State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 4065

03/07/2022	Authored by Schultz
	The bill was read for the first time and referred to the Committee on Human Services Finance and Policy
03/30/2022	Adoption of Report: Placed on the General Register as Amended
	Read for the Second Time
04/04/2022	Calendar for the Day, Amended
	Read Third Time as Amended
	Passed by the House as Amended and transmitted to the Senate to include Floor Amendments
05/22/2022	Passed by the Senate as Amended and returned to the House
05/24/2022	The House concurred in the Senate Amendments
	Read Third Time as Amended by the Senate
05/22/2022	Repassed the bill as Amended by the Senate
05/24/2022	Presented to Governor
06/02/2022	Governor Approval

A bill for an act

relating to state government; modifying provisions governing the Department of Health, health care, health-related licensing boards, health insurance, community supports, behavioral health, continuing care for older adults, child and vulnerable adult protection, economic assistance, direct care and treatment, preventing homelessness, human services licensing and operations, the Minnesota Rare Disease Advisory Council, nonintoxicating hemp regulation, organ donation regulation, mandated reports, and long-term care consultation services; making forecast adjustments; requiring reports; appropriating money; amending Minnesota Statutes 2020, sections 13.46, subdivision 7; 34A.01, subdivision 4; 62J.2930, subdivision 3; 62J.692, subdivision 5; 62Q.37, subdivision 7; 137.68; 144.057, subdivision 1; 144.0724, subdivision 11; 144.1201, subdivisions 2, 4; 144.1503; 144.1911, subdivision 4; 144.193; 144.292, subdivision 6; 144.294, subdivision 2; 144.4199, subdivision 8; 144.497; 144.565, subdivision 4; 144.6502, subdivision 1; 144A.01; 144A.03, subdivision 1; 144A.04, subdivisions 4, 6; 144A.06; 144A.10, subdivision 17; 144A.351, subdivision 1; 144A.4799, subdivisions 1, 3; 144A.483, subdivision 1; 144A.75, subdivision 12; 144G.08, by adding a subdivision; 144G.15; 144G.17; 144G.19, by adding a subdivision; 144G.20, subdivisions 1, 4, 5, 8, 9, 12, 15; 144G.30, subdivision 5; 144G.31, subdivisions 4, 8; 144G.41, subdivisions 7, 8; 144G.42, subdivision 10; 144G.45, subdivision 7; 144G.50, subdivision 2; 144G.52, subdivisions 2, 8, 9; 144G.53; 144G.55, subdivisions 1, 3; 144G.56, subdivisions 3, 5; 144G.57, subdivisions 1, 3, 5; 144G.70, subdivisions 2, 4; 144G.80, subdivision 2; 144G.90, subdivision 1, by adding a subdivision; 144G.91, subdivisions 13, 21; 144G.92, subdivision 1; 144G.93; 144G.95; 145.4134; 145.928, subdivision 13; 148B.33, by adding a subdivision; 148E.100, subdivision 3; 148E.105, subdivision 3, as amended; 148E.106, subdivision 3; 148E.110, subdivision 7; 150A.06, subdivisions 1c, 2c, 6, by adding a subdivision; 150A.09; 150A.091, subdivisions 2, 5, 8, 9, by adding subdivisions; 150A.10, subdivision 1a; 150A.105, subdivision 8; 151.01, subdivision 27; 151.72, subdivisions 1, 2, 3, 4, 6, by adding a subdivision; 152.02, subdivision 2; 152.125; 153.16, subdivision 1; 242.19, subdivision 2; 245.462, subdivision 4; 245.4661, subdivision 10; 245.4889, subdivision 3, by adding a subdivision; 245.713, subdivision 2; 245A.02, subdivision 5a; 245A.11, subdivisions 2, 2a, by adding a subdivision; 245A.14, subdivision 14; 245A.1443; 245C.31, subdivisions 1, 2, by adding subdivisions; 245D.10, subdivision 3a; 245D.12; 245F.15, subdivision 1; 245F.16, subdivision 1; 245G.01, subdivisions 4, 17, by adding a subdivision; 245G.06, subdivision 3, by adding subdivisions; 245G.07, by adding a subdivision; 245G.08, subdivision 5; 245G.09, subdivision 3; 245G.11, subdivisions 1, 10; 245G.12; 245G.13,

subdivision 1; 245G.20; 245G.22, subdivision 7; 253B.18, subdivision 6; 256.01, subdivision 29; 256.021, subdivision 3; 256.042, subdivision 5, as amended; 256.045, subdivision 3; 256.9657, subdivision 8; 256.975, subdivisions 7a, 7b, 7c, 7d, 11, 12; 256B.051, subdivision 4; 256B.055, subdivision 2; 256B.056, subdivisions 3b, 3c, 11; 256B.0561, subdivision 4; 256B.0595, subdivision 1; 256B.0625, subdivision 64; 256B.0646; 256B.0659, subdivisions 3a, 19; 256B.0911, subdivisions 1, 3c, 3d, 3e, 5, by adding subdivisions; 256B.0913, subdivision 4; 256B.092, subdivisions 1a, 1b; 256B.0922, subdivision 1; 256B.0941, by adding a subdivision; 256B.0949, subdivisions 8, 17; 256B.49, subdivisions 12, 13; 256B.493, subdivision 2; 256B.69, subdivision 9d; 256B.77, subdivision 13; 256D.0515; 256E.28, subdivision 6; 256E.33, subdivisions 1, 2; 256E.36, subdivision 1; 256G.02, subdivision 6; 256I.03, subdivision 6; 256K.26, subdivisions 2, 6, 7; 256K.45, subdivision 6, by adding a subdivision; 256P.04, subdivision 11; 256Q.06, by adding a subdivision; 256R.02, subdivisions 4, 17, 18, 22, 29, 42a, 48a, by adding subdivisions; 256R.07, subdivisions 1, 2, 3; 256R.08, subdivision 1; 256R.09, subdivisions 2, 5; 256R.10, by adding a subdivision; 256R.13, subdivision 4; 256R.16, subdivision 1; 256R.17, subdivision 3; 256R.18; 256R.26, subdivision 1; 256R.261, subdivision 13; 256R.37; 256R.39; 256S.02, subdivisions 15, 20; 256S.06, subdivisions 1, 2; 256S.10, subdivision 2; 257.0725; 260.012; 260.775; 260B.331, subdivision 1; 260C.001, subdivision 3; 260C.007, subdivision 27; 260C.151, subdivision 6; 260C.152, subdivision 5; 260C.175, subdivision 2; 260C.176, subdivision 2; 260C.178, subdivision 1; 260C.181, subdivision 2; 260C.193, subdivision 3; 260C.201, subdivisions 1, 2; 260C.202; 260C.203; 260C.204; 260C.212, subdivision 4a; 260C.221; 260C.331, subdivision 1; 260C.513; 260C.607, subdivisions 2, 5; 260C.613, subdivisions 1, 5; 260E.22, subdivision 2; 260E.24, subdivisions 2, 6; 260E.38, subdivision 3; 268.19, subdivision 1; 477A.0126, subdivision 7, by adding a subdivision; 518.17, subdivision 1; 518A.43, subdivision 1; 518A.77; 626.557, subdivisions 4, 9, 9b, 9c, 9d, 10, 10b, 12b; 626.5571, subdivisions 1, 2; 626.5572, subdivisions 2, 4, 17; Minnesota Statutes 2021 Supplement, sections 62A.673, subdivision 2; 144.0724, subdivisions 4, 12, as amended; 144.551, subdivision 1; 148B.5301, subdivision 2; 148F.11, subdivision 1; 151.72, subdivision 5; 245.467, subdivisions 2, 3; 245.4871, subdivision 21; 245.4876, subdivisions 2, 3; 245.4889, subdivision 1; 245.735, subdivision 3; 245A.03, subdivision 7; 245A.14, subdivision 4; 245C.03, subdivision 5a; 245I.02, subdivisions 19, 36; 245I.03, subdivisions 5, 9; 245I.04, subdivision 4; 245I.05, subdivision 3; 245I.08, subdivision 4; 245I.09, subdivision 2; 245I.10, subdivisions 2, 6; 245I.20, subdivision 5; 245I.23, subdivision 22; 254B.05, subdivision 5; 256.01, subdivision 42; 256.042, subdivision 4, as amended; 256B.0371, subdivision 4, as amended; 256B.0622, subdivision 2; 256B.0625, subdivisions 3b, 5m; 256B.0638, subdivision 5; 256B.0671, subdivision 6; 256B.0911, subdivision 3a; 256B.0943, subdivisions 1, 3, 4, 6, 7, 9, 11; 256B.0946, subdivision 1; 256B.0947, subdivisions 2, 3, 5, 6; 256B.0949, subdivisions 2, 13; 256B.49, subdivision 14; 256B.69, subdivision 9f; 256B.85, subdivisions 2, 5; 256P.01, subdivision 6a; 256P.06, subdivision 3; 256S.05, subdivision 2; 256S.205; 260C.212, subdivisions 1, 2; 260C.605, subdivision 1; 260C.607, subdivision 6; 260E.20, subdivision 2; 363A.50; Laws 2009, chapter 79, article 13, section 3, subdivision 10, as amended; Laws 2020, First Special Session chapter 7, section 1, subdivisions 1, as amended, 5, as amended; Laws 2021, First Special Session chapter 7, article 10, sections 1; 3; article 11, section 38; article 16, sections 2, subdivisions 23, 24, 29, 31, 32, 33; 3, subdivision 2; 5; article 17, sections 1, subdivision 2; 3; 6; 10; 11; 12; 17, subdivision 3; 19; Laws 2021, First Special Session chapter 8, article 6, section 1, subdivision 7; proposing coding for new law in Minnesota Statutes, chapters 4; 144A; 145; 245A; 256B; 626; repealing Minnesota Statutes 2020, sections 62U.10, subdivision 3; 144.1911, subdivision 10; 144.564, subdivision 3; 144A.483, subdivision 2; 150A.091, subdivisions 3, 15, 17; 245.981; 245A.03, subdivision 5; 245F.15, subdivision 2; 245G.11, subdivision 2; 246.0136; 246.131; 246B.03, subdivision 2; 246B.035; 252.025, subdivision 7; 252.035; 254A.04; 254A.21; 254B.14, subdivisions 1, 2,

3, 4, 6; 256.01, subdivision 31; 256B.057, subdivision 7; 256B.0638, subdivision 7; 256B.0911, subdivisions 2b, 2c, 3, 3b, 3g, 4d, 4e, 5, 6; 256B.0943, subdivision 8a; 256B.69, subdivision 20; 256D.055; 256R.08, subdivision 2; 501C.0408, subdivision 4; 501C.1206; Minnesota Statutes 2021 Supplement, sections 144G.07, subdivision 6; 254B.14, subdivision 5; 256B.0911, subdivisions 1a, 3a, 3f; Laws 1998, chapter 382, article 1, section 23; Minnesota Rules, parts 2960.0460, subpart 2; 9530.6565, subpart 2; 9555.6255.

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

ARTICLE 1

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2020, section 144.057, subdivision 1, is amended to read:

Subdivision 1. **Background studies required.** (a) Except as specified in paragraph (b), the commissioner of health shall contract with the commissioner of human services to conduct background studies of:

(1) individuals providing services that 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 section 245C.03, subdivision 1, who perform 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 under study resides outside 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 information is made available by that state, and must include a check of the National Crime Information Center database;

(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 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 under section 144A.70~~.~~; and

(6) license applicants, owners, managerial officials, and controlling individuals who are required under section 144A.476, subdivision 1, or 144G.13, subdivision 1, to undergo a background study under chapter 245C, regardless of the licensure status of the license applicant, owner, managerial official, or controlling individual.

(b) The commissioner of human services shall not conduct a background study on any individual identified in paragraph (a), clauses (1) to (5), if the individual has a valid license issued by a health-related licensing board as defined in section 214.01, subdivision 2, and has completed the criminal background check as required in section 214.075. An entity that is affiliated with individuals who meet the requirements of this paragraph must separate those individuals from the entity's roster for NETStudy 2.0.

(c) If a facility or program is licensed by the Department of Human Services and subject to the background study provisions of chapter 245C and is also licensed by the Department of Health, the Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed programs.

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

Sec. 2. Minnesota Statutes 2021 Supplement, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the federal database MDS assessments that conform with the assessment schedule defined by 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. 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 ARD within 92 days of a previous quarterly review assessment or a previous comprehensive assessment, which must occur at least once every 366 days;

(3) a significant change in status comprehensive assessment, which must have an ARD within 14 days 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 comprehensive assessment or quarterly review assessment;

(4) a quarterly review assessment must have an 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;

(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. If the most recent OBRA comprehensive or quarterly assessment completed does not result in a rehabilitation case mix classification, then the significant change in status assessment is not required. 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. If isolation was not coded on the most recent OBRA comprehensive or quarterly assessment completed, then the significant change in status assessment is not required. 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. 3. Minnesota Statutes 2020, section 144.1201, subdivision 2, is amended to read:

Subd. 2. **~~By-product nuclear~~ Byproduct material.** "~~By-product nuclear~~ Byproduct material" means ~~a radioactive material, other than special nuclear material, yielded in or made radioactive by exposure to radiation created incident to the process of producing or utilizing special nuclear material.~~:

(1) any radioactive material, except special nuclear material, yielded in or made radioactive by exposure to the radiation incident to the process of producing or using special nuclear material;

(2) the tailings or wastes produced by the extraction or concentration of uranium or thorium from ore processed primarily for its source material content, including discrete surface wastes resulting from uranium solution extraction processes. Underground ore bodies depleted by these solution extraction operations do not constitute byproduct material within this definition;

(3) any discrete source of radium-226 that is produced, extracted, or converted after extraction for commercial, medical, or research activity, or any material that:

(i) has been made radioactive by use of a particle accelerator; and

(ii) is produced, extracted, or converted after extraction for commercial, medical, or research activity; and

(4) any discrete source of naturally occurring radioactive material, other than source nuclear material, that:

(i) the United States Nuclear Regulatory Commission, in consultation with the Administrator of the Environmental Protection Agency, the Secretary of Energy, the Secretary of Homeland Security, and the head of any other appropriate federal agency determines would pose a threat similar to the threat posed by a discrete source of radium-226 to the public health and safety or the common defense and security; and

(ii) is extracted or converted after extraction for use in a commercial, medical, or research activity.

Sec. 4. Minnesota Statutes 2020, section 144.1201, subdivision 4, is amended to read:

Subd. 4. **Radioactive material.** "Radioactive material" means a matter that emits radiation. Radioactive material includes special nuclear material, source nuclear material, and ~~by-product nuclear~~ byproduct material.

Sec. 5. Minnesota Statutes 2020, section 144.1503, is amended to read:

144.1503 HOME AND COMMUNITY-BASED SERVICES EMPLOYEE SCHOLARSHIP AND LOAN FORGIVENESS PROGRAM.

Subdivision 1. **Creation.** The home and community-based services employee scholarship grant and loan forgiveness program is established for the ~~purpose~~ purposes of assisting qualified provider applicants to fund employee scholarships for education in nursing and other health care fields; funding scholarships to individual home and community-based services workers for education in nursing and other health care fields; and repaying qualified educational loans secured by employees for education in nursing or other health care fields.

Subd. 1a. **Definition.** For purposes of this section, "qualified educational loan" means a government, commercial, or foundation loan secured by an employee of a qualified provider of home and community-based services for older adults for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the employee's graduate or undergraduate education.

Subd. 2. **Provision of grants; scholarships; loan forgiveness.** (a) The commissioner shall make grants available to qualified providers of ~~older adult~~ home and community-based services for older adults. Grants must be used by home and community-based service providers to recruit and train staff through the establishment of an employee scholarship fund.

(b) The commissioner may provide scholarships for qualified educational expenses to individual home and community-based services workers who are employed in the home and community-based services field.

(c) The commissioner may use up to one-third of the annual funding available for this section to establish a loan forgiveness program for eligible home and community-based services workers who provide home and community-based services to older adults and for whom an eligible provider employer submits their names to the commissioner for consideration. To the extent possible, the loan forgiveness program must meet the standards of the loan forgiveness program in section 144.1501.

Subd. 3. **Eligibility.** (a) Eligible providers must primarily provide services to individuals who are 65 years of age and older in home and community-based settings, including ~~housing with services establishments as defined in section 144D.01, subdivision 4~~ assisted living facilities as defined in section 144G.08, subdivision 7; adult day care as defined in section 245A.02, subdivision 2a; and home care services as defined in section 144A.43, subdivision 3.

(b) Under the scholarship program, qualifying providers must establish a home and community-based services employee scholarship program, as specified in subdivision 4. Providers that receive funding under this section must use the funds to provide educational programs or award scholarships to employees who: (1) are enrolled in a course of study that leads to career advancement with the provider or in the field of long-term care, including home care, care of persons with disabilities, nursing, or as a licensed assisted living director; and (2) work an average of at least ~~16~~ ten hours per week for the provider. Employees who receive a scholarship under this section must use the scholarship funds for eligible costs of enrolling in a course of study that leads to career advancement in the facility or in the field of long-term care, including home care, care of persons with disabilities, nursing, or as a licensed assisted living director.

(c) Under the loan forgiveness program, qualifying providers that provide employee names to the commissioner for consideration must be located in Minnesota. If necessary due to the volume of applications for loan forgiveness, the commissioner, in collaboration with home and community-based services stakeholders, shall determine priority areas for loan forgiveness. Employees eligible for loan forgiveness include employees working as a licensed assisted living director. Employees selected to receive loan forgiveness must agree to work a minimum average of 32 hours per week for a minimum of two years for a qualifying provider organization in order to maintain eligibility for loan forgiveness under this section.

Subd. 4. ~~**Home and community-based services employee scholarship program**~~ **Duties of participating qualifying providers.** (a) Each qualifying provider under this section must propose a home and community-based services employee scholarship program, propose to provide contracted programming from a qualified educational institution, or submit employee names for consideration for participation in the loan forgiveness program.

(b) For the scholarship program, providers must establish criteria by which funds are to be distributed among employees. At a minimum, the scholarship program must cover employee costs related to a course of study that is expected to lead to career advancement

with the provider or in the field of long-term care, including home care, care of persons with disabilities, ~~or~~ nursing, or as a licensed assisted living director.

Subd. 5. **~~Participating providers~~ Request for proposals.** The commissioner shall publish a request for proposals in the State Register, specifying qualifying provider eligibility requirements, criteria for a qualifying employee scholarship program, provider selection criteria, documentation required for program participation, maximum award amount, and methods of evaluation. The commissioner must publish additional requests for proposals each year in which funding is available for this purpose.

Subd. 6. **Application requirements.** (a) Eligible providers seeking a grant to provide scholarships and educational programming and eligible employees seeking a scholarship shall submit an application to the commissioner. Applications from eligible providers must contain a complete description of the employee scholarship program being proposed by the applicant, including the need for the organization to enhance the education of its workforce, the process for determining which employees will be eligible for scholarships, any other sources of funding for scholarships, the expected degrees or credentials eligible for scholarships, the amount of funding sought for the scholarship program, a proposed budget detailing how funds will be spent, and plans for retaining eligible employees after completion of their scholarship.

(b) Eligible providers seeking loan forgiveness for employees shall submit to the commissioner the names of their employees to be considered for loan forgiveness. An employee whose name has been submitted to the commissioner and who wishes to apply for loan forgiveness must submit an application to the commissioner. The employee is responsible for securing the employee's qualified educational loans. The commissioner shall select employees for participation based on their suitability for practice as indicated by experience or training. The commissioner shall give preference to employees close to completing their training. For each year that an employee meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the employee equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the employee's selection for which information is available, not to exceed the balance of the employee's qualified educational loans. Before receiving loan repayment disbursements and as requested, the employee must complete and return to the commissioner a confirmation of practice form provided by the commissioner verifying that the employee is practicing as required under subdivision 3. The employee must provide the commissioner with verification that the full amount of loan repayment disbursement received by the employee has been

applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Employees who move to a different eligible provider remain eligible for loan repayment as long as they practice as required in subdivision 3. If an employee does not fulfill the required minimum service commitment according to subdivision 3, the commissioner shall collect from the employee the total amount paid to the employee under the loan forgiveness program, plus interest at a rate established according to section 270C.40. The commissioner shall deposit the money collected in an account in the special revenue fund and money in that account is annually appropriated to the commissioner for purposes of this section. The commissioner may allow waivers of all or part of the money owed to the commissioner as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum service commitment.

Subd. 7. **Selection process.** The commissioner shall determine a maximum award for grants and loan forgiveness, and shall make ~~grant~~ selections based on the information provided in the grant application, including the demonstrated need for an applicant provider to enhance the education of its workforce, the proposed employee scholarship or loan forgiveness selection process, the applicant's proposed budget, and other criteria as determined by the commissioner. Notwithstanding any law or rule to the contrary, ~~funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires~~ amounts appropriated for purposes of this section do not cancel and are available until expended, except that at the end of each biennium, any remaining amount that is not committed by contract and not needed to fulfill existing commitments shall cancel to the general fund.

Subd. 8. **Reporting requirements.** (a) Participating providers who receive a grant for employee scholarships shall submit an invoice for reimbursement and a report to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner. The report shall include the amount spent on scholarships; the number of employees who received scholarships; and, for each scholarship recipient, the name of the recipient, the current position of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, and the expected or actual program completion date. During the grant period, the commissioner may require and collect from grant recipients other information necessary to evaluate the program.

(b) Employees who receive scholarships from the commissioner shall report information to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner.

(c) Participating providers whose employees receive loan forgiveness shall submit a report to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner. The report must include the number of employees receiving loan forgiveness, and for each employee receiving loan forgiveness, the employee's name, current position, and average number of hours worked per week. During the loan forgiveness period, the commissioner may require and collect from participating providers and employees receiving loan forgiveness other information necessary to evaluate the program and ensure ongoing eligibility.

Sec. 6. Minnesota Statutes 2020, section 144.1911, subdivision 4, is amended to read:

Subd. 4. **Career guidance and support services.** ~~(a)~~ The commissioner shall award grants to eligible nonprofit organizations and eligible postsecondary educational institutions, including the University of Minnesota, to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce. Eligible grant activities include the following:

(1) educational and career navigation, including information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduate's skills, experience, resources, and interests;

(2) support in becoming proficient in medical English;

(3) support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology;

(4) support for increasing knowledge of and familiarity with the United States health care system;

(5) support for other foundational skills identified by the commissioner;

(6) support for immigrant international medical graduates in becoming certified by the Educational Commission on Foreign Medical Graduates, including help with preparation for required licensing examinations and financial assistance for fees; and

(7) assistance to international medical graduates in registering with the program's Minnesota international medical graduate roster.

~~(b) The commissioner shall award the initial grants under this subdivision by December 31, 2015.~~

Sec. 7. Minnesota Statutes 2020, section 144.292, subdivision 6, is amended to read:

Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of reviewing current medical care, the provider must not charge a fee.

(b) When a provider or its representative makes copies of patient records upon a patient's request under this section, the provider or its representative may charge the patient or the patient's representative no more than 75 cents per page, plus $10 for time spent retrieving and copying the records, unless other law or a rule or contract provide for a lower maximum charge. This limitation does not apply to x-rays. The provider may charge a patient no more than the actual cost of reproducing x-rays, plus no more than $10 for the time spent retrieving and copying the x-rays.

(c) The respective maximum charges of 75 cents per page and $10 for time provided in this subdivision are in effect for calendar year 1992 and may be adjusted annually each calendar year as provided in this subdivision. The permissible maximum charges shall change each year by an amount that reflects the change, as compared to the previous year, in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U), published by the Department of Labor.

(d) A provider or its representative may charge the $10 retrieval fee, but must not charge a per page fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act; except that no fee shall be charged to a ~~person~~ patient who is receiving public assistance, or to a patient who is represented by an attorney on behalf of a civil legal services program or a volunteer attorney program based on indigency. For the purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided. For purposes of this paragraph, a patient's authorized representative does not include units of state government engaged in the adjudication of Social Security disability claims.

Sec. 8. Minnesota Statutes 2020, section 144.497, is amended to read:

144.497 ST ELEVATION MYOCARDIAL INFARCTION.

The commissioner of health shall assess and report on the quality of care provided in the state for ST elevation myocardial infarction response and treatment. The commissioner shall:

(1) utilize and analyze data provided by ST elevation myocardial infarction receiving centers to the ACTION Registry-Get with the guidelines or an equivalent data platform that does not identify individuals or associate specific ST elevation myocardial infarction heart attack events with an identifiable individual;

(2) ~~quarterly~~ annually post a summary report of the data in aggregate form on the Department of Health website; and

~~(3) annually inform the legislative committees with jurisdiction over public health of progress toward improving the quality of care and patient outcomes for ST elevation myocardial infarctions; and~~

~~(4)~~ (3) coordinate to the extent possible with national voluntary health organizations involved in ST elevation myocardial infarction heart attack quality improvement to encourage ST elevation myocardial infarction receiving centers to report data consistent with nationally recognized guidelines on the treatment of individuals with confirmed ST elevation myocardial infarction heart attacks within the state and encourage sharing of information among health care providers on ways to improve the quality of care of ST elevation myocardial infarction patients in Minnesota.

