRANSFERS; HEALTH.**

Positions, salary money, and nonsalary administrative money may be transferred within the Department of Health as the commissioner considers necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance quarterly about transfers made under this section.

Sec. 20. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 21. **APPROPRIATION ENACTED MORE THAN ONCE.**

If an appropriation in this act is enacted more than once in the 2021 legislative session, the appropriation must be given effect only once.

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

Sec. 22. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2023, unless a different expiration date is explicit.

Sec. 23. **REPEALER.**

Minnesota Statutes 2020, section 16A.724, subdivision 2, is repealed effective June 30, 2025.

Sec. 24. **EFFECTIVE DATE.**

This article is effective July 1, 2021, unless a different effective date is specified.

16A.724 HEALTH CARE ACCESS FUND.

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in fiscal year 2016 shall not exceed $48,000,000, the amount in fiscal year 2017 shall not exceed $122,000,000, and the amount in any fiscal biennium thereafter shall not exceed $244,000,000. The purpose of this transfer is to meet the rate increase required under section 256B.04, subdivision 25.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

62A.67 SHORT TITLE.

Sections 62A.67 to 62A.672 may be cited as the "Minnesota Telemedicine Act."

62A.671 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 62A.67 to 62A.672, the terms defined in this section have the meanings given.

Subd. 2. **Distant site.** "Distant site" means a site at which a licensed health care provider is located while providing health care services or consultations by means of telemedicine.

Subd. 3. **Health care provider.** "Health care provider" has the meaning provided in section 62A.63, subdivision 2.

Subd. 4. **Health carrier.** "Health carrier" has the meaning provided in section 62A.011, subdivision 2.

Subd. 5. **Health plan.** "Health plan" means a health plan as defined in section 62A.011, subdivision 3, and includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred and are designed to pay benefits directly to the policyholder.

Subd. 6. **Licensed health care provider.** "Licensed health care provider" means a health care provider who is:

(1) licensed under chapter 147, 147A, 148, 148B, 148E, 148F, 150A, or 153; a mental health professional as defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; or vendor of medical care defined in section 256B.02, subdivision 7; and

(2) authorized within their respective scope of practice to provide the particular service with no supervision or under general supervision.

Subd. 7. **Originating site.** "Originating site" means a site including, but not limited to, a health care facility at which a patient is located at the time health care services are provided to the patient by means of telemedicine.

Subd. 8. **Store-and-forward technology.** "Store-and-forward technology" means the transmission of a patient's medical information from an originating site to a health care provider at a distant site without the patient being present, or the delivery of telemedicine that does not occur in real time via synchronous transmissions.

Subd. 9. **Telemedicine.** "Telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

62A.672 COVERAGE OF TELEMEDICINE SERVICES.

Subdivision 1. **Coverage of telemedicine.** (a) A health plan sold, issued, or renewed by a health carrier for which coverage of benefits begins on or after January 1, 2017, shall include coverage for telemedicine benefits in the same manner as any other benefits covered under the policy, plan, or contract, and shall comply with the regulations of this section.

(b) Nothing in this section shall be construed to:

(1) require a health carrier to provide coverage for services that are not medically necessary;

(2) prohibit a health carrier from establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service via telemedicine for which the health carrier does not already reimburse other health care providers for delivering via telemedicine, so long as the criteria are not unduly burdensome or unreasonable for the particular service; or

(3) prevent a health carrier from requiring a health care provider to agree to certain documentation or billing practices designed to protect the health carrier or patients from fraudulent claims so long as the practices are not unduly burdensome or unreasonable for the particular service.

Subd. 2. **Parity between telemedicine and in-person services.** A health carrier shall not exclude a service for coverage solely because the service is provided via telemedicine and is not provided through in-person consultation or contact between a licensed health care provider and a patient.

Subd. 3. **Reimbursement for telemedicine services.** (a) A health carrier shall reimburse the distant site licensed health care provider for covered services delivered via telemedicine on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered in person by the distant site licensed health care provider.

(b) It is not a violation of this subdivision for a health carrier to include a deductible, co-payment, or coinsurance requirement for a health care service provided via telemedicine, provided that the deductible, co-payment, or coinsurance is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable if the same services were provided through in-person contact.

62J.63 CENTER FOR HEALTH CARE PURCHASING IMPROVEMENT.

Subd. 3. **Report.** The commissioner of health must report annually to the legislature and the governor on the operations, activities, and impacts of the center. The report must be posted on the Department of Health website and must be available to the public. The report must include a description of the state's efforts to develop and use more common strategies for health care performance measurement and health care purchasing. The report must also include an assessment of the impacts of these efforts, especially in promoting greater transparency of health care costs and quality, and greater accountability for health care results and improvement.

119B.04 FEDERAL CHILD CARE AND DEVELOPMENT FUND.

Subdivision 1. **Commissioner to administer program.** The commissioner is authorized and directed to receive, administer, and expend funds available under the child care and development fund under Public Law 104-193, Title VI.

Subd. 2. **Rulemaking authority.** The commissioner may adopt rules under chapter 14 to administer the child care and development fund.

119B.125 PROVIDER REQUIREMENTS.

Subd. 5. **Provisional payment.** After a county receives a completed application from a provider, the county may issue provisional authorization and payment to the provider during the time needed to determine whether to give final authorization to the provider.

144.0721 ASSESSMENTS OF CARE AND SERVICES TO NURSING HOME RESIDENTS.

Subdivision 1. **Appropriateness and quality.** Until the date of implementation of the revised case mix system based on the minimum data set, the commissioner of health shall assess the appropriateness and quality of care and services furnished to private paying residents in nursing homes and boarding care homes that are certified for participation in the medical assistance program under United States Code, title 42, sections 1396-1396p. These assessments shall be conducted until the date of implementation of the revised case mix system with the exception of provisions requiring recommendations for changes in the level of care provided to the private paying residents.

144.0722 RESIDENT REIMBURSEMENT CLASSIFICATIONS.

Subdivision 1. **Resident reimbursement classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under section 144.0721, or under rules established by the commissioner of human services under chapter 256R. The reimbursement classifications established by the commissioner must conform to the rules established by the commissioner of human services.

Subd. 2. **Notice of resident reimbursement classification.** The commissioner of health shall notify each resident, and the nursing home or boarding care home in which the resident resides, of the reimbursement classification established under subdivision 1. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification. The notice of resident classification must be sent by first-class mail. The individual resident notices may be sent to the resident's nursing home or boarding care home for distribution to the resident. The nursing home or boarding care home is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the notices from the department.

Subd. 2a. **Semiannual assessment by nursing facilities.** Notwithstanding Minnesota Rules, part 9549.0059, subpart 2, item B, the individual dependencies items 21 to 24 and 28 are required to be completed in accordance with the Facility Manual for Completing Case Mix Requests for Classification, July 1987, issued by the Minnesota Department of Health.

Subd. 3. **Request for reconsideration.** The resident or the nursing home or boarding care home may request that the commissioner reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the receipt of the notice of resident classification. For reconsideration requests submitted by or on behalf of the resident, the time period for submission of the request begins as of the date the resident or the resident's representative receives the classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation establishing that the needs of the resident at the time of the assessment resulting in the disputed classification justify a change of classification.

Subd. 3a. **Access to information.** Upon written request, the nursing home or boarding care home must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the department to support the assessment findings. The nursing home or boarding care home shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues. For the purposes of this section, "representative" includes the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the nursing home ombudsman's office whose assistance has been requested, or any other individual designated by the resident.

Subd. 3b. **Facility's request for reconsideration.** In addition to the information required in subdivision 3, a reconsideration request from a nursing home or boarding care home must contain the following information: the date the resident reimbursement classification notices were received by the facility; the date the classification notices were distributed to the resident or the resident's representative; and a copy of a notice sent to the resident or to the resident's representative. This notice must tell the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the department and the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide this information with the

reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

Subd. 4. **Reconsideration.** The commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under subdivision 3. If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. In its discretion, the commissioner may review the reimbursement classifications assigned to all residents in the facility. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the needs of the resident at the time of the assessment. The resident and the nursing home or boarding care home shall be notified within five working days after the decision is made. The commissioner's decision under this subdivision is the final administrative decision of the agency.

Subd. 5. **Audit authority.** The Department of Health may audit assessments of nursing home and boarding care home residents. These audits may be in addition to the assessments completed by the department under section 144.0721. The audits may be conducted at the facility, and the department may conduct the audits on an unannounced basis.

144.0724 RESIDENT REIMBURSEMENT CLASSIFICATION.

Subd. 10. **Transition.** After implementation of this section, reconsiderations requested for classifications made under section 144.0722, subdivision 1, shall be determined under section 144.0722, subdivision 3.

144.693 MEDICAL MALPRACTICE CLAIMS; REPORTS.

Subdivision 1. **Insurers' reports to commissioner.** On or before September 1, 1976, and on or before March 1 and September 1 of each year thereafter, each insurer providing professional liability insurance to one or more hospitals, outpatient surgery centers, or health maintenance organizations, shall submit to the state commissioner of health a report listing by facility or organization all claims which have been closed by or filed with the insurer during the period ending December 31 of the previous year or June 30 of the current year. The report shall contain, but not be limited to, the following information:

(1) the total number of claims made against each facility or organization which were filed or closed during the reporting period;

(2) the date each new claim was filed with the insurer;

(3) the allegations contained in each claim filed during the reporting period;

(4) the disposition and closing date of each claim closed during the reporting period;

(5) the dollar amount of the award or settlement for each claim closed during the reporting period; and

(6) any other information the commissioner of health may, by rule, require.

Any hospital, outpatient surgery center, or health maintenance organization which is self insured shall be considered to be an insurer for the purposes of this section and shall comply with the reporting provisions of this section.

A report from an insurer submitted pursuant to this section is private data, as defined in section 13.02, subdivision 12, accessible to the facility or organization which is the subject of the data, and to its authorized agents. Any data relating to patient records which is reported to the state commissioner of health pursuant to this section shall be reported in the form of summary data, as defined in section 13.02, subdivision 19.

Subd. 2. **Report to legislature.** The state commissioner of health shall collect and review the data reported pursuant to subdivision 1. On December 1, 1976, and on January 2 of each year thereafter, the state commissioner of health shall report to the legislature the findings related to the incidence and size of malpractice claims against hospitals, outpatient surgery centers, and health maintenance organizations, and shall make any appropriate recommendations to reduce the incidence and size of the claims. Data published by the state commissioner of health pursuant to this subdivision with respect to malpractice claims information shall be summary data within the meaning of section 13.02, subdivision 19.

Subd. 3. **Access to insurers' records.** The state commissioner of health shall have access to the records of any insurer relating to malpractice claims made against hospitals, outpatient surgery centers, and health maintenance organizations in years prior to 1976 if the commissioner determines the records are necessary to fulfill the duties of the commissioner under Laws 1976, chapter 325.

245.462 DEFINITIONS.

Subd. 4a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional cosigning individual treatment plans and by entries in the client's record regarding supervisory activities.

245.4871 DEFINITIONS.

Subd. 32a. **Responsible social services agency.** "Responsible social services agency" is defined in section 260C.007, subdivision 27a.

245.4879 EMERGENCY SERVICES.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to the child with an emotional disturbance provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) When emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

245.62 COMMUNITY MENTAL HEALTH CENTER.

Subd. 3. **Clinical supervisor.** All community mental health center services shall be provided under the clinical supervision of a licensed psychologist licensed under sections 148.88 to 148.98, or a physician who is board certified or eligible for board certification in psychiatry, and who is licensed under section 147.02.

Subd. 4. **Rules.** The commissioner shall promulgate rules to establish standards for the designation of an agency as a community mental health center. These standards shall include, but are not limited to:

(1) provision of mental health services in the prevention, identification, treatment and aftercare of emotional disorders, chronic and acute mental illness, developmental disabilities, and alcohol and drug abuse and dependency, including the services listed in section 245.61 except detoxification services;

(2) establishment of a community mental health center board pursuant to section 245.66; and

(3) approval pursuant to section 245.69, subdivision 2.

245.69 ADDITIONAL DUTIES OF COMMISSIONER.

Subd. 2. **Approval of centers and clinics.** The commissioner of human services has the authority to approve or disapprove public and private mental health centers and public and private mental health clinics for the purposes of section 62A.152, subdivision 2. For the purposes of this subdivision the commissioner shall promulgate rules in accordance with sections 14.001 to 14.69. The rules shall require each applicant to pay a fee to cover costs of processing applications and determining compliance with the rules and this subdivision. The commissioner may contract with any state agency, individual, corporation or association to which the commissioner shall delegate all but final approval and disapproval authority to determine compliance or noncompliance.

(a) Each approved mental health center and each approved mental health clinic shall have a multidisciplinary team of professional staff persons as required by rule. A mental health center or mental health clinic may provide the staffing required by rule by means of written contracts with professional persons or with other health care providers. Any personnel qualifications developed by rule shall be consistent with any personnel standards developed pursuant to chapter 214.

(b) Each approved mental health clinic and each approved mental health center shall establish a written treatment plan for each outpatient for whom services are reimbursable through insurance or public assistance. The treatment plan shall be developed in accordance with the rules and shall include a patient history, treatment goals, a statement of diagnosis and a treatment strategy. The clinic or center shall provide access to hospital admission as a bed patient as needed by any outpatient. The clinic or center shall ensure ongoing consultation among and availability of all members of the multidisciplinary team.

(c) As part of the required consultation, members of the multidisciplinary team shall meet at least twice monthly to conduct case reviews, peer consultations, treatment plan development and in-depth case discussion. Written minutes of these meetings shall be kept at the clinic or center for three years.

(d) Each approved center or clinic shall establish mechanisms for quality assurance and submit documentation concerning the mechanisms to the commissioner as required by rule, including:

(1) continuing education of each professional staff person;

(2) an ongoing internal utilization and peer review plan and procedures;

(3) mechanisms of staff supervision; and

(4) procedures for review by the commissioner or a delegate.

(e) The commissioner shall disapprove an applicant, or withdraw approval of a clinic or center, which the commissioner finds does not comply with the requirements of the rules or this subdivision. A clinic or center which is disapproved or whose approval is withdrawn is entitled to a contested case hearing and judicial review pursuant to sections 14.01 to 14.69.

(f) Data on individuals collected by approved clinics and centers, including written minutes of team meetings, is private data on individuals within the welfare system as provided in chapter 13.

(g) Each center or clinic that is approved and in compliance with the commissioner's existing rule on July 1, 1980, is approved for purposes of section 62A.152, subdivision 2, until rules are promulgated to implement this section.

245.735 EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.

Subdivision 1. **Excellence in Mental Health demonstration project.** The commissioner shall develop and execute projects to reform the mental health system by participating in the Excellence in Mental Health demonstration project.

Subd. 2. **Federal proposal.** The commissioner shall develop and submit to the United States Department of Health and Human Services a proposal for the Excellence in Mental Health demonstration project. The proposal shall include any necessary state plan amendments, waivers, requests for new funding, realignment of existing funding, and other authority necessary to implement the projects specified in subdivision 3.

Subd. 4. **Public participation.** In developing and implementing CCBHCs under subdivision 3, the commissioner shall consult, collaborate, and partner with stakeholders, including but not limited to mental health providers, substance use disorder treatment providers, advocacy organizations, licensed mental health professionals, counties, tribes, hospitals, other health care providers, and Minnesota public health care program enrollees who receive mental health services and their families.

245C.10 BACKGROUND STUDY; FEES.

Subd. 2. **Supplemental nursing services agencies.** The commissioner shall recover the cost of the background studies initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1, through a fee of no more than $20 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 2a. **Occupations regulated by commissioner of health.** The commissioner shall set fees to recover the cost of combined background studies and criminal background checks initiated by applicants, licensees, and certified practitioners regulated under sections 148.511 to 148.5198 and chapter 153A. The fees collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks.

Subd. 3. **Personal care provider organizations.** The commissioner shall recover the cost of background studies initiated by a personal care provider organization under sections 256B.0651 to 256B.0654 and 256B.0659 through a fee of no more than $20 per study charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 4. **Temporary personnel agencies, educational programs, and professional services agencies.** The commissioner shall recover the cost of the background studies initiated by temporary personnel agencies, educational programs, and professional services agencies that initiate background studies under section 245C.03, subdivision 4, through a fee of no more than $20 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 5. **Adult foster care and family adult day services.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for the purposes of adult foster care and family adult day services licensing, through a fee of no more than $20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** The commissioner shall recover the cost of background studies initiated by unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities under section 256B.4912 through a fee of no more than $20 per study.

Subd. 7. **Private agencies.** The commissioner shall recover the cost of conducting background studies under section 245C.33 for studies initiated by private agencies for the purpose of adoption through a fee of no more than $70 per study charged to the private agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 8. **Children's therapeutic services and supports providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 7, for the purposes of children's therapeutic services and supports under section 256B.0943, through a fee of no more than $20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for all programs that are licensed by the commissioner, except child foster care when the applicant or license holder resides in the home where child foster care services are provided, family child care, child care centers, certified license-exempt child care centers, and legal nonlicensed child care authorized under chapter 119B, through a fee of no more than $20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 9a. **Child care programs.** The commissioner shall recover the cost of a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care providers authorized under chapter 119B through a fee of no more than $40 per study charged to the license holder. A fee of no more than $20 per study shall be charged for studies conducted under section 245C.05, subdivision 5a, paragraph (a). The fees collected under this subdivision are appropriated to the commissioner to conduct background studies.

Subd. 10. **Community first services and supports organizations.** The commissioner shall recover the cost of background studies initiated by an agency-provider delivering services under section 256B.85, subdivision 11, or a financial management services provider providing service functions under section 256B.85, subdivision 13, through a fee of no more than $20 per study, charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 11. **Providers of housing support.** The commissioner shall recover the cost of background studies initiated by providers of housing support under section 256I.04 through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 12. **Child protection workers or social services staff having responsibility for child protective duties.** The commissioner shall recover the cost of background studies initiated by county social services agencies and local welfare agencies for individuals who are required to have a background study under section 626.559, subdivision 1b, through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 13. **Providers of special transportation service.** The commissioner shall recover the cost of background studies initiated by providers of special transportation service under section 174.30 through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 14. **Children's residential facilities.** The commissioner shall recover the cost of background studies initiated by a licensed children's residential facility through a fee of no more than $51 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Subd. 16. **Providers of housing support services.** The commissioner shall recover the cost of background studies initiated by providers of housing support services under section 256B.051 through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

256B.0596 MENTAL HEALTH CASE MANAGEMENT.

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Counties shall contract with eligible providers willing to provide mental health case management services under section 256B.0625, subdivision 20. In order to be eligible, in addition to general provider requirements under this chapter, the provider must:

(1) be willing to provide the mental health case management services; and

(2) have a minimum of at least one contact with the client per week. This section is not intended to limit the ability of a county to provide its own mental health case management services.

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256B.0615 MENTAL HEALTH CERTIFIED PEER SPECIALIST.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified peer specialist program model, which:

(1) provides nonclinical peer support counseling by certified peer specialists;

(2) provides a part of a wraparound continuum of services in conjunction with other community mental health services;

(3) is individualized to the consumer; and

(4) promotes socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

256B.0616 MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified family peer specialists program model which:

(1) provides nonclinical family peer support counseling, building on the strengths of families and helping them achieve desired outcomes;

(2) collaborates with others providing care or support to the family;

(3) provides nonadversarial advocacy;

(4) promotes the individual family culture in the treatment milieu;

(5) links parents to other parents in the community;

(6) offers support and encouragement;

(7) assists parents in developing coping mechanisms and problem-solving skills;

(8) promotes resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services;

(9) establishes and provides peer-led parent support groups; and

(10) increases the child's ability to function better within the child's home, school, and community by educating parents on community resources, assisting with problem solving, and educating parents on mental illnesses.

256B.0622 ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL TREATMENT SERVICES.

Subd. 3. **Eligibility for intensive residential treatment services.** An eligible client for intensive residential treatment services is an individual who:

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

(4) because of a mental illness, has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced;

(5) has one or more of the following: a history of recurring or prolonged inpatient hospitalizations in the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services yielding poor outcomes; and

(6) in the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided.

Subd. 5a. **Standards for intensive residential rehabilitative mental health services.** (a) The standards in this subdivision apply to intensive residential mental health services.

(b) The provider of intensive residential treatment services must have sufficient staff to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the treatment plan and to safely supervise and direct the activities of clients, given the client's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education, when appropriate.

(c) At a minimum:

(1) staff must provide direction and supervision whenever clients are present in the facility;

(2) staff must remain awake during all work hours;

(3) there must be a staffing ratio of at least one to nine clients for each day and evening shift. If more than nine clients are present at the residential site, there must be a minimum of two staff during day and evening shifts, one of whom must be a mental health practitioner or mental health professional;

(4) if services are provided to clients who need the services of a medical professional, the provider shall ensure that these services are provided either by the provider's own medical staff or through referral to a medical professional; and

(5) the provider must ensure the timely availability of a licensed registered nurse, either directly employed or under contract, who is responsible for ensuring the effectiveness and safety of medication administration in the facility and assessing clients for medication side effects and drug interactions.

(d) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5, who are trained and supervised according to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, paragraph (a), clause (4), item (iv).

(e) The clinical supervisor must be an active member of the intensive residential services treatment team. The team must meet with the clinical supervisor at least weekly to discuss clients' progress and make rapid adjustments to meet clients' needs. The team meeting shall include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the client's treatment record.

(f) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(g) The initial functional assessment must be completed within ten days of intake and updated at least every 30 days, or prior to discharge from the service, whichever comes first.

(h) The initial individual treatment plan must be completed within 24 hours of admission. Within ten days of admission, the initial treatment plan must be refined and further developed, except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the client and updated at least monthly.

256B.0623 ADULT REHABILITATIVE MENTAL HEALTH SERVICES COVERED.

Subd. 7. **Personnel file.** The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff. Each file must contain:

(1) an annual performance review;

(2) a summary of on-site service observations and charting review;

(3) a criminal background check of all direct service staff;

(4) evidence of academic degree and qualifications;

(5) a copy of professional license;

(6) any job performance recognition and disciplinary actions;

(7) any individual staff written input into own personnel file;

(8) all clinical supervision provided; and

(9) documentation of compliance with continuing education requirements.

Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within three years preceding admission, an adult diagnostic assessment update must be completed. An update shall include a face-to-face interview with the recipient and a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required.