Sec. 9. Minnesota Statutes 2021 Supplement, 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; (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;

(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) upon submission of a plan to the commissioner for public interest review under section 144.552 and the addition of the 15 inpatient mental health beds specified in clause (28), to its bed capacity, 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. Five of the 45 additional beds authorized under this clause must be designated for use for inpatient mental health and must be added to the hospital's bed capacity before the remaining 40 beds are added. Notwithstanding section 144.552, the hospital may add licensed beds under this clause prior to completion of the public interest review, provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for the public interest review described in section 144.552; ~~or~~

(30) upon submission of a plan to the commissioner for public interest review under section 144.552, a project to add up to 30 licensed beds in an existing psychiatric hospital in Hennepin County that exclusively provides care to patients who are under 21 years of age on the date of admission. Notwithstanding section 144.552, the psychiatric hospital may add licensed beds under this clause prior to completion of the public interest review, provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for the public interest review described in section 144.552~~.~~;

(31) any project to add licensed beds in a hospital located in Cook County or Mahnomen County that: (i) is designated as a critical access hospital under section 144.1483, clause (9), and United States Code, title 42, section 1395i-4; (ii) has a licensed bed capacity of fewer than 25 beds; and (iii) has an attached nursing home, so long as the total number of

licensed beds in the hospital after the bed addition does not exceed 25 beds. Notwithstanding section 144.552, a public interest review is not required for a project authorized under this clause; or

(32) upon submission of a plan to the commissioner for public interest review under section 144.552, a project to add 22 licensed beds at a Minnesota freestanding children's hospital in St. Paul that is part of an independent pediatric health system with freestanding inpatient hospitals located in Minneapolis and St. Paul. The beds shall be utilized for pediatric inpatient behavioral health services. Notwithstanding section 144.552, the hospital may add licensed beds under this clause prior to completion of the public interest review, provided the hospital submits its plan by the 2022 deadline and adheres to the timelines for the public interest review described in section 144.552.

Sec. 10. Minnesota Statutes 2020, section 144.565, subdivision 4, is amended to read:

Subd. 4. **Definitions.** (a) For purposes of this section, the following terms have the meanings given:.

(b) "Diagnostic imaging facility" means a health care facility that is not a hospital or location licensed as a hospital which offers diagnostic imaging services in Minnesota, regardless of whether the equipment used to provide the service is owned or leased. For the purposes of this section, diagnostic imaging facility includes, but is not limited to, facilities such as a physician's office, clinic, mobile transport vehicle, outpatient imaging center, or surgical center. A dental clinic or office is not considered a diagnostic imaging facility for the purpose of this section when the clinic or office performs diagnostic imaging through dental cone beam computerized tomography.

(c) "Diagnostic imaging service" means the use of ionizing radiation or other imaging technique on a human patient including, but not limited to, magnetic resonance imaging (MRI) or computerized tomography (CT) other than dental cone beam computerized tomography, positron emission tomography (PET), or single photon emission computerized tomography (SPECT) scans using fixed, portable, or mobile equipment.

(d) "Financial or economic interest" means a direct or indirect:

(1) equity or debt security issued by an entity, including, but not limited to, shares of stock in a corporation, membership in a limited liability company, beneficial interest in a trust, units or other interests in a partnership, bonds, debentures, notes or other equity interests or debt instruments, or any contractual arrangements;

(2) membership, proprietary interest, or co-ownership with an individual, group, or organization to which patients, clients, or customers are referred to; or

(3) employer-employee or independent contractor relationship, including, but not limited to, those that may occur in a limited partnership, profit-sharing arrangement, or other similar arrangement with any facility to which patients are referred, including any compensation between a facility and a health care provider, the group practice of which the provider is a member or employee or a related party with respect to any of them.

(e) "Fixed equipment" means a stationary diagnostic imaging machine installed in a permanent location.

(f) "Mobile equipment" means a diagnostic imaging machine in a self-contained transport vehicle designed to be brought to a temporary ~~offsite~~ off-site location to perform diagnostic imaging services.

(g) "Portable equipment" means a diagnostic imaging machine designed to be temporarily transported within a permanent location to perform diagnostic imaging services.

(h) "Provider of diagnostic imaging services" means a diagnostic imaging facility or an entity that offers and bills for diagnostic imaging services at a facility owned or leased by the entity.

Sec. 11. Minnesota Statutes 2020, section 144.6502, 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) "Commissioner" means the commissioner of health.

(c) "Department" means the Department of Health.

(d) "Electronic monitoring" means the placement and use of an electronic monitoring device ~~by a resident~~ in the resident's room or private living unit in accordance with this section.

(e) "Electronic monitoring device" means a camera or other device that captures, records, or broadcasts audio, video, or both, that is placed in a resident's room or private living unit and is used to monitor the resident or activities in the room or private living unit.

(f) "Facility" means a facility that is:

(1) licensed as a nursing home under chapter 144A;

(2) licensed as a boarding care home under sections 144.50 to 144.56;

(3) until August 1, 2021, a housing with services establishment registered under chapter 144D that is either subject to chapter 144G or has a disclosed special unit under section 325F.72; or

(4) on or after August 1, 2021, an assisted living facility.

(g) "Resident" means a person 18 years of age or older residing in a facility.

(h) "Resident representative" means one of the following in the order of priority listed, to the extent the person may reasonably be identified and located:

(1) a court-appointed guardian;

(2) a health care agent as defined in section 145C.01, subdivision 2; or

(3) a person who is not an agent of a facility or of a home care provider designated in writing by the resident and maintained in the resident's records on file with the facility.

Sec. 12. Minnesota Statutes 2020, section 144A.01, is amended to read:

144A.01 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 144A.01 to 144A.27, the terms defined in this section have the meanings given them.

Subd. 2. **Commissioner of health.** "Commissioner of health" means the state commissioner of health established by section 144.011.

Subd. 3. **Board of Executives for Long Term Services and Supports.** "Board of Executives for Long Term Services and Supports" means the Board of Executives for Long Term Services and Supports established by section 144A.19.

Subd. 3a. **Certified.** "Certified" means certified for participation as a provider in the Medicare or Medicaid programs under title XVIII or XIX of the Social Security Act.

Subd. 4. **Controlling person.** (a) "Controlling person" means ~~any public body, governmental agency, business entity,~~ an owner and the following individuals and entities, if applicable:

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

(2) the nursing home administrator~~, or director whose responsibilities include the direction of the management or policies of a nursing home~~; and

(3) any managerial official.

(b) "Controlling person" also means any entity or natural person who~~, directly or indirectly, beneficially owns any~~ has any direct or indirect ownership interest in:

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

(2) the land on which a nursing home is located;

(3) the structure in which a nursing home is located;

(4) any entity with at least a five percent mortgage, contract for deed, deed of trust, or other ~~obligation secured in whole or part by~~ security interest in the land or structure comprising a nursing home; or

(5) any lease or sublease of the land, structure, or facilities comprising a nursing home.

~~(b)~~ (c) "Controlling person" does not include:

(1) a bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity directly or through a subsidiary operates a nursing home;

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

~~(2)~~ (3) an individual who is a state or federal official ~~or~~, a state or federal employee, or a member or employee of the governing body of a political subdivision of the state ~~which~~ or federal government that operates one or more nursing homes, unless the individual is also an officer ~~or director of a~~, owner, or managerial official of the nursing home, receives any remuneration from a nursing home, or ~~owns any of the beneficial interests~~ who is a controlling person not otherwise excluded in this subdivision;

~~(3)~~ (4) a natural person who is a member of a tax-exempt organization under section 290.05, subdivision 2, unless the individual is also ~~an officer or director of a nursing home, or owns any of the beneficial interests~~ a controlling person not otherwise excluded in this subdivision; and

~~(4)~~ (5) a natural person who owns less than five percent of the outstanding common shares of a corporation:

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

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

Subd. 4a. **Emergency.** "Emergency" means a situation or physical condition that creates or probably will create an immediate and serious threat to a resident's health or safety.

Subd. 5. **Nursing home.** "Nursing home" means a facility or that part of a facility which provides nursing care to five or more persons. "Nursing home" does not include a facility or that part of a facility which is a hospital, a hospital with approved swing beds as defined in section 144.562, clinic, doctor's office, diagnostic or treatment center, or a residential program licensed pursuant to sections 245A.01 to 245A.16 or 252.28.

Subd. 6. **Nursing care.** "Nursing care" means health evaluation and treatment of patients and residents who are not in need of an acute care facility but who require nursing supervision on an inpatient basis. The commissioner of health may by rule establish levels of nursing care.

Subd. 7. **Uncorrected violation.** "Uncorrected violation" means a violation of a statute or rule or any other deficiency for which a notice of noncompliance has been issued and fine assessed and allowed to be recovered pursuant to section 144A.10, subdivision 8.

Subd. 8. **Managerial ~~employee~~ official.** "Managerial ~~employee~~ official" means an ~~employee of a~~ individual who has the decision-making authority related to the operation of the nursing home ~~whose duties include~~ and the responsibility for either: (1) the ongoing management of the nursing home; or (2) the direction of ~~some or all of the management or~~ policies, services, or employees of the nursing home.

Subd. 9. **Nursing home administrator.** "Nursing home administrator" means a person who administers, manages, supervises, or is in general administrative charge of a nursing home, whether or not the individual has an ownership interest in the home, and whether or not the person's functions and duties are shared with one or more individuals, and who is licensed pursuant to section 144A.21.

Subd. 10. **Repeated violation.** "Repeated violation" means the issuance of two or more correction orders, within a 12-month period, for a violation of the same provision of a statute or rule.

Subd. 11. **Change of ownership.** "Change of ownership" means a change in the licensee.

Subd. 12. **Direct ownership interest.** "Direct ownership interest" means an individual or legal entity with the possession of at least five percent equity in capital, stock, or profits of the licensee or who is a member of a limited liability company of the licensee.

Subd. 13. **Indirect ownership interest.** "Indirect ownership interest" means an individual or legal entity with a direct ownership interest in an entity that has a direct or indirect ownership interest of at least five percent in an entity that is a licensee.

Subd. 14. **Licensee.** "Licensee" means a person or legal entity to whom the commissioner issues a license for a nursing home and who is responsible for the management, control, and operation of the nursing home.

Subd. 15. **Management agreement.** "Management agreement" means a written, executed agreement between a licensee and manager regarding the provision of certain services on behalf of the licensee.

Subd. 16. **Manager.** "Manager" means an individual or legal entity designated by the licensee through a management agreement to act on behalf of the licensee in the on-site management of the nursing home.

Subd. 17. **Owner.** "Owner" means: (1) an individual or legal entity that has a direct or indirect ownership interest of five percent or more in a licensee; and (2) for purposes of this chapter, owner of a nonprofit corporation means the president and treasurer of the board of directors; and (3) for an entity owned by an employee stock ownership plan, owner means the president and treasurer of the entity. A government entity that is issued a license under this chapter shall be designated the owner.

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

Sec. 13. Minnesota Statutes 2020, section 144A.03, subdivision 1, is amended to read:

Subdivision 1. **Form; requirements.** (a) The commissioner of health by rule shall establish forms and procedures for the processing of nursing home license applications.

(b) An application for a nursing home license shall include ~~the following information~~:

(1) the ~~names~~ business name and ~~addresses of all controlling persons and managerial employees of the facility to be licensed~~ legal entity name of the licensee;

(2) the street address, mailing address, and legal property description of the facility;

(3) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling persons, managerial officials, and the nursing home administrator;

(4) the name and e-mail address of the managing agent and manager, if applicable;

(5) the licensed bed capacity;

(6) the license fee in the amount specified in section 144.122;

(7) documentation of compliance with the background study requirements in section 144.057 for the owner, controlling persons, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant;

~~(3)~~ (8) a copy of the architectural and engineering plans and specifications of the facility as prepared and certified by an architect or engineer registered to practice in this state; ~~and~~

(9) a representative copy of the executed lease agreement between the landlord and the licensee, if applicable;

(10) a representative copy of the management agreement, if applicable;

(11) a representative copy of the operations transfer agreement or similar agreement, if applicable;

(12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater and that specifies their relationship with the licensee and with each other;

(13) whether the applicant, owner, controlling person, managerial official, or nursing home administrator of the facility has ever been convicted of:

(i) a crime or found civilly liable for a federal or state felony-level offense that was detrimental to the best interests of the facility and its residents within the last ten years preceding submission of the license application. Offenses include: (A) felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; (B) financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; (C) any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and (D) any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act;

(ii) any misdemeanor under federal or state law related to the delivery of an item or service under Medicaid or a state health care program or the abuse or neglect of a patient in connection with the delivery of a health care item or service;

(iii) any misdemeanor under federal or state law related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service;

(iv) any felony or misdemeanor under federal or state law relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or 1001.201; or

(v) any felony or misdemeanor under federal or state law relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;

(14) whether the applicant, owner, controlling person, managerial official, or nursing home administrator of the facility has had:

(i) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of the license while a formal disciplinary proceeding was pending before a state licensing authority;

(ii) any revocation or suspension of accreditation; or

(iii) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program or any debarment from participation in any federal executive branch procurement or nonprocurement program;

(15) whether in the preceding three years the applicant or any owner, controlling person, managerial official, or nursing home administrator of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings;

(16) the signature of the owner of the licensee or an authorized agent of the licensee;

(17) identification of all states where the applicant or individual having a five percent or more ownership currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where the applicant's or individual's license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership or where these same actions are pending under the laws of any state or federal authority; and

~~(4)~~ (18) any other relevant information which the commissioner of health by rule or otherwise may determine is necessary to properly evaluate an application for license.

(c) A controlling person which is a corporation shall submit copies of its articles of incorporation and bylaws and any amendments thereto as they occur, together with the names and addresses of its officers and directors. A controlling person which is a foreign corporation shall furnish the commissioner of health with a copy of its certificate of authority to do business in this state. ~~An application on behalf of a controlling person which is a~~

~~corporation, association or a governmental unit or instrumentality shall be signed by at least two officers or managing agents of that entity.~~

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

Sec. 14. Minnesota Statutes 2020, section 144A.04, subdivision 4, is amended to read:

Subd. 4. **Controlling person restrictions.** (a) The commissioner has discretion to bar any controlling persons of a nursing home ~~may not include any~~ if the person ~~who~~ was a controlling person of ~~another~~ any other nursing home ~~during any period of time~~, assisted living facility, long-term care or health care facility, or agency in the previous two-year period and:

(1) during ~~which~~ that period of time ~~of control that other nursing home~~ the facility or agency incurred ~~the following number of uncorrected or repeated violations:~~

~~(i)~~ two or more uncorrected violations or one or more repeated violations which created an imminent risk to direct resident or client care or safety; or

~~(ii) four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the four highest daily fine categories prescribed in rule; or~~

(2) ~~who~~ during that period of time, was convicted of a felony or gross misdemeanor that ~~relates~~ related to operation of the ~~nursing home~~ facility or agency or directly ~~affects~~ affected resident safety or care~~, during that period~~.

(b) The provisions of this subdivision shall not apply to any controlling person who had no legal authority to affect or change decisions related to the operation of the nursing home which incurred the uncorrected violations.

(c) When the commissioner bars a controlling person under this subdivision, the controlling person has the right to appeal under chapter 14.

Sec. 15. Minnesota Statutes 2020, section 144A.04, subdivision 6, is amended to read:

Subd. 6. **Managerial ~~employee~~ official or licensed administrator; employment prohibitions.** A nursing home may not employ as a managerial ~~employee~~ official or as its licensed administrator any person who was a managerial ~~employee~~ official or the licensed administrator of another facility during any period of time in the previous two-year period:

(1) during which time of employment that other nursing home incurred the following number of uncorrected violations which were in the jurisdiction and control of the managerial ~~employee~~ official or the administrator:

(i) two or more uncorrected violations ~~or one or more repeated violations which created an imminent risk to direct resident care or safety~~; or

(ii) four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the four highest daily fine categories prescribed in rule; or

(2) who was convicted of a felony or gross misdemeanor that relates to operation of the nursing home or directly affects resident safety or care, during that period.

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

Sec. 16. Minnesota Statutes 2020, section 144A.06, is amended to read:

144A.06 TRANSFER OF ~~INTERESTS~~ LICENSE PROHIBITED.

Subdivision 1. ~~**Notice; expiration of license**~~ **Transfers prohibited.** ~~Any controlling person who makes any transfer of a beneficial interest in a nursing home shall notify the commissioner of health of the transfer within 14 days of its occurrence. The notification shall identify by name and address the transferor and transferee and shall specify the nature and amount of the transferred interest. On determining that the transferred beneficial interest exceeds ten percent of the total beneficial interest in the nursing home facility, the structure in which the facility is located, or the land upon which the structure is located, the commissioner may, and on determining that the transferred beneficial interest exceeds 50 percent of the total beneficial interest in the facility, the structure in which the facility is located, or the land upon which the structure is located, the commissioner shall require that the license of the nursing home expire 90 days after the date of transfer. The commissioner of health shall notify the nursing home by certified mail of the expiration of the license at least 60 days prior to the date of expiration.~~ A nursing home license may not be transferred.

Subd. 2. ~~**Relicensure**~~ **New license required; change of ownership.** (a) The commissioner of health by rule shall prescribe procedures for ~~relicensure~~ licensure under this section. ~~The commissioner of health shall relicense a nursing home if the facility satisfies the requirements for license renewal established by section 144A.05. A facility shall not be relicensed by the commissioner if at the time of transfer there are any uncorrected violations. The commissioner of health may temporarily waive correction of one or more violations if the commissioner determines that:~~

~~(1) temporary noncorrection of the violation will not create an imminent risk of harm to a nursing home resident; and~~

~~(2) a controlling person on behalf of all other controlling persons:~~

~~(i) has entered into a contract to obtain the materials or labor necessary to correct the violation, but the supplier or other contractor has failed to perform the terms of the contract and the inability of the nursing home to correct the violation is due solely to that failure; or~~

~~(ii) is otherwise making a diligent good faith effort to correct the violation.~~

(b) A new license is required and the prospective licensee must apply for a license prior to operating a currently licensed nursing home. The licensee must change whenever one of the following events occur:

(1) the form of the licensee's legal entity structure is converted or changed to a different type of legal entity structure;

(2) the licensee dissolves, consolidates, or merges with another legal organization and the licensee's legal organization does not survive;

(3) within the previous 24 months, 50 percent or more of the licensee's ownership interest is transferred, whether by a single transaction or multiple transactions to:

(i) a different person; or

(ii) a person who had less than a five percent ownership interest in the facility at the time of the first transaction; or

(4) any other event or combination of events that results in a substitution, elimination, or withdrawal of the licensee's responsibility for the facility.

Subd. 3. **Compliance.** The commissioner must consult with the commissioner of human services regarding the history of financial and cost reporting compliance of the prospective licensee and prospective licensee's financial operations in any nursing home that the prospective licensee or any controlling person listed in the license application has had an interest in.

Subd. 4. **Facility operation.** The current licensee remains responsible for the operation of the nursing home until the nursing home is licensed to the prospective licensee.

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

Sec. 17. **[144A.32] CONSIDERATION OF APPLICATIONS.**

(a) Before issuing a license or renewing an existing license, the commissioner shall consider an applicant's compliance history in providing care in a facility that provides care to children, the elderly, ill individuals, or individuals with disabilities.

(b) The applicant's compliance history shall include repeat violations, rule violations, and any license or certification involuntarily suspended or terminated during an enforcement process.

(c) The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license or impose conditions if:

(1) the applicant fails to provide complete and accurate information on the application and the commissioner concludes that the missing or corrected information is needed to determine if a license is granted;

(2) the applicant, knowingly or with reason to know, made a false statement of a material fact in an application for the license or any data attached to the application or in any matter under investigation by the department;

(3) the applicant refused to allow agents of the commissioner to inspect the applicant's books, records, files related to the license application, or any portion of the premises;

(4) the applicant willfully prevented, interfered with, or attempted to impede in any way:

(i) the work of any authorized representative of the commissioner, the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities; or

(ii) the duties of the commissioner, local law enforcement, city or county attorneys, adult protection, county case managers, or other local government personnel;

(5) the applicant has a history of noncompliance with federal or state regulations that were detrimental to the health, welfare, or safety of a resident or a client; or

(6) the applicant violates any requirement in this chapter or chapter 256R.

(d) If a license is denied, the applicant has the reconsideration rights available under chapter 14.

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

Sec. 18. Minnesota Statutes 2020, section 144A.4799, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The commissioner of health shall appoint ~~eight~~ 13 persons to a home care and assisted living program advisory council consisting of the following:

(1) ~~three~~ two public members as defined in section 214.02 who shall be persons who are currently receiving home care services, persons who have received home care services within five years of the application date, persons who have family members receiving home

care services, or persons who have family members who have received home care services within five years of the application date;

(2) ~~three~~ two Minnesota home care licensees representing basic and comprehensive levels of licensure who may be a managerial official, an administrator, a supervising registered nurse, or an unlicensed personnel performing home care tasks;

(3) one member representing the Minnesota Board of Nursing;

(4) one member representing the Office of Ombudsman for Long-Term Care; ~~and~~

(5) one member representing the Office of Ombudsman for Mental Health and Developmental Disabilities;

~~(5)~~ (6) beginning July 1, 2021, one member of a county health and human services or county adult protection office~~.~~;

(7) two Minnesota assisted living facility licensees representing assisted living facilities and assisted living facilities with dementia care levels of licensure who may be the facility's assisted living director, managerial official, or clinical nurse supervisor;

(8) one organization representing long-term care providers, home care providers, and assisted living providers in Minnesota; and

(9) two public members as defined in section 214.02. One public member shall be a person who either is or has been a resident in an assisted living facility and one public member shall be a person who has or had a family member living in an assisted living facility setting.

Sec. 19. Minnesota Statutes 2020, section 144A.4799, subdivision 3, is amended to read:

Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed assisted living and home care providers in this chapter, including advice on the following:

(1) community standards for home care practices;

(2) enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) ways of distributing information to licensees and consumers of home care and assisted living services defined under chapter 144G;

(4) training standards;

(5) identifying emerging issues and opportunities in home care and assisted living services defined under chapter 144G;

(6) identifying the use of technology in home and telehealth capabilities;

(7) allowable home care licensing modifications and exemptions, including a method for an integrated license with an existing license for rural licensed nursing homes to provide limited home care services in an adjacent independent living apartment building owned by the licensed nursing home; and

(8) recommendations for studies using the data in section 62U.04, subdivision 4, including but not limited to studies concerning costs related to dementia and chronic disease among an elderly population over 60 and additional long-term care costs, as described in section 62U.10, subdivision 6.

(b) The advisory council shall perform other duties as directed by the commissioner.

(c) The advisory council shall annually make recommendations to the commissioner for the purposes in section 144A.474, subdivision 11, paragraph (i). The recommendations shall address ways the commissioner may improve protection of the public under existing statutes and laws and include but are not limited to projects that create and administer training of licensees and their employees to improve residents' lives, supporting ways that licensees can improve and enhance quality care and ways to provide technical assistance to licensees to improve compliance; information technology and data projects that analyze and communicate information about trends of violations or lead to ways of improving client care; communications strategies to licensees and the public; and other projects or pilots that benefit clients, families, and the public.

Sec. 20. Minnesota Statutes 2020, section 144A.75, subdivision 12, is amended to read:

Subd. 12. **Palliative care.** "Palliative care" means ~~the total active care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social, and spiritual problems is paramount~~ specialized medical care for individuals living with a serious illness or life-limiting condition. This type of care is focused on reducing the pain, symptoms, and stress of a serious illness or condition. Palliative care is a team-based approach to care, providing essential support at any age or stage of a serious illness or condition, and is often provided together with curative treatment. The goal of palliative care is ~~the achievement of the best quality of life for patients and their families~~ to improve quality of life for both the patient and the patient's family or care partner.

Sec. 21. Minnesota Statutes 2020, section 144G.08, is amended by adding a subdivision to read:

Subd. 62a. **Serious injury.** "Serious injury" has the meaning given in section 245.91, subdivision 6.

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

Sec. 22. Minnesota Statutes 2020, section 144G.15, is amended to read:

144G.15 CONSIDERATION OF APPLICATIONS.

(a) Before issuing a provisional license or license or renewing a license, the commissioner shall consider an applicant's compliance history in providing care in this state or any other state in a facility that provides care to children, the elderly, ill individuals, or individuals with disabilities.

(b) The applicant's compliance history shall include repeat violation, rule violations, and any license or certification involuntarily suspended or terminated during an enforcement process.

(c) The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license or impose conditions if:

(1) the applicant fails to provide complete and accurate information on the application and the commissioner concludes that the missing or corrected information is needed to determine if a license shall be granted;

(2) the applicant, knowingly or with reason to know, made a false statement of a material fact in an application for the license or any data attached to the application or in any matter under investigation by the department;

(3) the applicant refused to allow agents of the commissioner to inspect its books, records, and files related to the license application, or any portion of the premises;

(4) the applicant willfully prevented, interfered with, or attempted to impede in any way: (i) the work of any authorized representative of the commissioner, the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities; or (ii) the duties of the commissioner, local law enforcement, city or county attorneys, adult protection, county case managers, or other local government personnel;

(5) the applicant, owner, controlling individual, managerial official, or assisted living director for the facility has a history of noncompliance with federal or state regulations that were detrimental to the health, welfare, or safety of a resident or a client; or

(6) the applicant violates any requirement in this chapter.

(d) If a license is denied, the applicant has the reconsideration rights available under section 144G.16, subdivision 4.

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

Sec. 23. Minnesota Statutes 2020, section 144G.17, is amended to read:

144G.17 LICENSE RENEWAL.

A license that is not a provisional license may be renewed for a period of up to one year if the licensee:

(1) submits an application for renewal in the format provided by the commissioner at least 60 calendar days before expiration of the license;

(2) submits the renewal fee under section 144G.12, subdivision 3;

(3) submits the late fee under section 144G.12, subdivision 4, if the renewal application is received less than 30 days before the expiration date of the license or after the expiration of the license;

(4) provides information sufficient to show that the applicant meets the requirements of licensure, including items required under section 144G.12, subdivision 1; ~~and~~

(5) provides information sufficient to show the licensee provided assisted living services to at least one resident during the immediately preceding license year and at the assisted living facility listed on the license; and

~~(5)~~ (6) provides any other information deemed necessary by the commissioner.

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

Sec. 24. Minnesota Statutes 2020, section 144G.19, is amended by adding a subdivision to read:

Subd. 4. **Change of licensee.** Notwithstanding any other provision of law, a change of licensee under subdivision 2 does not require the facility to meet the design requirements of section 144G.45, subdivisions 4 to 6, or 144G.81, subdivision 3.

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

Sec. 25. Minnesota Statutes 2020, section 144G.20, subdivision 1, is amended to read:

Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:

(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;

(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;

(3) performs any act detrimental to the health, safety, and welfare of a resident;

(4) obtains the license by fraud or misrepresentation;

(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;

(7) interferes with or impedes a representative of the department in contacting the facility's residents;

(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1;

(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;

(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;

(11) refuses to initiate a background study under section 144.057 or 245A.04;

(12) fails to timely pay any fines assessed by the commissioner;

(13) violates any local, city, or township ordinance relating to housing or assisted living services;

(14) has repeated incidents of personnel performing services beyond their competency level; or

(15) has operated beyond the scope of the assisted living facility's license category.

(b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility.

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

Sec. 26. Minnesota Statutes 2020, section 144G.20, subdivision 4, is amended to read:

Subd. 4. **Mandatory revocation.** Notwithstanding the provisions of subdivision 13, paragraph (a), the commissioner must revoke a license if a controlling individual of the facility is convicted of a felony or gross misdemeanor that relates to operation of the facility or directly affects resident safety or care. The commissioner shall notify the facility and the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities 30 calendar days in advance of the date of revocation.

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

Sec. 27. Minnesota Statutes 2020, section 144G.20, subdivision 5, is amended to read:

Subd. 5. **Owners and managerial officials; refusal to grant license.** (a) The owners and managerial officials of a facility whose Minnesota license has not been renewed or whose ~~Minnesota~~ license in this state or any other state has been revoked because of noncompliance with applicable laws or rules shall not be eligible to apply for nor will be granted an assisted living facility license under this chapter or a home care provider license under chapter 144A, or be given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659, for five years following the effective date of the nonrenewal or revocation. If the owners or managerial officials already have enrollment status, the Department of Human Services shall terminate that enrollment.

(b) The commissioner shall not issue a license to a facility for five years following the effective date of license nonrenewal or revocation if the owners or managerial officials, including any individual who was an owner or managerial official of another licensed provider, had a ~~Minnesota~~ license in this state or any other state that was not renewed or was revoked as described in paragraph (a).

(c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall suspend or revoke, the license of a facility that includes any individual as an owner or managerial official who was an owner or managerial official of a facility whose ~~Minnesota~~ license in

this state or any other state was not renewed or was revoked as described in paragraph (a) for five years following the effective date of the nonrenewal or revocation.

(d) The commissioner shall notify the facility 30 calendar days in advance of the date of nonrenewal, suspension, or revocation of the license.

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

Sec. 28. Minnesota Statutes 2020, section 144G.20, subdivision 8, is amended to read:

Subd. 8. **Controlling individual restrictions.** (a) The commissioner has discretion to bar any controlling individual of a facility if the person was a controlling individual of any other nursing home, home care provider licensed under chapter 144A, or given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659, or assisted living facility in the previous two-year period and:

(1) during that period of time the nursing home, home care provider licensed under chapter 144A, or given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659, or assisted living facility incurred the following number of uncorrected or repeated violations:

(i) two or more repeated violations that created an imminent risk to direct resident care or safety; or

(ii) four or more uncorrected violations that created an imminent risk to direct resident care or safety; or

(2) during that period of time, was convicted of a felony or gross misdemeanor that related to the operation of the nursing home, home care provider licensed under chapter 144A, or given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659, or assisted living facility, or directly affected resident safety or care.

(b) When the commissioner bars a controlling individual under this subdivision, the controlling individual may appeal the commissioner's decision under chapter 14.

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

Sec. 29. Minnesota Statutes 2020, section 144G.20, subdivision 9, is amended to read:

Subd. 9. **Exception to controlling individual restrictions.** Subdivision 8 does not apply to any controlling individual of the facility who had no legal authority to affect or change

decisions related to the operation of the nursing home ~~or~~, assisted living facility, or home care that incurred the uncorrected or repeated violations.

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

Sec. 30. Minnesota Statutes 2020, section 144G.20, subdivision 12, is amended to read:

Subd. 12. **Notice to residents.** (a) Within five business days after proceedings are initiated by the commissioner to revoke or suspend a facility's license, or a decision by the commissioner not to renew a living facility's license, the controlling individual of the facility or a designee must provide to the commissioner ~~and~~, the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities the names of residents and the names and addresses of the residents' designated representatives and legal representatives, and family or other contacts listed in the assisted living contract.

(b) The controlling individual or designees of the facility must provide updated information each month until the proceeding is concluded. If the controlling individual or designee of the facility fails to provide the information within this time, the facility is subject to the issuance of:

(1) a correction order; and

(2) a penalty assessment by the commissioner in rule.

(c) Notwithstanding subdivisions 21 and 22, 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 $500 fine the first day of noncompliance and an increase in the $500 fine by $100 increments for each day the noncompliance continues.

(d) Information provided under this subdivision may be used by the commissioner ~~or~~, the ombudsman for long-term care, or the Office of Ombudsman for Mental Health and Developmental Disabilities only for the purpose of providing affected consumers information about the status of the proceedings.

(e) Within ten business days after the commissioner initiates proceedings to revoke, suspend, or not renew a facility license, the commissioner must send a written notice of the action and the process involved to each resident of the facility, legal representatives and designated representatives, and at the commissioner's discretion, additional resident contacts.

(f) The commissioner shall provide the ombudsman for long-term care and the Office of Ombudsman for Mental Health and Developmental Disabilities with monthly information on the department's actions and the status of the proceedings.

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

Sec. 31. Minnesota Statutes 2020, section 144G.20, subdivision 15, is amended to read:

Subd. 15. **Plan required.** (a) The process of suspending, revoking, or refusing to renew a license must include a plan for transferring affected residents' cares to other providers by the facility. The commissioner shall monitor the transfer plan. Within three calendar days of being notified of the final revocation, refusal to renew, or suspension, the licensee shall provide the commissioner, the lead agencies as defined in section 256B.0911, county adult protection and case managers, ~~and~~ the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities with the following information:

(1) a list of all residents, including full names and all contact information on file;

(2) a list of the resident's legal representatives and designated representatives and family or other contacts listed in the assisted living contract, including full names and all contact information on file;

(3) the location or current residence of each resident;

(4) the ~~payor~~ payer sources for each resident, including ~~payor~~ payer source identification numbers; and

(5) for each resident, a copy of the resident's service plan and a list of the types of services being provided.

(b) The revocation, refusal to renew, or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The licensee shall cooperate with the commissioner and the lead agencies, county adult protection and case managers, ~~and~~ the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities during the process of transferring care of residents to qualified providers. Within three calendar days of being notified of the final revocation, refusal to renew, or suspension action, the facility must notify and disclose to each of the residents, or the resident's legal and designated representatives or emergency contact persons, that the commissioner is taking action against the facility's license by providing a copy of the revocation, refusal to renew, or suspension notice issued by the commissioner. If the facility does not comply with the disclosure requirements in this section, the commissioner shall

notify the residents, legal and designated representatives, or emergency contact persons about the actions being taken. Lead agencies, county adult protection and case managers, and the Office of Ombudsman for Long-Term Care may also provide this information. The revocation, refusal to renew, or suspension notice is public data except for any private data contained therein.

(c) A facility subject to this subdivision may continue operating while residents are being transferred to other service providers.

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

Sec. 32. Minnesota Statutes 2020, section 144G.30, subdivision 5, is amended to read:

Subd. 5. **Correction orders.** (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.

(b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.

(c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed.

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

Sec. 33. Minnesota Statutes 2020, section 144G.31, subdivision 4, is amended to read:

Subd. 4. **Fine amounts.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in subdivisions 2 and 3 as follows and may be imposed immediately with no opportunity to correct the violation prior to imposition:

(1) Level 1, no fines or enforcement;

(2) Level 2, a fine of $500 per violation, in addition to any enforcement mechanism authorized in section 144G.20 for widespread violations;

(3) Level 3, a fine of $3,000 per violation ~~per incident~~, in addition to any enforcement mechanism authorized in section 144G.20;

(4) Level 4, a fine of $5,000 per ~~incident~~ violation, in addition to any enforcement mechanism authorized in section 144G.20; and

(5) for maltreatment violations for which the licensee was determined to be responsible for the maltreatment under section 626.557, subdivision 9c, paragraph (c), a fine of $1,000 per incident. A fine of $5,000 per incident may be imposed if the commissioner determines the licensee is responsible for maltreatment consisting of sexual assault, death, or abuse resulting in serious injury.

(b) When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

Sec. 34. Minnesota Statutes 2020, section 144G.31, subdivision 8, is amended to read:

Subd. 8. **Deposit of fines.** Fines collected under this section shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner for special projects to improve ~~home care~~ resident quality of care and outcomes in assisted living facilities licensed under this chapter in Minnesota as recommended by the advisory council established in section 144A.4799.

EFFECTIVE DATE. This section is effective retroactively for fines collected on or after August 1, 2021.

Sec. 35. Minnesota Statutes 2020, section 144G.41, subdivision 7, is amended to read:

Subd. 7. **Resident grievances; reporting maltreatment.** All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the ~~state and applicable regional~~ Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The

notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.

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

Sec. 36. Minnesota Statutes 2020, section 144G.41, subdivision 8, is amended to read:

Subd. 8. **Protecting resident rights.** All facilities shall ensure that every resident has access to consumer advocacy or legal services by:

(1) providing names and contact information, including telephone numbers and e-mail addresses of at least three organizations that provide advocacy or legal services to residents, one of which must include the designated protection and advocacy organization in Minnesota that provides advice and representation to individuals with disabilities;

(2) providing the name and contact information for the Minnesota Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities~~, including both the state and regional contact information~~;

(3) assisting residents in obtaining information on whether Medicare or medical assistance under chapter 256B will pay for services;

(4) making reasonable accommodations for people who have communication disabilities and those who speak a language other than English; and

(5) providing all information and notices in plain language and in terms the residents can understand.

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

Sec. 37. Minnesota Statutes 2020, section 144G.42, subdivision 10, is amended to read:

Subd. 10. **Disaster planning and emergency preparedness plan.** (a) The facility 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) post an emergency disaster plan prominently;

(3) provide building emergency exit diagrams to all residents;

(4) post emergency exit diagrams on each floor; and

(5) have a written policy and procedure regarding missing ~~tenant~~ residents.

(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.

(c) The facility must meet any additional requirements adopted in rule.

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

Sec. 38. Minnesota Statutes 2020, section 144G.45, subdivision 7, is amended to read:

Subd. 7. **Variance or waiver.** (a) A facility may request that the commissioner grant a variance or waiver from the provisions of this section or section 144G.81, subdivision 5. A request for a waiver must be submitted to the commissioner in writing. Each request must contain:

(1) the specific requirement for which the variance or waiver is requested;

(2) the reasons for the request;

(3) the alternative measures that will be taken if a variance or waiver is granted;

(4) the length of time for which the variance or waiver is requested; and

(5) other relevant information deemed necessary by the commissioner to properly evaluate the request for the waiver.

(b) The decision to grant or deny a variance or waiver must be based on the commissioner's evaluation of the following criteria:

(1) whether the waiver will adversely affect the health, treatment, comfort, safety, or well-being of a resident;

(2) whether the alternative measures to be taken, if any, are equivalent to or superior to those permitted under section 144G.81, subdivision 5; ~~and~~

(3) whether compliance with the requirements would impose an undue burden on the facility; and

(4) notwithstanding clause (1), for construction existing as of August 1, 2021, the commissioner's evaluation of a variance from the requirement to provide an option for a bath under subdivision 4, paragraph (a), must be based on clauses (2) and (3) and whether the variance will adversely affect the health, treatment, or safety of a resident.

(c) The commissioner must notify the facility in writing of the decision. If a variance or waiver is granted, the notification must specify the period of time for which the variance or waiver is effective and the alternative measures or conditions, if any, to be met by the facility.

(d) Alternative measures or conditions attached to a variance or waiver have the force and effect of this chapter and are subject to the issuance of correction orders and fines in accordance with sections 144G.30, subdivision 7, and 144G.31. The amount of fines for a violation of this subdivision is that specified for the specific requirement for which the variance or waiver was requested.

(e) A request for renewal of a variance or waiver must be submitted in writing at least 45 days before its expiration date. Renewal requests must contain the information specified in paragraph (b). A variance or waiver must be renewed by the commissioner if the facility continues to satisfy the criteria in paragraph (a) and demonstrates compliance with the alternative measures or conditions imposed at the time the original variance or waiver was granted.

(f) The commissioner must deny, revoke, or refuse to renew a variance or waiver if it is determined that the criteria in paragraph (a) are not met. The facility must be notified in writing of the reasons for the decision and informed of the right to appeal the decision.

(g) A facility may contest the denial, revocation, or refusal to renew a variance or waiver by requesting a contested case hearing under chapter 14. The facility must submit, within 15 days of the receipt of the commissioner's decision, a written request for a hearing. The request for hearing must set forth in detail the reasons why the facility contends the decision of the commissioner should be reversed or modified. At the hearing, the facility has the burden of proving by a preponderance of the evidence that the facility satisfied the criteria specified in paragraph (b), except in a proceeding challenging the revocation of a variance or waiver.

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

Sec. 39. Minnesota Statutes 2020, section 144G.50, subdivision 2, is amended to read:

Subd. 2. **Contract information.** (a) The contract must include in a conspicuous place and manner on the contract the legal name and the ~~license number~~ health facility identification of the facility.

(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:

(1) the facility and contracted service provider when applicable;

(2) the licensee of the facility;

(3) the managing agent of the facility, if applicable; and

(4) the authorized agent for the facility.

(c) The contract must include:

(1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license;

(2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount;

(3) a delineation of the cost and nature of any other services to be provided for an additional fee;

(4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract;

(5) a delineation of the grounds under which the resident may be ~~discharged, evicted, or~~ transferred or have housing or services terminated or be subject to an emergency relocation;

(6) billing and payment procedures and requirements; and

(7) disclosure of the facility's ability to provide specialized diets.

(d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.

(e) The contract must include a clear and conspicuous notice of:

(1) the right under section 144G.54 to appeal the termination of an assisted living contract;

(2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;

(3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;

(4) the resident's right to obtain services from an unaffiliated service provider;

(5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:

(i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;

(ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b);

(iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;

(iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;

(v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;

(vi) a statement that residents may be eligible for assistance with rent through the housing support program; and

(vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;

(6) the contact information to obtain long-term care consulting services under section 256B.0911; and

(7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.

EFFECTIVE DATE. This section is effective August 1, 2022, and applies to assisted living contracts executed on or after that date.

Sec. 40. Minnesota Statutes 2020, section 144G.52, subdivision 2, is amended to read:

Subd. 2. **Prerequisite to termination of a contract.** (a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to:

(1) explain in detail the reasons for the proposed termination; and

(2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility.

(b) The meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting.

(c) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting.

(d) In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility ~~may attempt to schedule and participate in a meeting under this subdivision via~~ must use telephone, video, or other electronic means to conduct and participate in the meeting required under this subdivision and rules within Minnesota Rules, chapter 4659.

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

Sec. 41. Minnesota Statutes 2020, section 144G.52, subdivision 8, is amended to read:

Subd. 8. **Content of notice of termination.** The notice required under subdivision 7 must contain, at a minimum:

(1) the effective date of the termination of the assisted living contract;

(2) a detailed explanation of the basis for the termination, including the clinical or other supporting rationale;

(3) a detailed explanation of the conditions under which a new or amended contract may be executed;

(4) a statement that the resident has the right to appeal the termination by requesting a hearing, and information concerning the time frame within which the request must be submitted and the contact information for the agency to which the request must be submitted;

(5) a statement that the facility must participate in a coordinated move to another provider or caregiver, as required under section 144G.55;

(6) the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination;

(7) information on how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities to request an advocate to assist regarding the termination;

(8) information on how to contact the Senior LinkAge Line under section 256.975, subdivision 7, and an explanation that the Senior LinkAge Line may provide information about other available housing or service options; and

(9) if the termination is only for services, a statement that the resident may remain in the facility and may secure any necessary services from another provider of the resident's choosing.

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

Sec. 42. Minnesota Statutes 2020, section 144G.52, subdivision 9, is amended to read:

Subd. 9. **Emergency relocation.** (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.

(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:

(1) the reason for the relocation;

(2) the name and contact information for the location to which the resident has been relocated and any new service provider;

(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;

(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and

(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.

(c) The notice required under paragraph (b) must be delivered as soon as practicable to:

(1) the resident, legal representative, and designated representative;

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

(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.

(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.

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

Sec. 43. Minnesota Statutes 2020, section 144G.53, is amended to read:

144G.53 NONRENEWAL OF HOUSING.

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

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

(c) A facility must:

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

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

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

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

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

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

(d) A resident may decline to move to the location the facility identifies or to accept services from a service provider the facility identifies, and may instead choose to move to a location of the resident's choosing or receive services from a service provider of the resident's choosing within the timeline prescribed in the nonrenewal notice.

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

Sec. 44. Minnesota Statutes 2020, section 144G.55, subdivision 1, is amended to read:

Subdivision 1. **Duties of facility.** (a) If a facility terminates an assisted living contract, reduces services to the extent that a resident needs to move or obtain a new service provider or the facility has its license restricted under section 144G.20, or the facility conducts a planned closure under section 144G.57, the facility:

(1) must ensure, subject to paragraph (c), a coordinated move to a safe location that is appropriate for the resident and that is identified by the facility prior to any hearing under section 144G.54;

(2) must ensure a coordinated move of the resident to an appropriate service provider identified by the facility prior to any hearing under section 144G.54, provided services are still needed and desired by the resident; and

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

(b) A facility may satisfy the requirements of paragraph (a), clauses (1) and (2), by moving the resident to a different location within the same facility, if appropriate for the resident.

(c) A resident may decline to move to the location the facility identifies or to accept services from a service provider the facility identifies, and may choose instead to move to a location of the resident's choosing or receive services from a service provider of the resident's choosing within the timeline prescribed in the termination notice.

(d) Sixty days before the facility plans to reduce or eliminate one or more services for a particular resident, the facility must provide written notice of the reduction that includes:

(1) a detailed explanation of the reasons for the reduction and the date of the reduction;

(2) the contact information for the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the name and contact information of the person employed by the facility with whom the resident may discuss the reduction of services;

(3) a statement that if the services being reduced are still needed by the resident, the resident may remain in the facility and seek services from another provider; and

(4) a statement that if the reduction makes the resident need to move, the facility must participate in a coordinated move of the resident to another provider or caregiver, as required under this section.

(e) In the event of an unanticipated reduction in services caused by extraordinary circumstances, the facility must provide the notice required under paragraph (d) as soon as possible.

(f) If the facility, a resident, a legal representative, or a designated representative determines that a reduction in services will make a resident need to move to a new location, the facility must ensure a coordinated move in accordance with this section, and must provide notice to the Office of Ombudsman for Long-Term Care.

(g) Nothing in this section affects a resident's right to remain in the facility and seek services from another provider.

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

Sec. 45. Minnesota Statutes 2020, section 144G.55, subdivision 3, is amended to read:

Subd. 3. **Relocation plan required.** The facility must prepare a relocation plan to prepare for the move to ~~the~~ a new safe location or appropriate service provider, as required by this section.

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

Sec. 46. Minnesota Statutes 2020, section 144G.56, subdivision 3, is amended to read:

Subd. 3. **Notice required.** (a) A facility must provide at least 30 calendar days' advance written notice to the resident and the resident's legal and designated representative of a facility-initiated transfer. The notice must include:

(1) the effective date of the proposed transfer;

(2) the proposed transfer location;

(3) a statement that the resident may refuse the proposed transfer, and may discuss any consequences of a refusal with staff of the facility;

(4) the name and contact information of a person employed by the facility with whom the resident may discuss the notice of transfer; and

(5) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

(b) Notwithstanding paragraph (a), a facility may conduct a facility-initiated transfer of a resident with less than 30 days' written notice if the transfer is necessary due to:

(1) conditions that render the resident's room or private living unit uninhabitable;

(2) the resident's urgent medical needs; or

(3) a risk to the health or safety of another resident of the facility.

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

Sec. 47. Minnesota Statutes 2020, section 144G.56, subdivision 5, is amended to read:

Subd. 5. **Changes in facility operations.** (a) In situations where there is a curtailment, reduction, or capital improvement within a facility necessitating transfers, the facility must:

(1) minimize the number of transfers it initiates to complete the project or change in operations;

(2) consider individual resident needs and preferences;

(3) provide reasonable accommodations for individual resident requests regarding the transfers; and

(4) in advance of any notice to any residents, legal representatives, or designated representatives, provide notice to the Office of Ombudsman for Long-Term Care and~~, when appropriate,~~ the Office of Ombudsman for Mental Health and Developmental Disabilities of the curtailment, reduction, or capital improvement and the corresponding needed transfers.

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

Sec. 48. Minnesota Statutes 2020, section 144G.57, subdivision 1, is amended to read:

Subdivision 1. **Closure plan required.** In the event that an assisted living facility elects to voluntarily close the facility, the facility must notify the commissioner ~~and~~, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities in writing by submitting a proposed closure plan.

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

Sec. 49. Minnesota Statutes 2020, section 144G.57, subdivision 3, is amended to read:

Subd. 3. **Commissioner's approval required prior to implementation.** (a) The plan shall be subject to the commissioner's approval and subdivision 6. The facility shall take no action to close the residence prior to the commissioner's approval of the plan. The commissioner shall approve or otherwise respond to the plan as soon as practicable.

(b) The commissioner may require the facility to work with a transitional team comprised of department staff, staff of the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, and other professionals the commissioner deems necessary to assist in the proper relocation of residents.

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

Sec. 50. Minnesota Statutes 2020, section 144G.57, subdivision 5, is amended to read:

Subd. 5. **Notice to residents.** After the commissioner has approved the relocation plan and at least 60 calendar days before closing, except as provided under subdivision 6, the facility must notify residents, designated representatives, and legal representatives of the closure, the proposed date of closure, the contact information of the ombudsman for long-term care and the ombudsman for mental health and developmental disabilities, and that the facility will follow the termination planning requirements under section 144G.55, and final accounting and return requirements under section 144G.42, subdivision 5. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must also provide this information to the resident's case manager.

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

Sec. 51. Minnesota Statutes 2020, section 144G.70, subdivision 2, is amended to read:

Subd. 2. **Initial reviews, assessments, and monitoring.** (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.

(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.

(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.

(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.

(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

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

Sec. 52. Minnesota Statutes 2020, section 144G.70, subdivision 4, is amended to read:

Subd. 4. **Service plan, implementation, and revisions to service plan.** (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.

(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided.

The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

(c) The facility must implement and provide all services required by the current service plan.

(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.

(e) Staff providing services must be informed of the current written service plan.

(f) The service plan must include:

(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;

(2) the identification of staff or categories of staff who will provide the services;

(3) the schedule and methods of monitoring assessments of the resident;

(4) the schedule and methods of monitoring staff providing services; and

(5) a contingency plan that includes:

(i) the action to be taken if the scheduled service cannot be provided;

(ii) information and a method to contact the facility;

(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and

(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

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

Sec. 53. Minnesota Statutes 2020, section 144G.80, subdivision 2, is amended to read:

Subd. 2. **Demonstrated capacity.** (a) An applicant for licensure as an assisted living facility with dementia care must have the ability to provide services in a manner that is

consistent with the requirements in this section. The commissioner shall consider the following criteria, including, but not limited to:

(1) the experience of the ~~applicant in~~ applicant's assisted living director, managerial official, and clinical nurse supervisor managing residents with dementia or previous long-term care experience; and

(2) the compliance history of the applicant in the operation of any care facility licensed, certified, or registered under federal or state law.