Subd. 10. **Individual treatment plan.** All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient. The provisions in clauses (1) and (2) apply:

(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake. The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

(2) The individual treatment plan must include:

(i) a list of problems identified in the assessment;

(ii) the recipient's strengths and resources;

(iii) concrete, measurable goals to be achieved, including time frames for achievement;

(iv) specific objectives directed toward the achievement of each one of the goals;

(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;

(vi) cultural considerations, resources, and needs of the recipient must be included;

(vii) planned frequency and type of services must be initiated; and

(viii) clear progress notes on outcome of goals.

(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).

Subd. 11. **Recipient file.** Providers of adult rehabilitative mental health services must maintain a file for each recipient that contains the following information:

(1) diagnostic assessment or verification of its location that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;

(2) functional assessments;

(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(4) recipient history;

(5) signed release forms;

(6) recipient health information and current medications;

(7) emergency contacts for the recipient;

(8) case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;

(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;

(10) summary of recipient case reviews by staff; and

(11) written information by the recipient that the recipient requests be included in the file.

256B.0625 COVERED SERVICES.

Subd. 5l. **Intensive mental health outpatient treatment.** Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy. The commissioner shall establish:

(1) certification procedures to ensure that providers of these services are qualified; and

(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

Subd. 18c. **Nonemergency Medical Transportation Advisory Committee.** (a) The Nonemergency Medical Transportation Advisory Committee shall advise the commissioner on the administration of nonemergency medical transportation covered under medical assistance. The advisory committee shall meet at least quarterly the first year following January 1, 2015, and at least biannually thereafter and may meet more frequently as required by the commissioner. The advisory committee shall annually elect a chair from among its members, who shall work with the commissioner or the commissioner's designee to establish the agenda for each meeting. The commissioner, or the commissioner's designee, shall attend all advisory committee meetings.

(b) The Nonemergency Medical Transportation Advisory Committee shall advise and make recommendations to the commissioner on:

(1) updates to the nonemergency medical transportation policy manual;

(2) other aspects of the nonemergency medical transportation system, as requested by the commissioner; and

(3) other aspects of the nonemergency medical transportation system, as requested by:

(i) a committee member, who may request an item to be placed on the agenda for a future meeting. The request may be considered by the committee and voted upon. If the motion carries, the meeting agenda item may be developed for presentation to the committee; and

(ii) a member of the public, who may approach the committee by letter or e-mail requesting that an item be placed on a future meeting agenda. The request may be considered by the committee and voted upon. If the motion carries, the agenda item may be developed for presentation to the committee.

(c) The Nonemergency Medical Transportation Advisory Committee shall coordinate its activities with the Minnesota Council on Transportation Access established under section 174.285. The chair of the advisory committee, or the chair's designee, shall attend all meetings of the Minnesota Council on Transportation Access.

(d) The Nonemergency Medical Transportation Advisory Committee shall expire December 1, 2019.

Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical Transportation Advisory Committee consists of:

(1) four voting members who represent counties, utilizing the rural urban commuting area classification system. As defined in subdivision 17, these members shall be designated as follows:

(i) two counties within the 11-county metropolitan area;

(ii) one county representing the rural area of the state; and

(iii) one county representing the super rural area of the state.

The Association of Minnesota Counties shall appoint one county within the 11-county metropolitan area and one county representing the super rural area of the state. The Minnesota Inter-County Association shall appoint one county within the 11-county metropolitan area and one county representing the rural area of the state;

(2) three voting members who represent medical assistance recipients, including persons with physical and developmental disabilities, persons with mental illness, seniors, children, and low-income individuals;

(3) five voting members who represent providers that deliver nonemergency medical transportation services to medical assistance enrollees, one of whom is a taxicab owner or operator;

(4) two voting members of the house of representatives, one from the majority party and one from the minority party, appointed by the speaker of the house, and two voting members from the senate, one from the majority party and one from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(5) one voting member who represents demonstration providers as defined in section 256B.69, subdivision 2;

(6) one voting member who represents an organization that contracts with state or local governments to coordinate transportation services for medical assistance enrollees;

(7) one voting member who represents the Minnesota State Council on Disability;

(8) the commissioner of transportation or the commissioner's designee, who shall serve as a voting member;

(9) one voting member appointed by the Minnesota Ambulance Association; and

(10) one voting member appointed by the Minnesota Hospital Association.

(b) Members of the advisory committee shall not be employed by the Department of Human Services. Members of the advisory committee shall receive no compensation.

Subd. 18e. **Single administrative structure and delivery system.** The commissioner, in coordination with the commissioner of transportation, shall implement a single administrative structure and delivery system for nonemergency medical transportation, beginning the latter of the date the single administrative assessment tool required in this subdivision is available for use, as determined by the commissioner or by July 1, 2016.

In coordination with the Department of Transportation, the commissioner shall develop and authorize a web-based single administrative structure and assessment tool, which must operate 24 hours a day, seven days a week, to facilitate the enrollee assessment process for nonemergency medical transportation services. The web-based tool shall facilitate the transportation eligibility determination process initiated by clients and client advocates; shall include an accessible automated intake and assessment process and real-time identification of level of service eligibility; and shall authorize an appropriate and auditable mode of transportation authorization. The tool shall provide a single framework for reconciling trip information with claiming and collecting complaints regarding inappropriate level of need determinations, inappropriate transportation modes utilized, and interference with accessing nonemergency medical transportation. The web-based single administrative structure shall operate on a trial basis for one year from implementation and, if approved by the commissioner, shall be permanent thereafter. The commissioner shall seek input from the Nonemergency Medical Transportation Advisory Committee to ensure the software is effective and user-friendly and make recommendations regarding funding of the single administrative system.

Subd. 18h. **Managed care.** (a) The following subdivisions apply to managed care plans and county-based purchasing plans:

(1) subdivision 17, paragraphs (a), (b), (i), and (n);

(2) subdivision 18; and

(3) subdivision 18a.

(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service specified in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

Subd. 35a. **Children's mental health crisis response services.** Medical assistance covers children's mental health crisis response services according to section 256B.0944.

Subd. 35b. **Children's therapeutic services and supports.** Medical assistance covers children's therapeutic services and supports according to section 256B.0943.

Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who has determined it medically necessary to involve family members in the child's care. For the purposes of this subdivision, "family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

Subd. 65. **Outpatient mental health services.** Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy according to Minnesota Rules, part 9505.0372, when the mental health services are performed by a mental health practitioner working as a clinical trainee according to section 245.462, subdivision 17, paragraph (g).

256B.0916 EXPANSION OF HOME AND COMMUNITY-BASED SERVICES.

Subd. 2. **Distribution of funds; partnerships.** (a) Beginning with fiscal year 2000, the commissioner shall distribute all funding available for home and community-based waiver services for persons with developmental disabilities to individual counties or to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals. The commissioner shall encourage counties to form partnerships that have a sufficient number of recipients and funding to adequately manage the risk and maximize use of available resources.

(b) Counties must submit a request for funds and a plan for administering the program as required by the commissioner. The plan must identify the number of clients to be served, their ages, and their priority listing based on:

(1) requirements in Minnesota Rules, part 9525.1880; and

(2) statewide priorities identified in section 256B.092, subdivision 12.

The plan must also identify changes made to improve services to eligible persons and to improve program management.

(c) In allocating resources to counties, priority must be given to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals and to counties determined by the commissioner to have sufficient waiver capacity to maximize resource use.

(d) Within 30 days after receiving the county request for funds and plans, the commissioner shall provide a written response to the plan that includes the level of resources available to serve additional persons.

(e) Counties are eligible to receive medical assistance administrative reimbursement for administrative costs under criteria established by the commissioner.

(f) The commissioner shall manage waiver allocations in such a manner as to fully use available state and federal waiver appropriations.

Subd. 3. **Failure to develop partnerships or submit a plan.** (a) By October 1 of each year the commissioner shall notify the county board if any county determined by the commissioner to have insufficient capacity to maximize use of available resources fails to develop a partnership with other counties or fails to submit a plan as required in subdivision 2. The commissioner shall provide needed technical assistance to a county or group of counties that fails to form a partnership or submit a plan. If a county has not joined a county partnership or submitted a plan within 30 days following the notice by the commissioner of its failure, the commissioner shall require and assist that county to develop a plan or contract with another county or group of counties to plan and administer the waiver services program in that county.

(b) Counties may request technical assistance, management information, and administrative support from the commissioner at any time. The commissioner shall respond to county requests within 30 days. Priority shall be given to activities that support the administrative needs of newly formed county partnerships.

Subd. 4. **Allowed reserve.** Counties or groups of counties participating in partnerships that have submitted a plan under this section may develop an allowed reserve amount to meet crises and other unmet needs of current home and community-based waiver recipients. The amount of the allowed reserve shall be a county specific amount based upon documented past experience and projected need for the coming year described in an allowed reserve plan submitted for approval to the commissioner with the allocation request for the fiscal year.

Subd. 5. **Allocation of new diversions and priorities for reassignment of resources for developmental disabilities.** (a) The commissioner shall monitor county utilization of allocated resources and, as appropriate, reassign resources not utilized.

(b) Effective July 1, 2002, the commissioner shall authorize the spending of new diversion resources beginning January 1 of each year.

(c) Effective July 1, 2002, the commissioner shall manage the reassignment of waiver resources that occur from persons who have left the waiver in a manner that results in the cost reduction equivalent to delaying the reuse of those waiver resources by 180 days.

(d) Priority consideration for reassignment of resources shall be given to counties that form partnerships. In addition to the priorities listed in Minnesota Rules, part 9525.1880, the commissioner shall also give priority consideration to persons whose living situations are unstable due to the age or incapacity of the primary caregiver and to children to avoid out-of-home placement.

Subd. 8. **Financial and wait-list data reporting.** (a) The commissioner shall make available financial and waiting list information on the department's website.

(b) The financial information must include:

(1) the most recent end of session forecast available for the disability home and community-based waiver programs authorized under sections 256B.092 and 256B.49; and

(2) the most current financial information, updated at least monthly for the disability home and community-based waiver program authorized under section 256B.092 and three disability home and community-based waiver programs authorized under section 256B.49 for each county and tribal agency, including:

(i) the amount of resources allocated;

(ii) the amount of resources authorized for participants; and

(iii) the amount of allocated resources not authorized and the amount not used as provided in subdivision 12, and section 256B.49, subdivision 27.

(c) The waiting list information must be provided quarterly beginning August 1, 2016, and must include at least:

(1) the number of persons screened and waiting for services listed by urgency category, the number of months on the wait list, age group, and the type of services requested by those waiting;

(2) the number of persons beginning waiver services who were on the waiting list, and the number of persons beginning waiver services who were not on the waiting list;

(3) the number of persons who left the waiting list but did not begin waiver services; and

(4) the number of persons on the waiting list with approved funding but without a waiver service agreement and the number of days from funding approval until a service agreement is effective for each person.

(d) By December 1 of each year, the commissioner shall compile a report posted on the department's website that includes:

(1) the financial information listed in paragraph (b) for the most recently completed allocation period;

(2) for the previous four quarters, the waiting list information listed in paragraph (c);

(3) for a 12-month period ending October 31, a list of county and tribal agencies required to submit a corrective action plan under subdivisions 11 and 12, and section 256B.49, subdivisions 26 and 27; and

(4) for a 12-month period ending October 31, a list of the county and tribal agencies from which resources were moved as authorized in section 256B.092, subdivision 12, and section 256B.49, subdivision 11a, the amount of resources taken from each agency, the counties that were given increased resources as a result, and the amounts provided.

Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending in excess of the allocation made by the commissioner. In the event a county or tribal agency spends in excess of the allocation made by the commissioner for a given allocation period, they must submit a corrective action plan to the commissioner for approval. The plan must state the actions the agency will take to correct their overspending for the two years following the period when the overspending occurred. The commissioner shall recoup spending in excess of the allocation only in cases where statewide spending exceeds the appropriation designated for the home and community-based services waivers. Nothing in this subdivision shall be construed as reducing the county's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to them for that purpose.

Subd. 12. **Use of waiver allocations.** County and tribal agencies are responsible for spending the annual allocation made by the commissioner. In the event a county or tribal agency spends less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services. If a county or tribe does not submit a plan when required or implement the changes required, the commissioner shall assure access to waiver services within the county's or tribe's available allocation and take other actions needed to assure that all waiver participants in that county or tribe are receiving appropriate waiver services to meet their needs.

256B.0924 TARGETED CASE MANAGEMENT SERVICES.

Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment under subdivision 6 if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contact.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;

(3) established protocols addressing how and when to discontinue interactive video services; and

(4) established a quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video:

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

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the person receiving case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized;

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

(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).

256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.

Subd. 8. **Required preservice and continuing education.** (a) A provider entity shall establish a plan to provide preservice and continuing education for staff. The plan must clearly describe the type of training necessary to maintain current skills and obtain new skills and that relates to the provider entity's goals and objectives for services offered.

(b) A provider that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of preservice training. The preservice training must include parent team training. The preservice training must include 15 hours of in-person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Curricula for parent team training must be approved in advance by the commissioner. Components of parent team training include:

(1) partnering with parents;

(2) fundamentals of family support;

(3) fundamentals of policy and decision making;

(4) defining equal partnership;

(5) complexities of the parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses;

(6) sibling impacts;

(7) support networks; and

(8) community resources.

(c) A provider entity that employs a mental health practitioner and a mental health behavioral aide to provide children's therapeutic services and supports under this section must require the mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. The continuing education must be related to serving the needs of a child with emotional disturbance in the child's home environment and the child's family.

(d) The provider entity must document the mental health practitioner's or mental health behavioral aide's annual completion of the required continuing education. The documentation must include the date, subject, and number of hours of the continuing education, and attendance records, as verified by the staff member's signature, job title, and the instructor's name. The provider entity must keep documentation for each employee, including records of attendance at professional workshops and conferences, at a central location and in the employee's personnel file.

Subd. 10. **Service authorization.** Children's therapeutic services and supports are subject to authorization criteria and standards published by the commissioner according to section 256B.0625, subdivision 25.

256B.0944 CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.

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

(a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation that, but for the provision of crisis response services to the child, would likely result in significantly reduced levels of functioning in primary activities of daily living, an emergency situation, or the child's placement in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or crisis mental health practitioner determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests the child may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency. Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Mental health mobile services must be provided on site by a mobile crisis intervention team outside of an inpatient hospital setting.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

Subd. 2. **Medical assistance coverage.** Medical assistance covers medically necessary children's mental health crisis response services, subject to federal approval, if provided to an eligible recipient under subdivision 3, by a qualified provider entity under subdivision 4 or a qualified individual provider working within the provider's scope of practice, and identified in the recipient's individual crisis treatment plan under subdivision 8.

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is eligible for medical assistance;

(2) is under age 18 or between the ages of 18 and 21;

(3) is screened as possibly experiencing a mental health crisis or mental health emergency where a mental health crisis assessment is needed;

(4) is assessed as experiencing a mental health crisis or mental health emergency, and mental health mobile crisis intervention or mental health crisis stabilization services are determined to be medically necessary; and

(5) meets the criteria for emotional disturbance or mental illness.

Subd. 4. **Provider entity standards.** (a) A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:

(1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility;

(2) a county board-operated entity; or

(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.

(b) The children's mental health crisis response services provider entity must:

(1) ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(2) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;

(3) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4889; and

(4) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high-risk situations.

Subd. 4a. **Alternative provider standards.** If a provider entity demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services 24 hours a day, seven days a week, according to the standards in subdivision 4, paragraph (b), clause (1), the commissioner may approve a crisis response provider based on an alternative plan proposed by a provider entity. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of crisis services; and

(2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays.

Subd. 5. **Mobile crisis intervention staff qualifications.** (a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:

(1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph (o); or

(2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.

(b) The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including the county social services agency, mental health service providers, and local law enforcement, if necessary.

Subd. 6. **Initial screening and crisis assessment planning.** (a) Before initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening

may use the resources of crisis assistance and emergency services as defined in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify the parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment must evaluate any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As the opportunity presents itself during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required under subdivision 9.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The crisis treatment plan must be updated as needed to reflect current goals and services. The team must involve the client and the client's family in developing and implementing the plan.

(e) The team must document in progress notes which short-term goals have been met and when no further crisis intervention services are required.

(f) If the client's crisis is stabilized, but the client needs a referral for mental health crisis stabilization services or to other services, the team must provide a referral to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Subd. 7. **Crisis stabilization services.** Crisis stabilization services must be provided by a mental health professional or a mental health practitioner, as defined in section 245.462, subdivision 17, who works under the clinical supervision of a mental health professional and for a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 8;

(2) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community; and

(3) mental health practitioners must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 8. **Treatment plan.** (a) The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;

(4) specific objectives directed toward the achievement of each goal;

(5) documentation of the participants involved in the service planning;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur; and

(8) clear progress notes on the outcome of goals.

(b) The client, if clinically appropriate, must be a participant in the development of the crisis stabilization treatment plan. The client or the client's legal guardian must sign the service plan or

documentation must be provided why this was not possible. A copy of the plan must be given to the client and the client's legal guardian. The plan should include services arranged, including specific providers where applicable.

(c) A treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. A written plan must be completed within 24 hours of beginning services with the client.

Subd. 9. **Supervision.** (a) A mental health practitioner may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by telephone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by telephone, during the first three hours when a mental health practitioner provides on-site service; and

(4) the mental health professional must review and approve the tentative crisis assessment and crisis treatment plan, document the consultation, and sign the crisis assessment and treatment plan within the next business day.

(b) If the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan. The on-site observation must be documented in the client's record and signed by the mental health professional.

Subd. 10. **Client record.** The provider must maintain a file for each client that complies with the requirements under section 256B.0943, subdivision 11, and contains the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient for not signing the plan;

(2) signed release of information forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records that document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

Subd. 11. **Excluded services.** The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) transportation services under children's mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide children's mental health crisis response services;

(5) crisis response services provided by a residential treatment center to clients in their facility;

(6) services performed by volunteers;

(7) direct billing of time spent "on call" when not delivering services to a recipient;

(8) provider service time included in case management reimbursement;

(9) outreach services to potential recipients; and

(10) a mental health service that is not medically necessary.

256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.

Subd. 5. **Service authorization.** The commissioner will administer authorizations for services under this section in compliance with section 256B.0625, subdivision 25.

256B.097 STATE QUALITY ASSURANCE, QUALITY IMPROVEMENT, AND LICENSING SYSTEM.

Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a State Quality Assurance, Quality Improvement, and Licensing System for Minnesotans receiving disability services is enacted. This system is a partnership between the Department of Human Services and the State Quality Council established under subdivision 3.

(b) This system is a result of the recommendations from the Department of Human Services' licensing and alternative quality assurance study mandated under Laws 2005, First Special Session chapter 4, article 7, section 57, and presented to the legislature in February 2007.

(c) The disability services eligible under this section include:

(1) the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, or section 256B.49, including brain injuries and services for those who qualify for nursing facility level of care or hospital facility level of care and any other services licensed under chapter 245D;

(2) home care services under section 256B.0651;

(3) family support grants under section 252.32;

(4) consumer support grants under section 256.476;

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

(6) services provided through an intermediate care facility for the developmentally disabled.

(d) For purposes of this section, the following definitions apply:

(1) "commissioner" means the commissioner of human services;

(2) "council" means the State Quality Council under subdivision 3;

(3) "Quality Assurance Commission" means the commission under section 256B.0951; and

(4) "system" means the State Quality Assurance, Quality Improvement and Licensing System under this section.

Subd. 2. **Duties of commissioner of human services.** (a) The commissioner of human services shall establish the State Quality Council under subdivision 3.

(b) The commissioner shall initially delegate authority to perform licensing functions and activities according to section 245A.16 to a host county in Region 10. The commissioner must not license or reimburse a participating facility, program, or service located in Region 10 if the commissioner has received notification from the host county that the facility, program, or service has failed to qualify for licensure.

(c) The commissioner may conduct random licensing inspections based on outcomes adopted under section 256B.0951, subdivision 3, at facilities or programs, and of services eligible under this section. The role of the random inspections is to verify that the system protects the safety and well-being of persons served and maintains the availability of high-quality services for persons with disabilities.

(d) The commissioner shall ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety and health or violated services-related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

(e) The commissioner shall seek a federal waiver by July 1, 2012, to allow intermediate care facilities for persons with developmental disabilities to participate in this system.

Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality Council which must define regional quality councils, and carry out a community-based, person-directed quality review component, and a comprehensive system for effective incident reporting, investigation, analysis, and follow-up.

(b) By August 1, 2011, the commissioner of human services shall appoint the members of the initial State Quality Council. Members shall include representatives from the following groups:

(1) disability service recipients and their family members;

(2) during the first four years of the State Quality Council, there must be at least three members from the Region 10 stakeholders. As regional quality councils are formed under subdivision 4, each regional quality council shall appoint one member;

(3) disability service providers;

(4) disability advocacy groups; and

(5) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(c) Members of the council who do not receive a salary or wages from an employer for time spent on council duties may receive a per diem payment when performing council duties and functions.

(d) The State Quality Council shall:

(1) assist the Department of Human Services in fulfilling federally mandated obligations by monitoring disability service quality and quality assurance and improvement practices in Minnesota;

(2) establish state quality improvement priorities with methods for achieving results and provide an annual report to the legislative committees with jurisdiction over policy and funding of disability services on the outcomes, improvement priorities, and activities undertaken by the commission during the previous state fiscal year;

(3) identify issues pertaining to financial and personal risk that impede Minnesotans with disabilities from optimizing choice of community-based services; and

(4) recommend to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and civil law by January 15, 2014, statutory and rule changes related to the findings under clause (3) that promote individualized service and housing choices balanced with appropriate individualized protection.

(e) The State Quality Council, in partnership with the commissioner, shall:

(1) approve and direct implementation of the community-based, person-directed system established in this section;

(2) recommend an appropriate method of funding this system, and determine the feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

(3) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems;

(4) establish variable licensure periods not to exceed three years based on outcomes achieved; and

(5) in cooperation with the Quality Assurance Commission, design a transition plan for licensed providers from Region 10 into the alternative licensing system.

(f) The State Quality Council shall notify the commissioner of human services that a facility, program, or service has been reviewed by quality assurance team members under subdivision 4, paragraph (b), clause (13), and qualifies for a license.

(g) The State Quality Council, in partnership with the commissioner, shall establish an ongoing review process for the system. The review shall take into account the comprehensive nature of the system which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to persons with disabilities. The review shall address efficiencies and effectiveness of the system.