(b) If the ~~applicant does~~ applicant's assisted living director and clinical nurse supervisor do not have experience in managing residents with dementia, the applicant must employ a consultant for at least the first six months of operation. The consultant must meet the requirements in paragraph (a), clause (1), and make recommendations on providing dementia care services consistent with the requirements of this chapter. The consultant must (1) have two years of work experience related to dementia, health care, gerontology, or a related field, and (2) have completed at least the minimum core training requirements in section 144G.64. The applicant must document an acceptable plan to address the consultant's identified concerns and must either implement the recommendations or document in the plan any consultant recommendations that the applicant chooses not to implement. The commissioner must review the applicant's plan upon request.

(c) The commissioner shall conduct an on-site inspection prior to the issuance of an assisted living facility with dementia care license to ensure compliance with the physical environment requirements.

(d) The label "Assisted Living Facility with Dementia Care" must be identified on the license.

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

Sec. 54. Minnesota Statutes 2020, section 144G.90, subdivision 1, is amended to read:

Subdivision 1. **Assisted living bill of rights; notification to resident.** (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand.

(b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse:

"If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may ~~also~~ contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."

(c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint.

(d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record.

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

Sec. 55. Minnesota Statutes 2020, section 144G.90, is amended by adding a subdivision to read:

Subd. 6. **Notice to residents.** For any notice to a resident, legal representative, or designated representative provided under this chapter or under Minnesota Rules, chapter 4659, that is required to include information regarding the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, the notice must contain the following language: "You may contact the Ombudsman for Long-Term Care for questions about your rights as an assisted living facility resident and to request advocacy services. As an assisted living facility resident, you may contact the Ombudsman for Mental Health and Developmental Disabilities to request advocacy regarding your rights, concerns, or questions on issues relating to services for mental health, developmental disabilities, or chemical dependency."

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

Sec. 56. Minnesota Statutes 2020, section 144G.91, subdivision 13, is amended to read:

Subd. 13. **Personal and treatment privacy.** (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or ~~where clearly inadvisable or~~ unless otherwise documented in the resident's service plan.

(b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan.

(c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.

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

Sec. 57. Minnesota Statutes 2020, section 144G.91, subdivision 21, is amended to read:

Subd. 21. **Access to counsel and advocacy services.** Residents have the right to the immediate access by:

(1) the resident's legal counsel;

(2) any representative of the protection and advocacy system designated by the state under Code of Federal Regulations, title 45, section 1326.21; or

(3) any representative of the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities.

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

Sec. 58. Minnesota Statutes 2020, section 144G.92, subdivision 1, is amended to read:

Subdivision 1. **Retaliation prohibited.** A facility or agent of a facility may not retaliate against a resident or employee if the resident, employee, or any person acting on behalf of the resident:

(1) files a good faith complaint or grievance, makes a good faith inquiry, or asserts any right;

(2) indicates a good faith intention to file a complaint or grievance, make an inquiry, or assert any right;

(3) files, in good faith, or indicates an intention to file a maltreatment report, whether mandatory or voluntary, under section 626.557;

(4) seeks assistance from or reports a reasonable suspicion of a crime or systemic problems or concerns to the director or manager of the facility, the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, a regulatory or other government agency, or a legal or advocacy organization;

(5) advocates or seeks advocacy assistance for necessary or improved care or services or enforcement of rights under this section or other law;

(6) takes or indicates an intention to take civil action;

(7) participates or indicates an intention to participate in any investigation or administrative or judicial proceeding;

(8) contracts or indicates an intention to contract to receive services from a service provider of the resident's choice other than the facility; or

(9) places or indicates an intention to place a camera or electronic monitoring device in the resident's private space as provided under section 144.6502.

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

Sec. 59. Minnesota Statutes 2020, section 144G.93, is amended to read:

144G.93 CONSUMER ADVOCACY AND LEGAL SERVICES.

Upon execution of an assisted living contract, every facility must provide the resident with the names and contact information, including telephone numbers and e-mail addresses, of:

(1) nonprofit organizations that provide advocacy or legal services to residents including but not limited to the designated protection and advocacy organization in Minnesota that provides advice and representation to individuals with disabilities; and

(2) the Office of Ombudsman for Long-Term Care~~, including both the state and regional contact information~~ and the Office of Ombudsman for Mental Health and Developmental Disabilities.

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

Sec. 60. Minnesota Statutes 2020, section 144G.95, is amended to read:

144G.95 OFFICE OF OMBUDSMAN FOR LONG-TERM CARE AND OFFICE OF OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES.

Subdivision 1. **Immunity from liability.** (a) The Office of Ombudsman for Long-Term Care and representatives of the office are immune from liability for conduct described in section 256.9742, subdivision 2.

(b) The Office of Ombudsman for Mental Health and Developmental Disabilities and representatives of the office are immune from liability for conduct described in section 245.96.

Subd. 2. **Data classification.** (a) All forms and notices received by the Office of Ombudsman for Long-Term Care under this chapter are classified under section 256.9744.

(b) All data collected or received by the Office of Ombudsman for Mental Health and Developmental Disabilities are classified under section 245.94.

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

Sec. 61. **[145.267] FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION GRANTS.**

(a) The commissioner of health shall award a grant to a statewide organization that focuses solely on prevention of and intervention with fetal alcohol spectrum disorders. The grant recipient must make subgrants to eligible regional collaboratives in rural and urban areas of the state for the purposes specified in paragraph (c).

(b) "Eligible regional collaboratives" means a partnership between at least one local government or Tribal government and at least one community-based organization and, where available, a family home visiting program. For purposes of this paragraph, a local government includes a county or a multicounty organization, a county-based purchasing entity, or a community health board.

(c) Eligible regional collaboratives must use subgrant funds to reduce the incidence of fetal alcohol spectrum disorders and other prenatal drug-related effects in children in Minnesota by identifying and serving pregnant women suspected of or known to use or abuse alcohol or other drugs. Eligible regional collaboratives must provide intensive services to chemically dependent women to increase positive birth outcomes.

(d) An eligible regional collaborative that receives a subgrant under this section must report to the grant recipient by January 15 of each year on the services and programs funded by the subgrant. The report must include measurable outcomes for the previous year, including the number of pregnant women served and the number of toxin-free babies born. The grant recipient must compile the information in the subgrant reports and submit a summary report to the commissioner of health by February 15 of each year.

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

Sec. 62. Minnesota Statutes 2021 Supplement, section 245C.03, subdivision 5a, is amended to read:

Subd. 5a. **Facilities serving children or adults licensed or regulated by the Department of Health.** (a) Except as specified in paragraph (b), 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.~~.~~; and

(6) license applicants, owners, managerial officials, and controlling individuals who are required under section 144A.476, subdivision 1, or 144G.13, subdivision 1, to undergo a background study under this chapter, regardless of the licensure status of the license applicant, owner, managerial official, or controlling individual.

(b) The commissioner of human services shall not conduct a background study on any individual identified in paragraph (a), clauses (1) to (5), if the individual has a valid license issued by a health-related licensing board as defined in section 214.01, subdivision 2, and has completed the criminal background check as required in section 214.075. An entity that is affiliated with individuals who meet the requirements of this paragraph must separate those individuals from the entity's roster for NETStudy 2.0.

(c) 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)~~ (d) 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.

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

Sec. 63. Minnesota Statutes 2020, section 245C.31, subdivision 1, is amended to read:

Subdivision 1. **Board determines disciplinary or corrective action.** (a) ~~When the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the commissioner determines that the regulated individual is responsible for substantiated maltreatment under section 626.557 or chapter 260E, instead of the commissioner making a decision regarding disqualification, the board shall make a determination whether to impose disciplinary or corrective action under chapter 214~~ The commissioner shall notify a health-related licensing board as defined in section 214.01,

subdivision 2, if the commissioner determines that an individual who is licensed by the health-related licensing board and who is included on the board's roster list provided in accordance with subdivision 3a is responsible for substantiated maltreatment under section 626.557 or chapter 260E, in accordance with subdivision 2. Upon receiving notification, the health-related licensing board shall make a determination as to whether to impose disciplinary or corrective action under chapter 214.

(b) This section does not apply to a background study of an individual regulated by a health-related licensing board if the individual's study is related to child foster care, adult foster care, or family child care licensure.

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

Sec. 64. Minnesota Statutes 2020, section 245C.31, subdivision 2, is amended to read:

Subd. 2. **Commissioner's notice to board.** ~~(a)~~ The commissioner shall notify ~~the~~ a health-related licensing board:

(1) ~~upon completion of a background study that produces~~ of a record showing that the individual licensed by the board was determined to have been responsible for substantiated maltreatment;

(2) upon the commissioner's completion of an investigation that determined ~~the~~ an individual licensed by the board was responsible for substantiated maltreatment; or

(3) upon receipt from another agency of a finding of substantiated maltreatment for which ~~the~~ an individual licensed by the board was responsible.

~~(b) The commissioner's notice to the health-related licensing board shall indicate whether the commissioner would have disqualified the individual for the substantiated maltreatment if the individual were not regulated by the board.~~

~~(c) The commissioner shall concurrently send the notice under this subdivision to the individual who is the subject of the background study.~~

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

Sec. 65. Minnesota Statutes 2020, section 245C.31, is amended by adding a subdivision to read:

Subd. 3a. **Agreements with health-related licensing boards.** The commissioner and each health-related licensing board shall enter into an agreement in order for each board to provide the commissioner with a daily roster list of individuals who have a license issued

by the board in active status. The list must include for each licensed individual the individual's name, aliases, date of birth, and license number; the date the license was issued; status of the license; and the last four digits of the individual's Social Security number.

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

Sec. 66. Minnesota Statutes 2020, section 245C.31, is amended by adding a subdivision to read:

Subd. 3b. **Maltreatment study; fees.** (a) The administrative service unit for the health-related licensing boards shall apportion between the health-related licensing boards that are required to submit a daily roster list in accordance with subdivision 3a an amount to be paid through an additional fee collected by each board in accordance with paragraph (b). The amount apportioned to each health-related licensing board must equal the board's share of the annual appropriation from the state government special revenue fund to the commissioner of human services to conduct the maltreatment studies on licensees who are listed on the daily roster lists and to comply with the notification requirement under subdivision 2. Each board's apportioned share must be based on the number of licensees that each health-related licensing board licenses as a percentage of the total number of licensees licensed collectively by all health-related licensing boards.

(b) Each health-related licensing board may collect an additional fee from a licensee at the time the initial license fee is collected to compensate for the amount apportioned to each board by the administrative services unit. If an additional fee is collected by the health-related licensing board under this paragraph, the fee must be deposited in the state government special revenue fund.

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

Sec. 67. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 33, is amended to read:

Subd. 33. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	4,273,000	4,274,000
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.** $2,000,000 in fiscal year 2022 and $2,000,000 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. The general fund base for this appropriation is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025

(c) **Base Level Adjustment.** The general fund base is ~~$4,636,000~~ $3,886,000 in fiscal year 2024 and ~~$2,636,000~~ $1,886,000 in fiscal year 2025. The opiate epidemic response fund base is $500,000 in fiscal year 2024 and $0 in fiscal year 2025.

Sec. 68. Laws 2021, First Special Session chapter 7, article 16, section 3, subdivision 2, is amended to read:

Subd. 2. **Health Improvement**

	Appropriations by Fund	
General	123,714,000	124,000,000
State Government Special Revenue	11,967,000	11,290,000
Health Care Access	37,512,000	36,832,000
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) **Tribal Public Health Grants.** $500,000 in fiscal year 2022 and $500,000 in fiscal year 2023 are from the general fund for Tribal public health grants under Minnesota Statutes, section 145A.14, for public health infrastructure projects as defined by the Tribal government.

(d) **Public Health Infrastructure Funds.** $6,000,000 in fiscal year 2022 and $6,000,000 in fiscal year 2023 are from the general fund for public health infrastructure funds to distribute to community health boards and Tribal governments to support their ability to meet national public health standards.

(e) **Public Health System Assessment and Oversight.** $1,500,000 in fiscal year 2022 and $1,500,000 in fiscal year 2023 are from the general fund for the commissioner to assess the capacity of the public health system to meet national public health standards and

oversee public health system improvement efforts.

(f) **Health Professional Education Loan Forgiveness.** Notwithstanding the priorities and distribution requirements under Minnesota Statutes, section 144.1501, $3,000,000 in fiscal year 2022 and $3,000,000 in fiscal year 2023 are from the general fund for loan forgiveness under article 3, section 43, for individuals who are eligible alcohol and drug counselors, eligible medical residents, or eligible mental health professionals, as defined in article 3, section 43. The general fund base for this appropriation is $2,625,000 in fiscal year 2024 and $0 in fiscal year 2025. The health care access fund base for this appropriation is $875,000 in fiscal year 2024, $3,500,000 in fiscal year 2025, and $0 in fiscal year 2026. The general fund amounts in this paragraph are available until March 31, 2024. This paragraph expires on April 1, 2024.

(g) **Mental Health Cultural Community Continuing Education Grant Program.** $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. This is a onetime appropriation

(h) **Birth Records; Homeless Youth.** $72,000 in fiscal year 2022 and $32,000 in fiscal year 2023 are from the state government special revenue 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.

(i) **Supporting Healthy Development of Babies During Pregnancy and Postpartum.** $260,000 in fiscal year 2022 and $260,000 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. This is a onetime appropriation and is available until June 30, 2023.

(j) **Dignity in Pregnancy and Childbirth.** $494,000 in fiscal year 2022 and $200,000 in fiscal year 2023 are from the general fund for purposes of Minnesota Statutes, section 144.1461. Of this appropriation: (1) $294,000 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); and (2) $200,000 in fiscal year 2022 and $200,000 in fiscal year 2023 are for purposes of

Minnesota Statutes, section 144.1461, subdivision 3.

(k) **Congenital Cytomegalovirus (CMV).** (1) $196,000 in fiscal year 2022 and $196,000 in fiscal year 2023 are from the general fund for outreach and education on congenital cytomegalovirus (CMV) under Minnesota Statutes, section 144.064.

(2) Contingent on the Advisory Committee on Heritable and Congenital Disorders recommending and the commissioner of health approving inclusion of CMV in the newborn screening panel in accordance with Minnesota Statutes, section 144.065, subdivision 3, paragraph (d), $656,000 in fiscal year 2023 is from the state government special revenue fund for follow-up services.

(l) **Nonnarcotic Pain Management and Wellness.** $649,000 in fiscal year 2022 is from the general fund for nonnarcotic pain management and wellness in accordance with Laws 2019, chapter 63, article 3, section 1, paragraph (n).

(m) **Base Level Adjustments.** The general fund base is ~~$120,451,000~~ $121,201,000 in fiscal year 2024 and ~~$115,594,000~~ $116,344,000 in fiscal year 2025, of which $750,000 in fiscal year 2024 and $750,000 in fiscal year 2025 are for fetal alcohol spectrum disorders prevention grants under Minnesota Statutes, section 145.267. The health care access fund base is $38,385,000 in fiscal year 2024 and $40,644,000 in fiscal year 2025.

Sec. 69. **DIRECTION TO COMMISSIONER OF HEALTH; J-1 VISA WAIVER PROGRAM RECOMMENDATION.**

(a) For purposes of this section:

(1) "Department of Health recommendation" means a recommendation from the state Department of Health that a foreign medical graduate should be considered for a J-1 visa waiver under the J-1 visa waiver program; and

(2) "J-1 visa waiver program" means a program administered by the United States Department of State under United States Code, title 8, section 1184(l), in which a waiver is sought for the requirement that a foreign medical graduate with a J-1 visa must return to the graduate's home country for two years at the conclusion of the graduate's medical study before applying for employment authorization in the United States.

(b) In administering the program to issue Department of Health recommendations for purposes of the J-1 visa waiver program, the commissioner of health shall allow an applicant to submit to the commissioner evidence that the foreign medical graduate for whom the waiver is sought is licensed to practice medicine in Minnesota in place of evidence that the foreign medical graduate has passed steps 1, 2, and 3 of the United States Medical Licensing Examination.

Sec. 70. **APPROPRIATION; ELIMINATION OF DUPLICATIVE BACKGROUND STUDIES.**

$522,000 in fiscal year 2023 is appropriated from the state government special revenue fund to the commissioner of human services to implement provisions to eliminate duplicative background studies. The state government special revenue fund base for this appropriation is $334,000 in fiscal year 2024, $574,000 in fiscal year 2025, $170,000 in fiscal year 2026, and $170,000 in fiscal year 2027.

Sec. 71. **REVISOR INSTRUCTION.**

The revisor of statutes shall make any necessary cross-reference changes required as a result of the amendments in this article to Minnesota Statutes, sections 144A.01; 144A.03, subdivision 1; 144A.04, subdivisions 4 and 6; and 144A.06.

Sec. 72. **REPEALER.**

(a) Minnesota Statutes 2020, section 254A.21, is repealed effective July 1, 2023.

(b) Minnesota Statutes 2021 Supplement, section 144G.07, subdivision 6, is repealed.

ARTICLE 2
HEALTH CARE

Section 1. Minnesota Statutes 2020, section 62J.2930, subdivision 3, is amended to read:

Subd. 3. **Consumer information.** (a) The information clearinghouse or another entity designated by the commissioner shall provide consumer information to health plan company enrollees to:

(1) assist enrollees in understanding their rights;

(2) explain and assist in the use of all available complaint systems, including internal complaint systems within health carriers, community integrated service networks, and the Departments of Health and Commerce;

(3) provide information on coverage options in each region of the state;

(4) provide information on the availability of purchasing pools and enrollee subsidies; and

(5) help consumers use the health care system to obtain coverage.

(b) The information clearinghouse or other entity designated by the commissioner for the purposes of this subdivision shall not:

(1) provide legal services to consumers;

(2) represent a consumer or enrollee; or

(3) serve as an advocate for consumers in disputes with health plan companies.

(c) Nothing in this subdivision shall interfere with the ombudsman program established under section ~~256B.69, subdivision 20~~ 256B.6903, or other existing ombudsman programs.

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

Sec. 2. Minnesota Statutes 2020, section 152.125, is amended to read:

152.125 INTRACTABLE PAIN.

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

(b) "Drug diversion" means the unlawful transfer of prescription drugs from their licit medical purpose to the illicit marketplace.

(c) "Intractable pain" means a pain state in which the cause of the pain cannot be removed or otherwise treated with the consent of the patient and in which, in the generally accepted

course of medical practice, no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts. Conditions associated with intractable pain may include cancer and the recovery period, sickle cell disease, noncancer pain, rare diseases, orphan diseases, severe injuries, and health conditions requiring the provision of palliative care or hospice care. Reasonable efforts for relieving or curing the cause of the pain may be determined on the basis of, but are not limited to, the following:

(1) when treating a nonterminally ill patient for intractable pain, an evaluation conducted by the attending physician, advanced practice registered nurse, or physician assistant and one or more physicians, advanced practice registered nurses, or physician assistants specializing in pain medicine or the treatment of the area, system, or organ of the body confirmed or perceived as the source of the intractable pain; or

(2) when treating a terminally ill patient, an evaluation conducted by the attending physician, advanced practice registered nurse, or physician assistant who does so in accordance with the standard of care and the level of care, skill, and treatment that would be recognized by a reasonably prudent physician, advanced practice registered nurse, or physician assistant under similar conditions and circumstances.

(d) "Palliative care" has the meaning given in section 144A.75, subdivision 12.

(e) "Rare disease" means a disease, disorder, or condition that affects fewer than 200,000 individuals in the United States and is chronic, serious, life altering, or life threatening.

Subd. 1a. **Criteria for the evaluation and treatment of intractable pain.** The evaluation and treatment of intractable pain when treating a nonterminally ill patient is governed by the following criteria:

(1) a diagnosis of intractable pain by the treating physician, advanced practice registered nurse, or physician assistant and either by a physician, advanced practice registered nurse, or physician assistant specializing in pain medicine or a physician, advanced practice registered nurse, or physician assistant treating the area, system, or organ of the body that is the source of the pain is sufficient to meet the definition of intractable pain; and

(2) the cause of the diagnosis of intractable pain must not interfere with medically necessary treatment, including but not limited to prescribing or administering a controlled substance in Schedules II to V of section 152.02.

Subd. 2. **Prescription and administration of controlled substances for intractable pain.** (a) Notwithstanding any other provision of this chapter, a physician, advanced practice registered nurse, or physician assistant may prescribe or administer a controlled substance

in Schedules II to V of section 152.02 to ~~an individual~~ a patient in the course of the physician's, advanced practice registered nurse's, or physician assistant's treatment of the ~~individual~~ patient for a diagnosed condition causing intractable pain. No physician, advanced practice registered nurse, or physician assistant shall be subject to disciplinary action by the Board of Medical Practice or Board of Nursing for appropriately prescribing or administering a controlled substance in Schedules II to V of section 152.02 in the course of treatment of ~~an individual~~ a patient for intractable pain, provided the physician, advanced practice registered nurse, or physician assistant:

(1) keeps accurate records of the purpose, use, prescription, and disposal of controlled substances, writes accurate prescriptions, and prescribes medications in conformance with chapter 147~~.~~ or 148 or in accordance with the current standard of care; and

(2) enters into a patient-provider agreement that meets the criteria in subdivision 5.

(b) No physician, advanced practice registered nurse, or physician assistant, acting in good faith and based on the needs of the patient, shall be subject to disenrollment or termination by the commissioner of health solely for prescribing a dosage that equates to an upward deviation from morphine milligram equivalent dosage recommendations or thresholds specified in state or federal opioid prescribing guidelines or policies, including but not limited to the Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention and Minnesota opioid prescribing guidelines.

(c) A physician, advanced practice registered nurse, or physician assistant treating intractable pain by prescribing, dispensing, or administering a controlled substance in Schedules II to V of section 152.02 that includes but is not limited to opioid analgesics must not taper a patient's medication dosage solely to meet a predetermined morphine milligram equivalent dosage recommendation or threshold if the patient is stable and compliant with the treatment plan, is experiencing no serious harm from the level of medication currently being prescribed or previously prescribed, and is in compliance with the patient-provider agreement as described in subdivision 5.

(d) A physician's, advanced practice registered nurse's, or physician assistant's decision to taper a patient's medication dosage must be based on factors other than a morphine milligram equivalent recommendation or threshold.

(e) No pharmacist, health plan company, or pharmacy benefit manager shall refuse to fill a prescription for an opiate issued by a licensed practitioner with the authority to prescribe opiates solely based on the prescription exceeding a predetermined morphine milligram equivalent dosage recommendation or threshold. Health plan companies that participate in

Minnesota health care programs under chapters 256B and 256L, and pharmacy benefit managers under contract with these health plan companies, must comply with section 1004 of the federal SUPPORT Act, Public Law 115-271, when providing services to medical assistance and MinnesotaCare enrollees.

Subd. 3. **Limits on applicability.** This section does not apply to:

(1) a physician's, advanced practice registered nurse's, or physician assistant's treatment of ~~an individual~~ a patient 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~~ a patient whom the physician, advanced practice registered nurse, or physician assistant knows to be using the controlled substances for nontherapeutic or drug diversion 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~~ a patient 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.

Subd. 4. **Notice of risks.** Prior to treating ~~an individual~~ a patient for intractable pain in accordance with subdivision 2, a physician, advanced practice registered nurse, or physician assistant shall discuss with the ~~individual~~ patient or the patient's legal guardian, if applicable, the risks associated with the controlled substances in Schedules II to V of section 152.02 to be prescribed or administered in the course of the physician's, advanced practice registered nurse's, or physician assistant's treatment of ~~an individual~~ a patient, and document the discussion in the ~~individual's~~ patient's record as required in the patient-provider agreement described in subdivision 5.

Subd. 5. **Patient-provider agreement.** (a) Before treating a patient for intractable pain, a physician, advanced practice registered nurse, or physician assistant and the patient or the patient's legal guardian, if applicable, must mutually agree to the treatment and enter into a provider-patient agreement. The agreement must include a description of the prescriber's and the patient's expectations, responsibilities, and rights according to best practices and current standards of care.

(b) The agreement must be signed by the patient or the patient's legal guardian, if applicable, and the physician, advanced practice registered nurse, or physician assistant and included in the patient's medical records. A copy of the signed agreement must be provided to the patient.

(c) The agreement must be reviewed by the patient and the physician, advanced practice registered nurse, or physician assistant annually. If there is a change in the patient's treatment plan, the agreement must be updated and a revised agreement must be signed by the patient or the patient's legal guardian. A copy of the revised agreement must be included in the patient's medical record and a copy must be provided to the patient.

(d) Absent clear evidence of drug diversion, nonadherence with the agreement must not be used as the sole reason to stop a patient's treatment with scheduled drugs. If a patient experiences difficulty adhering to the agreement, the prescriber must evaluate the patient for other conditions, including but not limited to substance use disorder, and must ensure that the patient's course of treatment is appropriately adjusted to reflect any change in diagnosis.

(e) A patient-provider agreement is not required in an emergency or inpatient hospital setting.

Sec. 3. Minnesota Statutes 2021 Supplement, section 256B.0371, subdivision 4, as amended by Laws 2022, chapter 55, article 1, section 128, is amended to read:

Subd. 4. **Dental utilization report.** (a) The commissioner shall submit an annual report beginning March 15, 2022, and ending March 15, 2026, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance that includes the percentage for adults and children one through 20 years of age for the most recent complete calendar year receiving at least one dental visit for both fee-for-service and the prepaid medical assistance program. The report must include:

(1) statewide utilization for both fee-for-service and for the prepaid medical assistance program;

(2) utilization by county;

(3) utilization by children receiving dental services through fee-for-service and through a managed care plan or county-based purchasing plan; and

(4) utilization by adults receiving dental services through fee-for-service and through a managed care plan or county-based purchasing plan.

(b) The report must also include a description of any corrective action plans required to be submitted under subdivision 2.

(c) The initial report due on March 15, 2022, must include the utilization metrics described in paragraph (a) for each of the following calendar years: 2017, 2018, 2019, and 2020.

(d) In the annual report due on March 15, 2023, and in each report due thereafter, the commissioner shall include the following:

(1) the number of dentists enrolled with the commissioner as a medical assistance dental provider and the congressional district or districts in which the dentist provides services;

(2) the number of enrolled dentists who provided fee-for-service dental services to medical assistance or MinnesotaCare patients within the previous calendar year in the following increments: one to nine patients, ten to 100 patients, and over 100 patients;

(3) the number of enrolled dentists who provided dental services to medical assistance or MinnesotaCare patients through a managed care plan or county-based purchasing plan within the previous calendar year in the following increments: one to nine patients, ten to 100 patients, and over 100 patients; and

(4) the number of dentists who provided dental services to a new patient who was enrolled in medical assistance or MinnesotaCare within the previous calendar year.

(e) The report due on March 15, 2023, must include the metrics described in paragraph (d) for each of the following years: 2017, 2018, 2019, 2020, and 2021.

Sec. 4. Minnesota Statutes 2020, section 256B.055, subdivision 2, is amended to read:

Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible for or receiving foster care maintenance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, and for a child who is not eligible for Title IV-E of the Social Security Act but who is ~~determined eligible for~~ placed in foster care as determined by Minnesota Statutes or receiving kinship assistance under chapter 256N.

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

Sec. 5. Minnesota Statutes 2020, section 256B.056, subdivision 3b, is amended to read:

Subd. 3b. **Treatment of trusts.** (a) It is the public policy of this state that individuals use all available resources to pay for the cost of long-term care services, as defined in section 256B.0595, before turning to Minnesota health care program funds, and that trust instruments

should not be permitted to shield available resources of an individual or an individual's spouse from such use.

~~(a)~~ (b) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with a developmental disability living in an intermediate care facility for persons with developmental disabilities; or (3) a trust set up by a person with payments made by the Social Security Administration pursuant to the United States Supreme Court decision in Sullivan v. Zebley, 110 S. Ct. 885 (1990). The maximum amount of payments that a trustee of a medical assistance qualifying trust may make to a person under the terms of the trust is considered to be available assets to the person, without regard to whether the trustee actually makes the maximum payments to the person and without regard to the purpose for which the medical assistance qualifying trust was established.

~~(b)~~ (c) Trusts established after August 10, 1993, are treated according to United States Code, title 42, section 1396p(d).

~~(c)~~ (d) For purposes of paragraph ~~(d)~~ (e), a pooled trust means a trust established under United States Code, title 42, section 1396p(d)(4)(C).

~~(d)~~ (e) A beneficiary's interest in a pooled trust is considered an available asset unless the trust provides that upon the death of the beneficiary or termination of the trust during the beneficiary's lifetime, whichever is sooner, the department receives any amount, up to the amount of medical assistance benefits paid on behalf of the beneficiary, remaining in the beneficiary's trust account after a deduction for reasonable administrative fees and expenses, and an additional remainder amount. The retained remainder amount of the subaccount must not exceed ten percent of the account value at the time of the beneficiary's death or termination of the trust, and must only be used for the benefit of disabled individuals who have a beneficiary interest in the pooled trust.

~~(e)~~ (f) Trusts may be established on or after December 12, 2016, by a person who has been determined to be disabled, according to United States Code, title 42, section 1396p(d)(4)(A), as amended by section 5007 of the 21st Century Cures Act, Public Law 114-255.

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

Sec. 6. Minnesota Statutes 2020, section 256B.056, subdivision 3c, is amended to read:

Subd. 3c. **Asset limitations for families and children.** (a) A household of two or more persons must not own more than $20,000 in total net assets, and a household of one person must not own more than $10,000 in total net assets. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business up to $200,000 are not considered;

(3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;

(4) assets designated as burial expenses are excluded to the same extent they are excluded by the Supplemental Security Income program;

(5) court-ordered settlements up to $10,000 are not considered;

(6) individual retirement accounts and funds are not considered;

(7) assets owned by children are not considered; and

(8) ~~effective July 1, 2009,~~ certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(b) ~~Beginning January 1, 2014, this subdivision~~ Paragraph (a) applies only to parents and caretaker relatives who qualify for medical assistance under subdivision 5.

(c) Eligibility for children under age 21 must be determined without regard to the asset limitations described in paragraphs (a) and (b) and subdivision 3.

Sec. 7. Minnesota Statutes 2020, section 256B.056, subdivision 11, is amended to read:

Subd. 11. **Treatment of annuities.** (a) Any person requesting medical assistance payment of long-term care services shall provide a complete description of any interest either the person or the person's spouse has in annuities on a form designated by the department. The

form shall include a statement that the state becomes a preferred remainder beneficiary of annuities or similar financial instruments by virtue of the receipt of medical assistance payment of long-term care services. The person and the person's spouse shall furnish the agency responsible for determining eligibility with complete current copies of their annuities and related documents and complete the form designating the state as the preferred remainder beneficiary for each annuity in which the person or the person's spouse has an interest.

(b) The department shall provide notice to the issuer of the department's right under this section as a preferred remainder beneficiary under the annuity or similar financial instrument for medical assistance furnished to the person or the person's spouse, and provide notice of the issuer's responsibilities as provided in paragraph (c).

(c) An issuer of an annuity or similar financial instrument who receives notice of the state's right to be named a preferred remainder beneficiary as described in paragraph (b) shall provide confirmation to the requesting agency that the state has been made a preferred remainder beneficiary. The issuer shall also notify the county agency when a change in the amount of income or principal being withdrawn from the annuity or other similar financial instrument or a change in the state's preferred remainder beneficiary designation under the annuity or other similar financial instrument occurs. The county agency shall provide the issuer with the name, address, and telephone number of a unit within the department that the issuer can contact to comply with this paragraph.

(d) "Preferred remainder beneficiary" for purposes of this subdivision and sections 256B.0594 and 256B.0595 means the state is a remainder beneficiary in the first position in an amount equal to the amount of medical assistance paid on behalf of the institutionalized person, or is a remainder beneficiary in the second position if the institutionalized person designates and is survived by a remainder beneficiary who is (1) a spouse who does not reside in a medical institution, (2) a minor child, or (3) a child of any age who is blind or permanently and totally disabled as defined in the Supplemental Security Income program. Notwithstanding this paragraph, the state is the remainder beneficiary in the first position if the spouse or child disposes of the remainder for less than fair market value.

(e) For purposes of this subdivision, "institutionalized person" and "long-term care services" have the meanings given in section 256B.0595, subdivision 1, paragraph ~~(g)~~ (f).

(f) For purposes of this subdivision, "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with developmental disabilities, nursing facility, or inpatient hospital.

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

Sec. 8. Minnesota Statutes 2020, section 256B.0595, subdivision 1, is amended to read:

Subdivision 1. **Prohibited transfers.** (a) Effective for transfers made after August 10, 1993, an institutionalized person, an institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or institutionalized person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the Supplemental Security Income program, for the purpose of establishing or maintaining medical assistance eligibility. This applies to all transfers, including those made by a community spouse after the month in which the institutionalized spouse is determined eligible for medical assistance. For purposes of determining eligibility for long-term care services, any transfer of such assets within 36 months before or any time after an institutionalized person requests medical assistance payment of long-term care services, or 36 months before or any time after a medical assistance recipient becomes an institutionalized person, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the institutionalized person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the institutionalized person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4. In the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, or in the case of any other disposal of assets made on or after February 8, 2006, any transfers made within 60 months before or any time after an institutionalized person requests medical assistance payment of long-term care services and within 60 months before or any time after a medical assistance recipient becomes an institutionalized person, may be considered.

(b) This section applies to transfers, for less than fair market value, of income or assets, including assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments or income to which the institutionalized person or the institutionalized person's spouse is entitled but does not receive due to action by the institutionalized person, the institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or the institutionalized person's spouse.

(c) This section applies to payments for care or personal services provided by a relative, unless the compensation was stipulated in a notarized, written agreement ~~which~~ that was in existence when the service was performed, the care or services directly benefited the

person, and the payments made represented reasonable compensation for the care or services provided. A notarized written agreement is not required if payment for the services was made within 60 days after the service was provided.

~~(d) This section applies to the portion of any asset or interest that an institutionalized person, an institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or the institutionalized person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the institutionalized person or institutionalized person's spouse while alive, based on estimated life expectancy as determined according to the current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration. The commissioner may adopt rules reducing life expectancies based on the need for long-term care. This section applies to an annuity purchased on or after March 1, 2002, that:~~

~~(1) is not purchased from an insurance company or financial institution that is subject to licensing or regulation by the Minnesota Department of Commerce or a similar regulatory agency of another state;~~

~~(2) does not pay out principal and interest in equal monthly installments; or~~

~~(3) does not begin payment at the earliest possible date after annuitization.~~

~~(e)~~ (d) Effective for transactions, including the purchase of an annuity, occurring on or after February 8, 2006, by or on behalf of an institutionalized person who has applied for or is receiving long-term care services or the institutionalized person's spouse shall be treated as the disposal of an asset for less than fair market value unless the department is named a preferred remainder beneficiary as described in section 256B.056, subdivision 11. Any subsequent change to the designation of the department as a preferred remainder beneficiary shall result in the annuity being treated as a disposal of assets for less than fair market value. The amount of such transfer shall be the maximum amount the institutionalized person or the institutionalized person's spouse could receive from the annuity or similar financial instrument. Any change in the amount of the income or principal being withdrawn from the annuity or other similar financial instrument at the time of the most recent disclosure shall be deemed to be a transfer of assets for less than fair market value unless the institutionalized person or the institutionalized person's spouse demonstrates that the transaction was for fair market value. In the event a distribution of income or principal has been improperly distributed or disbursed from an annuity or other retirement planning instrument of an institutionalized person or the institutionalized person's spouse, a cause of action exists

against the individual receiving the improper distribution for the cost of medical assistance services provided or the amount of the improper distribution, whichever is less.

~~(f)~~ (e) Effective for transactions, including the purchase of an annuity, occurring on or after February 8, 2006, by or on behalf of an institutionalized person applying for or receiving long-term care services shall be treated as a disposal of assets for less than fair market value unless it is:

(1) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(2) purchased with proceeds from:

(i) an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal Revenue Code;

(ii) a simplified employee pension within the meaning of section 408(k) of the Internal Revenue Code; or

(iii) a Roth IRA described in section 408A of the Internal Revenue Code; or

(3) an annuity that is irrevocable and nonassignable; is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration; and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

~~(g)~~ (f) For purposes of this section, long-term care services include services in a nursing facility, services that are eligible for payment according to section 256B.0625, subdivision 2, because they are provided in a swing bed, intermediate care facility for persons with developmental disabilities, and home and community-based services provided pursuant to chapter 256S and sections 256B.092 and 256B.49. For purposes of this subdivision and subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in a nursing facility or in a swing bed, or intermediate care facility for persons with developmental disabilities or who is receiving home and community-based services under chapter 256S and sections 256B.092 and 256B.49.

~~(h)~~ (g) This section applies to funds used to purchase a promissory note, loan, or mortgage unless the note, loan, or mortgage:

(1) has a repayment term that is actuarially sound;

(2) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(3) prohibits the cancellation of the balance upon the death of the lender.

(h) In the case of a promissory note, loan, or mortgage that does not meet an exception in paragraph (g), clauses (1) to (3), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the institutionalized person's request for medical assistance payment of long-term care services.

(i) This section applies to the purchase of a life estate interest in another person's home unless the purchaser resides in the home for a period of at least one year after the date of purchase.

(j) This section applies to transfers into a pooled trust that qualifies under United States Code, title 42, section 1396p(d)(4)(C), by:

(1) a person age 65 or older or the person's spouse; or

(2) any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of a person age 65 or older or the person's spouse.

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

Sec. 9. Minnesota Statutes 2020, section 256B.0625, subdivision 64, is amended to read:

Subd. 64. **Investigational drugs, biological products, devices, and clinical trials.** Medical assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do not cover ~~the costs of any services that are incidental to, associated with, or resulting from the use of~~ investigational drugs, biological products, or devices as defined in section 151.375 or any other treatment that is part of an approved clinical trial as defined in section 62Q.526. Participation of an enrollee in an approved clinical trial does not preclude coverage of medically necessary services covered under this chapter that are not related to the approved clinical trial. Any items or services that are provided solely to satisfy data collection and analysis for a clinical trial, and not for direct clinical management of the enrollee, are not covered.

Sec. 10. Minnesota Statutes 2021 Supplement, 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' 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.

(e) No physician, advanced practice registered nurse, or physician assistant, acting in good faith based on the needs of the patient, may be disenrolled by the commissioner of human services solely for prescribing a dosage that equates to an upward deviation from morphine milligram equivalent dosage recommendations specified in state or federal opioid prescribing guidelines or policies, or quality improvement thresholds established under this section.

Sec. 11. Minnesota Statutes 2021 Supplement, section 256B.69, subdivision 9f, is amended to read:

Subd. 9f. **Annual report on provider reimbursement rates.** (a) The commissioner, by December 15 of each year, ~~beginning December 15, 2021,~~ 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.

(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 if within the county there are more than three medical assistance enrolled providers providing the specific service within the specific category:

(1) physician prenatal services;

(2) physician preventive services;

(3) physician services other than prenatal or preventive;

(4) dental services;

(5) inpatient hospital services;

(6) outpatient hospital services; ~~and~~

(7) mental health services; and

(8) substance use disorder 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. 12. **[256B.6903] OMBUDSPERSON FOR MANAGED CARE.**

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

(b) "Adverse benefit determination" has the meaning provided in Code of Federal Regulations, title 42, section 438.400, subpart (b).

(c) "Appeal" means an oral or written request from an enrollee to the managed care organization for review of an adverse benefit determination.

(d) "Commissioner" means the commissioner of human services.

(e) "Complaint" means an enrollee's informal expression of dissatisfaction about any matter relating to the enrollee's prepaid health plan other than an adverse benefit determination.

(f) "Data analyst" means the person employed by the ombudsperson that uses research methodologies to conduct research on data collected from prepaid health plans, including but not limited to scientific theory; hypothesis testing; survey research techniques; data collection; data manipulation; and statistical analysis interpretation, including multiple regression techniques.

(g) "Enrollee" means a person enrolled in a prepaid health plan under section 256B.69. When applicable, an enrollee includes an enrollee's authorized representative.

(h) "External review" means the process described under Code of Federal Regulations, title 42, section 438.408, subpart (f); and section 62Q.73, subdivision 2.

(i) "Grievance" means an enrollee's expression of dissatisfaction about any matter relating to the enrollee's prepaid health plan other than an adverse benefit determination that follows the procedures outlined in Code of Federal Regulations, title 42, part 438, subpart (f). A grievance may include but is not limited to concerns relating to quality of care, services provided, or failure to respect an enrollee's rights under a prepaid health plan.

(j) "Managed care advocate" means a county or Tribal employee who works with managed care enrollees when the enrollee has service, billing, or access problems with the enrollee's prepaid health plan.

(k) "Prepaid health plan" means a plan under contract with the commissioner according to section 256B.69.

(l) "State fair hearing" means the appeals process mandated under section 256.045, subdivision 3a.

Subd. 2. **Ombudsperson.** The commissioner must designate an ombudsperson to advocate for enrollees. At the time of enrollment in a prepaid health plan, the local agency must inform enrollees about the ombudsperson.

Subd. 3. **Duties and cost.** (a) The ombudsperson must work to ensure enrollees receive covered services as described in the enrollee's prepaid health plan by:

(1) providing assistance and education to enrollees, when requested, regarding covered health care benefits or services; billing and access; or the grievance, appeal, or state fair hearing processes;

(2) with the enrollee's permission and within the ombudsperson's discretion, using an informal review process to assist an enrollee with a resolution involving the enrollee's prepaid health plan's benefits;

(3) assisting enrollees, when requested, with prepaid health plan grievances, appeals, or the state fair hearing process;

(4) overseeing, reviewing, and approving documents used by enrollees relating to prepaid health plans' grievances, appeals, and state fair hearings;

(5) reviewing all state fair hearings and requests by enrollees for external review; overseeing entities under contract to provide external reviews, processes, and payments for services; and utilizing aggregated results of external reviews to recommend health care benefits policy changes; and

(6) providing trainings to managed care advocates.

(b) The ombudsperson must not charge an enrollee for the ombudsperson's services.

Subd. 4. **Powers.** In exercising the ombudsperson's authority under this section, the ombudsperson may:

(1) gather information and evaluate any practice, policy, procedure, or action by a prepaid health plan, state human services agency, county, or Tribe; and

(2) prescribe the methods by which complaints are to be made, received, and acted upon. The ombudsperson's authority under this clause includes but is not limited to:

(i) determining the scope and manner of a complaint;

(ii) holding a prepaid health plan accountable to address a complaint in a timely manner as outlined in state and federal laws;

(iii) requiring a prepaid health plan to respond in a timely manner to a request for data, case details, and other information as needed to help resolve a complaint or to improve a prepaid health plan's policy; and

(iv) making recommendations for policy, administrative, or legislative changes regarding prepaid health plans to the proper partners.

Subd. 5. **Data.** (a) The data analyst must review and analyze prepaid health plan data on denial, termination, and reduction notices (DTRs), grievances, appeals, and state fair hearings by:

(1) analyzing, reviewing, and reporting on DTRs, grievances, appeals, and state fair hearings data collected from each prepaid health plan;

(2) collaborating with the commissioner's partners and the Department of Health for the Triennial Compliance Assessment under Code of Federal Regulations, title 42, section 438.358, subpart (b);

(3) reviewing state fair hearing decisions for policy or coverage issues that may affect enrollees; and

(4) providing data required under Code of Federal Regulations, title 42, section 438.66 (2016), to the Centers for Medicare and Medicaid Services.

(b) The data analyst must share the data analyst's data observations and trends under this subdivision with the ombudsperson, prepaid health plans, and commissioner's partners.

Subd. 6. **Collaboration and independence.** (a) The ombudsperson must work in collaboration with the commissioner and the commissioner's partners when the ombudsperson's collaboration does not otherwise interfere with the ombudsperson's duties under this section.

(b) The ombudsperson may act independently of the commissioner when:

(1) providing information or testimony to the legislature; and

(2) contacting and making reports to federal and state officials.

Subd. 7. **Civil actions.** The ombudsperson is not civilly liable for actions 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.

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

Sec. 13. Minnesota Statutes 2020, section 256B.77, subdivision 13, is amended to read:

Subd. 13. **Ombudsman.** Enrollees shall have access to ombudsman services established in section ~~256B.69, subdivision 20~~ 256B.6903, and advocacy services provided by the ombudsman for mental health and developmental disabilities established in sections 245.91

to 245.97. The managed care ombudsman and the ombudsman for mental health and developmental disabilities shall coordinate services provided to avoid duplication of services. For purposes of the demonstration project, the powers and responsibilities of the Office of Ombudsman for Mental Health and Developmental Disabilities, as provided in sections 245.91 to 245.97 are expanded to include all eligible individuals, health plan companies, agencies, and providers participating in the demonstration project.

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

Sec. 14. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; ENTERAL NUTRITION AND SUPPLIES.**

Notwithstanding Minnesota Statutes, section 256B.766, paragraph (i), but subject to Minnesota Statutes, section 256B.766, paragraph (l), effective for dates of service on or after the effective date of this section through June 30, 2023, the commissioner of human services shall not adjust rates paid for enteral nutrition and supplies.

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

Sec. 15. **TEMPORARY TELEPHONE-ONLY TELEHEALTH AUTHORIZATION.**

Beginning July 1, 2021, and until the COVID-19 federal public health emergency ends or July 1, 2023, whichever is earlier, telehealth visits, as described in Minnesota Statutes, section 256B.0625, subdivision 3b, provided through telephone may satisfy the face-to-face requirements for reimbursement under the payment methods that apply to a federally qualified health center, rural health clinic, Indian health service, 638 Tribal clinic, and certified community behavioral health clinic, if the service would have otherwise qualified for payment if performed in person.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2021, and expires when the COVID-19 federal public health emergency ends or July 1, 2023, whichever is earlier. The commissioner of human services shall notify the revisor of statutes when this section expires.

Sec. 16. **REPEALER.**

(a) Minnesota Statutes 2020, section 256B.057, subdivision 7, is repealed on July 1, 2022.

(b) Minnesota Statutes 2020, sections 256B.69, subdivision 20; 501C.0408, subdivision 4; and 501C.1206, are repealed the day following final enactment.

ARTICLE 3
HEALTH-RELATED LICENSING BOARDS

Section 1. Minnesota Statutes 2020, section 148B.33, is amended by adding a subdivision to read:

Subd. 1a. **Supervision requirement; postgraduate experience.** The board must allow an applicant to satisfy the requirement for supervised postgraduate experience in marriage and family therapy with all required hours of supervision provided through real-time, two-way interactive audio and visual communication.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to supervision requirements in effect on or after that date.

Sec. 2. Minnesota Statutes 2021 Supplement, 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 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 or through real-time, two-way interactive audio and visual communication, and the board must allow an applicant to satisfy this supervision requirement with all required hours of supervision received through real-time, two-way interactive audio and visual communication. 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.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to supervision requirements in effect on or after that date.

Sec. 3. Minnesota Statutes 2020, section 148E.100, subdivision 3, is amended to read:

Subd. 3. **Types of supervision.** Of the 100 hours of supervision required under subdivision 1:

(1) 50 hours must be provided through one-on-one supervision~~, including: (i) a minimum of 25 hours of in-person supervision, and (ii) no more than 25 hours of supervision~~. The supervision must be provided either in person or via eye-to-eye electronic media, while maintaining visual contact. The board must allow a licensed social worker to satisfy the supervision requirement of this clause with all required hours of supervision provided via eye-to-eye electronic media, while maintaining visual contact; and

(2) 50 hours must be provided through: (i) one-on-one supervision, or (ii) group supervision. The supervision may be in person, by telephone, or via eye-to-eye electronic media, while maintaining visual contact. The supervision must not be provided by e-mail. Group supervision is limited to six supervisees.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to supervision requirements in effect on or after that date.

Sec. 4. Minnesota Statutes 2020, section 148E.105, subdivision 3, as amended by Laws 2022, chapter 55, article 1, section 42, is amended to read:

Subd. 3. **Types of supervision.** Of the 100 hours of supervision required under subdivision 1:

(1) 50 hours must be provided through one-on-one supervision~~, including: (i) a minimum of 25 hours of in-person supervision, and (ii) no more than 25 hours of supervision~~. The supervision must be provided either in person or via eye-to-eye electronic media, while maintaining visual contact. The board must allow a licensed graduate social worker to satisfy the supervision requirement of this clause with all required hours of supervision provided via eye-to-eye electronic media, while maintaining visual contact; and

(2) 50 hours must be provided through: (i) one-on-one supervision, or (ii) group supervision. The supervision may be in person, by telephone, or via eye-to-eye electronic media, while maintaining visual contact. The supervision must not be provided by e-mail. Group supervision is limited to six supervisees.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to supervision requirements in effect on or after that date.

Sec. 5. Minnesota Statutes 2020, section 148E.106, subdivision 3, is amended to read:

Subd. 3. **Types of supervision.** Of the 200 hours of supervision required under subdivision 1:

(1) 100 hours must be provided through one-on-one supervision~~, including: (i) a minimum of 50 hours of in-person supervision, and (ii) no more than 50 hours of supervision~~. The supervision must be provided either in person or via eye-to-eye electronic media, while maintaining visual contact. The board must allow a licensed graduate social worker to satisfy the supervision requirement of this clause with all required hours of supervision provided via eye-to-eye electronic media, while maintaining visual contact; and

(2) 100 hours must be provided through: (i) one-on-one supervision, or (ii) group supervision. The supervision may be in person, by telephone, or via eye-to-eye electronic media, while maintaining visual contact. The supervision must not be provided by e-mail. Group supervision is limited to six supervisees.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to supervision requirements in effect on or after that date.