(h) The State Quality Council may recommend to the commissioner certain variances from the standards governing licensure of programs for persons with disabilities in order to improve the

quality of services so long as the recommended variances do not adversely affect the health or safety of persons being served or compromise the qualifications of staff to provide services.

(i) The safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make recommendations to the commissioner or to the legislature in the report required under paragraph (c) regarding alternatives or modifications to the safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c).

(j) The State Quality Council may hire staff to perform the duties assigned in this subdivision.

Subd. 4. **Regional quality councils.** (a) The commissioner shall establish, as selected by the State Quality Council, regional quality councils of key stakeholders, including regional representatives of:

(1) disability service recipients and their family members;

(2) disability service providers;

(3) disability advocacy groups; and

(4) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(b) Each regional quality council shall:

(1) direct and monitor the community-based, person-directed quality assurance system in this section;

(2) approve a training program for quality assurance team members under clause (13);

(3) review summary reports from quality assurance team reviews and make recommendations to the State Quality Council regarding program licensure;

(4) make recommendations to the State Quality Council regarding the system;

(5) resolve complaints between the quality assurance teams, counties, providers, persons receiving services, their families, and legal representatives;

(6) analyze and review quality outcomes and critical incident data reporting incidents of life safety concerns immediately to the Department of Human Services licensing division;

(7) provide information and training programs for persons with disabilities and their families and legal representatives on service options and quality expectations;

(8) disseminate information and resources developed to other regional quality councils;

(9) respond to state-level priorities;

(10) establish regional priorities for quality improvement;

(11) submit an annual report to the State Quality Council on the status, outcomes, improvement priorities, and activities in the region;

(12) choose a representative to participate on the State Quality Council and assume other responsibilities consistent with the priorities of the State Quality Council; and

(13) recruit, train, and assign duties to members of quality assurance teams, taking into account the size of the service provider, the number of services to be reviewed, the skills necessary for the team members to complete the process, and ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with anyone served at the facility, program, or service. Quality assurance teams must be comprised of county staff, persons receiving services or the person's families, legal representatives, members of advocacy organizations, providers, and other involved community members. Team members must complete the training program approved by the regional quality council and must demonstrate performance-based competency. Team members may be paid a per diem and reimbursed for expenses related to their participation in the quality assurance process.

(c) The commissioner shall monitor the safety standards, rights, and procedural protections for the monitoring of psychotropic medications and those identified under sections 245.825; 245.91 to 245.97; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivision 1b, clause (7); and 626.557; and chapter 260E.

(d) The regional quality councils may hire staff to perform the duties assigned in this subdivision.

(e) The regional quality councils may charge fees for their services.

(f) The quality assurance process undertaken by a regional quality council consists of an evaluation by a quality assurance team of the facility, program, or service. The process must include an evaluation of a random sample of persons served. The sample must be representative of each service provided. The sample size must be at least five percent but not less than two persons served. All persons must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.

(g) A facility, program, or service may contest a licensing decision of the regional quality council as permitted under chapter 245A.

Subd. 5. **Annual survey of service recipients.** The commissioner, in consultation with the State Quality Council, shall conduct an annual independent statewide survey of service recipients, randomly selected, to determine the effectiveness and quality of disability services. The survey must be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services (CMS) Quality Framework. The survey must analyze whether desired outcomes for persons with different demographic, diagnostic, health, and functional needs, who are receiving different types of services in different settings and with different costs, have been achieved. Annual statewide and regional reports of the results must be published and used to assist regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 6. **Mandated reporters.** Members of the State Quality Council under subdivision 3, the regional quality councils under subdivision 4, and quality assurance team members under subdivision 4, paragraph (b), clause (13), are mandated reporters as defined in sections 260E.06, subdivision 1, and 626.5572, subdivision 16.

256B.49 HOME AND COMMUNITY-BASED SERVICE WAIVERS FOR PERSONS WITH DISABILITIES.

Subd. 26. **Excess allocations.** Effective July 1, 2018, county and tribal agencies will be responsible for spending in excess of the annual allocation made by the commissioner. In the event a county or tribal agency spends in excess of the allocation made by the commissioner for a given allocation period, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The plan must state the actions the agency will take to correct its overspending for the two years following the period when the overspending occurred. The commissioner shall recoup funds spent in excess of the allocation only in cases when statewide spending exceeds the appropriation designated for the home and community-based services waivers. Nothing in this subdivision shall be construed as reducing the county or tribe's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to it for that purpose.

Subd. 27. **Use of waiver allocations.** (a) Effective until June 30, 2018, county and tribal agencies are responsible for authorizing the annual allocation made by the commissioner. In the event a county or tribal agency authorizes less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services.

(b) Effective July 1, 2018, county and tribal agencies are responsible for spending the annual allocation made by the commissioner. In the event a county or tribal agency spends less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services.

(c) If a county or tribe does not submit a plan when required or implement the changes required, the commissioner shall assure access to waiver services within the county or tribe's available allocation, and take other actions needed to assure that all waiver participants in that county or tribe are receiving appropriate waiver services to meet their needs.

256D.051 SNAP EMPLOYMENT AND TRAINING PROGRAM.

Subdivision 1. **SNAP employment and training program.** The commissioner shall implement a SNAP employment and training program in order to meet the SNAP employment and training participation requirements of the United States Department of Agriculture. Unless exempt under subdivision 3a, each adult recipient in the unit must participate in the SNAP employment and training program each month that the person is eligible for SNAP benefits. The person's participation in SNAP employment and training services must begin no later than the first day of the calendar month following the determination of eligibility for SNAP benefits. With the county agency's consent, and to the extent of available resources, the person may voluntarily continue to participate in SNAP employment and training services for up to three additional consecutive months immediately following termination of SNAP benefits in order to complete the provisions of the person's employability development plan.

Subd. 1a. **Notices and sanctions.** (a) At the time the county agency notifies the household that it is eligible for SNAP benefits, the county agency must inform all mandatory employment and training services participants as identified in subdivision 1 in the household that they must comply with all SNAP employment and training program requirements each month, including the requirement to attend an initial orientation to the SNAP employment and training program and that SNAP eligibility will end unless the participants comply with the requirements specified in the notice.

(b) A participant who fails without good cause to comply with SNAP employment and training program requirements of this section, including attendance at orientation, will lose SNAP eligibility for the following periods:

(1) for the first occurrence, for one month or until the person complies with the requirements not previously complied with, whichever is longer;

(2) for the second occurrence, for three months or until the person complies with the requirements not previously complied with, whichever is longer; or

(3) for the third and any subsequent occurrence, for six months or until the person complies with the requirements not previously complied with, whichever is longer.

If the participant is not the SNAP head of household, the person shall be considered an ineligible household member for SNAP purposes. If the participant is the SNAP head of household, the entire household is ineligible for SNAP as provided in Code of Federal Regulations, title 7, section 273.7(g). "Good cause" means circumstances beyond the control of the participant, such as illness or injury, illness or injury of another household member requiring the participant's presence, a household emergency, or the inability to obtain child care for children between the ages of six and 12 or to obtain transportation needed in order for the participant to meet the SNAP employment and training program participation requirements.

(c) The county agency shall mail or hand deliver a notice to the participant not later than five days after determining that the participant has failed without good cause to comply with SNAP employment and training program requirements which specifies the requirements that were not complied with, the factual basis for the determination of noncompliance, and the right to reinstate eligibility upon a showing of good cause for failure to meet the requirements. The notice must ask the reason for the noncompliance and identify the participant's appeal rights. The notice must request that the participant inform the county agency if the participant believes that good cause existed for the failure to comply and must state that the county agency intends to terminate eligibility for SNAP benefits due to failure to comply with SNAP employment and training program requirements.

(d) If the county agency determines that the participant did not comply during the month with all SNAP employment and training program requirements that were in effect, and if the county agency determines that good cause was not present, the county must provide a ten-day notice of termination of SNAP benefits. The amount of SNAP benefits that are withheld from the household and determination of the impact of the sanction on other household members is governed by Code of Federal Regulations, title 7, section 273.7.

(e) The participant may appeal the termination of SNAP benefits under the provisions of section 256.045.

Subd. 2. **County agency duties.** (a) The county agency shall provide to SNAP benefit recipients a SNAP employment and training program. The program must include:

(1) orientation to the SNAP employment and training program;

(2) an individualized employability assessment and an individualized employability development plan that includes assessment of literacy, ability to communicate in the English language, educational and employment history, and that estimates the length of time it will take the participant to obtain employment. The employability assessment and development plan must be completed in consultation with the participant, must assess the participant's assets, barriers, and strengths, and must identify steps necessary to overcome barriers to employment. A copy of the employability development plan must be provided to the registrant;

(3) referral to available accredited remedial or skills training programs designed to address participant's barriers to employment;

(4) referral to available programs that provide subsidized or unsubsidized employment as necessary;

(5) a job search program, including job seeking skills training; and

(6) other activities, to the extent of available resources designed by the county agency to prepare the participant for permanent employment.

In order to allow time for job search, the county agency may not require an individual to participate in the SNAP employment and training program for more than 32 hours a week. The county agency shall require an individual to spend at least eight hours a week in job search or other SNAP employment and training program activities.

(b) The county agency shall prepare an annual plan for the operation of its SNAP employment and training program. The plan must be submitted to and approved by the commissioner of employment and economic development. The plan must include:

(1) a description of the services to be offered by the county agency;

(2) a plan to coordinate the activities of all public entities providing employment-related services in order to avoid duplication of effort and to provide services more efficiently;

(3) a description of the factors that will be taken into account when determining a client's employability development plan; and

(4) provisions to ensure that the county agency's employment and training service provider provides each recipient with an orientation, employability assessment, and employability development plan as specified in paragraph (a), clauses (1) and (2), within 30 days of the recipient's eligibility for assistance.

Subd. 2a. **Duties of commissioner.** In addition to any other duties imposed by law, the commissioner shall:

(1) based on this section and section 256D.052 and Code of Federal Regulations, title 7, section 273.7, supervise the administration of SNAP employment and training services to county agencies;

(2) disburse money appropriated for SNAP employment and training services to county agencies based upon the county's costs as specified in section 256D.051, subdivision 6c;

(3) accept and supervise the disbursement of any funds that may be provided by the federal government or from other sources for use in this state for SNAP employment and training services;

(4) cooperate with other agencies including any agency of the United States or of another state in all matters concerning the powers and duties of the commissioner under this section and section 256D.052; and

(5) in cooperation with the commissioner of employment and economic development, ensure that each component of an employment and training program carried out under this section is delivered through a statewide workforce development system, unless the component is not available locally through such a system.

Subd. 3. **Participant duties.** In order to receive SNAP assistance, a registrant shall: (1) cooperate with the county agency in all aspects of the SNAP employment and training program; (2) accept any suitable employment, including employment offered through the Job Training Partnership Act, and other employment and training options; and (3) participate in SNAP employment and training activities assigned by the county agency. The county agency may terminate assistance to a registrant who fails to cooperate in the SNAP employment and training program, as provided in subdivision 1a.

Subd. 3a. **Requirement to register work.** (a) To the extent required under Code of Federal Regulations, title 7, section 273.7(a), each applicant for and recipient of SNAP benefits is required to register for work as a condition of eligibility for SNAP benefits. Applicants and recipients are registered by signing an application or annual reapplication for SNAP benefits, and must be informed that they are registering for work by signing the form.

(b) The commissioner shall determine, within federal requirements, persons required to participate in the SNAP employment and training program.

(c) The following SNAP benefit recipients are exempt from mandatory participation in SNAP employment and training services:

(1) recipients of benefits under the Minnesota family investment program, Minnesota supplemental aid program, or the general assistance program;

(2) a child;

(3) a recipient over age 55;

(4) a recipient who has a mental or physical illness, injury, or incapacity which is expected to continue for at least 30 days and which impairs the recipient's ability to obtain or retain employment as evidenced by professional certification or the receipt of temporary or permanent disability benefits issued by a private or government source;

(5) a parent or other household member responsible for the care of either a dependent child in the household who is under age six or a person in the household who is professionally certified as having a physical or mental illness, injury, or incapacity. Only one parent or other household member may claim exemption under this provision;

(6) a recipient receiving unemployment insurance or who has applied for unemployment insurance and has been required to register for work with the Department of Employment and Economic Development as part of the unemployment insurance application process;

(7) a recipient participating each week in a drug addiction or alcohol abuse treatment and rehabilitation program, provided the operators of the treatment and rehabilitation program, in consultation with the county agency, recommend that the recipient not participate in the SNAP employment and training program;

(8) a recipient employed or self-employed for 30 or more hours per week at employment paying at least minimum wage, or who earns wages from employment equal to or exceeding 30 hours multiplied by the federal minimum wage; or

(9) a student enrolled at least half time in any school, training program, or institution of higher education. When determining if a student meets this criteria, the school's, program's or institution's criteria for being enrolled half time shall be used.

Subd. 3b. **Orientation.** The county agency or its employment and training service provider must provide an orientation to SNAP employment and training services to each nonexempt SNAP benefit recipient within 30 days of the date that SNAP eligibility is determined. The orientation must inform the participant of the requirement to participate in services, the date, time, and address to report to for services, the name and telephone number of the SNAP employment and training service provider, the consequences for failure without good cause to comply, the services and support services available through SNAP employment and training services and other providers of similar services, and must encourage the participant to view the SNAP benefits program as a temporary means of supplementing the family's food needs until the family achieves self-sufficiency through employment. The orientation may be provided through audio-visual methods, but the participant must have the opportunity for face-to-face interaction with county agency staff.

Subd. 6b. **Federal reimbursement.** (a) Federal financial participation from the United States Department of Agriculture for SNAP employment and training expenditures that are eligible for reimbursement through the SNAP employment and training program are dedicated funds and are annually appropriated to the commissioner of human services for the operation of the SNAP employment and training program.

(b) The appropriation must be used for skill attainment through employment, training, and support services for SNAP participants.

(c) Federal financial participation for the nonstate portion of SNAP employment and training costs must be paid to the county agency or service provider that incurred the costs.

Subd. 6c. **Program funding.** Within the limits of available resources, the commissioner shall reimburse the actual costs of county agencies and their employment and training service providers for the provision of SNAP employment and training services, including participant support services, direct program services, and program administrative activities. The cost of services for each county's SNAP employment and training program shall not exceed the annual allocated amount. No more than 15 percent of program funds may be used for administrative activities. The county agency may expend county funds in excess of the limits of this subdivision without state reimbursement.

Program funds shall be allocated based on the county's average number of SNAP eligible cases as compared to the statewide total number of such cases. The average number of cases shall be based on counts of cases as of March 31, June 30, September 30, and December 31 of the previous calendar year. The commissioner may reallocate unexpended money appropriated under this section to those county agencies that demonstrate a need for additional funds.

Subd. 7. **Registrant status.** A registrant under this section is not an employee for the purposes of workers' compensation, unemployment benefits, retirement, or civil service laws, and shall not perform work ordinarily performed by a regular public employee.

Subd. 8. **Voluntary quit.** A person who is required to participate in SNAP employment and training services is not eligible for SNAP benefits if, without good cause, the person refuses a legitimate offer of, or quits, suitable employment within 60 days before the date of application. A person who is required to participate in SNAP employment and training services and, without good cause, voluntarily quits suitable employment or refuses a legitimate offer of suitable employment while receiving SNAP benefits shall be terminated from the SNAP program as specified in subdivision 1a.

Subd. 9. **Subcontractors.** A county agency may, at its option, subcontract any or all of the duties under this section to a public or private entity approved by the commissioner of employment and economic development.

Subd. 18. **Work experience placements.** (a) To the extent of available resources, each county agency must establish and operate a work experience component in the SNAP employment and training program for recipients who are subject to a federal limit of three months of SNAP eligibility in any 36-month period. The purpose of the work experience component is to enhance the participant's employability, self-sufficiency, and to provide meaningful, productive work activities.

(b) The commissioner shall assist counties in the design and implementation of these components. The commissioner must ensure that job placements under a work experience component comply with section 256J.72. Written or oral concurrence with job duties of persons placed under the community work experience program shall be obtained from the appropriate exclusive bargaining representative.

(c) Worksites developed under this section are limited to projects that serve a useful public service such as health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, community service, services to aged citizens or citizens with a disability, and child care. To the extent possible, the prior training, skills, and experience of a recipient must be used in making appropriate work experience assignments.

(d) Structured, supervised volunteer work with an agency or organization that is monitored by the county service provider may, with the approval of the county agency, be used as a work experience placement.

(e) As a condition of placing a person receiving SNAP benefits in a program under this subdivision, the county agency shall first provide the recipient the opportunity:

(1) for placement in suitable subsidized or unsubsidized employment through participation in job search under section 256D.051; or

(2) for placement in suitable employment through participation in on-the-job training, if such employment is available.

(f) The county agency shall limit the maximum monthly number of hours that any participant may work in a work experience placement to a number equal to the amount of the family's monthly SNAP benefit allotment divided by the greater of the federal minimum wage or the applicable state minimum wage.

After a participant has been assigned to a position for nine months, the participant may not continue in that assignment unless the maximum number of hours a participant works is no greater

than the amount of the SNAP benefit divided by the rate of pay for individuals employed in the same or similar occupations by the same employer at the same site.

(g) The participant's employability development plan must include the length of time needed in the work experience program, the need to continue job seeking activities while participating in work experience, and the participant's employment goals.

(h) After each six months of a recipient's participation in a work experience job placement, and at the conclusion of each work experience assignment under this section, the county agency shall reassess and revise, as appropriate, the participant's employability development plan.

(i) A participant has good cause for failure to cooperate with a work experience job placement if, in the judgment of the employment and training service provider, the reason for failure is reasonable and justified. Good cause for purposes of this section is defined in subdivision 1a, paragraph (b).

(j) A recipient who has failed without good cause to participate in or comply with the work experience job placement shall be terminated from participation in work experience job activities. If the recipient is not exempt from mandatory SNAP employment and training program participation under subdivision 3a, the recipient will be assigned to other mandatory program activities. If the recipient is exempt from mandatory participation but is participating as a volunteer, the person shall be terminated from the SNAP employment and training program.

256D.052 LITERACY TRAINING FOR RECIPIENTS.

Subd. 3. **Participant literacy transportation costs.** Within the limits of the state appropriation the county agency must provide transportation to enable Supplemental Nutrition Assistance Program (SNAP) employment and training participants to participate in literacy training under this section. The state shall reimburse county agencies for the costs of providing transportation under this section up to the amount of the state appropriation. Counties must make every effort to ensure that child care is available as needed by recipients who are pursuing literacy training.

256J.08 DEFINITIONS.

Subd. 10. **Budget month.** "Budget month" means the calendar month which the county agency uses to determine the income or circumstances of an assistance unit to calculate the amount of the assistance payment in the payment month.

Subd. 53. **Lump sum.** "Lump sum" means nonrecurring income that is not excluded in section 256J.21.

Subd. 61. **Monthly income test.** "Monthly income test" means the test used to determine ongoing eligibility and the assistance payment amount according to section 256J.21.

Subd. 62. **Nonrecurring income.** "Nonrecurring income" means a form of income which is received:

(1) only one time or is not of a continuous nature; or

(2) in a prospective payment month but is no longer received in the corresponding retrospective payment month.

Subd. 81. **Retrospective budgeting.** "Retrospective budgeting" means a method of determining the amount of the assistance payment in which the payment month is the second month after the budget month.

Subd. 83. **Significant change.** "Significant change" means a decline in gross income of the amount of the disregard as defined in section 256P.03 or more from the income used to determine the grant for the current month.

256J.21 INCOME LIMITATIONS.

Subdivision 1. **Income inclusions.** To determine MFIP eligibility, the county agency must evaluate income received by members of an assistance unit, or by other persons whose income is considered available to the assistance unit, and only count income that is available to the member of the assistance unit. Income is available if the individual has legal access to the income. All payments, unless specifically excluded in subdivision 2, must be counted as income. The county agency shall verify the income of all MFIP recipients and applicants.

Subd. 2. **Income exclusions.** The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9555.5050 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0654, payments for family foster care for children under section 260C.4411 or chapter 256N, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

(2) reimbursements for employment training received through the Workforce Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

(3) reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, employment, or informal carpooling arrangements directly related to employment;

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

(5) loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

(6) loans from private individuals, regardless of purpose, provided an applicant or participant documents that the lender expects repayment;

(7)(i) state income tax refunds; and

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

(iii) state homeowners and renters credits under chapter 290A; and

(iv) federal or state tax rebates;

(9) funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency, state or local government, or disaster assistance organizations, subsequent to a presidential declaration of disaster;

(10) the portion of an insurance settlement that is used to pay medical, funeral, and burial expenses, or to repair or replace insured property;

(11) reimbursements for medical expenses that cannot be paid by medical assistance;

(12) payments by a vocational rehabilitation program administered by the state under chapter 268A, except those payments that are for current living expenses;

(13) in-kind income, including any payments directly made by a third party to a provider of goods and services;

(14) assistance payments to correct underpayments, but only for the month in which the payment is received;

(15) payments for short-term emergency needs under section 256J.626, subdivision 2;

(16) funeral and cemetery payments as provided by section 256.935;

(17) nonrecurring cash gifts of $30 or less, not exceeding $30 per participant in a calendar month;

(18) any form of energy assistance payment made through Public Law 97-35, Low-Income Home Energy Assistance Act of 1981, payments made directly to energy providers by other public and private agencies, and any form of credit or rebate payment issued by energy providers;

(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient;

(20) Minnesota supplemental aid, including retroactive payments;

(21) proceeds from the sale of real or personal property;

(22) adoption or kinship assistance payments under chapter 256N or 259A and Minnesota permanency demonstration title IV-E waiver payments;

(23) state-funded family subsidy program payments made under section 252.32 to help families care for children with developmental disabilities, consumer support grant funds under section 256.476, and resources and services for a disabled household member under one of the home and community-based waiver services programs under chapter 256B;

(24) interest payments and dividends from property that is not excluded from and that does not exceed the asset limit;

(25) rent rebates;

(26) income earned by a minor caregiver, minor child through age 6, or a minor child who is at least a half-time student in an approved elementary or secondary education program;

(27) income earned by a caregiver under age 20 who is at least a half-time student in an approved elementary or secondary education program;

(28) MFIP child care payments under section 119B.05;

(29) all other payments made through MFIP to support a caregiver's pursuit of greater economic stability;

(30) income a participant receives related to shared living expenses;

(31) reverse mortgages;

(32) benefits provided by the Child Nutrition Act of 1966, United States Code, title 42, chapter 13A, sections 1771 to 1790;

(33) benefits provided by the women, infants, and children (WIC) nutrition program, United States Code, title 42, chapter 13A, section 1786;

(34) benefits from the National School Lunch Act, United States Code, title 42, chapter 13, sections 1751 to 1769e;

(35) relocation assistance for displaced persons under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12, chapter 13, sections 1701 to 1750jj;

(36) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part 2, sections 2271 to 2322;

(37) war reparations payments to Japanese Americans and Aleuts under United States Code, title 50, sections 1989 to 1989d;

(38) payments to veterans or their dependents as a result of legal settlements regarding Agent Orange or other chemical exposure under Public Law 101-239, section 10405, paragraph (a)(2)(E);

(39) income that is otherwise specifically excluded from MFIP consideration in federal law, state law, or federal regulation;

(40) security and utility deposit refunds;

(41) American Indian tribal land settlements excluded under Public Laws 98-123, 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and Mille Lacs reservations and payments to members of the White Earth Band, under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

(42) all income of the minor parent's parents and stepparents when determining the grant for the minor parent in households that include a minor parent living with parents or stepparents on MFIP with other children;

(43) income of the minor parent's parents and stepparents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor parent's child in households that include a minor parent living with parents or stepparents not on MFIP when determining the grant for the minor parent. The remainder of income is deemed as specified in section 256J.37, subdivision 1b;

(44) payments made to children eligible for relative custody assistance under section 257.85;

(45) vendor payments for goods and services made on behalf of a client unless the client has the option of receiving the payment in cash;

(46) the principal portion of a contract for deed payment;

(47) cash payments to individuals enrolled for full-time service as a volunteer under AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps National, and AmeriCorps NCCC;

(48) housing assistance grants under section 256J.35, paragraph (a); and

(49) child support payments of up to $100 for an assistance unit with one child and up to $200 for an assistance unit with two or more children.