Sec. 6. Minnesota Statutes 2020, section 148E.110, subdivision 7, is amended to read:

Subd. 7. **Supervision; clinical social work practice after licensure as licensed independent social worker.** Of the 200 hours of supervision required under subdivision 5:

(1) 100 hours must be provided through one-on-one supervision~~, including:~~. The supervision must be provided either in person or via eye-to-eye electronic media, while maintaining visual contact. The board must allow a licensed independent social worker to satisfy the supervision requirement of this clause with all required hours of supervision provided via eye-to-eye electronic media, while maintaining visual contact; and

~~(i) a minimum of 50 hours of in-person supervision; and~~

~~(ii) no more than 50 hours of supervision via eye-to-eye electronic media, while maintaining visual contact; and~~

(2) 100 hours must be provided through:

(i) one-on-one supervision; or

(ii) group supervision.

The supervision may be in person, by telephone, or via eye-to-eye electronic media, while maintaining visual contact. The supervision must not be provided by e-mail. Group supervision is limited to six supervisees.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to supervision requirements in effect on or after that date.

Sec. 7. Minnesota Statutes 2020, section 150A.06, subdivision 1c, is amended to read:

Subd. 1c. **Specialty dentists.** (a) The board may grant one or more specialty licenses in the specialty areas of dentistry that are recognized by the Commission on Dental Accreditation.

(b) An applicant for a specialty license shall:

(1) have successfully completed a postdoctoral specialty program accredited by the Commission on Dental Accreditation, or have announced a limitation of practice before 1967;

(2) have been certified by a specialty board approved by the Minnesota Board of Dentistry, or provide evidence of having passed a clinical examination for licensure required for practice in any state or Canadian province, or in the case of oral and maxillofacial surgeons only, have a Minnesota medical license in good standing;

(3) have been in active practice or a postdoctoral specialty education program or United States government service at least 2,000 hours in the 36 months prior to applying for a specialty license;

(4) if requested by the board, be interviewed by a committee of the board, which may include the assistance of specialists in the evaluation process, and satisfactorily respond to questions designed to determine the applicant's knowledge of dental subjects and ability to practice;

(5) if requested by the board, present complete records on a sample of patients treated by the applicant. The sample must be drawn from patients treated by the applicant during

the 36 months preceding the date of application. The number of records shall be established by the board. The records shall be reasonably representative of the treatment typically provided by the applicant for each specialty area;

(6) at board discretion, pass a board-approved English proficiency test if English is not the applicant's primary language;

(7) pass all components of the National Board Dental Examinations;

(8) pass the Minnesota Board of Dentistry jurisprudence examination;

(9) abide by professional ethical conduct requirements; and

(10) meet all other requirements prescribed by the Board of Dentistry.

(c) The application must include:

(1) a completed application furnished by the board;

~~(2) at least two character references from two different dentists for each specialty area, one of whom must be a dentist practicing in the same specialty area, and the other from the director of each specialty program attended;~~

~~(3) a licensed physician's statement attesting to the applicant's physical and mental condition;~~

~~(4) a statement from a licensed ophthalmologist or optometrist attesting to the applicant's visual acuity;~~

~~(5)~~ (2) a nonrefundable fee; and

~~(6)~~ (3) a ~~notarized, unmounted passport-type photograph, three inches by three inches, taken not more than six months before the date of application~~ copy of the applicant's government issued photo identification card.

(d) A specialty dentist holding one or more specialty licenses is limited to practicing in the dentist's designated specialty area or areas. The scope of practice must be defined by each national specialty board recognized by the Commission on Dental Accreditation.

(e) A specialty dentist holding a general dental license is limited to practicing in the dentist's designated specialty area or areas if the dentist has announced a limitation of practice. The scope of practice must be defined by each national specialty board recognized by the Commission on Dental Accreditation.

(f) All specialty dentists who have fulfilled the specialty dentist requirements and who intend to limit their practice to a particular specialty area or areas may apply for one or more specialty licenses.

Sec. 8. Minnesota Statutes 2020, section 150A.06, subdivision 2c, is amended to read:

Subd. 2c. **Guest license.** (a) The board shall grant a guest license to practice as a dentist, dental hygienist, or licensed dental assistant if the following conditions are met:

(1) the dentist, dental hygienist, or dental assistant is currently licensed in good standing in another United States jurisdiction;

(2) the dentist, dental hygienist, or dental assistant is currently engaged in the practice of that person's respective profession in another United States jurisdiction;

(3) the dentist, dental hygienist, or dental assistant will limit that person's practice to a public health setting in Minnesota that (i) is approved by the board; (ii) was established by a nonprofit organization that is tax exempt under chapter 501(c)(3) of the Internal Revenue Code of 1986; and (iii) provides dental care to patients who have difficulty accessing dental care;

(4) the dentist, dental hygienist, or dental assistant agrees to treat indigent patients who meet the eligibility criteria established by the clinic; and

(5) the dentist, dental hygienist, or dental assistant has applied to the board for a guest license and has paid a nonrefundable license fee to the board ~~not to exceed $75~~.

(b) A guest license must be renewed annually with the board and an annual renewal fee ~~not to exceed $75~~ must be paid to the board. Guest licenses expire on December 31 of each year.

(c) A dentist, dental hygienist, or dental assistant practicing under a guest license under this subdivision shall have the same obligations as a dentist, dental hygienist, or dental assistant who is licensed in Minnesota and shall be subject to the laws and rules of Minnesota and the regulatory authority of the board. If the board suspends or revokes the guest license of, or otherwise disciplines, a dentist, dental hygienist, or dental assistant practicing under this subdivision, the board shall promptly report such disciplinary action to the dentist's, dental hygienist's, or dental assistant's regulatory board in the jurisdictions in which they are licensed.

(d) The board may grant a guest license to a dentist, dental hygienist, or dental assistant licensed in another United States jurisdiction to provide dental care to patients on a voluntary

basis without compensation for a limited period of time. The board shall not assess a fee for the guest license for volunteer services issued under this paragraph.

(e) The board shall issue a guest license for volunteer services if:

(1) the board determines that the applicant's services will provide dental care to patients who have difficulty accessing dental care;

(2) the care will be provided without compensation; and

(3) the applicant provides adequate proof of the status of all licenses to practice in other jurisdictions. The board may require such proof on an application form developed by the board.

(f) The guest license for volunteer services shall limit the licensee to providing dental care services for a period of time not to exceed ten days in a calendar year. Guest licenses expire on December 31 of each year.

(g) The holder of a guest license for volunteer services shall be subject to state laws and rules regarding dentistry and the regulatory authority of the board. The board may revoke the license of a dentist, dental hygienist, or dental assistant practicing under this subdivision or take other regulatory action against the dentist, dental hygienist, or dental assistant. If an action is taken, the board shall report the action to the regulatory board of those jurisdictions where an active license is held by the dentist, dental hygienist, or dental assistant.

Sec. 9. Minnesota Statutes 2020, section 150A.06, subdivision 6, is amended to read:

Subd. 6. **Display of name and certificates.** (a) The renewal certificate of ~~every dentist, dental therapist, dental hygienist, or dental assistant~~ every licensee or registrant must be conspicuously displayed in plain sight of patients in every office in which that person practices. Duplicate renewal certificates may be obtained from the board.

(b) Near or on the entrance door to every office where dentistry is practiced, the name of each dentist practicing there, as inscribed on the current license certificate, must be displayed in plain sight.

(c) The board must allow the display of a mini-license for guest license holders performing volunteer dental services. There is no fee for the mini-license for guest volunteers.

Sec. 10. Minnesota Statutes 2020, section 150A.06, is amended by adding a subdivision to read:

Subd. 12. **Licensure by credentials for dental therapy.** (a) Any dental therapist may, upon application and payment of a fee established by the board, apply for licensure based on an evaluation of the applicant's education, experience, and performance record. The applicant may be interviewed by the board to determine if the applicant:

(1) graduated with a baccalaureate or master's degree from a dental therapy program accredited by the Commission on Dental Accreditation;

(2) provided evidence of successfully completing the board's jurisprudence examination;

(3) actively practiced at least 2,000 hours within 36 months of the application date or passed a board-approved reentry program within 36 months of the application date;

(4) either:

(i) is currently licensed in another state or Canadian province and not subject to any pending or final disciplinary action; or

(ii) was previously licensed in another state or Canadian province in good standing and not subject to any final or pending disciplinary action at the time of surrender;

(5) passed a board-approved English proficiency test if English is not the applicant's primary language required at the board's discretion; and

(6) met all curriculum equivalency requirements regarding dental therapy scope of practice in Minnesota.

(b) The 2,000 practice hours required by clause (3) may count toward the 2,000 practice hours required for consideration for advanced dental therapy certification, provided that all other requirements of section 150A.106, subdivision 1, are met.

(c) The board, at its discretion, may waive specific licensure requirements in paragraph (a).

(d) The board must license an applicant who fulfills the conditions of this subdivision and demonstrates the minimum knowledge in dental subjects required for licensure under subdivision 1d to practice the applicant's profession.

(e) The board must deny the application if the applicant does not demonstrate the minimum knowledge in dental subjects required for licensure under subdivision 1d. If licensure is denied, the board may notify the applicant of any specific remedy the applicant

could take to qualify for licensure. A denial does not prohibit the applicant from applying for licensure under subdivision 1d.

(f) A candidate may appeal a denied application to the board according to subdivision 4a.

Sec. 11. Minnesota Statutes 2020, section 150A.09, is amended to read:

150A.09 ~~REGISTRATION OF~~ LICENSES ~~AND~~ OR REGISTRATION CERTIFICATES.

Subdivision 1. **Registration information and procedure.** On or before the license certificate expiration date every ~~licensed dentist, dental therapist, dental hygienist, and dental assistant~~ licensee or registrant shall ~~transmit to the executive secretary of the board, pertinent information~~ submit the renewal required by the board, together with the applicable fee ~~established by the board~~ under section 150A.091. At least 30 days before a license certificate expiration date, the board shall send a written notice stating the amount and due date of the fee ~~and the information to be provided to every licensed dentist, dental therapist, dental hygienist, and dental assistant~~.

Subd. 3. **Current address, change of address.** Every ~~dentist, dental therapist, dental hygienist, and dental assistant~~ licensee or registrant shall maintain with the board a correct and current mailing address and electronic mail address. For dentists engaged in the practice of dentistry, the postal address shall be that of the location of the primary dental practice. Within 30 days after changing postal or electronic mail addresses, every ~~dentist, dental therapist, dental hygienist, and dental assistant~~ licensee or registrant shall provide the board ~~written~~ notice ~~of the new address either personally or by first class mail~~.

Subd. 4. **Duplicate certificates.** Duplicate licenses or duplicate certificates of ~~license~~ renewal may be issued by the board upon satisfactory proof of the need for the duplicates and upon payment of the fee established by the board.

Subd. 5. **Late fee.** A late fee established by the board shall be paid if the ~~information and~~ fee required by subdivision 1 is not received by ~~the executive secretary of~~ the board on or before the registration or ~~license~~ renewal date.

Sec. 12. Minnesota Statutes 2020, section 150A.091, subdivision 2, is amended to read:

Subd. 2. **Application and initial license or registration fees.** Each applicant shall submit with a license, advanced dental therapist certificate, or permit application a

nonrefundable fee in the following amounts in order to administratively process an application:

(1) dentist, ~~$140~~ $308;

(2) full faculty dentist, ~~$140~~ $308;

(3) limited faculty dentist, $140;

(4) resident dentist or dental provider, $55;

(5) advanced dental therapist, $100;

(6) dental therapist, ~~$100~~ $220;

(7) dental hygienist, ~~$55~~ $115;

(8) licensed dental assistant, ~~$55; and~~ $115;

(9) dental assistant with ~~a permit~~ registration as described in Minnesota Rules, part 3100.8500, subpart 3, ~~$15.~~ $27; and

(10) guest license, $50.

Sec. 13. Minnesota Statutes 2020, section 150A.091, subdivision 5, is amended to read:

Subd. 5. **Biennial license or ~~permit~~ registration renewal fees.** Each of the following applicants shall submit with a biennial license or permit renewal application a fee as established by the board, not to exceed the following amounts:

(1) dentist or full faculty dentist, $475;

(2) dental therapist, $300;

(3) dental hygienist, $200;

(4) licensed dental assistant, $150; and

(5) dental assistant with a ~~permit~~ registration as described in Minnesota Rules, part 3100.8500, subpart 3, $24.

Sec. 14. Minnesota Statutes 2020, section 150A.091, subdivision 8, is amended to read:

Subd. 8. **Duplicate license or certificate fee.** Each applicant shall submit, with a request for issuance of a duplicate of the original license, or of an annual or biennial renewal certificate for a license or permit, a fee in the following amounts:

(1) original dentist, full faculty dentist, dental therapist, dental hygiene, or dental assistant license, $35; and

(2) annual or biennial renewal certificates, $10~~; and~~.

~~(3) wallet-sized license and renewal certificate, $15.~~

Sec. 15. Minnesota Statutes 2020, section 150A.091, subdivision 9, is amended to read:

Subd. 9. **Licensure by credentials.** Each applicant for licensure as a dentist, dental hygienist, or dental assistant by credentials pursuant to section 150A.06, subdivisions 4 and 8, and Minnesota Rules, part 3100.1400, shall submit with the license application a fee in the following amounts:

(1) dentist, ~~$725~~ $893;

(2) dental hygienist, ~~$175; and~~ $235;

(3) dental assistant, ~~$35.~~ $71; and

(4) dental therapist, $340.

Sec. 16. Minnesota Statutes 2020, section 150A.091, is amended by adding a subdivision to read:

Subd. 21. **Failure to practice with a current license.** (a) If a licensee practices without a current license and pursues reinstatement, the board may take the following administrative actions based on the length of time practicing without a current license:

(1) for under one month, the board may not assess a penalty fee;

(2) for one month to six months, the board may assess a penalty of $250;

(3) for over six months, the board may assess a penalty of $500; and

(4) for over 12 months, the board may assess a penalty of $1,000.

(b) In addition to the penalty fee, the board shall initiate the complaint process against the licensee for failure to practice with a current license for over 12 months.

Sec. 17. Minnesota Statutes 2020, section 150A.091, is amended by adding a subdivision to read:

Subd. 22. **Delegating regulated procedures to an individual with a terminated license.** (a) If a dentist or dental therapist delegates regulated procedures to another dental professional who had their license terminated, the board may take the following

administrative actions against the delegating dentist or dental therapist based on the length of time they delegated regulated procedures:

(1) for under one month, the board may not assess a penalty fee;

(2) for one month to six months, the board may assess a penalty of $100;

(3) for over six months, the board may assess a penalty of $250; and

(4) for over 12 months, the board may assess a penalty of $500.

(b) In addition to the penalty fee, the board shall initiate the complaint process against a dentist or dental therapist who delegated regulated procedures to a dental professional with a terminated license for over 12 months.

Sec. 18. Minnesota Statutes 2020, section 150A.10, subdivision 1a, is amended to read:

Subd. 1a. **Collaborative practice authorization for dental hygienists in community settings.** (a) Notwithstanding subdivision 1, a dental hygienist licensed under this chapter may be employed or retained by a health care facility, program, ~~or~~ nonprofit organization, or licensed dentist to perform the dental hygiene services listed in Minnesota Rules, part 3100.8700, subpart 1, without the patient first being examined by a licensed dentist if the dental hygienist:

(1) has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist; and

(2) has documented completion of a course on medical emergencies within each continuing education cycle.

(b) A collaborating dentist must be licensed under this chapter and may enter into a collaborative agreement with no more than four dental hygienists unless otherwise authorized by the board. The board shall develop parameters and a process for obtaining authorization to collaborate with more than four dental hygienists. The collaborative agreement must include:

(1) consideration for medically compromised patients and medical conditions for which a dental evaluation and treatment plan must occur prior to the provision of dental hygiene services;

(2) age- and procedure-specific standard collaborative practice protocols, including recommended intervals for the performance of dental hygiene services and a period of time in which an examination by a dentist should occur;

(3) copies of consent to treatment form provided to the patient by the dental hygienist;

(4) specific protocols for the placement of pit and fissure sealants and requirements for follow-up care to ~~assure the~~ ensure efficacy ~~of the sealants after application~~; and

(5) the procedure for creating and maintaining dental records for patients who are treated by the dental hygienist under Minnesota Rules, part 3100.9600, including specifying where records will be located.

~~The collaborative agreement must be signed and maintained by the dentist, the dental hygienist, and the facility, program, or organization; must be reviewed annually by the collaborating dentist and dental hygienist and must be made available to the board upon request.~~

(c) The collaborative agreement must be:

(1) signed and maintained by the dentist; the dental hygienist; and the facility, program, or organization;

(2) reviewed annually by the collaborating dentist and the dental hygienist; and

(3) made available to the board upon request.

~~(c)~~ (d) Before performing any services authorized under this subdivision, a dental hygienist must provide the patient with a consent to treatment form which must include a statement advising the patient that the dental hygiene services provided are not a substitute for a dental examination by a licensed dentist. When the patient requires a referral for additional dental services, the dental hygienist shall complete a referral form and provide a copy to the patient, the facility, if applicable, the dentist to whom the patient is being referred, and the collaborating dentist, if specified in the collaborative agreement. A copy of the referral form shall be maintained in the patient's health care record. The patient does not become a new patient of record of the dentist to whom the patient was referred until the dentist accepts the patient for follow-up services after referral from the dental hygienist.

~~(d)~~ (e) For the purposes of this subdivision, a "health care facility, program, or nonprofit organization" includes a hospital; nursing home; home health agency; group home serving the elderly, disabled, or juveniles; state-operated facility licensed by the commissioner of human services or the commissioner of corrections; a state agency administered public health program or event; and federal, state, or local public health facility, community clinic, tribal clinic, school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients.

~~(e)~~ (f) For purposes of this subdivision, a "collaborative agreement" means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist.

(g) A collaborative practice dental hygienist must be reimbursed for all services performed through a health care facility, program, nonprofit organization, or licensed dentist.

Sec. 19. Minnesota Statutes 2020, section 150A.105, subdivision 8, is amended to read:

Subd. 8. **Definitions.** (a) For the purposes of this section, the following definitions apply.

(b) "Practice settings that serve the low-income and underserved" mean:

(1) critical access dental provider settings as designated by the commissioner of human services under section 256B.76, subdivision 4;

(2) dental hygiene collaborative practice settings identified in section 150A.10, subdivision 1a, paragraph ~~(d)~~ (e), and including medical facilities, assisted living facilities, federally qualified health centers, and organizations eligible to receive a community clinic grant under section 145.9268, subdivision 1;

(3) military and veterans administration hospitals, clinics, and care settings;

(4) a patient's residence or home when the patient is home-bound or receiving or eligible to receive home care services or home and community-based waivered services, regardless of the patient's income;

(5) oral health educational institutions; or

(6) any other clinic or practice setting, including mobile dental units, in which at least 50 percent of the total patient base of the dental therapist or advanced dental therapist consists of patients who:

(i) are enrolled in a Minnesota health care program;

(ii) have a medical disability or chronic condition that creates a significant barrier to receiving dental care;

(iii) do not have dental health coverage, either through a public health care program or private insurance, and have an annual gross family income equal to or less than 200 percent of the federal poverty guidelines; or

(iv) do not have dental health coverage, either through a state public health care program or private insurance, and whose family gross income is equal to or less than 200 percent of the federal poverty guidelines.

(c) "Dental health professional shortage area" means an area that meets the criteria established by the secretary of the United States Department of Health and Human Services and is designated as such under United States Code, title 42, section 254e.

Sec. 20. Minnesota Statutes 2020, section 151.01, subdivision 27, is amended to read:

Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

(1) interpretation and evaluation of prescription drug orders;

(2) compounding, labeling, and dispensing drugs and devices (except labeling by a manufacturer or packager of nonprescription drugs or commercially packaged legend drugs and devices);

(3) participation in clinical interpretations and monitoring of drug therapy for assurance of safe and effective use of drugs, including the performance of laboratory tests that are waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code, title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory tests but may modify drug therapy only pursuant to a protocol or collaborative practice agreement;

(4) participation in drug and therapeutic device selection; drug administration for first dosage and medical emergencies; intramuscular and subcutaneous drug administration ~~used for the treatment of alcohol or opioid dependence~~ under a prescription drug order; drug regimen reviews; and drug or drug-related research;

(5) drug administration, through intramuscular and subcutaneous administration used to treat mental illnesses as permitted under the following conditions:

(i) upon the order of a prescriber and the prescriber is notified after administration is complete; or

(ii) pursuant to a protocol or collaborative practice agreement as defined by section 151.01, subdivisions 27b and 27c, and participation in the initiation, management, modification, administration, and discontinuation of drug therapy is according to the protocol or collaborative practice agreement between the pharmacist and a dentist, optometrist, physician, podiatrist, or veterinarian, or an advanced practice registered nurse authorized to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy or medication administration made pursuant to a protocol or collaborative practice agreement must be documented by the pharmacist in the patient's medical record or reported by the pharmacist to a practitioner responsible for the patient's care;

(6) participation in administration of influenza vaccines and vaccines approved by the United States Food and Drug Administration related to COVID-19 or SARS-CoV-2 to all eligible individuals six years of age and older and all other vaccines to patients 13 years of age and older by written protocol with a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe drugs under section 148.235, provided that:

(i) the protocol includes, at a minimum:

(A) the name, dose, and route of each vaccine that may be given;

(B) the patient population for whom the vaccine may be given;

(C) contraindications and precautions to the vaccine;

(D) the procedure for handling an adverse reaction;

(E) the name, signature, and address of the physician, physician assistant, or advanced practice registered nurse;

(F) a telephone number at which the physician, physician assistant, or advanced practice registered nurse can be contacted; and

(G) the date and time period for which the protocol is valid;

(ii) the pharmacist has successfully completed a program approved by the Accreditation Council for Pharmacy Education specifically for the administration of immunizations or a program approved by the board;

(iii) the pharmacist utilizes the Minnesota Immunization Information Connection to assess the immunization status of individuals prior to the administration of vaccines, except when administering influenza vaccines to individuals age nine and older;

(iv) the pharmacist reports the administration of the immunization to the Minnesota Immunization Information Connection; and

(v) the pharmacist complies with guidelines for vaccines and immunizations established by the federal Advisory Committee on Immunization Practices, except that a pharmacist does not need to comply with those portions of the guidelines that establish immunization schedules when administering a vaccine pursuant to a valid, patient-specific order issued by a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe drugs under section 148.235, provided that the order is consistent with the United States Food and Drug Administration approved labeling of the vaccine;

(7) participation in the initiation, management, modification, and discontinuation of drug therapy according to a written protocol or collaborative practice agreement between: (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more physician assistants authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice registered nurses authorized to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement must be documented by the pharmacist in the patient's medical record or reported by the pharmacist to a practitioner responsible for the patient's care;

(8) participation in the storage of drugs and the maintenance of records;

(9) patient counseling on therapeutic values, content, hazards, and uses of drugs and devices;

(10) offering or performing those acts, services, operations, or transactions necessary in the conduct, operation, management, and control of a pharmacy;

(11) participation in the initiation, management, modification, and discontinuation of therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

(i) a written protocol as allowed under clause (7); or

(ii) a written protocol with a community health board medical consultant or a practitioner designated by the commissioner of health, as allowed under section 151.37, subdivision 13; ~~and~~

(12) prescribing self-administered hormonal contraceptives; nicotine replacement medications; and opiate antagonists for the treatment of an acute opiate overdose pursuant to section 151.37, subdivision 14, 15, or 16~~.~~; and

(13) participation in the placement of drug monitoring devices according to a prescription, protocol, or collaborative practice agreement.

Sec. 21. Minnesota Statutes 2020, section 153.16, subdivision 1, is amended to read:

Subdivision 1. **License requirements.** The board shall issue a license to practice podiatric medicine to a person who meets the following requirements:

(a) The applicant for a license shall file a written notarized application on forms provided by the board, showing to the board's satisfaction that the applicant is of good moral character and satisfies the requirements of this section.

(b) The applicant shall present evidence satisfactory to the board of being a graduate of a podiatric medical school approved by the board based upon its faculty, curriculum, facilities, accreditation by a recognized national accrediting organization approved by the board, and other relevant factors.

(c) The applicant must have received a passing score on each part of the national board examinations, parts one and two, prepared and graded by the National Board of Podiatric Medical Examiners. The passing score for each part of the national board examinations, parts one and two, is as defined by the National Board of Podiatric Medical Examiners.

(d) Applicants graduating after ~~1986~~ 1990 from a podiatric medical school shall present evidence of successful completion of a residency program approved by a national accrediting podiatric medicine organization.