256J.30 APPLICANT AND PARTICIPANT REQUIREMENTS AND RESPONSIBILITIES.

Subd. 5. **Monthly MFIP household reports.** Each assistance unit with a member who has earned income or a recent work history, and each assistance unit that has income deemed to it from a financially responsible person must complete a monthly MFIP household report form. "Recent work history" means the individual received earned income in the report month or any of the previous three calendar months even if the earnings are excluded. To be complete, the MFIP household report form must be signed and dated by the caregivers no earlier than the last day of the reporting period. All questions required to determine assistance payment eligibility must be answered, and documentation of earned income must be included.

Subd. 7. **Due date of MFIP household report form.** An MFIP household report form must be received by the county agency by the eighth calendar day of the month following the reporting period covered by the form. When the eighth calendar day of the month falls on a weekend or holiday, the MFIP household report form must be received by the county agency the first working day that follows the eighth calendar day.

Subd. 8. **Late MFIP household report forms.** (a) Paragraphs (b) to (e) apply to the reporting requirements in subdivision 7.

(b) When the county agency receives an incomplete MFIP household report form, the county agency must immediately return the incomplete form and clearly state what the caregiver must do for the form to be complete.

(c) The automated eligibility system must send a notice of proposed termination of assistance to the assistance unit if a complete MFIP household report form is not received by a county agency. The automated notice must be mailed to the caregiver by approximately the 16th of the month. When a caregiver submits an incomplete form on or after the date a notice of proposed termination has been sent, the termination is valid unless the caregiver submits a complete form before the end of the month.

(d) An assistance unit required to submit an MFIP household report form is considered to have continued its application for assistance if a complete MFIP household report form is received within a calendar month after the month in which the form was due and assistance shall be paid for the period beginning with the first day of that calendar month.

(e) A county agency must allow good cause exemptions from the reporting requirements under subdivision 5 when any of the following factors cause a caregiver to fail to provide the county agency with a completed MFIP household report form before the end of the month in which the form is due:

(1) an employer delays completion of employment verification;

(2) a county agency does not help a caregiver complete the MFIP household report form when the caregiver asks for help;

(3) a caregiver does not receive an MFIP household report form due to mistake on the part of the department or the county agency or due to a reported change in address;

(4) a caregiver is ill, or physically or mentally incapacitated; or

(5) some other circumstance occurs that a caregiver could not avoid with reasonable care which prevents the caregiver from providing a completed MFIP household report form before the end of the month in which the form is due.

256J.33 PROSPECTIVE AND RETROSPECTIVE MFIP ELIGIBILITY.

Subd. 3. **Retrospective eligibility.** After the first two months of MFIP eligibility, a county agency must continue to determine whether an assistance unit is prospectively eligible for the payment month by looking at all factors other than income and then determine whether the assistance unit is retrospectively income eligible by applying the monthly income test to the income from the budget month. When the monthly income test is not satisfied, the assistance payment must be suspended when ineligibility exists for one month or ended when ineligibility exists for more than one month.

Subd. 4. **Monthly income test.** A county agency must apply the monthly income test retrospectively for each month of MFIP eligibility. An assistance unit is not eligible when the countable income equals or exceeds the MFIP standard of need or the family wage level for the assistance unit. The income applied against the monthly income test must include:

(1) gross earned income from employment, prior to mandatory payroll deductions, voluntary payroll deductions, wage authorizations, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36, unless the employment income is specifically excluded under section 256J.21, subdivision 2;

(2) gross earned income from self-employment less deductions for self-employment expenses in section 256J.37, subdivision 5, but prior to any reductions for personal or business state and federal income taxes, personal FICA, personal health and life insurance, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36;

(3) unearned income after deductions for allowable expenses in section 256J.37, subdivision 9, and allocations in section 256J.36, unless the income has been specifically excluded in section 256J.21, subdivision 2;

(4) gross earned income from employment as determined under clause (1) which is received by a member of an assistance unit who is a minor child or minor caregiver and less than a half-time student;

(5) child support received by an assistance unit, excluded under section 256J.21, subdivision 2, clause (49), or section 256P.06, subdivision 3, clause (2), item (xvi);

(6) spousal support received by an assistance unit;

(7) the income of a parent when that parent is not included in the assistance unit;

(8) the income of an eligible relative and spouse who seek to be included in the assistance unit; and

(9) the unearned income of a minor child included in the assistance unit.

Subd. 5. **When to terminate assistance.** When an assistance unit is ineligible for MFIP assistance for two consecutive months, the county agency must terminate MFIP assistance.

256J.34 CALCULATING ASSISTANCE PAYMENTS.

Subdivision 1. **Prospective budgeting.** A county agency must use prospective budgeting to calculate the assistance payment amount for the first two months for an applicant who has not received assistance in this state for at least one payment month preceding the first month of payment under a current application. Notwithstanding subdivision 3, paragraph (a), clause (2), a county agency must use prospective budgeting for the first two months for a person who applies to be added to an assistance unit. Prospective budgeting is not subject to overpayments or underpayments unless fraud is determined under section 256.98.

(a) The county agency must apply the income received or anticipated in the first month of MFIP eligibility against the need of the first month. The county agency must apply the income received or anticipated in the second month against the need of the second month.

(b) When the assistance payment for any part of the first two months is based on anticipated income, the county agency must base the initial assistance payment amount on the information available at the time the initial assistance payment is made.

(c) The county agency must determine the assistance payment amount for the first two months of MFIP eligibility by budgeting both recurring and nonrecurring income for those two months.

Subd. 2. **Retrospective budgeting.** The county agency must use retrospective budgeting to calculate the monthly assistance payment amount after the payment for the first two months has been made under subdivision 1.

Subd. 3. **Additional uses of retrospective budgeting.** Notwithstanding subdivision 1, the county agency must use retrospective budgeting to calculate the monthly assistance payment amount for the first two months under paragraphs (a) and (b).

(a) The county agency must use retrospective budgeting to determine the amount of the assistance payment in the first two months of MFIP eligibility:

(1) when an assistance unit applies for assistance for the same month for which assistance has been interrupted, the interruption in eligibility is less than one payment month, the assistance payment for the preceding month was issued in this state, and the assistance payment for the immediately preceding month was determined retrospectively; or

(2) when a person applies in order to be added to an assistance unit, that assistance unit has received assistance in this state for at least the two preceding months, and that person has been living with and has been financially responsible for one or more members of that assistance unit for at least the two preceding months.

(b) Except as provided in clauses (1) to (4), the county agency must use retrospective budgeting and apply income received in the budget month by an assistance unit and by a financially responsible household member who is not included in the assistance unit against the MFIP standard of need or family wage level to determine the assistance payment to be issued for the payment month.

(1) When a source of income ends prior to the third payment month, that income is not considered in calculating the assistance payment for that month. When a source of income ends prior to the fourth payment month, that income is not considered when determining the assistance payment for that month.

(2) When a member of an assistance unit or a financially responsible household member leaves the household of the assistance unit, the income of that departed household member is not budgeted retrospectively for any full payment month in which that household member does not live with that household and is not included in the assistance unit.

(3) When an individual is removed from an assistance unit because the individual is no longer a minor child, the income of that individual is not budgeted retrospectively for payment months in which that individual is not a member of the assistance unit, except that income of an ineligible child in the household must continue to be budgeted retrospectively against the child's needs when the parent or parents of that child request allocation of their income against any unmet needs of that ineligible child.

(4) When a person ceases to have financial responsibility for one or more members of an assistance unit, the income of that person is not budgeted retrospectively for the payment months which follow the month in which financial responsibility ends.

Subd. 4. **Significant change in gross income.** The county agency must recalculate the assistance payment when an assistance unit experiences a significant change, as defined in section 256J.08, resulting in a reduction in the gross income received in the payment month from the gross income received in the budget month. The county agency must issue a supplemental assistance payment based on the county agency's best estimate of the assistance unit's income and circumstances for the payment month. Supplemental assistance payments that result from significant changes are limited to two in a 12-month period regardless of the reason for the change. Notwithstanding any other statute or rule of law, supplementary assistance payments shall not be made when the significant change in income is the result of receipt of a lump sum, receipt of an extra paycheck, business fluctuation in self-employment income, or an assistance unit member's participation in a strike or other labor action.

256J.37 TREATMENT OF INCOME AND LUMP SUMS.

Subd. 10. **Treatment of lump sums.** (a) The agency must treat lump-sum payments as earned or unearned income. If the lump-sum payment is included in the category of income identified in subdivision 9, it must be treated as unearned income. A lump sum is counted as income in the month received and budgeted either prospectively or retrospectively depending on the budget cycle at the time of receipt. When an individual receives a lump-sum payment, that lump sum must be combined with all other earned and unearned income received in the same budget month, and it must be applied according to paragraphs (a) to (c). A lump sum may not be carried over into subsequent

months. Any funds that remain in the third month after the month of receipt are counted in the asset limit.

(b) For a lump sum received by an applicant during the first two months, prospective budgeting is used to determine the payment and the lump sum must be combined with other earned or unearned income received and budgeted in that prospective month.

(c) For a lump sum received by a participant after the first two months of MFIP eligibility, the lump sum must be combined with other income received in that budget month, and the combined amount must be applied retrospectively against the applicable payment month.

(d) When a lump sum, combined with other income under paragraphs (b) and (c), is less than the MFIP transitional standard for the appropriate payment month, the assistance payment must be reduced according to the amount of the countable income. When the countable income is greater than the MFIP standard or family wage level, the assistance payment must be suspended for the payment month.

256S.20 CUSTOMIZED LIVING SERVICES; POLICY.

Subd. 2. **Customized living services requirements.** Customized living services and 24-hour customized living services may only be provided in a building that is registered as a housing with services establishment under chapter 144D.

9505.0275 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT.

Subpart 1. **Definition.** "Early and periodic screening, diagnosis, and treatment service" means a service provided to a recipient under age 21 to identify a potentially disabling condition and to provide diagnosis and treatment for a condition identified according to the requirements of the Code of Federal Regulations, title 42, section 441.55 and parts 9505.1693 to 9505.1748.

Subp. 2. **Duties of provider.** The provider shall sign a provider agreement stating that the provider will provide screening services according to standards in parts 9505.1693 to 9505.1748 and Code of Federal Regulations, title 42, sections 441.50 to 441.62.

9505.0370 DEFINITIONS.

Subpart 1. **Scope.** For parts 9505.0370 to 9505.0372, the following terms have the meanings given them.

Subp. 2. **Adult day treatment.** "Adult day treatment" or "adult day treatment program" means a structured program of treatment and care.

Subp. 3. **Child.** "Child" means a person under 18 years of age.

Subp. 4. **Client.** "Client" means an eligible recipient who is determined to have or who is being assessed for a mental illness as specified in part 9505.0371.

Subp. 5. **Clinical summary.** "Clinical summary" means a written description of a clinician's formulation of the cause of the client's mental health symptoms, the client's prognosis, and the likely consequences of the symptoms; how the client meets the criteria for the diagnosis by describing the client's symptoms, the duration of symptoms, and functional impairment; an analysis of the client's other symptoms, strengths, relationships, life situations, cultural influences, and health concerns and their potential interaction with the diagnosis and formulation of the client's mental health condition; and alternative diagnoses that were considered and ruled out.

Subp. 6. **Clinical supervision.** "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

Subp. 7. **Clinical supervisor.** "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

Subp. 8. **Cultural competence or culturally competent.** "Cultural competence" or "culturally competent" means the mental health provider's:

A. awareness of the provider's own cultural background, and the related assumptions, values, biases, and preferences that influence assessment and intervention processes;

B. ability and will to respond to the unique needs of an individual client that arise from the client's culture;

C. ability to utilize the client's culture as a resource and as a means to optimize mental health care; and

D. willingness to seek educational, consultative, and learning experiences to expand knowledge of and increase effectiveness with culturally diverse populations.

Subp. 9. **Cultural influences.** "Cultural influences" means historical, geographical, and familial factors that affect assessment and intervention processes. Cultural influences that are relevant to the client may include the client's:

A. racial or ethnic self-identification;

B. experience of cultural bias as a stressor;

C. immigration history and status;

D. level of acculturation;

E. time orientation;

F. social orientation;

G. verbal communication style;

H. locus of control;

I. spiritual beliefs; and

J. health beliefs and the endorsement of or engagement in culturally specific healing practices.

Subp. 10. **Culture.** "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

Subp. 11. **Diagnostic assessment.** "Diagnostic assessment" means a written assessment that documents a clinical and functional face-to-face evaluation of the client's mental health, including the nature, severity and impact of behavioral difficulties, functional impairment, and subjective distress of the client, and identifies the client's strengths and resources.

Subp. 12. **Dialectical behavior therapy.** "Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program is certified by the commissioner and involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

Subp. 13. **Explanation of findings.** "Explanation of findings" means the explanation of a client's diagnostic assessment, psychological testing, treatment program, and consultation with culturally informed mental health consultants as required under parts 9520.0900 to 9520.0926, or other accumulated data and recommendations to the client, client's family, primary caregiver, or other responsible persons.

Subp. 14. **Family.** "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, or persons who are presently residing together as a family unit.

Subp. 15. **Individual treatment plan.** "Individual treatment plan" means a written plan that outlines and defines the course of treatment. It delineates the goals, measurable objectives, target dates for achieving specific goals, main participants in treatment process, and recommended services that are based on the client's diagnostic assessment and other meaningful data that are needed to aid the client's recovery and enhance resiliency.

Subp. 16. **Medication management.** "Medication management" means a service that determines the need for or effectiveness of the medication prescribed for the treatment of a client's symptoms of a mental illness.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a person who is qualified according to part 9505.0371, subpart 5, items B and C, and provides mental health services to a client with a mental illness under the clinical supervision of a mental health professional.

Subp. 18. **Mental health professional.** "Mental health professional" means a person who is enrolled to provide medical assistance services and is qualified according to part 9505.0371, subpart 5, item A.

Subp. 19. **Mental health telemedicine.** "Mental health telemedicine" has the meaning given in Minnesota Statutes, section 256B.0625, subdivision 46.

Subp. 20. **Mental illness.** "Mental illness" has the meaning given in Minnesota Statutes, section 245.462, subdivision 20. "Mental illness" includes "emotional disturbance" as defined in Minnesota Statutes, section 245.4871, subdivision 15.

Subp. 21. **Multidisciplinary staff.** "Multidisciplinary staff" means a group of individuals from diverse disciplines who come together to provide services to clients under part 9505.0372, subparts 8, 9, and 10.

Subp. 22. **Neuropsychological assessment.** "Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist.

Subp. 23. **Neuropsychological testing.** "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn and recall information; and use problem-solving and judgment.

Subp. 24. **Partial hospitalization program.** "Partial hospitalization program" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x, (ff), that is provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services.

Subp. 25. **Primary caregiver.** "Primary caregiver" means a person, other than the facility staff, who has primary legal responsibility for providing the client with food, clothing, shelter, direction, guidance, and nurturance.

Subp. 26. **Psychological testing.** "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the recipient's mental, intellectual, and emotional functioning.

Subp. 27. **Psychotherapy.** "Psychotherapy" means treatment of a client with mental illness that applies the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client.

Subp. 28. **Supervisee.** "Supervisee" means an individual who requires clinical supervision because the individual does not meet mental health professional standards in part 9505.0371, subpart 5, item A.

9505.0371 MEDICAL ASSISTANCE COVERAGE REQUIREMENTS FOR OUTPATIENT MENTAL HEALTH SERVICES.

Subpart 1. **Purpose.** This part describes the requirements that outpatient mental health services must meet to receive medical assistance reimbursement.

Subp. 2. **Client eligibility for mental health services.** The following requirements apply to mental health services:

A. The provider must use a diagnostic assessment as specified in part 9505.0372 to determine a client's eligibility for mental health services under this part, except:

(1) prior to completion of a client's initial diagnostic assessment, a client is eligible for:

(a) one explanation of findings;

(b) one psychological testing; and

(c) either one individual psychotherapy session, one family psychotherapy session, or one group psychotherapy session; and

(2) for a client who is not currently receiving mental health services covered by medical assistance, a crisis assessment as specified in Minnesota Statutes, section 256B.0624 or 256B.0944, conducted in the past 60 days may be used to allow up to ten sessions of mental health services within a 12-month period.

B. A brief diagnostic assessment must meet the requirements of part 9505.0372, subpart 1, item D, and:

(1) may be used to allow up to ten sessions of mental health services as specified in part 9505.0372 within a 12-month period before a standard or extended diagnostic assessment is required when the client is:

(a) a new client; or

(b) an existing client who has had fewer than ten sessions of psychotherapy in the previous 12 months and is projected to need fewer than ten sessions of psychotherapy in the next 12 months, or who only needs medication management; and

(2) may be used for a subsequent annual assessment, if based upon the client's treatment history and the provider's clinical judgment, the client will need ten or fewer sessions of mental health services in the upcoming 12-month period; and

(3) must not be used for:

(a) a client or client's family who requires a language interpreter to participate in the assessment unless the client meets the requirements of subitem (1), unit (b), or (2); or

(b) more than ten sessions of mental health services in a 12-month period. If, after completion of ten sessions of mental health services, the mental health professional determines the need for additional sessions, a standard assessment or extended assessment must be completed.

C. For a child, a new standard or extended diagnostic assessment must be completed:

(1) when the child does not meet the criteria for a brief diagnostic assessment;

(2) at least annually following the initial diagnostic assessment, if:

(a) additional services are needed; and

(b) the child does not meet criteria for brief assessment;

(3) when the child's mental health condition has changed markedly since the child's most recent diagnostic assessment; or

(4) when the child's current mental health condition does not meet criteria of the child's current diagnosis.

D. For an adult, a new standard diagnostic assessment or extended diagnostic assessment must be completed:

(1) when the adult does not meet the criteria for a brief diagnostic assessment or an adult diagnostic assessment update;

(2) at least every three years following the initial diagnostic assessment for an adult who receives mental health services;

(3) when the adult's mental health condition has changed markedly since the adult's most recent diagnostic assessment; or

(4) when the adult's current mental health condition does not meet criteria of the current diagnosis.

E. An adult diagnostic assessment update must be completed at least annually unless a new standard or extended diagnostic assessment is performed. An adult diagnostic assessment update must include an update of the most recent standard or extended diagnostic assessment and any recent adult diagnostic assessment updates that have occurred since the last standard or extended diagnostic assessment.

Subp. 3. **Authorization for mental health services.** Mental health services under this part are subject to authorization criteria and standards published by the commissioner according to Minnesota Statutes, section 256B.0625, subdivision 25.

Subp. 4. **Clinical supervision.**

A. Clinical supervision must be based on each supervisee's written supervision plan and must:

(1) promote professional knowledge, skills, and values development;

(2) model ethical standards of practice;

(3) promote cultural competency by:

(a) developing the supervisee's knowledge of cultural norms of behavior for individual clients and generally for the clients served by the supervisee regarding the client's cultural influences, age, class, gender, sexual orientation, literacy, and mental or physical disability;

(b) addressing how the supervisor's and supervisee's own cultures and privileges affect service delivery;

(c) developing the supervisee's ability to assess their own cultural competence and to identify when consultation or referral of the client to another provider is needed; and

(d) emphasizing the supervisee's commitment to maintaining cultural competence as an ongoing process;

(4) recognize that the client's family has knowledge about the client and will continue to play a role in the client's life and encourage participation among the client, client's family, and providers as treatment is planned and implemented; and

(5) monitor, evaluate, and document the supervisee's performance of assessment, treatment planning, and service delivery.

B. Clinical supervision must be conducted by a qualified supervisor using individual or group supervision. Individual or group face-to-face supervision may be conducted via electronic communications that utilize interactive telecommunications equipment that includes at a minimum audio and video equipment for two-way, real-time, interactive communication between the supervisor and supervisee, and meet the equipment and connection standards of part 9505.0370, subpart 19.

(1) Individual supervision means one or more designated clinical supervisors and one supervisee.

(2) Group supervision means one clinical supervisor and two to six supervisees in face-to-face supervision.

C. The supervision plan must be developed by the supervisor and the supervisee. The plan must be reviewed and updated at least annually. For new staff the plan must be completed and implemented within 30 days of the new staff person's employment. The supervision plan must include:

(1) the name and qualifications of the supervisee and the name of the agency in which the supervisee is being supervised;

(2) the name, licensure, and qualifications of the supervisor;

(3) the number of hours of individual and group supervision to be completed by the supervisee including whether supervision will be in person or by some other method approved by the commissioner;

(4) the policy and method that the supervisee must use to contact the clinical supervisor during service provision to a supervisee;

(5) procedures that the supervisee must use to respond to client emergencies; and

(6) authorized scope of practices, including:

(a) description of the supervisee's service responsibilities;

(b) description of client population; and

(c) treatment methods and modalities.

D. Clinical supervision must be recorded in the supervisee's supervision record. The documentation must include:

(1) date and duration of supervision;

(2) identification of supervision type as individual or group supervision;

(3) name of the clinical supervisor;

(4) subsequent actions that the supervisee must take; and

(5) date and signature of the clinical supervisor.

E. Clinical supervision pertinent to client treatment changes must be recorded by a case notation in the client record after supervision occurs.

Subp. 5. **Qualified providers.** Medical assistance covers mental health services according to part 9505.0372 when the services are provided by mental health professionals or mental health practitioners qualified under this subpart.

A. A mental health professional must be qualified in one of the following ways:

(1) in clinical social work, a person must be licensed as an independent clinical social worker by the Minnesota Board of Social Work under Minnesota Statutes, chapter 148D until August 1, 2011, and thereafter under Minnesota Statutes, chapter 148E;

(2) in psychology, a person licensed by the Minnesota Board of Psychology under Minnesota Statutes, sections 148.88 to 148.98, who has stated to the board competencies in the diagnosis and treatment of mental illness;

(3) in psychiatry, a physician licensed under Minnesota Statutes, chapter 147, who is certified by the American Board of Psychiatry and Neurology or is eligible for board certification;

(4) in marriage and family therapy, a person licensed as a marriage and family therapist by the Minnesota Board of Marriage and Family Therapy under Minnesota Statutes, sections 148B.29 to 148B.39, and defined in parts 5300.0100 to 5300.0350;

(5) in professional counseling, a person licensed as a professional clinical counselor by the Minnesota Board of Behavioral Health and Therapy under Minnesota Statutes, section 148B.5301;

(6) a tribally approved mental health care professional, who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), and who is serving a federally recognized Indian tribe; or

(7) in psychiatric nursing, a registered nurse who is licensed under Minnesota Statutes, sections 148.171 to 148.285, and meets one of the following criteria:

(a) is certified as a clinical nurse specialist;

(b) for children, is certified as a nurse practitioner in child or adolescent or family psychiatric and mental health nursing by a national nurse certification organization; or

(c) for adults, is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization.

B. A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults. A mental health practitioner must be qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university; and

(a) has at least 2,000 hours of supervised experience in the delivery of mental health services to clients with mental illness; or

(b) is fluent in the non-English language of the cultural group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once a week until the requirements of 2,000 hours of supervised experience are met;

(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to clients with mental illness. Hours worked as a mental health behavioral aide I or II under Minnesota Statutes, section 256B.0943, subdivision 7, may be included in the 6,000 hours of experience for child clients;

(3) is a graduate student in one of the mental health professional disciplines defined in item A and is formally assigned by an accredited college or university to an agency or facility for clinical training;

(4) holds a master's or other graduate degree in one of the mental health professional disciplines defined in item A from an accredited college or university; or

(5) is an individual who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), who is serving a federally recognized Indian tribe.

C. Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy performed by a mental health practitioner working as a clinical trainee when:

(1) the mental health practitioner is:

(a) complying with requirements for licensure or board certification as a mental health professional, as defined in item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or

(b) a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional defined in item A; and

(2) the mental health practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of:

(a) direct practice;

(b) treatment team collaboration;

(c) continued professional learning; and

(d) job management.

D. A clinical supervisor must:

(1) be a mental health professional licensed as specified in item A;

(2) hold a license without restrictions that has been in good standing for at least one year while having performed at least 1,000 hours of clinical practice;

(3) be approved, certified, or in some other manner recognized as a qualified clinical supervisor by the person's professional licensing board, when this is a board requirement;

(4) be competent as demonstrated by experience and graduate-level training in the area of practice and the activities being supervised;

(5) not be the supervisee's blood or legal relative or cohabitant, or someone who has acted as the supervisee's therapist within the past two years;

(6) have experience and skills that are informed by advanced training, years of experience, and mastery of a range of competencies that demonstrate the following:

(a) capacity to provide services that incorporate best practice;

(b) ability to recognize and evaluate competencies in supervisees;

(c) ability to review assessments and treatment plans for accuracy and appropriateness;

(d) ability to give clear direction to mental health staff related to alternative strategies when a client is struggling with moving towards recovery; and

(e) ability to coach, teach, and practice skills with supervisees;

(7) accept full professional liability for a supervisee's direction of a client's mental health services;

(8) instruct a supervisee in the supervisee's work, and oversee the quality and outcome of the supervisee's work with clients;

(9) review, approve, and sign the diagnostic assessment, individual treatment plans, and treatment plan reviews of clients treated by a supervisee;

(10) review and approve the progress notes of clients treated by the supervisee according to the supervisee's supervision plan;

(11) apply evidence-based practices and research-informed models to treat clients;

(12) be employed by or under contract with the same agency as the supervisee;

(13) develop a clinical supervision plan for each supervisee;

(14) ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices;

(15) establish an evaluation process that identifies the performance and competence of each supervisee; and

(16) document clinical supervision of each supervisee and securely maintain the documentation record.

Subp. 6. **Release of information.** Providers who receive a request for client information and providers who request client information must:

A. comply with data practices and medical records standards in Minnesota Statutes, chapter 13, and Code of Federal Regulations, title 45, part 164; and

B. subject to the limitations in item A, promptly provide client information, including a written diagnostic assessment, to other providers who are treating the client to ensure that the client will get services without undue delay.

Subp. 7. **Individual treatment plan.** Except as provided in subpart 2, item A, subitem (1), a medical assistance payment is available only for services provided in accordance with the client's written individual treatment plan (ITP). The client must be involved in the development, review, and revision of the client's ITP. For all mental health services, except as provided in subpart 2, item A, subitem (1), and medication management, the ITP and subsequent revisions of the ITP must be signed by the client before treatment begins. The mental health professional or practitioner shall request the client, or other person authorized by statute to consent to mental health services for the client, to sign the client's ITP or revision of the ITP. In the case of a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child shall be asked to sign the child's ITP and revisions of the ITP. If the client or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the refusal to sign the plan and the reason or reasons for the refusal. A client's individual treatment plan must be:

A. based on the client's current diagnostic assessment;

B. developed by identifying the client's service needs and considering relevant cultural influences to identify planned interventions that contain specific treatment goals and measurable objectives for the client; and

C. reviewed at least once every 90 days, and revised as necessary. Revisions to the initial individual treatment plan do not require a new diagnostic assessment unless the client's mental health status has changed markedly as provided in subpart 2.

Subp. 8. **Documentation.** To obtain medical assistance payment for an outpatient mental health service, a mental health professional or a mental health practitioner must promptly document:

A. in the client's mental health record:

(1) each occurrence of service to the client including the date, type of service, start and stop time, scope of the mental health service, name and title of the person who gave the service, and date of documentation; and

(2) all diagnostic assessments and other assessments, psychological test results, treatment plans, and treatment plan reviews;

B. the provider's contact with persons interested in the client such as representatives of the courts, corrections systems, or schools, or the client's other mental health providers, case manager, family, primary caregiver, legal representative, including the name and date of the contact or, if applicable, the reason the client's family, primary caregiver, or legal representative was not contacted; and

C. dates that treatment begins and ends and reason for the discontinuation of the mental health service.

Subp. 9. **Service coordination.** The provider must coordinate client services as authorized by the client as follows:

A. When a recipient receives mental health services from more than one mental health provider, each provider must coordinate mental health services they provide to the client with other mental health service providers to ensure services are provided in the most efficient manner to achieve maximum benefit for the client.

B. The mental health provider must coordinate mental health care with the client's physical health provider.

Subp. 10. **Telemedicine services.** Mental health services in part 9505.0372 covered as direct face-to-face services may be provided via two-way interactive video if it is medically appropriate to the client's condition and needs. The interactive video equipment and connection must comply with Medicare standards that are in effect at the time of service. The commissioner may specify parameters within which mental health services can be provided via telemedicine.

9505.0372 COVERED SERVICES.

Subpart 1. **Diagnostic assessment.** Medical assistance covers four types of diagnostic assessments when they are provided in accordance with the requirements in this subpart.

A. To be eligible for medical assistance payment, a diagnostic assessment must:

(1) identify a mental health diagnosis and recommended mental health services, which are the factual basis to develop the recipient's mental health services and treatment plan; or

(2) include a finding that the client does not meet the criteria for a mental health disorder.

B. A standard diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The standard diagnostic assessment must be done within the cultural context of the client and must include relevant information about:

(1) the client's current life situation, including the client's:

(a) age;

(b) current living situation, including household membership and housing status;

(c) basic needs status including economic status;

(d) education level and employment status;

(e) significant personal relationships, including the client's evaluation of relationship quality;

(f) strengths and resources, including the extent and quality of social networks;

(g) belief systems;

(h) contextual nonpersonal factors contributing to the client's presenting concerns;

(i) general physical health and relationship to client's culture; and

(j) current medications;

(2) the reason for the assessment, including the client's:

(a) perceptions of the client's condition;

(b) description of symptoms, including reason for referral;

(c) history of mental health treatment, including review of the client's records;

(d) important developmental incidents;

(e) maltreatment, trauma, or abuse issues;

(f) history of alcohol and drug usage and treatment;

(g) health history and family health history, including physical, chemical, and mental health history; and

(h) cultural influences and their impact on the client;

(3) the client's mental status examination;

(4) the assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(5) the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

(6) assessment methods and use of standardized assessment tools by the provider as determined and periodically updated by the commissioner;

(7) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(8) the client data that is adequate to support the findings on all axes of the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and any differential diagnosis.

C. An extended diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The face-to-face interview is conducted over three or more assessment appointments because the client's complex needs necessitate significant additional assessment time. Complex needs are those caused by acuity of psychotic disorder; cognitive or neurocognitive impairment; need to consider past diagnoses and determine their current applicability; co-occurring substance abuse use disorder; or disruptive or changing environments, communication barriers, or cultural considerations as documented in the assessment. For child clients, the appointments may be conducted outside the diagnostician's office for face-to-face consultation and information gathering with family members, doctors, caregivers, teachers, and other providers, with or without the child present, and may involve directly observing the child in various settings that the child frequents such as home, school, or care settings. To complete the diagnostic assessment with adult clients, the appointments may be conducted outside of the diagnostician's office for face-to-face assessment with the adult client. The appointment may involve directly observing the adult client in various settings that the adult frequents, such as home, school, job, service settings, or community settings. The appointments may include face-to-face meetings with the adult client and the client's family members, doctors, caregivers, teachers, social support network members, recovery support resource representatives, and other providers for consultation and information gathering for the diagnostic assessment. The components of an extended diagnostic assessment include the following relevant information:

(1) for children under age 5:

(a) utilization of the DC:0-3R diagnostic system for young children;

(b) an early childhood mental status exam that assesses the client's developmental, social, and emotional functioning and style both within the family and with the examiner and includes:

i. physical appearance including dysmorphic features;

ii. reaction to new setting and people and adaptation during evaluation;

iii. self-regulation, including sensory regulation, unusual behaviors, activity level, attention span, and frustration tolerance;

iv. physical aspects, including motor function, muscle tone, coordination, tics, abnormal movements, and seizure activity;

v. vocalization and speech production, including expressive and receptive language;

vi. thought, including fears, nightmares, dissociative states, and hallucinations;

vii. affect and mood, including modes of expression, range, responsiveness, duration, and intensity;

viii. play, including structure, content, symbolic functioning, and modulation of aggression;

ix. cognitive functioning; and

x. relatedness to parents, other caregivers, and examiner; and

(c) other assessment tools as determined and periodically revised by the commissioner;

(2) for children ages 5 to 18, completion of other assessment standards for children as determined and periodically revised by the commissioner; and

(3) for adults, completion of other assessment standards for adults as determined and periodically revised by the commissioner.

D. A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The professional or practitioner must gather initial background information using the components of a standard diagnostic assessment in item B, subitems (1), (2), unit (b), (3), and (5), and draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem. Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.

E. Adult diagnostic assessment update includes a face-to-face interview with the client, and contains a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C, who reviews a standard or extended diagnostic assessment. The adult diagnostic assessment update must update the most recent assessment document in writing in the following areas:

(1) review of the client's life situation, including an interview with the client about the client's current life situation, and a written update of those parts where significant new or changed information exists, and documentation where there has not been significant change;

(2) review of the client's presenting problems, including an interview with the client about current presenting problems and a written update of those parts where there is significant new or changed information, and note parts where there has not been significant change;

(3) screenings for substance use, abuse, or dependency and other screenings as determined by the commissioner;

(4) the client's mental health status examination;

(5) assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(6) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary, or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(7) the client's diagnosis on all axes of the current edition of the Diagnostic and Statistical Manual and any differential diagnosis.

Subp. 2. **Neuropsychological assessment.** A neuropsychological assessment must include a face-to-face interview with the client, the interpretation of the test results, and preparation and completion of a report. A client is eligible for a neuropsychological assessment if at least one of the following criteria is met:

A. There is a known or strongly suspected brain disorder based on medical history or neurological evaluation such as a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorders, significant exposure to neurotoxins, central nervous system infections, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformations of the brain; or

B. In the absence of a medically verified brain disorder based on medical history or neurological evaluation, there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology, or suspected neuropsychological impairment in addition to functional psychopathology. Examples include:

(1) poor memory or impaired problem solving;

(2) change in mental status evidenced by lethargy, confusion, or disorientation;

(3) deterioration in level of functioning;

(4) marked behavioral or personality change;

(5) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;

(6) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers; and

(7) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

C. If neither criterion in item A nor B is fulfilled, neuropsychological evaluation is not indicated.

D. The neuropsychological assessment must be conducted by a neuropsychologist with competence in the area of neuropsychological assessment as stated to the Minnesota Board of Psychology who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program:

(a) completed an internship, or its equivalent, in a clinically relevant area of professional psychology;

(b) completed the equivalent of two full-time years of experience and specialized training, at least one which is at the postdoctoral level, in the study and practices of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist; and

(c) holds a current license to practice psychology independently in accordance with Minnesota Statutes, sections 148.88 to 148.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in subitem (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010.

Subp. 3. **Neuropsychological testing.**

A. Medical assistance covers neuropsychological testing when the client has either:

(1) a significant mental status change that is not a result of a metabolic disorder that has failed to respond to treatment;

(2) in children or adolescents, a significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers;

(3) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities, as required to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(a) traumatic brain injury;

(b) stroke;

(c) brain tumor;

(d) substance abuse or dependence;

(e) cerebral anoxic or hypoxic episode;

(f) central nervous system infection or other infectious disease;

(g) neoplasms or vascular injury of the central nervous system;

(h) neurodegenerative disorders;

(i) demyelinating disease;

(j) extrapyramidal disease;

(k) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(l) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders such as lupus, erythematosis, or celiac disease;

(m) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, such as phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(n) severe or prolonged nutrition or malabsorption syndromes; or

(o) a condition presenting in a manner making it difficult for a clinician to distinguish between:

i. the neurocognitive effects of a neurogenic syndrome such as dementia or encephalopathy; and

ii. a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function, or another disorder such as autism, selective mutism, anxiety disorder, or reactive attachment disorder.

B. Neuropsychological testing must be administered or clinically supervised by a neuropsychologist qualified as defined in subpart 2, item D.

C. Neuropsychological testing is not covered when performed:

(1) primarily for educational purposes;

(2) primarily for vocational counseling or training;

(3) for personnel or employment testing;

(4) as a routine battery of psychological tests given at inpatient admission or continued stay; or

(5) for legal or forensic purposes.

Subp. 4. **Psychological testing.** Psychological testing must meet the following requirements:

A. The psychological testing must:

(1) be administered or clinically supervised by a licensed psychologist with competence in the area of psychological testing as stated to the Minnesota Board of Psychology; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a mental health practitioner working as a clinical psychology trainee as required by part 9505.0371, subpart 5, item C, under the clinical supervision of a licensed psychologist according to part 9505.0371, subpart 5, item A, subitem (2).

B. The administration, scoring, and interpretation of the psychological tests must be done under the clinical supervision of a licensed psychologist when performed by a technician, psychometrist, or psychological assistant or as part of a computer-assisted psychological testing program.

C. The report resulting from the psychological testing must be:

(1) signed by the psychologist conducting the face-to-face interview;

(2) placed in the client's record; and

(3) released to each person authorized by the client.

Subp. 5. **Explanations of findings.** To be eligible for medical assistance payment, the mental health professional providing the explanation of findings must obtain the authorization of the client or the client's representative to release the information as required in part 9505.0371, subpart 6. Explanation of findings is provided to the client, client's family, and caregivers, or to other providers to help them understand the results of the testing or diagnostic assessment, better understand the client's illness, and provide professional insight needed to carry out a plan of treatment. An explanation of findings is not paid separately when the results of psychological testing or a diagnostic assessment are explained to the client or the client's representative as part of the psychological testing or a diagnostic assessment.

Subp. 6. **Psychotherapy.** Medical assistance covers psychotherapy as conducted by a mental health professional or a mental health practitioner as defined in part 9505.0371, subpart 5, item C, as provided in this subpart.

A. Individual psychotherapy is psychotherapy designed for one client.

B. Family psychotherapy is designed for the client and one or more family members or the client's primary caregiver whose participation is necessary to accomplish the client's

treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance. For purposes of this subpart, the phrase "whose participation is necessary to accomplish the client's treatment goals" does not include shift or facility staff members at the client's residence. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of time of the exclusion. The mental health professional must also document the reason or reasons why a member of the client's family is excluded.

C. Group psychotherapy is appropriate for individuals who because of the nature of their emotional, behavioral, or social dysfunctions can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or practitioner is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two mental health practitioners or one mental health professional and one mental health practitioner is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 persons.

D. A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in client's treatment plan. If the client is excluded, the mental health professional or practitioner must document the reason for and the length of the time of the exclusion. The mental health professional or practitioner must document the reasons why a member of the client's family is excluded.

Subp. 7. **Medication management.** The determination or evaluation of the effectiveness of a client's prescribed drug must be carried out by a physician or by an advanced practice registered nurse, as defined in Minnesota Statutes, sections 148.171 to 148.285, who is qualified in psychiatric nursing.

Subp. 8. **Adult day treatment.** Adult day treatment payment limitations include the following conditions.

A. Adult day treatment must consist of at least one hour of group psychotherapy, and must include group time focused on rehabilitative interventions, or other therapeutic services that are provided by a multidisciplinary staff. Adult day treatment is an intensive psychotherapeutic treatment. The services must stabilize the client's mental health status, and develop and improve the client's independent living and socialization skills. The goal of adult day treatment is to reduce or relieve the effects of mental illness so that an individual is able to benefit from a lower level of care and to enable the client to live and function more independently in the community. Day treatment services are not a part of inpatient or residential treatment services.

B. To be eligible for medical assistance payment, a day treatment program must:

(1) be reviewed by and approved by the commissioner;

(2) be provided to a group of clients by a multidisciplinary staff under the clinical supervision of a mental health professional;

(3) be available to the client at least two days a week for at least three consecutive hours per day. The day treatment may be longer than three hours per day, but medical assistance must not reimburse a provider for more than 15 hours per week;

(4) include group psychotherapy done by a mental health professional, or mental health practitioner qualified according to part 9505.0371, subpart 5, item C, and rehabilitative interventions done by a mental health professional or mental health practitioner daily;

(5) be included in the client's individual treatment plan as necessary and appropriate. The individual treatment plan must include attainable, measurable goals as they relate to services and must be completed before the first day treatment session. The vendor must review the recipient's progress and update the treatment plan at least every 30 days until the client is discharged and include an available discharge plan for the client in the treatment plan; and

(6) document the interventions provided and the client's response daily.

C. To be eligible for adult day treatment, a recipient must:

(1) be 18 years of age or older;

(2) not be residing in a nursing facility, hospital, institute of mental disease, or regional treatment center, unless the recipient has an active discharge plan that indicates a move to an independent living arrangement within 180 days;

(3) have a diagnosis of mental illness as determined by a diagnostic assessment;

(4) have the capacity to engage in the rehabilitative nature, the structured setting, and the therapeutic parts of psychotherapy and skills activities of a day treatment program and demonstrate measurable improvements in the recipient's functioning related to the recipient's mental illness that would result from participating in the day treatment program;

(5) have at least three areas of functional impairment as determined by a functional assessment with the domains prescribed by Minnesota Statutes, section 245.462, subdivision 11a;

(6) have a level of care determination that supports the need for the level of intensity and duration of a day treatment program; and

(7) be determined to need day treatment by a mental health professional who must deem the day treatment services medically necessary.

D. The following services are not covered by medical assistance if they are provided by a day treatment program:

(1) a service that is primarily recreation-oriented or that is provided in a setting that is not medically supervised. This includes: sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultation with other providers or service agency staff about the care or progress of a client;

(4) prevention or education programs provided to the community;

(5) day treatment for recipients with primary diagnoses of alcohol or other drug abuse;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours daily; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Subp. 9. **Partial hospitalization.** Partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission as specified in part 9505.0520, subpart 1, and who has the family and community resources

necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services provided by a multidisciplinary staff to treat the client's mental illness.

Subp. 10. **Dialectical behavior therapy (DBT).** Dialectical behavior therapy (DBT) treatment services must meet the following criteria:

A. DBT must be provided according to this subpart and Minnesota Statutes, section 256B.0625, subdivision 5l.

B. DBT is an outpatient service that is determined to be medically necessary by either: (1) a mental health professional qualified according to part 9505.0371, subpart 5, or (2) a mental health practitioner working as a clinical trainee according to part 9505.0371, subpart 5, item C, who is under the clinical supervision of a mental health professional according to part 9505.0371, subpart 5, item D, with specialized skill in dialectical behavior therapy. The treatment recommendation must be based upon a comprehensive evaluation that includes a diagnostic assessment and functional assessment of the client, and review of the client's prior treatment history. Treatment services must be provided pursuant to the client's individual treatment plan and provided to a client who satisfies the criteria in item C.

C. To be eligible for DBT, a client must:

(1) be 18 years of age or older;

(2) have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services;

(3) meet one of the following criteria:

(a) have a diagnosis of borderline personality disorder; or

(b) have multiple mental health diagnoses and exhibit behaviors characterized by impulsivity, intentional self-harm behavior, and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas;

(4) understand and be cognitively capable of participating in DBT as an intensive therapy program and be able and willing to follow program policies and rules assuring safety of self and others; and

(5) be at significant risk of one or more of the following if DBT is not provided:

(a) mental health crisis;

(b) requiring a more restrictive setting such as hospitalization;

(c) decompensation; or

(d) engaging in intentional self-harm behavior.