(e) The applicant shall appear in person before the board or its designated representative to show that the applicant satisfies the requirements of this section, including knowledge of laws, rules, and ethics pertaining to the practice of podiatric medicine. The board may establish as internal operating procedures the procedures or requirements for the applicant's personal presentation. Upon completion of all other application requirements, a doctor of podiatric medicine applying for a temporary military license has six months in which to comply with this subdivision.

(f) The applicant shall pay a fee established by the board by rule. The fee shall not be refunded.

(g) The applicant must not have engaged in conduct warranting disciplinary action against a licensee. If the applicant does not satisfy the requirements of this paragraph, the board may refuse to issue a license unless it determines that the public will be protected through issuance of a license with conditions and limitations the board considers appropriate.

(h) Upon payment of a fee as the board may require, an applicant who fails to pass an examination and is refused a license is entitled to reexamination within one year of the board's refusal to issue the license. No more than two reexaminations are allowed without a new application for a license.

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

Sec. 22. Laws 2021, First Special Session chapter 7, article 16, section 5, is amended to read:

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD**	**$ 4,780,000**	**$ 4,576,000**

(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 for Continuing Education.** $585,000 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) **Regional Grants for Local and Regional Emergency Medical Services.**~~ (c) **Emergency Medical Services Fund.** ~~$800,000~~ $1,385,000 in fiscal year 2022 and ~~$800,000~~ $1,385,000 in fiscal year 2023 are for distribution to regional emergency medical services ~~regions~~ systems for ~~regional emergency medical services programs~~ the purposes specified in Minnesota Statutes,

section 144E.50. Notwithstanding Minnesota Statutes, section 144E.50, subdivision 5, in each year the board shall distribute the appropriation equally among the eight emergency medical services ~~regions~~ systems designated by the board. ~~This is a onetime appropriation~~ The general fund base for this appropriation is $585,000 in fiscal year 2024 and $585,000 in fiscal year 2025.

~~(c)~~ (d) **Ambulance Training Grants.** $565,000 in fiscal year 2022 and $361,000 in fiscal year 2023 are for training grants under Minnesota Statutes, section 144E.35.

~~(f)~~ (e) **Base Level Adjustment.** The general fund base is $3,776,000 in fiscal year 2024 and $3,776,000 in fiscal year 2025.

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

Sec. 23. **TEMPORARY REQUIREMENTS GOVERNING AMBULANCE SERVICE OPERATIONS AND THE PROVISION OF EMERGENCY MEDICAL SERVICES.**

Subdivision 1. **Application.** Notwithstanding any law to the contrary in Minnesota Statutes, chapter 144E, an ambulance service may operate according to this section, and emergency medical technicians, advanced emergency medical technicians, and paramedics may provide emergency medical services according to this section.

Subd. 2. **Definitions.** (a) The terms defined in this subdivision apply to this section.

(b) "Advanced emergency medical technician" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 5d.

(c) "Advanced life support" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 1b.

(d) "Ambulance" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 2.

(e) "Ambulance service personnel" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 3a.

(f) "Basic life support" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 4b.

(g) "Board" means the Emergency Medical Services Regulatory Board.

(h) "Emergency medical technician" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 5c.

(i) "Paramedic" has the meaning given in Minnesota Statutes, section 144E.001, subdivision 5e.

(j) "Primary service area" means the area designated by the board according to Minnesota Statutes, section 144E.06, to be served by an ambulance service.

Subd. 3. **Staffing.** (a) For emergency ambulance calls and interfacility transfers in an ambulance service's primary service area, an ambulance service must staff an ambulance that provides basic life support with at least:

(1) one emergency medical technician, who must be in the patient compartment when a patient is being transported; and

(2) one individual to drive the ambulance. The driver must hold a valid driver's license from any state, must have attended an emergency vehicle driving course approved by the ambulance service, and must have completed a course on cardiopulmonary resuscitation approved by the ambulance service.

(b) For emergency ambulance calls and interfacility transfers in an ambulance service's primary service area, an ambulance service must staff an ambulance that provides advanced life support with at least:

(1) one paramedic; one registered nurse who meets the requirements in Minnesota Statutes, section 144E.001, subdivision 3a, clause (2); or one physician assistant who meets the requirements in Minnesota Statutes, section 144E.001, subdivision 3a, clause (3), and who must be in the patient compartment when a patient is being transported; and

(2) one individual to drive the ambulance. The driver must hold a valid driver's license from any state, must have attended an emergency vehicle driving course approved by the ambulance service, and must have completed a course on cardiopulmonary resuscitation approved by the ambulance service.

(c) The ambulance service director and medical director must approve the staffing of an ambulance according to this subdivision.

(d) An ambulance service staffing an ambulance according to this subdivision must immediately notify the board in writing and in a manner prescribed by the board. The notice must specify how the ambulance service is staffing its basic life support or advanced life support ambulances and the time period the ambulance service plans to staff the ambulances according to this subdivision. If an ambulance service continues to staff an ambulance according to this subdivision after the date provided to the board in its initial notice, the ambulance service must provide a new notice to the board in a manner that complies with this paragraph.

(e) If an individual serving as a driver under this subdivision commits an act listed in Minnesota Statutes, section 144E.27, subdivision 5, paragraph (a), the board may temporarily suspend or prohibit the individual from driving an ambulance or place conditions on the individual's ability to drive an ambulance using the procedures and authority in Minnesota Statutes, section 144E.27, subdivisions 5 and 6.

Subd. 4. **Use of expired emergency medications and medical supplies.** (a) If an ambulance service experiences a shortage of an emergency medication or medical supply, ambulance service personnel may use an emergency medication or medical supply for up to six months after the emergency medication's or medical supply's specified expiration date, provided:

(1) the ambulance service director and medical director approve the use of the expired emergency medication or medical supply;

(2) ambulance service personnel use an expired emergency medication or medical supply only after depleting the ambulance service's supply of that emergency medication or medical supply that is unexpired;

(3) the ambulance service has stored and maintained the expired emergency medication or medical supply according to the manufacturer's instructions;

(4) if possible, ambulance service personnel obtain consent from the patient to use the expired emergency medication or medical supply prior to its use; and

(5) when the ambulance service obtains a supply of that emergency medication or medical supply that is unexpired, ambulance service personnel cease use of the expired emergency medication or medical supply and instead use the unexpired emergency medication or medical supply.

(b) Before approving the use of an expired emergency medication, an ambulance service director and medical director must consult with the Board of Pharmacy regarding the safety and efficacy of using the expired emergency medication.

(c) An ambulance service must keep a record of all expired emergency medications and all expired medical supplies used and must submit that record in writing to the board in a time and manner specified by the board. The record must list the specific expired emergency medications and medical supplies used and the time period during which ambulance service personnel used the expired emergency medication or medical supply.

Subd. 5. **Provision of emergency medical services after certification expires.** (a) At the request of an emergency medical technician, advanced emergency medical technician, or paramedic, and with the approval of the ambulance service director, an ambulance service medical director may authorize the emergency medical technician, advanced emergency medical technician, or paramedic to provide emergency medical services for the ambulance service for up to three months after the certification of the emergency medical technician, advanced emergency medical technician, or paramedic expires.

(b) An ambulance service must immediately notify the board each time its medical director issues an authorization under paragraph (a). The notice must be provided in writing and in a manner prescribed by the board and must include information on the time period each emergency medical technician, advanced emergency medical technician, or paramedic will provide emergency medical services according to an authorization under this subdivision; information on why the emergency medical technician, advanced emergency medical technician, or paramedic needs the authorization; and an attestation from the medical director that the authorization is necessary to help the ambulance service adequately staff its ambulances.

Subd. 6. **Reports.** The board must provide quarterly reports to the chairs and ranking minority members of the legislative committees with jurisdiction over the board regarding actions taken by ambulance services according to subdivisions 3, 4, and 5. The board must submit reports by June 30, September 30, and December 31 of 2022; and by March 31, June 30, September 30, and December 31 of 2023. Each report must include the following information:

(1) for each ambulance service staffing basic life support or advanced life support ambulances according to subdivision 3, the primary service area served by the ambulance service, the number of ambulances staffed according to subdivision 3, and the time period

the ambulance service has staffed and plans to staff the ambulances according to subdivision 3;

(2) for each ambulance service that authorized the use of an expired emergency medication or medical supply according to subdivision 4, the expired emergency medications and medical supplies authorized for use and the time period the ambulance service used each expired emergency medication or medical supply; and

(3) for each ambulance service that authorized the provision of emergency medical services according to subdivision 5, the number of emergency medical technicians, advanced emergency medical technicians, and paramedics providing emergency medical services under an expired certification and the time period each emergency medical technician, advanced emergency medical technician, or paramedic provided and will provide emergency medical services under an expired certification.

Subd. 7. **Expiration.** This section expires January 1, 2024.

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

Sec. 24. **EXPEDITED REREGISTRATION FOR LAPSED NURSING LICENSES.**

(a) Notwithstanding Minnesota Statutes, section 148.231, a nurse who desires to resume the practice of professional or practical nursing at a licensed nursing facility or licensed assisted living facility but whose license to practice nursing has lapsed effective on or after January 1, 2019, may submit an application to the Board of Nursing for reregistration. The application must be submitted and received by the board between March 31, 2022, and March 31, 2023, and must be accompanied with the reregistration fee specified in Minnesota Statutes, section 148.243, subdivision 5. The applicant must include with the application the name and location of the facility where the nurse is or will be employed.

(b) The board shall issue a current registration if upon a licensure history review, the board determines that at the time the nurse's license lapsed:

(1) the nurse's license was in good standing; and

(2) the nurse was not the subject of any pending investigations or disciplinary actions or was not disqualified to practice in any way.

The board shall waive any other requirements for reregistration including any continuing education requirements.

(c) The registration issued under this section shall remain valid until the nurse's next registration period. If the nurse desires to continue to practice after that date, the nurse must

meet the reregistration requirements under Minnesota Statutes, section 148.231, including any penalty fees required.

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

Sec. 25. **APPROPRIATION; BOARD OF DENTISTRY.**

$3,000 in fiscal year 2023 is appropriated from the state government special revenue fund to the Board of Dentistry to process new credential applications and to administer administrative fines. This is a onetime appropriation.

Sec. 26. **REPEALER.**

Minnesota Statutes 2020, section 150A.091, subdivisions 3, 15, and 17, are repealed.

ARTICLE 4
COMMUNITY SUPPORTS AND BEHAVIORAL HEALTH POLICY

Section 1. Minnesota Statutes 2021 Supplement, section 62A.673, subdivision 2, is amended to read:

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

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

(c) "Health care provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law. A health care provider includes a mental health professional ~~as defined~~ under section ~~245.462, subdivision 18, or 245.4871, subdivision 27~~ 245I.04, subdivision 2; a mental health practitioner ~~as defined~~ under section ~~245.462, subdivision 17, or 245.4871, subdivision 26~~ 245I.04, subdivision 4; a clinical trainee under section 245I.04, subdivision 6; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

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

(e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental

plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

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

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

(h) "Telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Until July 1, 2023, telehealth also includes audio-only communication between a health care provider and a patient in accordance with subdivision 6, paragraph (b). Telehealth does not include communication between health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an e-mail or facsimile transmission. Telehealth does not include telemonitoring services as defined in paragraph (i).

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

EFFECTIVE DATE. This section is effective July 1, 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. 2. Minnesota Statutes 2021 Supplement, 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, clauses (1) to (6),~~ staff persons providing 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).

EFFECTIVE DATE. This section 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.

Sec. 3. Minnesota Statutes 2020, section 245.462, subdivision 4, is amended to read:

Subd. 4. **Case management service provider.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711.

(b) A case manager must:

(1) be skilled in the process of identifying and assessing a wide range of client needs;

(2) be knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) be a mental health practitioner as defined in section 245I.04, subdivision 4, or have a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university ~~or~~. A case manager who is not a mental health practitioner and who does not have a bachelor's degree in one of the behavioral sciences or related fields must meet the requirements of paragraph (c); and

(4) meet the supervision and continuing education requirements described in paragraphs (d), (e), and (f), as applicable.

(c) Case managers without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(1) have three or four years of experience as a case manager associate as defined in this section;

(2) be a registered nurse without a bachelor's degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or

(3) be a person who qualified as a case manager under the 1998 Department of Human Service waiver provision and meet the continuing education and mentoring requirements in this section.

(d) A case manager with at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness must receive regular ongoing supervision and clinical supervision totaling 38 hours per year of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The

remaining 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours. Clinical supervision must be documented in the client record.

(e) A case manager without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must:

(1) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour per week until the requirement of 2,000 hours of experience is met; and

(2) complete 40 hours of training approved by the commissioner in case management skills and the characteristics and needs of adults with serious and persistent mental illness.

(f) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness and mental health services every two years.

(g) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a certified peer specialist under section 256B.0615;

(iii) be a registered nurse without a bachelor's degree;

(iv) within the previous ten years, have three years of life experience with serious and persistent mental illness as defined in subdivision 20; or as a child had severe emotional disturbance as defined in section 245.4871, subdivision 6; or have three years life experience as a primary caregiver to an adult with serious and persistent mental illness within the previous ten years;

(v) have 6,000 hours work experience as a nondegreed state hospital technician; or

(vi) have at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness.

Individuals meeting one of the criteria in items (i) to (v) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals

meeting the criteria in item (vi) may qualify as a case manager after three years of supervised experience as a case manager associate.

(h) A case management associate must meet the following supervision, mentoring, and continuing education requirements:

(1) have 40 hours of preservice training described under paragraph (e), clause (2);

(2) receive at least 40 hours of continuing education in mental illness and mental health services annually; and

(3) receive at least five hours of mentoring per week from a case management mentor.

A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(i) A case management supervisor must meet the criteria for mental health professionals, as specified in subdivision 18.

(j) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to adult immigrants with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of this subdivision are met.

Sec. 4. Minnesota Statutes 2021 Supplement, section 245.467, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~Providers~~ A provider of services governed by this section must complete a diagnostic assessment of a client according to the standards of section 245I.10~~, subdivisions 4 to 6~~.

EFFECTIVE DATE. This section 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.

Sec. 5. Minnesota Statutes 2021 Supplement, section 245.467, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~Providers~~ A provider of services governed by this section must complete an individual treatment plan for a client according to the standards of section 245I.10, subdivisions 7 and 8.

EFFECTIVE DATE. This section 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.

Sec. 6. Minnesota Statutes 2021 Supplement, section 245.4871, subdivision 21, is amended to read:

Subd. 21. **Individual treatment plan.** (a) "Individual treatment plan" means 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.

(b) A children's residential facility licensed under Minnesota Rules, chapter 2960, is exempt from the requirements of section 245I.10, subdivisions 7 and 8. Instead, the individual treatment plan must:

(1) include a written plan of intervention, treatment, and services for a child with an emotional disturbance that the service provider develops under the clinical supervision of a mental health professional on the basis of a diagnostic assessment;

(2) be developed in conjunction with the family unless clinically inappropriate; and

(3) identify 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.

EFFECTIVE DATE. This section 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.

Sec. 7. Minnesota Statutes 2021 Supplement, section 245.4876, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~Providers~~ A provider of services governed by this section ~~shall~~ must complete a diagnostic assessment of a client according to the standards of section 245I.10~~, subdivisions 4 to 6~~. Notwithstanding the required timelines for completing a diagnostic assessment in section 245I.10, a children's residential facility licensed under Minnesota Rules, chapter 2960, that provides mental health services to children must, within ten days of the client's admission: (1) complete the client's diagnostic assessment; or (2) review and update the client's diagnostic assessment with a summary of the child's current mental health status and service needs if a diagnostic assessment is available that was completed within 180 days preceding admission and the client's mental health status has not changed markedly since the diagnostic assessment.

EFFECTIVE DATE. This section 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.

Sec. 8. Minnesota Statutes 2021 Supplement, section 245.4876, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~Providers~~ A provider of services governed by this section ~~shall~~ must complete an individual treatment plan for a client according to the standards of section 245I.10, subdivisions 7 and 8. A children's residential facility licensed according to Minnesota Rules, chapter 2960, is exempt from the requirements in section 245I.10, subdivisions 7 and 8. Instead, the facility must involve the child and the child's family in all phases of developing and implementing the individual treatment plan to the extent appropriate and must review the individual treatment plan every 90 days after intake.

EFFECTIVE DATE. This section 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.

Sec. 9. Minnesota Statutes 2021 Supplement, 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 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 a mental health ~~clinics~~ clinic under section ~~245.69, subdivision 2~~ 245I.20;

(9) comply with standards established by the commissioner relating to 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~~ section 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)~~ subdivision 2, clause (8), as applicable when peer services are provided.

(b) If a certified CCBHC is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the CCBHC may contract with another entity that has the required authority to provide that service and that meets the following criteria as a designated collaborating organization:

(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.

EFFECTIVE DATE. This section 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.

Sec. 10. Minnesota Statutes 2021 Supplement, 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 family child foster care home or family adult foster care home 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 where at least 80 percent of the residents are 55 years of age or older;

(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)~~ (5) 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 the day following final enactment.

Sec. 11. Minnesota Statutes 2020, section 245A.11, subdivision 2, is amended to read:

Subd. 2. **Permitted single-family residential use.** (a) Residential programs with a licensed capacity of six or fewer persons shall be considered a permitted single-family residential use of property for the purposes of zoning and other land use regulations, except that a residential program whose primary purpose is to treat juveniles who have violated criminal statutes relating to sex offenses or have been adjudicated delinquent on the basis of conduct in violation of criminal statutes relating to sex offenses shall not be considered a permitted use. This exception shall not apply to residential programs licensed before July 1, 1995. Programs otherwise allowed under this subdivision shall not be prohibited by operation of restrictive covenants or similar restrictions, regardless of when entered into, which cannot be met because of the nature of the licensed program, including provisions which require the home's occupants be related, and that the home must be occupied by the owner, or similar provisions.

(b) Unless otherwise provided in any town, municipal, or county zoning regulation, licensed residential services provided to more than four persons with developmental disabilities in a supervised living facility, including intermediate care facilities for persons with developmental disabilities, with a licensed capacity of seven to eight persons shall be considered a permitted single-family residential use of property for the purposes of zoning and other land use regulations. A town, municipal, or county zoning authority may require a conditional use or special use permit to assure proper maintenance and operation of the residential program. Conditions imposed on the residential program must not be more restrictive than those imposed on other conditional uses or special uses of residential property in the same zones, unless the additional conditions are necessary to protect the health and safety of the persons being served by the program. This paragraph expires July 1, 2023.

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

Sec. 12. Minnesota Statutes 2020, section 245A.11, subdivision 2a, is amended to read:

Subd. 2a. **Adult foster care and community residential setting license capacity.** (a) The commissioner shall issue adult foster care and community residential setting licenses with a maximum licensed capacity of four beds, including nonstaff roomers and boarders, except that the commissioner may issue a license with a capacity of five beds, including roomers and boarders, according to paragraphs (b) to (g).

(b) The license holder may have a maximum license capacity of five if all persons in care are age 55 or over and do not have a serious and persistent mental illness or a developmental disability.

(c) The commissioner may grant variances to paragraph (b) to allow a facility with a licensed capacity of up to five persons to admit an individual under the age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

(d) The commissioner may grant variances to paragraph (a) to allow the use of an additional bed, up to ~~five~~ six, for emergency crisis services for a person with serious and persistent mental illness or a developmental disability, regardless of age, if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

(e) The commissioner may grant a variance to paragraph (b) to allow for the use of an additional bed, up to ~~five~~ six, for respite services, as defined in section 245A.02, for persons with disabilities, regardless of age, if the variance complies with sections 245A.03, subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located. Respite care may be provided under the following conditions:

(1) staffing ratios cannot be reduced below the approved level for the individuals being served in the home on a permanent basis;

(2) no more than two different individuals can be accepted for respite services in any calendar month and the total respite days may not exceed 120 days per program in any calendar year;

(3) the person receiving respite services must have his or her own bedroom, which could be used for alternative purposes when not used as a respite bedroom, and cannot be the room of another person who lives in the facility; and

(4) individuals living in the facility must be notified when the variance is approved. The provider must give 60 days' notice in writing to the residents and their legal representatives prior to accepting the first respite placement. Notice must be given to residents at least two days prior to service initiation, or as soon as the license holder is able if they receive notice of the need for respite less than two days prior to initiation, each time a respite client will be served, unless the requirement for this notice is waived by the resident or legal guardian.

(f) The commissioner may issue an adult foster care or community residential setting license with a capacity of five adults if the fifth bed does not increase the overall statewide capacity of licensed adult foster care or community residential setting beds in homes that are not the primary residence of the license holder, as identified in a plan submitted to the commissioner by the county, when the capacity is recommended by the county licensing agency of the county in which the facility is located and if the recommendation verifies that:

(1) the facility meets the physical environment requirements in the adult foster care licensing rule;

(2) the five-bed living arrangement is specified for each resident in the resident's:

(i) individualized plan of care;

(ii) individual service plan under section 256B.092, subdivision 1b, if required; or

(iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required;

(3) the license holder obtains written and signed informed consent from each resident or resident's legal representative documenting the resident's informed choice to remain living in the home and that the resident's refusal to consent would not have resulted in service termination; and

(4) the facility was licensed for adult foster care before March 1, 2016.

(g) The commissioner shall not issue a new adult foster care license under paragraph (f) after December 31, 2020. The commissioner shall allow a facility with an adult foster care license issued under paragraph (f) before December 31, 2020, to continue with a capacity of five adults if the license holder continues to comply with the requirements in paragraph (f).

(h) Notwithstanding Minnesota Rules, part 9520.0500, adult foster care and community residential setting licenses with a capacity of up to six adults as allowed under this subdivision

are not required to be licensed as an adult mental health residential program according to Minnesota Rules, parts 9520.0500 to 9520.0670.

EFFECTIVE DATE. This section is effective upon federal approval. The amendments to paragraphs (d) and (e) expire 365 calendar days after federal approval is obtained and the language of Minnesota Statutes 2020, section 245A.11, subdivision 2a, paragraphs (d) and (e), is revived and reenacted as of that date. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 13. Minnesota Statutes 2020, section 245A.11, is amended by adding a subdivision to read:

Subd. 2c. **Residential programs in intermediate care facilities; license capacity.** Notwithstanding subdivision 4 and section 252.28, subdivision 3, for licensed residential services provided to more than four persons with developmental disabilities in a supervised living facility, including intermediate care facilities for persons with developmental disabilities, located in a single-family home and in a town, municipal, or county zoning authority that will permit a licensed capacity of seven or eight persons in a single-family home, the commissioner may increase the licensed capacity of the program to seven or eight if the seventh or eighth bed does not increase the overall statewide capacity in intermediate care facilities for persons with developmental disabilities. If the licensed capacity of these facilities is increased under this subdivision, the capacity of the license may remain at the increased number of persons. This subdivision expires July 1, 2023.

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

Sec. 14. Minnesota Statutes 2020, section 245D.12, is amended to read:

245D.12 INTEGRATED COMMUNITY SUPPORTS; SETTING CAPACITY REPORT.

(a) The license holder providing integrated community support, as defined in section 245D.03, subdivision 1, paragraph (c), clause (8), must submit a setting capacity report to the commissioner to ensure the identified location of service delivery meets the criteria of the home and community-based service requirements as specified in section 256B.492.

(b) The license holder shall provide the setting capacity report on the forms and in the manner prescribed by the commissioner. The report must include:

(1) the address of the multifamily housing building where the license holder delivers integrated community supports and owns, leases, or has a direct or indirect financial relationship with the property owner;

(2) the total number of living units in the multifamily housing building described in clause (1) where integrated community supports are delivered;

(3) the total number of living units in the multifamily housing building described in clause (1), including the living units identified in clause (2); ~~and~~

(4) the total number of people who could reside in the living units in the multifamily housing building described in clause (2) and receive integrated community supports; and

~~(4)~~ (5) the percentage of living units that are controlled by the license holder in the multifamily housing building by dividing clause (2) by clause (3).

(c) Only one license holder may deliver integrated community supports at the address of the multifamily housing building.

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

Sec. 15. Minnesota Statutes 2020, section 245G.01, is amended by adding a subdivision to read:

Subd. 13b. **Guest speaker.** "Guest speaker" means an individual who is not an alcohol and drug counselor qualified according to section 245G.11, subdivision 5; is not qualified according to the commissioner's list of professionals under section 245G.07, subdivision 3; and who works under the direct observation of an alcohol and drug counselor to present to clients on topics in which the guest speaker has expertise and that the license holder has determined to be beneficial to a client's recovery. Tribally licensed programs have autonomy to identify the qualifications of their guest speakers.

Sec. 16. Minnesota Statutes 2020, section 245G.07, is amended by adding a subdivision to read:

Subd. 3a. **Use of guest speakers.** (a) The license holder may allow a guest speaker to present information to clients as part of a treatment service provided by an alcohol and drug counselor, according to the requirements of this subdivision.

(b) An alcohol and drug counselor must visually observe and listen to the presentation of information by a guest speaker the entire time the guest speaker presents information to

the clients. The alcohol and drug counselor is responsible for all information the guest speaker presents to the clients.