D. The treatment components of DBT are individual therapy and group skills as follows:

(1) Individual DBT combines individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and reinforce the use of adaptive skillful behaviors. The therapist must:

(a) identify, prioritize, and sequence behavioral targets;

(b) treat behavioral targets;

(c) generalize DBT skills to the client's natural environment through telephone coaching outside of the treatment session;

(d) measure the client's progress toward DBT targets;

(e) help the client manage crisis and life-threatening behaviors; and

(f) help the client learn and apply effective behaviors when working with other treatment providers.

(2) Individual DBT therapy is provided by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

(3) Group DBT skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce the client's suicidal and other dysfunctional coping behaviors and restore function by teaching the client adaptive skills in the following areas:

(a) mindfulness;

(b) interpersonal effectiveness;

(c) emotional regulation; and

(d) distress tolerance.

(4) Group DBT skills training is provided by two mental health professionals, or by a mental health professional cofacilitating with a mental health practitioner.

(5) The need for individual DBT skills training must be determined by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

E. A program must be certified by the commissioner as a DBT provider. To qualify for certification, a provider must:

(1) hold current accreditation as a DBT program from a nationally recognized certification body approved by the commissioner or submit to the commissioner's inspection and provide evidence that the DBT program's policies, procedures, and practices will continuously meet the requirements of this subpart;

(2) be enrolled as a MHCP provider;

(3) collect and report client outcomes as specified by the commissioner; and

(4) have a manual that outlines the DBT program's policies, procedures, and practices which meet the requirements of this subpart.

F. The DBT treatment team must consist of persons who are trained in DBT treatment. The DBT treatment team may include persons from more than one agency. Professional and clinical affiliations with the DBT team must be delineated:

(1) A DBT team leader must:

(a) be a mental health professional employed by, affiliated with, or contracted by a DBT program certified by the commissioner;

(b) have appropriate competencies and working knowledge of the DBT principles and practices; and

(c) have knowledge of and ability to apply the principles and DBT practices that are consistent with evidence-based practices.

(2) DBT team members who provide individual DBT or group skills training must:

(a) be a mental health professional or be a mental health practitioner, who is employed by, affiliated with, or contracted with a DBT program certified by the commissioner;

(b) have or obtain appropriate competencies and working knowledge of DBT principles and practices within the first six months of becoming a part of the DBT program;

(c) have or obtain knowledge of and ability to apply the principles and practices of DBT consistently with evidence-based practices within the first six months of working at the DBT program;

(d) participate in DBT consultation team meetings; and

(e) require mental health practitioners to have ongoing clinical supervision by a mental health professional who has appropriate competencies and working knowledge of DBT principles and practices.

Subp. 11. **Noncovered services.** The mental health services in items A to J are not eligible for medical assistance payment under this part:

A. a mental health service that is not medically necessary;

B. a neuropsychological assessment carried out by a person other than a neuropsychologist who is qualified according to part 9505.0372, subpart 2, item D;

C. a service ordered by a court that is solely for legal purposes and not related to the recipient's diagnosis or treatment for mental illness;

D. services dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health;

E. a service that is only for a vocational purpose or an educational purpose that is not mental health related;

F. staff training that is not related to a client's individual treatment plan or plan of care;

G. child and adult protection services;

H. fund-raising activities;

I. community planning; and

J. client transportation.

9505.1693 SCOPE AND PURPOSE.

Parts 9505.1693 to 9505.1748 govern the early and periodic screening, diagnosis, and treatment (EPSDT) program.

Parts 9505.1693 to 9505.1748 must be read in conjunction with section 1905(a)(4)(B) of the Social Security Act, as amended through December 31, 1981, and the Code of Federal Regulations, title 42, part 441, subpart B, as amended through October 1, 1987, and section 6403 of the Omnibus Budget Reconciliation Act of 1989. The purpose of the EPSDT program is to identify potentially disabling conditions in children eligible for medical assistance, to provide diagnosis and treatment for conditions identified, and to encourage parents and their children to use health care services when necessary.

9505.1696 DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 9505.1693 to 9505.1748, the following terms have the meanings given them.

Subp. 2. **Child.** "Child" means a person who is eligible for early and periodic screening, diagnosis, and treatment under part 9505.1699.

Subp. 3. **Community health clinic.** "Community health clinic" means a clinic that provides services by or under the supervision of a physician and that:

A. is incorporated as a nonprofit corporation under Minnesota Statutes, chapter 317A;

B. is exempt from federal income tax under Internal Revenue Code of 1986, section 501(c)(3), as amended through December 31, 1987;

C. is established to provide health services to low-income population groups; and

D. has written clinic policies describing the services provided by the clinic and concerning (1) the medical management of health problems, including problems that require referral to physicians, (2) emergency health services, and (3) the maintenance and review of health records by the physician.

Subp. 4. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 5. **Diagnosis.** "Diagnosis" means the identification and determination of the nature or cause of a disease or abnormality through the use of a health history; physical, developmental, and psychological examination; and laboratory tests.

Subp. 6. **Early and periodic screening clinic or EPS clinic.** "Early and periodic screening clinic" or "EPS clinic" means an individual or facility that is approved by the Minnesota Department of Health under parts 4615.0900 to 4615.2000.

Subp. 7. **Early and periodic screening, diagnosis, and treatment program or EPSDT program.** "Early and periodic screening, diagnosis, and treatment program" or "EPSDT program" means the program that provides screening, diagnosis, and treatment under parts 9505.1693 to 9505.1748; Code of Federal Regulations, title 42, section 441.55, as amended through October 1, 1986; and Minnesota Statutes, section 256B.02, subdivision 8, paragraph (12).

Subp. 8. **EPSDT clinic.** "EPSDT clinic" means a facility supervised by a physician that provides screening according to parts 9505.1693 to 9505.1748 or an EPS clinic.

Subp. 9. **EPSDT provider agreement.** "EPSDT provider agreement" means the agreement required by part 9505.1703, subpart 2.

Subp. 11. **Follow-up.** "Follow-up" means efforts by a local agency to ensure that a screening requested for a child is provided to that child and that diagnosis and treatment indicated as necessary by a screening are also provided to that child.

Subp. 12. **Head Start agency.** "Head Start agency" refers to the child development program administered by the United States Department of Health and Human Services, Office of Administration for Children, Youth and Families.

Subp. 13. **Local agency.** "Local agency" means the county welfare board, multicounty welfare board, or human service agency established in Minnesota Statutes, section 256B.02, subdivision 6, and Minnesota Statutes, chapter 393.

Subp. 14. **Medical assistance.** "Medical assistance" means the program authorized by title XIX of the Social Security Act and Minnesota Statutes, chapters 256 and 256B.

Subp. 15. **Outreach.** "Outreach" means efforts by the department or a local agency to inform eligible persons about early and periodic screening, diagnosis, and treatment or to encourage persons to use the EPSDT program.

Subp. 16. **Parent.** "Parent" refers to the genetic or adoptive parent of a child.

Subp. 17. **Physician.** "Physician" means a person who is licensed to provide health services within the scope of the person's profession under Minnesota Statutes, chapter 147.

Subp. 18. **Prepaid health plan.** "Prepaid health plan" means a health insurer licensed and operating under Minnesota Statutes, chapters 60A, 62A, and 62C, and a health maintenance organization licensed and operating under Minnesota Statutes, chapter 62D to provide health services to recipients of medical assistance entitlements.

Subp. 19. **Public health nursing service.** "Public health nursing service" means the nursing program provided by a community health board under Minnesota Statutes, section 145A.04, subdivisions 1 and 1a.

Subp. 20. **Screening.** "Screening" means the use of quick, simple procedures to separate apparently well children from those who need further examination for possible physical, developmental, or psychological problems.

Subp. 21. **Skilled professional medical personnel and supporting staff.** "Skilled professional medical personnel" and "supporting staff" means persons as defined by Code of Federal Regulations, title 42, section 432.2, as amended through October 1, 1987.

Subp. 22. **Treatment.** "Treatment" means the prevention, correction, or amelioration of a disease or abnormality identified by screening or diagnosis.

9505.1699 ELIGIBILITY TO BE SCREENED.

A person under age 21 who is eligible for medical assistance is eligible for the EPSDT program.

9505.1701 CHOICE OF PROVIDER.

Subpart 1. **Choice of screening provider.** Except as provided by subpart 3, a child or parent of a child who requests screening may choose any screening provider who has signed an EPSDT provider agreement and a medical assistance provider agreement.

Subp. 2. **Choice of diagnosis and treatment provider.** Except as provided by subpart 3, a child or parent of a child may choose any diagnosis and treatment provider as provided by part 9505.0190.

Subp. 3. **Exception to subparts 1 and 2.** A child who is enrolled in a prepaid health plan must receive screening, diagnosis, and treatment from that plan.

9505.1703 ELIGIBILITY TO PROVIDE SCREENING.

Subpart 1. **Providers.** An EPSDT clinic or a community health clinic shall be approved for medical assistance reimbursement for EPSDT services if it complies with the requirements of parts 9505.1693 to 9505.1748. A Head Start agency shall be approved as provided by subpart 2.

Subp. 2. **EPSDT provider agreement.** To be eligible to provide screening and receive reimbursement under the EPSDT program, an individual or facility must sign an EPSDT provider agreement provided by the department and a medical assistance provider agreement under part 9505.0195 or be a prepaid health plan.

Subp. 3. **Terms of EPSDT provider agreement.** The EPSDT provider agreement required by subpart 2 must state that the provider must:

A. screen children according to parts 9505.1693 to 9505.1748;

B. report all findings of the screenings on EPSDT screening forms; and

C. refer children for diagnosis and treatment if a referral is indicated by the screening.

The EPSDT provider agreement also must state that the department will provide training according to part 9505.1712 and will train and consult with the provider on billing and reporting procedures.

9505.1706 REIMBURSEMENT.

Subpart 1. **Maximum payment rates.** Payment rates shall be as provided by part 9505.0445, item M.

Subp. 2. **Eligibility for reimbursement; Head Start agency.** A Head Start agency may complete all the screening components under part 9505.1718, subparts 2 to 14 or those components that have not been completed by another provider within the six months before completion of the screening components by the Head Start agency. A Head Start agency that completes the previously incomplete screening components must document on the EPSDT screening form that the other screening components of part 9505.1718, subparts 2 to 14, have been completed by another provider.

The department shall reimburse a Head Start agency for those screening components of part 9505.1718, subparts 2 to 14, that the Head Start agency has provided. The amount of reimbursement must be the same as a Head Start agency's usual and customary cost for each screening component or the maximum fee determined under subpart 1, whichever is lower.

Subp. 3. **Prepaid health plan.** A prepaid health plan is not eligible for a separate payment for screening. The early and periodic screening, diagnosis, and treatment screening must be a service included within the prepaid capitation rate specified in its contract with the department.

9505.1712 TRAINING.

The department must train the staff of an EPSDT clinic that is supervised by a physician on how to comply with the procedures required by part 9505.1718 if the EPSDT clinic requests the training.

9505.1715 COMPLIANCE WITH SURVEILLANCE AND UTILIZATION REVIEW.

A screening provider must comply with the surveillance and utilization review requirements of parts 9505.2160 to 9505.2245.

9505.1718 SCREENING STANDARDS FOR AN EPSDT CLINIC.

Subpart 1. **Requirement.** An early and periodic screening, diagnosis, and treatment screening must meet the requirements of subparts 2 to 15 except as provided by part 9505.1706, subpart 2.

Subp. 2. **Health and developmental history.** A history of a child's health and development must be obtained from the child, parent of the child, or an adult who is familiar with the child's health history. The history must include information on sexual development, lead and tuberculosis exposure, nutrition intake, chemical abuse, and social, emotional, and mental health status.

Subp. 3. **Assessment of physical growth.** The child's height or length and the child's weight must be measured and the results plotted on a growth grid based on data from the National Center for Health Statistics (NCHS). The head circumference of a child up to 36 months of age or a child whose growth in head circumference appears to deviate from the expected circumference for that child must be measured and plotted on an NCHS-based growth grid.

Subp. 4. **Physical examination.** The following must be checked according to accepted medical procedures: pulse; respiration; blood pressure; head; eyes; ears; nose; mouth; pharynx; neck; chest; heart; lungs; abdomen; spine; genitals; extremities; joints; muscle tone; skin; and neurological condition.

Subp. 5. **Vision.** A child must be checked for a family history of maternal and neonatal infection and ocular abnormalities. A child must be observed for pupillary reflex; the presence of nystagmus; and muscle balance, which includes an examination for esotropia, exotropia, phorias, and extraocular movements. The external parts of a child's eyes must be examined including the lids, conjunctiva, cornea, iris, and pupils. A child or parent of the child must be asked whether he or she has concerns about the child's vision.

Subp. 6. **Vision of a child age three or older.** In addition to the requirements of subpart 5, the visual acuity of a child age three years or older must be checked by use of the Screening Test for Young Children and Retardates (STYCAR) or the Snellen Alphabet Chart.

Subp. 7. **Hearing.** A child must be checked for a family history of hearing disability or loss, delay of language acquisition or history of such delay, the ability to determine the direction of a sound, and a history of repeated otitis media during early life. A child or parent of the child must be asked whether he or she has any concerns regarding the child's hearing.

Subp. 8. **Hearing of a child age three or older.** In addition to the requirements of subpart 7, a child age three or older must receive a pure tone audiometric test or referral for the test if the examination under subpart 7 indicates the test is needed.

Subp. 9. **Development.** A child must be screened for the following according to the screening provider's standard procedures: fine and gross motor development, speech and language development, social development, cognitive development, and self-help skills. Standardized tests that are used in screening must be culturally sensitive and have norms for the age range tested, written procedures for administration and for scoring and interpretation that are statistically reliable and valid. The provider must use a combination of the child's health and developmental history and standardized test or clinical judgment to determine the child's developmental status or need for further assessment.

Subp. 10. **Sexual development.** A child must be evaluated to determine whether the child's sexual development is consistent with the child's chronological age. A female must receive a breast examination and pelvic examination when indicated. A male must receive a testicular examination when indicated. If it is in the best interest of a child, counseling on normal sexual development, information on birth control and sexually transmitted diseases, and prescriptions and tests must be offered to a child. If it is in the best interest of a child, a screening provider may refer the child to other resources for counseling or a pelvic examination.

Subp. 11. **Nutrition.** When the assessment of a child's physical growth performed according to subpart 3 indicates a nutritional risk condition, the child must be referred for further assessment, receive nutritional counseling, or be referred to a nutrition program such as the Special Supplemental Food Program for Women, Infants, and Children; food stamps or food support; Expanded Food and Nutrition Education Program; or Head Start.

Subp. 12. **Immunizations.** The immunization status of a child must be compared to the "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition. Immunizations that the comparison shows are needed must be offered to the child and given to the child if the child or parent of the child accepts the offer. The "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition, is developed and distributed by the Minnesota Department of Health, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440. The "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition, is incorporated by reference and is available at the State Law Library, Judicial Center, 25 Rev. Dr. Martin Luther King Jr. Blvd., Saint Paul, Minnesota 55155. It is subject to frequent change.

Subp. 13. **Laboratory tests.** Laboratory tests must be done according to items A to F.

A. A Mantoux test must be administered yearly to a child whose health history indicates ongoing exposure to tuberculosis, unless the child has previously tested positive. A child who tests positive must be referred for diagnosis and treatment.

B. A child aged one to five years must initially be screened for lead through the use of either an erythrocyte protoporphyrin (EP) test or a direct blood lead screening test until December 31, 1992. Beginning January 1, 1993, a child age one to five must initially be screened using a direct blood lead screening test. Either capillary or venous blood may be used as the specimen for the direct blood lead test. Blood tests must be performed at a

minimum of once at 12 months of age and once at 24 months of age or whenever the history indicates that there are risk factors for lead poisoning. When the result of the EP or capillary blood test is greater than the maximum allowable level set by the Centers for Disease Control of the United States Public Health Service, the child must be referred for a venous blood lead test. A child with a venous blood lead level greater than the maximum allowable level set by the Centers for Disease Control must be referred for diagnosis and treatment.

C. The urine of a child must be tested for the presence of glucose, ketones, protein, and other abnormalities. A female at or near the age of four and a female at or near the age of ten must be tested for bacteriuria.

D. Either a microhematocrit determination or a hemoglobin concentration test for anemia must be done.

E. A test for sickle cell or other hemoglobinopathy, or abnormal blood conditions must be offered to a child who is at risk of such abnormalities and who has not yet been tested. These tests must be provided if accepted or requested by the child or parent of the child. If the tests identify a hemoglobin abnormality or other abnormal blood condition, the child must be referred for genetic counseling.

F. Other laboratory tests such as those for cervical cancer, sexually transmitted diseases, pregnancy, and parasites must be performed when indicated by a child's medical or family history.

Subp. 14. **Oral examination.** An oral examination of a child's mouth must be performed to detect deterioration of hard tissue, and inflammation or swelling of soft tissue. Counseling about the systemic use of fluoride must be given to a child when fluoride is not available through the community water supply or school programs.

Subp. 14a. **Health education and health counseling.** Health education and health counseling concerning the child's health must be offered to the child who is being screened and to the child's parent or representative. The health education and health counseling are for the purposes of assisting the child or the parent or representative of the child to understand the expected growth and development of the child and of informing the child or the parent or representative of the child about the benefits of healthy lifestyles and about practices to promote accident and disease prevention.

Subp. 15. **Schedule of age related screening standards.** An early and periodic screening, diagnosis, and treatment screening for a child at a specific age must include, at a minimum, the screening requirements of subparts 2 to 14 as provided by the following schedule:

Schedule of age related screening standards

A. Infancy:

Standards	Ages					
	By 1 month	2 months	4 months	6 months	9 months	12 months
Health History	X	X	X	X	X	X
Assessment of Physical Growth:						
Height	X	X	X	X	X	X
Weight	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X
Physical Examination	X	X	X	X	X	X

Vision	X	X	X	X	X	X
Hearing	X	X	X	X	X	X
Development	X	X	X	X	X	X
Health Education/Counseling	X	X	X	X	X	X
Sexual Development	X	X	X	X	X	X
Nutrition	X	X	X	X	X	X
Immunizations/Review		X	X	X	X	X
Laboratory Tests:						
Tuberculin		if history indicates				
Lead Absorption		if history indicates				X
Urinalysis	←	←	←	X	←	←
Hematocrit or Hemoglobin	←	←	←	←	X	X
Sickle Cell			at parent's or child's request			
Other Laboratory Tests			as indicated			
Oral Examination	X	X	X	X	X	X

X = Procedure to be completed.

← = Procedure to be completed if not done at the previous visit, or on the first visit.

B. Early Childhood:

Standards	Ages				
	15 months	18 months	24 months	3 years	4 years
Health History	X	X	X	X	X
Assessment of Physical Growth:					
Height	X	X	X	X	X
Weight	X	X	X	X	X
Head Circumference	X	X	X	X	X
Physical Examination	X	X	X	X	X
Vision	X	X	X	X	X
Hearing	X	X	X	X	X
Blood Pressure				X	X
Development	X	X	X	X	X
Health Education/Counseling	X	X	X	X	X

Sexual Development	X	X	X	X	X
Nutrition	X	X	X	X	X
Immunizations/Review	X	X	X	X	X
Laboratory Tests:					
Tuberculin	if history indicates				
Lead Absorption	if history indicates		X	if history indicates	
Urinalysis	←	←	X	←	←
Bacteriuria (females)					X
Hematocrit or Hemoglobin	←	←	←	←	←
Sickle Cell	at parent's or child's request				
Other Laboratory Tests	as indicated				
Oral Examination	X	X	X	X	X

X = Procedure to be completed.

← = Procedure to be completed if not done at the previous visit, or on the first visit.

C. Late childhood:

Standards	Ages				
	5 years	6 years	8 years	10 years	12 years
Health History	X	X	X	X	X
Assessment of Physical Growth:					
Height	X	X	X	X	X
Weight	X	X	X	X	X
Physical Examination	X	X	X	X	X
Vision	X	X	X	X	X
Hearing	X	X	X	X	X
Blood Pressure	X	X	X	X	X
Development	X	X	X	X	X
Health Education/Counseling	X	X	X	X	X
Sexual Development	X	X	X	X	X
Nutrition	X	X	X	X	X
Immunizations/Review	X	X	X	X	X
Laboratory Tests:					
Tuberculin	if history indicates				

Lead Absorption			if history indicates		
Urinalysis	←	←	X	←	←
Bacteriuria (females)	←	←	X	←	←
Hemoglobin or Hematocrit	←	←	X	←	
Sickle Cell			at parent's or child's request		
Other Laboratory Tests			as indicated		
Oral Examination	X	X	X	X	X

X = Procedure to be completed.

← = Procedure to be completed if not done at the previous visit, or on the first visit.

D. Adolescence:

Standards	Ages			
	14 years	16 years	18 years	20 years
Health History	X	X	X	X
Assessment of Physical Growth:				
Height	X	X	X	X
Weight	X	X	X	X
Physical Examination	X	X	X	X
Vision	X	X	X	X
Hearing	X	X	X	X
Blood Pressure	X	X	X	X
Development	X	X	X	X
Health Education/Counseling	X	X	X	X
Sexual Development	X	X	X	X
Nutrition	X	X	X	X
Immunizations/Review	X	X	X	X
Laboratory Tests:				
Tuberculin		if history indicates		
Lead Absorption		if history indicates		
Urinalysis	←		X	
Bacteriuria (females)	←		←	
Hemoglobin or Hematocrit	←		X	
Sickle Cell		at parent's or child's request		
Other Laboratory Tests		as indicated		

Oral Examination	X	X

X = Procedure to be completed.

← = Procedure to be completed if not done at the previous visit, or on the first visit.

Subp. 15a. **Additional screenings.** A child may have a partial or complete screening between the ages specified in the schedule under subpart 15 if the screening is medically necessary or a concern develops about the child's health or development.

9505.1724 PROVISION OF DIAGNOSIS AND TREATMENT.

Diagnosis and treatment identified as needed under part 9505.1718 shall be eligible for medical assistance payment subject to the provisions of parts 9505.0170 to 9505.0475.

9505.1727 INFORMING.

A local agency must inform each child or parent of a child about the EPSDT program no later than 60 days after the date the child is determined to be eligible for medical assistance. The information about the EPSDT program must be given orally and in writing, indicate the purpose and benefits of the EPSDT program, indicate that the EPSDT program is without cost to the child or parent of the child while the child is eligible for medical assistance, state the types of medical and dental services available under the EPSDT program, and state that the transportation and appointment scheduling assistance required under part 9505.1730 is available.

The department must send a written notice to a child or parent of a child who has been screened informing the child or parent that the child should be screened again. This notice must be sent at the following ages of the child: six months, nine months, one year, 18 months, two years, four years, and every three years after age four.

Each year, on the date the child was determined eligible for medical assistance entitlements, the department must send a written notice to a child or parent of a child who has never been screened informing the child or parent that the child is eligible to be screened.

9505.1730 ASSISTANCE WITH OBTAINING A SCREENING.

Within ten working days of receiving a request for screening from a child or parent of a child, a local agency must give or mail to the child or parent of the child:

A. a written list of EPSDT clinics in the area in which the child lives; and

B. a written offer of help in making a screening appointment and in transporting the child to the site of the screening.

If the child or parent of the child requests help, the local agency must provide it.

Transportation under this item must be provided according to part 9505.0140, subpart 1.

9505.1733 ASSISTANCE WITH OBTAINING DIAGNOSIS AND TREATMENT.

An EPSDT clinic must notify a child or parent of a child who is referred for diagnosis and treatment that the local agency will provide names and addresses of diagnosis and treatment providers and will help with appointment scheduling and transportation to the diagnosis and treatment provider. The notice must be on a form provided by the department and must be given to the child or parent of the child on the day the child is screened.

If a child or parent of a child asks a local agency for assistance with obtaining diagnosis and treatment, the local agency must provide that assistance within ten working days of the date of the request.

9505.1736 SPECIAL NOTIFICATION REQUIREMENT.

A local agency must effectively inform an individual who is blind or deaf, or who cannot read or understand the English language, about the EPSDT program.

9505.1739 CHILDREN IN FOSTER CARE.

Subpart 1. **Dependent or neglected state wards.** The local agency must provide early and periodic screening, diagnosis, and treatment services for a child in foster care who is a dependent or neglected state ward under parts 9560.0410 to 9560.0470, and who is eligible for medical assistance unless the early and periodic screening, diagnosis, and treatment services are not in the best interest of the child.

Subp. 2. **Other children in foster care.** The local agency must discuss the EPSDT program with a parent of a child in foster care who is under the legal custody or protective supervision of the local agency or whose parent has entered into a voluntary placement agreement with the local agency. The local agency must help the parent decide whether to accept early and periodic screening, diagnosis, and treatment services for the child. If a parent cannot be consulted, the local agency must decide whether to accept early and periodic screening, diagnosis, and treatment services for the child and must document the reasons for the decision.

Subp. 3. **Assistance with appointment scheduling and transportation.** The local agency must help a child in foster care with appointment scheduling and transportation for screening, diagnosis, and treatment as provided by parts 9505.1730 to 9505.1733.

Subp. 4. **Notification.** The department must send a written notice to the local agency stating that a child in foster care who has been screened should be screened again. This notice must be sent at the following ages of the child: six months, nine months, one year, 18 months, two years, four years, and every three years thereafter.

Each year, by the anniversary of the date the child was determined eligible for medical assistance entitlements, the department must send a written notice to the local agency that a child in foster care who has never been screened is eligible to be screened.

If a written notice under this subpart pertains to a child who is a dependent or neglected state ward, the local agency must proceed according to subpart 1. The local agency must proceed according to subpart 2 if the written notice pertains to a child who is not a dependent or neglected state ward.

9505.1742 DOCUMENTATION.

The local agency must document compliance with parts 9505.1693 to 9505.1748 on forms provided by the department.

9505.1745 INTERAGENCY COORDINATION.

The local agency must coordinate the EPSDT program with other programs that provide health services to children as provided by Code of Federal Regulations, title 42, section 441.61(c), as amended through October 1, 1986. Examples of such agencies are a public health nursing service, a Head Start agency, and a school district.

9505.1748 CONTRACTS FOR ADMINISTRATIVE SERVICES.

Subpart 1. **Authority.** A local agency may contract with a county public health nursing service, a community health clinic, a Head Start agency, a community action agency, or a school district for early and periodic screening, diagnosis, and treatment administrative services. Early and periodic screening, diagnosis, and treatment administrative services include outreach; notification; appointment scheduling and transportation; follow-up; and documentation. For purposes of this subpart, "community action agency" means an entity defined in Minnesota Statutes, section 256E.31, subdivision 1, and "school district" means

a school district as defined in Minnesota Statutes, section 120A.05, subdivisions 5, 10, and 14.

Subp. 2. **Federal financial participation.** The percent of federal financial participation for salaries, fringe benefits, and travel of skilled professional medical personnel and their supporting staff shall be paid as provided by Code of Federal Regulations, title 42, section 433.15(b)(5), as amended through October 1, 1986.

Subp. 3. **State reimbursement.** State reimbursement for contracts for EPSDT administrative services under this part shall be as provided by Minnesota Statutes, section 256B.19, subdivision 1, except for the provisions under subdivision 1 that pertain to a prepaid health plan.

Subp. 4. **Approval.** A contract for administrative services must be approved by the local agency and submitted to the department for approval by November 1 of the year before the beginning of the calendar year in which the contract will be effective. A contract must contain items A to L to be approved by the department for reimbursement:

A. names of the contracting parties;

B. purpose of the contract;

C. beginning and ending dates of the contract;

D. amount of the contract, budget breakdown, and a clause that stipulates that the department's procedures for certifying expenditures will be followed by the local agency;

E. the method by which the contract may be amended or terminated;

F. a clause that stipulates that the contract will be renegotiated if federal or state program regulations or federal financial reimbursement regulations change;

G. a clause that stipulates that the contracting parties will provide program and fiscal records and maintain all nonpublic data required by the contract according to the Minnesota Government Data Practices Act and will cooperate with state and federal program reviews;

H. a description of the services contracted for and the agency that will perform them;

I. methods by which the local agency will monitor and evaluate the contract;

J. signatures of the representatives of the contracting parties with the authority to obligate the parties by contract and dates of those signatures;

K. a clause that stipulates that the services provided under contract must be performed by or under the supervision of skilled medical personnel; and

L. a clause that stipulates that the contracting parties will comply with state and federal requirements for the receipt of medical assistance funds.

9520.0010 STATUTORY AUTHORITY AND PURPOSE.

Parts 9520.0010 to 9520.0230 provide methods and procedures relating to the establishment and operation of area-wide, comprehensive, community-based mental health, developmental disability, and chemical dependency programs under state grant-in-aid as provided under Minnesota Statutes, sections 245.61 to 245.69. Minnesota Statutes, sections 245.61 to 245.69 are entitled The Community Mental Health Services Act. For purposes of these parts, "community mental health services" includes services to persons who have mental or emotional disorders or other psychiatric disabilities, developmental disabilities, and chemical dependency, including drug abuse and alcoholism.

9520.0020 BOARD DUTIES.

The community mental health board has the responsibility for ensuring the planning, development, implementation, coordination, and evaluation of the community comprehensive mental health program for the mentally ill/behaviorally disabled, developmentally disabled, and chemically dependent populations in the geographic area it serves. It also has the responsibility for ensuring delivery of services designated by statute.

9520.0030 DEFINITIONS.

Parts 9520.0040 and 9520.0050 also set forth definitions of community mental health centers and community mental health clinics.

9520.0040 COMMUNITY MENTAL HEALTH CENTER.

A community mental health center means an agency which includes all of the following:

A. Established under the provision of Minnesota Statutes, sections 245.61 to 245.69.

B. Provides as a minimum the following services for individuals with mental or emotional disorders, developmental disabilities, alcoholism, drug abuse, and other psychiatric conditions. The extent of each service to be provided by the center shall be indicated in the program plan, which is to reflect the problems, needs, and resources of the community served:

(1) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, developmental disability, alcoholism, drug abuse, and other psychiatric disorders;

(2) informational and educational services to schools, courts, health and welfare agencies, both public and private;

(3) informational and educational services to the general public, lay, and professional groups;

(4) consultative services to schools, courts, and health and welfare agencies, both public and private;

(5) outpatient diagnostic and treatment services; and

(6) rehabilitative services, particularly for those who have received prior treatment in an inpatient facility.

C. Provides or contracts for detoxification, evaluation, and referral for chemical dependency services (Minnesota Statutes, section 254A.08).

D. Provides specific coordination for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. (Minnesota Statutes, sections 254A.07 and 245.61).

E. Has a competent multidisciplinary mental health/developmental disability/chemical dependency professional team whose members meet the professional standards in their respective fields.

F. The professional mental health team is qualified by specific mental health training and experience and shall include as a minimum the services of each of the following:

(1) a licensed physician, who has completed an approved residency program in psychiatry; and

(2) a doctoral clinical, counseling, or health care psychologist, who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

(3) a clinical social worker with a master's degree in social work from an accredited college or university; and/or

(4) a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health nursing with mental health major, maternal and child health with mental health major, etc.

G. The multidisciplinary staff shall be sufficient in number to implement and operate the described program of the center. In addition to the above, this team should include other professionals, paraprofessionals, and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner. If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the center, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts to acquire such staff and show evidence of how the specialized functions of the required professionals are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0050 COMMUNITY MENTAL HEALTH CLINIC.

Subpart 1. **Definitions.** A community mental health clinic is an agency which devotes, as its major service, at least two-thirds of its resources for outpatient mental health diagnosis, treatment, and consultation by a multidisciplinary professional mental health team. The multidisciplinary professional mental health team is qualified by special mental health training and experience and shall include as a minimum the services of each of the following:

A. a licensed physician, who has completed an approved residency program in psychiatry; and

B. a doctoral clinical, or counseling or health care psychologist who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

C. a clinical social worker with a master's degree in social work from an accredited college or university; and/or

D. a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health with a mental health major, maternal and child health with a mental health major.

Subp. 2. **Other members of multidisciplinary team.** The multidisciplinary team shall be sufficient in number to implement and operate the described program of the clinic. In addition to the above, this team should include other professionals, paraprofessionals and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner.

Subp. 3. **Efforts to acquire staff.** If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the clinic, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts to acquire such staff and evidence of how the specialized functions of the required professional positions are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0060 ANNUAL PLAN AND BUDGET.

On or before the date designated by the commissioner, each year the chair of the community mental health board or director of the community mental health program, provided for in Minnesota Statutes, section 245.62, shall submit an annual plan identifying

program priorities in accordance with state grant-in-aid guidelines, and a budget on prescribed report forms for the next state fiscal year, together with the recommendations of the community mental health board, to the commissioner of human services for approval as provided under Minnesota Statutes, section 245.63.

9520.0070 FISCAL AFFILIATES.

Other providers of community mental health services may affiliate with the community mental health center and may be approved and eligible for state grant-in-aid funds. The state funding for other community mental health services shall be contingent upon appropriate inclusion in the center's community mental health plan for the continuum of community mental health services and conformity with the state's appropriate disability plan for mental health, developmental disability, or chemical dependency. Fiscal affiliates (funded contracting agencies) providing specialized services under contract must meet all rules and standards that apply to the services they are providing.

9520.0080 OTHER REQUIRED REPORTS.

The program director of the community mental health program shall provide the commissioner of human services with such reports of program activities as the commissioner may require.

9520.0090 FUNDING.

All state community mental health funding shall go directly to the community mental health board or to a human service board established pursuant to Laws of Minnesota 1975, chapter 402, which itself provides or contracts with another agency to provide the community mental health program. Such programs must meet the standards and rules for community mental health programs as enunciated in parts 9520.0010 to 9520.0230 in accordance with Laws of Minnesota 1975, chapter 402.

9520.0100 OPERATION OF OTHER PROGRAMS.

When the governing authority of the community mental health program operates other programs, services, or activities, only the community mental health center program shall be subject to these parts.

9520.0110 APPLICATIONS AND AGREEMENTS BY LOCAL COUNTIES.

New applications for state assistance or applications for renewal of support must be accompanied by an agreement executed by designated signatories on behalf of the participating counties that specifies the involved counties, the amount and source of local funds in each case, and the period of support. The local funds to be used to match state grant-in-aid must be assured in writing on Department of Human Services forms by the local funding authority(ies).

9520.0120 USE OF MATCHING FUNDS.

Funds utilized by the director as authorized by the community mental health board to match a state grant-in-aid must be available to that director for expenditures for the same general purpose as the state grant-in-aid funds.

9520.0130 QUARTERLY REPORTS.

The director of the community mental health program shall, within 20 days after the end of the quarter, submit quarterly prescribed reports to the commissioner of human services (controller's office), containing all receipts, expenditures, and cash balance, subject to an annual audit by the commissioner or his/her designee.

9520.0140 PAYMENTS.

Payments on approved grants will be made subsequent to the department's receipt of the program's quarterly reporting forms, unless the commissioner of human services has determined that funds allocated to a program are not needed for that program. Payments shall be in an amount of at least equal to the quarterly allocation minus any unexpended balance from the previous quarter providing this payment does not exceed the program grant award. In the event the program does not report within the prescribed time, the department will withhold the process of the program's payment until the next quarterly cycle.

9520.0150 FEES.

No fees shall be charged until the director with approval of the community mental health board has established fee schedules for the services rendered and they have been submitted to the commissioner of human services at least two months prior to the effective date thereof and have been approved by him/her. All fees shall conform to the approved schedules, which are accessible to the public.

9520.0160 SUPPLEMENTAL AWARDS.

The commissioner of human services may make supplemental awards to the community mental health boards.

9520.0170 WITHDRAWAL OF FUNDS.

The commissioner of human services may withdraw funds from any program that is not administered in accordance with its approved plan and budget. Written notice of such intended action will be provided to the director and community mental health board. Opportunity for hearing before the commissioner or his/her designee shall be provided.

9520.0180 BUDGET TRANSFERS.

Community mental health boards may make budget transfers within specified limits during any fiscal year without prior approval of the department. The specified limit which can be transferred in any fiscal year between program activity budgets shall be up to ten percent or up to $5,000 whichever is less. Transfers within an activity can be made into or out of line items with a specified limit of up to ten percent or up to $5,000 whichever is less. No line item can be increased or decreased by more than $5,000 or ten percent in a fiscal year without prior approval of the commissioner. Transfers above the specified limits can be made with prior approval from the commissioner. All transfers within and into program budget activities and/or line items must have prior approval by the community mental health board and this approval must be reflected in the minutes of its meeting, it must be reported to the commissioner with the reasons therefor, including a statement of how the transfer will affect program objectives.

9520.0190 BUDGET ADJUSTMENTS.

Budget adjustments made necessary by funding limitations shall be made by the commissioner and provided in writing to the director and board of the community mental health center.

9520.0200 CENTER DIRECTOR.

Every community mental health board receiving state funds for a community mental health program shall have a center director, who is the full-time qualified professional staff member who serves as the executive officer. To be considered qualified, the individual must have professional training to at least the level of graduate degree in his/her clinical and/or administrative discipline, which is relevant to MH-DD-CD and a minimum of two years experience in community mental health programs. The center director is responsible for the

planning/design, development, coordination, and evaluation of a comprehensive, area-wide program and for the overall administration of services operated by the board.

The center director shall be appointed by the community mental health board and shall be approved by the commissioner of human services.

9520.0210 DEADLINE FOR APPROVAL OR DENIAL OF REQUEST FOR APPROVAL STATUS.

The commissioner shall approve or deny, in whole or in part, an application for state financial assistance within 90 days of receipt of the grant-in-aid application or by the beginning of the state fiscal year, whichever is the later.

9520.0230 ADVISORY COMMITTEE.

Subpart 1. **Purpose.** To assist the community mental health board in meeting its responsibilities as described in Minnesota Statutes, section 245.68 and to provide opportunity for broad community representation necessary for effective comprehensive mental health, developmental disability, and chemical dependency program planning, each community mental health board shall appoint a separate advisory committee in at least the three disability areas of mental health, developmental disability, and chemical dependency.

Subp. 2. **Membership.** The advisory committees shall consist of residents of the geographic area served who are interested and knowledgeable in the area governed by such committee.

Subp. 3. **Nominations for membership.** Nominations for appointments as members of the advisory committees are to be made to the community mental health board from agencies, organizations, groups, and individuals within the area served by the community mental health center. Appointments to the advisory committees are made by the community mental health board.

Subp. 4. **Board member on committee.** One community mental health board member shall serve on each advisory committee.

Subp. 5. **Nonprovider members.** Each advisory committee shall have at least one-half of its membership composed of individuals who are not providers of services to the three disability groups.

Subp. 6. **Representative membership.** Membership of each advisory committee shall generally reflect the population distribution of the service delivery area of the community mental health center.

Subp. 7. **Chairperson appointed.** The community mental health board shall appoint a chairperson for each advisory committee. The chairperson shall not be a community mental health board member nor a staff member. The power to appoint the chairperson may be delegated by the community mental health board to the individual advisory committee.

Subp. 8. **Committee responsibility to board.** Each advisory committee shall be directly responsible to the community mental health board. Direct communication shall be effected and maintained through contact between the chairperson of the particular advisory committee, or his/her designee, and the chairperson of the community mental health board, or his/her designee.

Subp. 9. **Staff.** Staff shall be assigned by the director to serve the staffing needs of each advisory committee.

Subp. 10. **Study groups and task forces.** Each advisory committee may appoint study groups and task forces upon consultation with the community mental health board. It is strongly recommended that specific attention be given to the aging and children and youth populations.

Subp. 11. **Quarterly meetings required.** Each advisory committee shall meet at least quarterly.

Subp. 12. **Annual report required.** Each advisory committee must make a formal written and oral report on its work to the community mental health board at least annually.

Subp. 13. **Minutes.** Each advisory committee shall submit copies of minutes of their meetings to the community mental health board and to the Department of Human Services (respective disability group program divisions).

Subp. 14. **Duties of advisory committee.** The advisory committees shall be charged by the community mental health board with assisting in the identification of the community's needs for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. The advisory committee also assists the community mental health board in determining priorities for the community programs. Based on the priorities, each advisory committee shall recommend to the community mental health board ways in which the limited available community resources (work force, facilities, and finances) can be put to maximum and optimal use.

Subp. 15. **Recommendations.** The advisory committee recommendations made to the community mental health board shall be included as a separate section in the grant-in-aid request submitted to the Department of Human Services by the community mental health board.

Subp. 16. **Assessment of programs.** The advisory committees shall assist the community mental health board in assessing the programs carried on by the community mental health board, and make recommendations regarding the reordering of priorities and modifying of programs where necessary.

9520.0750 PURPOSE.

Parts 9520.0750 to 9520.0870 establish standards for approval of mental health centers and mental health clinics for purposes of insurance and subscriber contract reimbursement under Minnesota Statutes, section 62A.152.

9520.0760 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9520.0760 to 9520.0870, the following terms have the meanings given them.

Subp. 2. **Application.** "Application" means the formal statement by a center to the commissioner, on the forms created for this purpose, requesting recognition as meeting the requirements of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 3. **Approval.** "Approval" means the determination by the commissioner that the applicant center has met the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870, and is therefore eligible to claim reimbursement for outpatient clinical services under the terms of Minnesota Statutes, section 62A.152. Approval of a center under these parts does not mean approval of a multidisciplinary staff person of such center to claim reimbursement from medical assistance or other third-party payors when practicing privately. Approval of a center under these parts does not mean approval of such center to claim reimbursement from medical assistance.

Subp. 4. **Case review.** "Case review" means a consultation process thoroughly examining a client's condition and treatment. It includes review of the client's reason for seeking treatment, diagnosis and assessment, and the individual treatment plan; review of the appropriateness, duration, and outcome of treatment provided; and treatment recommendations.

Subp. 5. **Center.** "Center" means a public or private health and human services facility which provides clinical services in the treatment of mental illness. It is an abbreviated term

used in place of "mental health center" or "mental health clinic" throughout parts 9520.0750 to 9520.0870.

Subp. 6. **Client.** "Client" means a person accepted by the center to receive clinical services in the diagnosis and treatment of mental illness.

Subp. 7. **Clinical services.** "Clinical services" means services provided to a client to diagnose, describe, predict, and explain that client's status relative to a disabling condition or problem, and where necessary, to treat the client to reduce impairment due to that condition. Clinical services also include individual treatment planning, case review, record keeping required for treatment, peer review, and supervision.

Subp. 8. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or a designated representative.

Subp. 9. **Competent.** "Competent" means having sufficient knowledge of and proficiency in a specific mental illness assessment or treatment service, technique, method, or procedure, documented by experience, education, training, and certification, to be able to provide it to a client with little or no supervision.

Subp. 10. **Consultation.** "Consultation" means the process of deliberating or conferring between multidisciplinary staff regarding a client and the client's treatment.

Subp. 11. **Deferral.** "Deferral" means the determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 and is not approved, but is granted a period of time to comply with these standards and receive a second review without reapplication.

Subp. 12. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 13. **Disapproval or withdrawal of approval.** "Disapproval" or "withdrawal of approval" means a determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 14. **Discipline.** "Discipline" means a branch of professional knowledge or skill acquired through a specific course of study and training and usually documented by a specific educational degree or certification of proficiency. Examples of the mental health disciplines include but are not limited to psychiatry, psychology, clinical social work, and psychiatric nursing.

Subp. 15. **Documentation.** "Documentation" means the automatically or manually produced and maintained evidence that can be read by person or machine, and that will attest to the compliance with requirements of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 16. **Individual treatment plan.** "Individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results for a specific client, and updated as necessary. The plan specifies the goals and objectives in measurable terms, states the treatment strategy, and identifies responsibilities of multidisciplinary staff.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a staff person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

A. by having a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and 2,000 hours of supervised experience in the delivery of clinical services in the treatment of mental illness;

B. by having 6,000 hours of supervised experience in the delivery of clinical services in the treatment of mental illness;

C. by being a graduate student in one of the behavioral sciences or related fields formally assigned to the center for clinical training by an accredited college or university; or

D. by having a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university.

Documentation of compliance with part 9520.0800, subpart 4, item B is required for designation of work as supervised experience in the delivery of clinical services. Documentation of the accreditation of a college or university shall be a listing in Accredited Institutions of Postsecondary Education Programs, Candidates for the year the degree was issued. The master's degree in behavioral sciences or related fields shall include a minimum of 28 semester hours of graduate course credit in mental health theory and supervised clinical training, as documented by an official transcript.

Subp. 18. **Mental health professional.** "Mental health professional" has the meaning given in Minnesota Statutes, section 245.462, subdivision 18.

Subp. 19. **Mental illness.** "Mental illness" means a condition which results in an inability to interpret the environment realistically and in impaired functioning in primary aspects of daily living such as personal relations, living arrangements, work, and recreation, and which is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), Ninth Revision (1980), code range 290.0-302.99 or 306.0-316, or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III), Third Edition (1980), Axes I, II or III. These publications are available from the State Law Library.

Subp. 20. **Multidisciplinary staff.** "Multidisciplinary staff" means the mental health professionals and mental health practitioners employed by or under contract to the center to provide outpatient clinical services in the treatment of mental illness.

Subp. 21. **Serious violations of policies and procedures.** "Serious violations of policies and procedures" means a violation which threatens the health, safety, or rights of clients or center staff; the repeated nonadherence to center policies and procedures; and the nonadherence to center policies and procedures which result in noncompliance with Minnesota Statutes, section 245.69, subdivision 2 and parts 9520.0760 to 9520.0870.

Subp. 22. **Treatment strategy.** "Treatment strategy" means the particular form of service delivery or intervention which specifically addresses the client's characteristics and mental illness, and describes the process for achievement of individual treatment plan goals.

9520.0770 ORGANIZATIONAL STRUCTURE OF CENTER.

Subpart 1. **Basic unit.** The center or the facility of which it is a unit shall be legally constituted as a partnership, corporation, or government agency. The center shall be either the entire facility or a clearly identified unit within the facility which is administratively and clinically separate from the rest of the facility. All business shall be conducted in the name of the center or facility, except medical assistance billing by individually enrolled providers when the center is not enrolled.

Subp. 2. **Purpose, services.** The center shall document that the prevention, diagnosis, and treatment of mental illness are the main purposes of the center. If the center is a unit within a facility, the rest of the facility shall not provide clinical services in the outpatient treatment of mental illness. The facility may provide services other than clinical services in the treatment of mental illness, including medical services, chemical dependency services, social services, training, and education. The provision of these additional services is not reviewed in granting approval to the center under parts 9520.0760 to 9520.0870.

Subp. 3. **Governing body.** The center shall have a governing body. The governing body shall provide written documentation of its source of authority. The governing body shall be legally responsible for the implementation of the standards set forth in Minnesota

Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 through the establishment of written policy and procedures.

Subp. 4. **Chart or statement of organization.** The center shall have an organizational chart or statement which specifies the relationships among the governing body, any administrative and support staff, mental health professional staff, and mental health practitioner staff; their respective areas of responsibility; the lines of authority involved; the formal liaison between administrative and clinical staff; and the relationship of the center to the rest of the facility and any additional services provided.

9520.0780 SECONDARY LOCATIONS.

Subpart 1. **Main and satellite offices.** The center shall notify the commissioner of all center locations. If there is more than one center location, the center shall designate one as the main office and all secondary locations as satellite offices. The main office as a unit and the center as a whole shall be in compliance with part 9520.0810. The main office shall function as the center records and documentation storage area and house most administrative functions for the center. Each satellite office shall:

A. be included as a part of the legally constituted entity;

B. adhere to the same clinical and administrative policies and procedures as the main office;

C. operate under the authority of the center's governing body;

D. store all center records and the client records of terminated clients at the main office;

E. ensure that a mental health professional is at the satellite office and competent to supervise and intervene in the clinical services provided there, whenever the satellite office is open;

F. ensure that its multidisciplinary staff have access to and interact with main center staff for consultation, supervision, and peer review; and

G. ensure that clients have access to all clinical services provided in the treatment of mental illness and the multidisciplinary staff of the center.

Subp. 2. **Noncompliance.** If the commissioner determines that a secondary location is not in compliance with subpart 1, it is not a satellite office. Outpatient clinical services in the treatment of mental illness delivered by the center or facility of which it is a unit shall cease at that location, or the application shall be disapproved.

9520.0790 MINIMUM TREATMENT STANDARDS.

Subpart 1. **Multidisciplinary approach.** The center shall document that services are provided in a multidisciplinary manner. That documentation shall include evidence that staff interact in providing clinical services, that the services provided to a client involve all needed disciplines represented on the center staff, and that staff participate in case review and consultation procedures as described in subpart 6.

Subp. 2. **Intake and case assignment.** The center shall establish an intake or admission procedure which outlines the intake process, including the determination of the appropriateness of accepting a person as a client by reviewing the client's condition and need for treatment, the clinical services offered by the center, and other available resources. The center shall document that case assignment for assessment, diagnosis, and treatment is made to a multidisciplinary staff person who is competent in the service, in the recommended treatment strategy and in treating the individual client characteristics. Responsibility for each case shall remain with a mental health professional.

Subp. 3. **Assessment and diagnostic process.** The center shall establish an assessment and diagnostic process that determines the client's condition and need for clinical services.

The assessment of each client shall include clinical consideration of the client's general physical, medical, developmental, family, social, psychiatric, and psychological history and current condition. The diagnostic statement shall include the diagnosis based on the codes in the International Classification of Diseases or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and refer to the pertinent assessment data. The diagnosis shall be by or under the supervision of and signed by a psychiatrist or licensed psychologist. The diagnostic assessment, as defined by Minnesota Statutes, sections 245.462, subdivision 9, for adults, and 245.4871, subdivision 11, for children, must be provided by a licensed mental health professional in accordance with Minnesota Statutes, section 245.467, subdivision 2.

Subp. 4. **Treatment planning.** The individual treatment plan, based upon a diagnostic assessment of mental illness, shall be jointly developed by the client and the mental health professional. This planning procedure shall ensure that the client has been informed in the following areas: assessment of the client condition; treatment alternatives; possible outcomes and side effects of treatment; treatment recommendations; approximate length, cost, and hoped-for outcome of treatment; the client's rights and responsibilities in implementation of the individual treatment plan; staff rights and responsibilities in the treatment process; the Government Data Practices Act; and procedures for reporting grievances and alleged violation of client rights. If the client is considering chemotherapy, hospitalization, or other medical treatment, the appropriate medical staff person shall inform the client of the treatment alternatives, the effects of the medical procedures, and possible side effects. Clinical services shall be appropriate to the condition, age, sex, socioeconomic, and ethnic background of the client, and provided in the least restrictive manner. Clinical services shall be provided according to the individual treatment plan and existing professional codes of ethics.

Subp. 5. **Client record.** The center shall maintain a client record for each client. The record must document the assessment process, the development and updating of the treatment plan, the treatment provided and observed client behaviors and response to treatment, and serve as data for the review and evaluation of the treatment provided to a client. The record shall include:

A. a statement of the client's reason for seeking treatment;

B. a record of the assessment process and assessment data;

C. the initial diagnosis based upon the assessment data;

D. the individual treatment plan;

E. a record of all medication prescribed or administered by multidisciplinary staff;

F. documentation of services received by the client, including consultation and progress notes;

G. when necessary, the client's authorization to release private information, and client information obtained from outside sources;

H. at the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome; and

I. correspondence and other necessary information.

Subp. 6. **Consultation; case review.** The center shall establish standards for case review and encourage the ongoing consultation among multidisciplinary staff. The multidisciplinary staff shall attend staff meetings at least twice monthly for a minimum of four hours per month, or a minimum of two hours per month if the multidisciplinary staff person provides clinical services in the treatment of mental illness less than 15 hours per week. The purpose of these meetings shall be case review and consultation. Written minutes of the meeting shall be maintained at the center for at least three years after the meeting.

Subp. 7. **Referrals.** If the necessary treatment or the treatment desired by the client is not available at the center, the center shall facilitate appropriate referrals. The

multidisciplinary staff person shall discuss with the client the reason for the referral, potential treatment resources, and what the process will involve. The staff person shall assist in the process to ensure continuity of the planned treatment.

Subp. 8. **Emergency service.** The center shall ensure that clinical services to treat mental illness are available to clients on an emergency basis.

Subp. 9. **Access to hospital.** The center shall document that it has access to hospital admission for psychiatric inpatient care, and shall provide that access when needed by a client. This requirement for access does not require direct hospital admission privileges on the part of qualified multidisciplinary staff.

9520.0800 MINIMUM QUALITY ASSURANCE STANDARDS.

Subpart 1. **Policies and procedures.** The center shall develop written policies and procedures and shall document the implementation of these policies and procedures for each treatment standard and each quality assurance standard in subparts 2 to 7. The policies shall be approved by the governing body. The procedures shall indicate what actions or accomplishments are to be performed, who is responsible for each action, and any documentation or required forms. Multidisciplinary staff shall have access to a copy of the policies and procedures at all times.

Subp. 2. **Peer review.** The center shall have a multidisciplinary peer review system to assess the manner in which multidisciplinary staff provide clinical services in the treatment of mental illness. Peer review shall include the examination of clinical services to determine if the treatment provided was effective, necessary, and sufficient and of client records to determine if the recorded information is necessary and sufficient. The system shall ensure review of a randomly selected sample of five percent or six cases, whichever is less, of the annual caseload of each mental health professional by other mental health professional staff. Peer review findings shall be discussed with staff involved in the case and followed up by any necessary corrective action. Peer review records shall be maintained at the center.

Subp. 3. **Internal utilization review.** The center shall have a system of internal utilization review to examine the quality and efficiency of resource usage and clinical service delivery. The center shall develop and carry out a review procedure consistent with its size and organization which includes collection or review of information, analysis or interpretation of information, and application of findings to center operations. The review procedure shall minimally include, within any three year period of time, review of the appropriateness of intake, the provision of certain patterns of services, and the duration of treatment. Criteria may be established for treatment length and the provision of services for certain client conditions. Utilization review records shall be maintained, with an annual report to the governing body for applicability of findings to center operations.

Subp. 4. **Staff supervision.** Staff supervision:

A. The center shall have a clinical evaluation and supervision procedure which identifies each multidisciplinary staff person's areas of competence and documents that each multidisciplinary staff person receives the guidance and support needed to provide clinical services for the treatment of mental illness in the areas they are permitted to practice.

B. A mental health professional shall be responsible for the supervision of the mental health practitioner, including approval of the individual treatment plan and bimonthly case review of every client receiving clinical services from the practitioner. This supervision shall include a minimum of one hour of face-to-face, client-specific supervisory contact for each 40 hours of clinical services in the treatment of mental illness provided by the practitioner.

Subp. 5. **Continuing education.** The center shall require that each multidisciplinary staff person attend a minimum of 36 clock hours every two years of academic or practical course work and training. This education shall augment job-related knowledge, understanding, and skills to update or enhance staff competencies in the delivery of clinical services to treat

mental illness. Continued licensure as a mental health professional may be substituted for the continuing education requirement of this subpart.

Subp. 6. **Violations of standards.** The center shall have procedures for the reporting and investigating of alleged unethical, illegal, or grossly negligent acts, and of the serious violation of written policies and procedures. The center shall document that the reported behaviors have been reviewed and that responsible disciplinary or corrective action has been taken if the behavior was substantiated. The procedures shall address both client and staff reporting of complaints or grievances regarding center procedures, staff, and services. Clients and staff shall be informed they may file the complaint with the department if it was not resolved to mutual satisfaction. The center shall have procedures for the reporting of suspected abuse or neglect of clients, in accordance with Minnesota Statutes, sections 611A.32, subdivision 5; 626.556; and 626.557.

Subp. 7. **Data classification.** Client information compiled by the center, including client records and minutes of case review and consultation meetings, shall be protected as private data under the Minnesota Government Data Practices Act.

9520.0810 MINIMUM STAFFING STANDARDS.

Subpart 1. **Required staff.** Required staff:

A. The multidisciplinary staff of a center shall consist of at least four mental health professionals. At least two of the mental health professionals shall each be employed or under contract for a minimum of 35 hours a week by the center. Those two mental health professionals shall be of different disciplines.

B. The mental health professional staff shall include a psychiatrist and a licensed psychologist.

C. The mental health professional employed or under contract to the center to meet the requirement of item B shall be at the main office of the center and providing clinical services in the treatment of mental illness at least eight hours every two weeks.

Subp. 2. **Additional staff; staffing balance.** Additional mental health professional staff may be employed by or under contract to the center provided that no single mental health discipline or combination of allied fields shall comprise more than 60 percent of the full-time equivalent mental health professional staff. This provision does not apply to a center with fewer than six full-time equivalent mental health professional staff. Mental health practitioners may also be employed by or under contract to a center to provide clinical services for the treatment of mental illness in their documented area of competence. Mental health practitioners shall not comprise more than 25 percent of the full-time equivalent multidisciplinary staff. In determination of full-time equivalence, only time spent in clinical services for the treatment of mental illness shall be considered.

Subp. 3. **Multidisciplinary staff records.** The center shall maintain records sufficient to document that the center has determined and verified the clinical service qualifications of each multidisciplinary staff person, and sufficient to document each multidisciplinary staff person's terms of employment.

Subp. 4. **Credentialed occupations.** The center shall adhere to the qualifications and standards specified by rule for any human service occupation credentialed under Minnesota Statutes, section 214.13 and employed by or under contract to the center.

9520.0820 APPLICATION PROCEDURES.

Subpart 1. **Form.** A facility seeking approval as a center for insurance reimbursement of its outpatient clinical services in treatment of mental illness must make formal application to the commissioner for such approval. The application form for this purpose may be obtained from the Mental Illness Program Division of the department. The application form shall require only information which is required by statute or rule, and shall require the applicant

center to explain and provide documentation of compliance with the minimum standards in Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 2. **Fee.** Each application shall be accompanied by payment of the nonrefundable application fee. The fee shall be established and adjusted in accordance with Minnesota Statutes, section 16A.128 to cover the costs to the department in implementing Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 3. **Completed application.** The application is considered complete on the date the application fee and all information required in the application form are received by the department.

Subp. 4. **Coordinator.** The center shall designate in the application a mental health professional as the coordinator for issues surrounding compliance with parts 9520.0760 to 9520.0870.

9520.0830 REVIEW OF APPLICANT CENTERS.

Subpart 1. **Site visit.** The formal review shall begin after the completed application has been received, and shall include an examination of the written application and a visit to the center. The applicant center shall be offered a choice of site visit dates, with at least one date falling within 60 days of the date on which the department receives the complete application. The site visit shall include interviews with multidisciplinary staff and examination of a random sample of client records, consultation minutes, quality assurance reports, and multidisciplinary staff records.

Subp. 2. **Documentation.** If implementation of a procedure is too recent to be reliably documented, a written statement of the planned implementation shall be accepted as documentation on the initial application. The evidence of licensure or accreditation through another regulating body shall be accepted as documentation of a specific procedure when the required minimum standard of that body is the same or higher than a specific provision of parts 9520.0760 to 9520.0870.

9520.0840 DECISION ON APPLICATION.

Subpart 1. **Written report.** Upon completion of the site visit, a report shall be written. The report shall include a statement of findings, a recommendation to approve, defer, or disapprove the application, and the reasons for the recommendation.

Subp. 2. **Written notice to center.** The applicant center shall be sent written notice of approval, deferral, or disapproval within 30 days of the completion of the site visit. If the decision is a deferral or a disapproval, the notice shall indicate the specific areas of noncompliance.

Subp. 3. **Noncompliance with statutes and rules.** An application shall be disapproved or deferred if it is the initial application of a center, when the applicant center is not in compliance with Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 4. **Deferral of application.** If an application is deferred, the length of deferral shall not exceed 180 days. If the areas of noncompliance stated in the deferral notice are not satisfactorily corrected by the end of the deferral period, the application shall be disapproved. The applicant center shall allow the commissioner to inspect the center at any time during the deferral period, whether or not the site visit has been announced in advance. A site visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center. At any time during the deferral period, the applicant center may submit documentation indicating correction of noncompliance. The application shall then be approved or disapproved. At any time during the deferral period, the applicant center may submit a written request to the commissioner to change the application status to disapproval. The request shall be complied with within 14 days of receiving this written

request. The applicant center is not an approved center for purposes of Minnesota Statutes, section 62A.152 during a deferral period.

Subp. 5. **Effective date of decision.** The effective date of a decision is the date the commissioner signs a letter notifying the applicant center of that decision.

9520.0850 APPEALS.

If an application is disapproved or approval is withdrawn, a contested case hearing and judicial review as provided in Minnesota Statutes, sections 14.48 to 14.69, may be requested by the center within 30 days of the commissioner's decision.

9520.0860 POSTAPPROVAL REQUIREMENTS.

Subpart 1. **Duration of approval.** Initial approval of an application is valid for 12 months from the effective date, subsequent approvals for 24 months, except when approval is withdrawn according to the criteria in subpart 4.

Subp. 2. **Reapplication.** The center shall contact the department for reapplication forms, and submit the completed application at least 90 days prior to the expected expiration date. If an approved center has met the conditions of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870, including reapplication when required, its status as an approved center shall remain in effect pending department processing of the reapplication.

Subp. 3. **Restrictions.** The approval is issued only for the center named in the application and is not transferable or assignable to another center. The approval is issued only for the center location named in the application and is not transferable or assignable to another location. If the commissioner is notified in writing at least 30 days in advance of a change in center location and can determine that compliance with all provisions of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 are maintained, the commissioner shall continue the approval of the center at the new location.

Subp. 4. **Noncompliance.** Changes in center organization, staffing, treatment, or quality assurance procedures that affect the ability of the center to comply with the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 shall be reported in writing by the center to the commissioner within 15 days of occurrence. Review of the change shall be conducted by the commissioner. A center with changes resulting in noncompliance in minimum standards shall receive written notice and may have up to 180 days to correct the areas of noncompliance before losing approval status. Interim procedures to resolve the noncompliance on a temporary basis shall be developed and submitted in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. Nonreporting within 15 days of occurrence of a change that results in noncompliance, failure to develop an approved interim procedure within 30 days of the determination of the noncompliance, or nonresolution of the noncompliance within 180 days shall result in the immediate withdrawal of approval status.

Serious violation of policies or procedures, professional association or board sanctioning or loss of licensure for unethical practices, or the conviction of violating a state or federal statute shall be reported in writing by the center to the commissioner within ten days of the substantiation of such behavior. Review of this report and the action taken by the center shall be conducted by the commissioner. Approval shall be withdrawn immediately unless the commissioner determines that: the center acted with all proper haste and thoroughness in investigating the behavior, the center acted with all proper haste and thoroughness in taking appropriate disciplinary and corrective action, and that no member of the governing body was a party to the behavior. Failure to report such behavior within ten days of its substantiation shall result in immediate withdrawal of approval.

Subp. 5. **Compliance reports.** The center may be required to submit written information to the department during the approval period to document that the center has

maintained compliance with the rule and center procedures. The center shall allow the commissioner to inspect the center at any time during the approval period, whether or not the site visit has been announced in advance. A site visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center.

9520.0870 VARIANCES.

Subpart 1. **When allowed.** The standards and procedures established by parts 9520.0760 to 9520.0860 may be varied by the commissioner. Standards and procedures established by statute shall not be varied.

Subp. 2. **Request procedure.** A request for a variance must be submitted in writing to the commissioner, accompanying or following the submission of a completed application for approval under Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870. The request shall state:

A. the standard or procedure to be varied;

B. the specific reasons why the standard or procedure cannot be or should not be complied with; and

C. the equivalent standard or procedure the center will establish to achieve the intent of the standard or procedure to be varied.

Subp. 3. **Decision procedure.** Upon receiving the variance request, the commissioner shall consult with a panel of experts in the mental health disciplines regarding the request. Criteria for granting a variance shall be the commissioner's determination that subpart 2, items A to C are met. Hardship shall not be a sufficient reason to grant a variance. No variance shall be granted that would threaten the health, safety, or rights of clients. Variances granted by the commissioner shall specify in writing the alternative standards or procedures to be implemented and any specific conditions or limitations imposed on the variance by the commissioner. Variances denied by the commissioner shall specify in writing the reason for the denial.

Subp. 4. **Notification.** The commissioner shall send the center a written notice granting or not granting the variance within 90 days of receiving the written variance request. This notice shall not be construed as approval or disapproval of the center under Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

9530.6800 ASSESSMENT OF NEED FOR TREATMENT PROGRAMS.

Subpart 1. **Assessment of need required for licensure.** Before a license or a provisional license may be issued, the need for the chemical dependency treatment or rehabilitation program must be determined by the commissioner. Need for an additional or expanded chemical dependency treatment program must be determined, in part, based on the recommendation of the county board of commissioners of the county in which the program will be located and the documentation submitted by the applicant at the time of application.

If the county board fails to submit a statement to the commissioner within 60 days of the county board's receipt of the written request from an applicant, as required under part 9530.6810, the commissioner shall determine the need for the applicant's proposed chemical dependency treatment program based on the documentation submitted by the applicant at the time of application.

Subp. 2. **Documentation of need requirements.** An applicant for licensure under parts 9530.2500 to 9530.4000 and Minnesota Statutes, chapter 245G, must submit the documentation in items A and B to the commissioner with the application for licensure:

A. The applicant must submit documentation that it has requested the county board of commissioners of the county in which the chemical dependency treatment program will be located to submit to the commissioner both a written statement that supports or does not

support the need for the program and documentation of the rationale used by the county board to make its determination.

B. The applicant must submit a plan for attracting an adequate number of clients to maintain its proposed program capacity, including:

(1) a description of the geographic area to be served;

(2) a description of the target population to be served;

(3) documentation that the capacity or program designs of existing programs are not sufficient to meet the service needs of the chemically abusing or chemically dependent target population if that information is available to the applicant;

(4) a list of referral sources, with an estimation as to the number of clients the referral source will refer to the applicant's program in the first year of operation; and

(5) any other information available to the applicant that supports the need for new or expanded chemical dependency treatment capacity.

9530.6810 COUNTY BOARD RESPONSIBILITY TO REVIEW PROGRAM NEED.

When an applicant for licensure under parts 9530.2500 to 9530.4000 or Minnesota Statutes, chapter 245G, requests a written statement of support for a proposed chemical dependency treatment program from the county board of commissioners of the county in which the proposed program is to be located, the county board, or the county board's designated representative, shall submit a statement to the commissioner that either supports or does not support the need for the applicant's program. The county board's statement must be submitted in accordance with items A and B:

A. the statement must be submitted within 60 days of the county board's receipt of a written request from the applicant for licensure; and

B. the statement must include the rationale used by the county board to make its determination.