(c) The presentation of information by a guest speaker constitutes a direct contact service, as defined in section 245C.02, subdivision 11.

(d) The license holder must provide the guest speaker with all training required for staff members. If the guest speaker provides direct contact services one day a month or less, the license holder must only provide the guest speaker with orientation training on the following subjects before the guest speaker provides direct contact services:

(1) mandatory reporting of maltreatment, as specified in sections 245A.65, 626.557, and 626.5572 and chapter 260E;

(2) applicable client confidentiality rules and regulations;

(3) ethical standards for client interactions; and

(4) emergency procedures.

Sec. 17. Minnesota Statutes 2020, section 245G.12, is amended to read:

245G.12 PROVIDER POLICIES AND PROCEDURES.

A license holder must develop a written policies and procedures manual, indexed according to section 245A.04, subdivision 14, paragraph (c), that provides staff members immediate access to all policies and procedures and provides a client and other authorized parties access to all policies and procedures. The manual must contain the following materials:

(1) assessment and treatment planning policies, including screening for mental health concerns and treatment objectives related to the client's identified mental health concerns in the client's treatment plan;

(2) policies and procedures regarding HIV according to section 245A.19;

(3) the license holder's methods and resources to provide information on tuberculosis and tuberculosis screening to each client and to report a known tuberculosis infection according to section 144.4804;

(4) personnel policies according to section 245G.13;

(5) policies and procedures that protect a client's rights according to section 245G.15;

(6) a medical services plan according to section 245G.08;

(7) emergency procedures according to section 245G.16;

(8) policies and procedures for maintaining client records according to section 245G.09;

(9) procedures for reporting the maltreatment of minors according to chapter 260E, and vulnerable adults according to sections 245A.65, 626.557, and 626.5572;

(10) a description of treatment services that: (i) includes the amount and type of services provided; (ii) identifies which services meet the definition of group counseling under section 245G.01, subdivision 13a; ~~and~~ (iii) identifies which groups and topics on which a guest speaker could provide services under the direct observation of an alcohol and drug counselor; and (iv) defines the program's treatment week;

(11) the methods used to achieve desired client outcomes;

(12) the hours of operation; and

(13) the target population served.

Sec. 18. Minnesota Statutes 2021 Supplement, section 245I.02, subdivision 19, is amended to read:

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) or another tool authorized by the commissioner.

Sec. 19. Minnesota Statutes 2021 Supplement, section 245I.02, subdivision 36, is amended to read:

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 but does have physical access 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.

EFFECTIVE DATE. This section 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.

Sec. 20. Minnesota Statutes 2021 Supplement, section 245I.03, subdivision 5, is amended to read:

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~~ 5, and the documentation requirements in section 245I.08, subdivision 5.

EFFECTIVE DATE. This section 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.

Sec. 21. Minnesota Statutes 2021 Supplement, section 245I.03, subdivision 9, is amended to read:

Subd. 9. **Volunteers.** ~~A~~ If a license holder uses volunteers, the license holder must have policies and procedures for using volunteers, including when ~~a~~ the license holder must submit a background study for a volunteer, and the specific tasks that a volunteer may perform.

EFFECTIVE DATE. This section 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.

Sec. 22. Minnesota Statutes 2021 Supplement, section 245I.04, subdivision 4, is amended to read:

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~~.~~; 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) 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.

EFFECTIVE DATE. This section 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.

Sec. 23. Minnesota Statutes 2021 Supplement, section 245I.05, subdivision 3, is amended to read:

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, and 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~~ required to receive the training according to 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.

EFFECTIVE DATE. This section 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.

Sec. 24. Minnesota Statutes 2021 Supplement, section 245I.08, subdivision 4, is amended to read:

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.

EFFECTIVE DATE. This section 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.

Sec. 25. Minnesota Statutes 2021 Supplement, section 245I.09, subdivision 2, is amended to read:

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~~ closes a program must retain ~~the~~ a 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.

EFFECTIVE DATE. This section 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.

Sec. 26. Minnesota Statutes 2021 Supplement, section 245I.10, subdivision 2, is amended to read:

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~~ 245I.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.

EFFECTIVE DATE. This section 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.

Sec. 27. Minnesota Statutes 2021 Supplement, section 245I.10, subdivision 6, is amended to read:

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~~ paragraph 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.

EFFECTIVE DATE. This section 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.

Sec. 28. Minnesota Statutes 2021 Supplement, section 245I.20, subdivision 5, is amended to read:

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 and document 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.

Sec. 29. Minnesota Statutes 2021 Supplement, section 245I.23, subdivision 22, is amended to read:

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~~ 15 to 17.

(c) The license holder must have policies and procedures for discharging clients under subdivision ~~17~~ 18. In the policies and procedures, the license holder must identify the staff persons who are authorized to discharge clients from the program.

EFFECTIVE DATE. This section 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.

Sec. 30. Minnesota Statutes 2021 Supplement, 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;

(3) disability responsive programs as defined in section 254B.01, subdivision 4b;

(4) 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; or

(5) 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)~~ under section 245I.04, subdivision 2, or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and ~~licensed~~ mental health professional under section 245I.04, subdivision 2, 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, substance use disorder services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of 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.

(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.

(h) 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 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.

Sec. 31. Minnesota Statutes 2021 Supplement, 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 a plan described by section 245I.10, subdivisions 7 and 8.

(e) "Crisis assessment and intervention" means ~~mental health~~ mobile crisis response services ~~as defined in~~ under section 256B.0624~~, subdivision 2~~.

(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.

(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.

(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.

EFFECTIVE DATE. This section 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.

Sec. 32. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 3b, is amended to read:

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

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

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

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

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

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

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

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

(1) the type of service delivered through telehealth;

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

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

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

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

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

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

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

~~(e) For mental health services or assessments delivered through telehealth that are based on an individual treatment plan, the provider may document the client's verbal approval or electronic written approval of the treatment plan or change in the treatment plan in lieu of the client's signature in accordance with Minnesota Rules, part 9505.0371.~~

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

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

(2) "health care provider" means a health care provider as defined under section 62A.673, a community paramedic as defined under section 144E.001, subdivision 5f, a community health worker who meets the criteria under subdivision 49, paragraph (a), a mental health certified peer specialist under section ~~256B.0615, subdivision 5~~ 245I.04, subdivision 10, a mental health certified family peer specialist under section ~~256B.0616, subdivision 5~~ 245I.04, subdivision 12, a mental health rehabilitation worker under section ~~256B.0623, subdivision 5, paragraph (a), clause (4), and paragraph (b)~~ 245I.04, subdivision 14, a mental health behavioral aide under section ~~256B.0943, subdivision 7, paragraph (b), clause (3)~~ 245I.04, subdivision 16, a treatment coordinator under section 245G.11, subdivision 7, an alcohol and drug counselor under section 245G.11, subdivision 5, or a recovery peer under section 245G.11, subdivision 8; and

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

EFFECTIVE DATE. This section is effective July 1, 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. 33. Minnesota Statutes 2020, section 256B.0659, subdivision 19, is amended to read:

Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a) Under personal care assistance choice, the recipient or responsible party shall:

(1) recruit, hire, schedule, and terminate personal care assistants according to the terms of the written agreement required under subdivision 20, paragraph (a);

(2) develop a personal care assistance care plan based on the assessed needs and addressing the health and safety of the recipient with the assistance of a qualified professional as needed;

(3) orient and train the personal care assistant with assistance as needed from the qualified professional;

(4) ~~effective January 1, 2010,~~ supervise and evaluate the personal care assistant with the qualified professional, who is required to visit the recipient at least every 180 days;

(5) monitor and verify in writing and report to the personal care assistance choice agency the number of hours worked by the personal care assistant and the qualified professional;

(6) engage in an annual ~~face-to-face~~ reassessment as required in subdivision 3a to determine continuing eligibility and service authorization; and

(7) use the same personal care assistance choice provider agency if shared personal assistance care is being used.

(b) The personal care assistance choice provider agency shall:

(1) meet all personal care assistance provider agency standards;

(2) enter into a written agreement with the recipient, responsible party, and personal care assistants;

(3) not be related as a parent, child, sibling, or spouse to the recipient or the personal care assistant; and

(4) ensure arm's-length transactions without undue influence or coercion with the recipient and personal care assistant.

(c) The duties of the personal care assistance choice provider agency are to:

(1) be the employer of the personal care assistant and the qualified professional for employment law and related regulations including~~,~~ but not limited to~~,~~ purchasing and maintaining workers' compensation, unemployment insurance, surety and fidelity bonds, and liability insurance, and submit any or all necessary documentation including~~,~~ but not limited to~~,~~ workers' compensation, unemployment insurance, and labor market data required under section 256B.4912, subdivision 1a;

(2) bill the medical assistance program for personal care assistance services and qualified professional services;

(3) request and complete background studies that comply with the requirements for personal care assistants and qualified professionals;

(4) pay the personal care assistant and qualified professional based on actual hours of services provided;

(5) withhold and pay all applicable federal and state taxes;

(6) verify and keep records of hours worked by the personal care assistant and qualified professional;

(7) make the arrangements and pay taxes and other benefits, if any, and comply with any legal requirements for a Minnesota employer;

(8) enroll in the medical assistance program as a personal care assistance choice agency; and

(9) enter into a written agreement as specified in subdivision 20 before services are provided.

Sec. 34. Minnesota Statutes 2021 Supplement, section 256B.0671, subdivision 6, is amended to read:

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)~~ (1) have mental health needs that available community-based services cannot meet or that the client must receive concurrently with other community-based services;

~~(3)~~ (2) 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)~~ (3) 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)~~ (4) 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.

EFFECTIVE DATE. This section 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.

Sec. 35. Minnesota Statutes 2021 Supplement, 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. Assessments must be conducted according to paragraphs (b) to (r).

(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 (r), 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) An assessment that is 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 the 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 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 fewer 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 paragraph shall change annual long-term care consultation reassessment requirements, payment for institutional or treatment services, medical assistance financial eligibility, or any other law.

(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.

(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.

(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.

(r) All assessments performed according to this subdivision must be face-to-face unless the assessment is a reassessment meeting the requirements of this paragraph. Remote reassessments conducted by interactive video or telephone may substitute for face-to-face reassessments. For services provided by 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. For services provided by alternative care under section 256B.0913, essential community supports under section 256B.0922, and the elderly waiver under chapter 256S, remote reassessments may be substituted for one reassessment if followed by a face-to-face reassessment. A remote reassessment is permitted only if the lead agency provides informed

choice and the person being reassessed~~, or the person's legal representative, and the lead agency case manager both 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~~ or the person's legal representative provides informed consent for a remote assessment. Lead agencies must document that informed choice was offered. 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 a face-to-face reassessment is necessary ~~in order~~ to complete the assessment, the lead agency shall schedule a face-to-face reassessment. All other requirements of a face-to-face reassessment shall apply to a remote reassessment, including updates to a person's support plan.

Sec. 36. Minnesota Statutes 2020, section 256B.092, subdivision 1a, is amended to read:

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

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

(1) development of the person-centered coordinated service and support plan under subdivision 1b;

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

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

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

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

(ii) employment service providers;

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

(iv) providers of financial management services;

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

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

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

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

(c) Case management service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. If a county agency contracts for case management services, the county agency must provide each recipient of home and community-based services who is receiving contracted case management services with the contact information the recipient may use to file a grievance with the county agency about the quality of the contracted services the recipient is receiving from a county-contracted case manager. Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

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

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

(1) phasing out the use of prohibited procedures;

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

(3) accomplishment of identified outcomes.

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

(f) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year. The education and training must include person-centered planning. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision 1a, paragraph (f).

Sec. 37. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) Subject to federal approval, medical assistance covers medically necessary intensive treatment services when the services are provided by a provider entity 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 (6) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional or a clinical trainee;

(2) crisis planning;

(3) individual, family, and group psychoeducation services provided by a mental health professional or a clinical trainee;

(4) clinical care consultation provided by a mental health professional or a clinical trainee;

(5) individual treatment plan development as defined in ~~Minnesota Rules, part 9505.0371, subpart 7~~ section 245I.10, subdivisions 7 and 8; and

(6) service delivery payment requirements as provided under subdivision 4.

EFFECTIVE DATE. This section 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.

Sec. 38. Minnesota Statutes 2021 Supplement, 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 who are eight years of age or older and under 26 years of age 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 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" means the assessment described in section 245I.10, subdivision 6.

(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.

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

(f) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.

(g) "Substance use disorders" means one or more of the disorders defined in the diagnostic and statistical manual of mental disorders, current edition.

(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.~~

(i) "Treatment team" means all staff who provide services to recipients under this section.

(j) "Family peer specialist" means a staff person who is qualified under section 256B.0616.

Sec. 39. Minnesota Statutes 2021 Supplement, 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 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~~ 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, according to section 245I.10, subdivisions 7 and 8, and the individual treatment plan must:

(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;

(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; and

(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.

EFFECTIVE DATE. This section 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.

Sec. 40. Minnesota Statutes 2021 Supplement, 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) "Advanced certification" means a person who has completed advanced certification in an approved modality under subdivision 13, paragraph (b).

~~(b)~~ (c) "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)~~ (d) "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)~~ (e) "Person" means a person under 21 years of age.

~~(e)~~ (f) "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)~~ (g) "Commissioner" means the commissioner of human services, unless otherwise specified.

~~(g)~~ (h) "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)~~ (i) "Department" means the Department of Human Services, unless otherwise specified.

~~(i)~~ (j) "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)~~ (k) "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)~~ (l) "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)~~ (m) "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)~~ (n) "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)~~ (o) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

~~(o)~~ (p) "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)~~ (q) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or level III treatment provider.

Sec. 41. Minnesota Statutes 2020, section 256B.0949, subdivision 8, is amended to read:

Subd. 8. **Refining the benefit with stakeholders.** Before making revisions to the EIDBI benefit or proposing statutory changes to this section, the commissioner must ~~refine the details of the benefit in consultation~~ consult with stakeholders and consider recommendations from the Department of Human Services Early Intensive Developmental and Behavioral Intervention Advisory Council, the early intensive developmental and behavioral intervention learning collaborative, and the Departments of Health, Education, Employment and Economic Development, and Human Services. ~~The details must~~ Revisions and proposed statutory changes subject to this subdivision include, but are not limited to, the following components:

(1) a definition of the qualifications, standards, and roles of the treatment team, including recommendations after stakeholder consultation on whether board-certified behavior analysts

and other professionals certified in other treatment approaches recognized by the department or trained in ASD or a related condition and child development should be added as professionals qualified to provide EIDBI clinical supervision or other functions under medical assistance;

(2) refinement of uniform parameters for CMDE and ongoing ITP progress monitoring standards;

(3) the design of an effective and consistent process for assessing the person's and the person's legal representative's and the person's caregiver's preferences and options to participate in the person's early intervention treatment and efficacy of methods to involve and educate the person's legal representative and caregiver in the treatment of the person;

(4) formulation of a collaborative process in which professionals have opportunities to collectively inform provider standards and qualifications; standards for CMDE; medical necessity determination; efficacy of treatment apparatus, including modality, intensity, frequency, and duration; and ITP progress monitoring processes to support quality improvement of EIDBI services;

(5) coordination of this benefit and its interaction with other services provided by the Departments of Human Services, Health, Employment and Economic Development, and Education;

(6) evaluation, on an ongoing basis, of EIDBI services outcomes and efficacy of treatment modalities provided to people under this benefit; and

(7) as provided under subdivision 17, determination of the availability of qualified EIDBI providers with necessary expertise and training in ASD or a related condition throughout the state to assess whether there are sufficient professionals to provide timely access and prevent delay in the CMDE and treatment of a person with ASD or a related condition.

Sec. 42. Minnesota Statutes 2021 Supplement, section 256B.0949, subdivision 13, is amended to read:

Subd. 13. **Covered services.** (a) The services described in paragraphs (b) to (l) are eligible for reimbursement by medical assistance under this section. Services must be provided by a qualified EIDBI provider and supervised by a QSP. An EIDBI service must address the person's medically necessary treatment goals and must be targeted to develop, enhance, or maintain the individual developmental skills of a person with ASD or a related condition to improve functional communication, including nonverbal or social communication, social or interpersonal interaction, restrictive or repetitive behaviors,

hyperreactivity or hyporeactivity to sensory input, behavioral challenges and self-regulation, cognition, learning and play, self-care, and safety.

(b) EIDBI treatment must be delivered consistent with the standards of an approved modality, as published by the commissioner. EIDBI modalities include:

(1) applied behavior analysis (ABA);

(2) developmental individual-difference relationship-based model (DIR/Floortime);

(3) early start Denver model (ESDM);

(4) PLAY project;

(5) relationship development intervention (RDI); or

(6) additional modalities not listed in clauses (1) to (5) upon approval by the commissioner.

(c) An EIDBI provider may use one or more of the EIDBI modalities in paragraph (b), clauses (1) to (5), as the primary modality for treatment as a covered service, or several EIDBI modalities in combination as the primary modality of treatment, as approved by the commissioner. An EIDBI provider that identifies and provides assurance of qualifications for a single specific treatment modality, including an EIDBI provider with advanced certification overseeing implementation, must document the required qualifications to meet fidelity to the specific model in a manner determined by the commissioner.

(d) Each qualified EIDBI provider must identify and provide assurance of qualifications for professional licensure certification, or training in evidence-based treatment methods, and must document the required qualifications outlined in subdivision 15 in a manner determined by the commissioner.

(e) CMDE is a comprehensive evaluation of the person's developmental status to determine medical necessity for EIDBI services and meets the requirements of subdivision 5. The services must be provided by a qualified CMDE provider.

(f) EIDBI intervention observation and direction is the clinical direction and oversight of EIDBI services by the QSP, level I treatment provider, or level II treatment provider, including developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for the direct benefit of a person. EIDBI intervention observation and direction informs any modification of the current treatment protocol to support the outcomes outlined in the ITP.

(g) Intervention is medically necessary direct treatment provided to a person with ASD or a related condition as outlined in their ITP. All intervention services must be provided under the direction of a QSP. Intervention may take place across multiple settings. The frequency and intensity of intervention services are provided based on the number of treatment goals, person and family or caregiver preferences, and other factors. Intervention services may be provided individually or in a group. Intervention with a higher provider ratio may occur when deemed medically necessary through the person's ITP.

(1) Individual intervention is treatment by protocol administered by a single qualified EIDBI provider delivered to one person.

(2) Group intervention is treatment by protocol provided by one or more qualified EIDBI providers, delivered to at least two people who receive EIDBI services.

(3) Higher provider ratio intervention is treatment with protocol modification provided by two or more qualified EIDBI providers delivered to one person in an environment that meets the person's needs and under the direction of the QSP or level I provider.

(h) ITP development and ITP progress monitoring is development of the initial, annual, and progress monitoring of an ITP. ITP development and ITP progress monitoring documents provide oversight and ongoing evaluation of a person's treatment and progress on targeted goals and objectives and integrate and coordinate the person's and the person's legal representative's information from the CMDE and ITP progress monitoring. This service must be reviewed and completed by the QSP, and may include input from a level I provider or a level II provider.

(i) Family caregiver training and counseling is specialized training and education for a family or primary caregiver to understand the person's developmental status and help with the person's needs and development. This service must be provided by the QSP, level I provider, or level II provider.

(j) A coordinated care conference is a voluntary meeting with the person and the person's family to review the CMDE or ITP progress monitoring and to integrate and coordinate services across providers and service-delivery systems to develop the ITP. This service ~~must be provided by the QSP and~~ may include the CMDE provider ~~or~~, QSP, a level I provider, or a level II provider.

(k) Travel time is allowable billing for traveling to and from the person's home, school, a community setting, or place of service outside of an EIDBI center, clinic, or office from a specified location to provide in-person EIDBI intervention, observation and direction, or

family caregiver training and counseling. The person's ITP must specify the reasons the provider must travel to the person.

(l) Medical assistance covers medically necessary EIDBI services and consultations delivered ~~by a licensed health care provider~~ via telehealth, as defined under section 256B.0625, subdivision 3b, in the same manner as if the service or consultation was delivered in person.

Sec. 43. Minnesota Statutes 2020, section 256G.02, subdivision 6, is amended to read:

Subd. 6. **Excluded time.** "Excluded time" means:

(1) any period an applicant spends in a hospital, sanitarium, nursing home, shelter other than an emergency shelter, halfway house, foster home, community residential setting licensed under chapter 245D, semi-independent living domicile or services program, residential facility offering care, board and lodging facility or other institution for the hospitalization or care of human beings, as defined in section 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter, or correctional facility; or any facility based on an emergency hold under section 253B.05, subdivisions 1 and 2;

(2) any period an applicant spends on a placement basis in a training and habilitation program, including: a rehabilitation facility or work or employment program as defined in section 268A.01; semi-independent living services provided under section 252.275, and chapter 245D; or day training and habilitation programs ~~and~~;

(3) any period an applicant is receiving assisted living services, integrated community supports, or day support services; and

~~(3)~~ (4) any placement for a person with an indeterminate commitment, including independent living.

Sec. 44. Minnesota Statutes 2020, section 256K.26, subdivision 2, is amended to read:

Subd. 2. **Implementation.** The commissioner, in consultation with the commissioners of the Department of Corrections and the Minnesota Housing Finance Agency, counties, Tribes, providers, and funders of supportive housing and services, shall develop application requirements and make funds available according to this section, with the goal of providing maximum flexibility in program design.

Sec. 45. Minnesota Statutes 2020, section 256K.26, subdivision 6, is amended to read:

Subd. 6. **Outcomes.** Projects will be selected to further the following outcomes:

(1) reduce the number of Minnesota individuals and families that experience long-term homelessness;

(2) increase the number of housing opportunities with supportive services;

(3) develop integrated, cost-effective service models that address the multiple barriers to obtaining housing stability faced by people experiencing long-term homelessness, including abuse, neglect, chemical dependency, disability, chronic health problems, or other factors including ethnicity and race that may result in poor outcomes or service disparities;

(4) encourage partnerships among counties, Tribes, community agencies, schools, and other providers so that the service delivery system is seamless for people experiencing long-term homelessness;

(5) increase employability, self-sufficiency, and other social outcomes for individuals and families experiencing long-term homelessness; and

(6) reduce inappropriate use of emergency health care, shelter, ~~chemical dependency~~ substance use disorder treatment, foster care, child protection, corrections, and similar services used by people experiencing long-term homelessness.

Sec. 46. Minnesota Statutes 2020, section 256K.26, subdivision 7, is amended to read:

Subd. 7. **Eligible services.** Services eligible for funding under this section are all services needed to maintain households in permanent supportive housing, as determined by the ~~county or~~ counties or Tribes administering the project or projects.

Sec. 47. Minnesota Statutes 2021 Supplement, 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 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)~~ 245I.04, subdivision 2, or an individual as defined in section 245G.11, subdivision 3, 4, or 5.

EFFECTIVE DATE. This section 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.

Sec. 48. Minnesota Statutes 2020, section 256Q.06, is amended by adding a subdivision to read:

Subd. 6. **Account creation.** If an eligible individual is unable to establish the eligible individual's own ABLE account, an ABLE account may be established on behalf of the eligible individual by the eligible individual's agent under a power of attorney or, if none, by the eligible individual's conservator or legal guardian, spouse, parent, sibling, or grandparent or a representative payee appointed for the eligible individual by the Social Security Administration, in that order.

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

Sec. 49. Laws 2020, First Special Session chapter 7, section 1, subdivision 1, as amended by Laws 2021, First Special Session chapter 7, article 2, section 71, is amended to read:

Subdivision 1. **Waivers and modifications; federal funding extension.** 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 20-11 and 20-12 ~~that are required to comply with federal law~~ may remain in effect for the time period set out in applicable federal law or for the time period set out in any applicable federally approved waiver or state plan amendment, whichever is later:

(1) CV15: allowing telephone or video visits for waiver programs;

(2) CV17: preserving health care coverage for Medical Assistance and MinnesotaCare;

(3) CV18: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(4) CV20: eliminating cost-sharing for COVID-19 diagnosis and treatment;

(5) CV24: allowing telephone or video use for targeted case management visits;

(6) CV30: expanding telemedicine in health care, mental health, and substance use disorder settings;

(7) CV37: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(8) CV39: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(9) CV42: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(10) CV43: expanding remote home and community-based waiver services;

(11) CV44: allowing remote delivery of adult day services;

(12) CV59: modifying eligibility period for the federally funded Refugee Cash Assistance Program;

(13) CV60: modifying eligibility period for the federally funded Refugee Social Services Program; and

(14) CV109: providing 15 percent increase for Minnesota Food Assistance Program and Minnesota Family Investment Program maximum food benefits.

Sec. 50. Laws 2021, First Special Session chapter 7, article 11, section 38, is amended to read:

Sec. 38. **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, 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 the 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~~ Within two years of contracting with a qualified vendor according to paragraph (d), 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. 51. **REVISOR INSTRUCTION.**

In Minnesota Statutes and Minnesota Rules, the revisor of statutes shall change the term "chemical dependency" or similar terms to "substance use disorder." The revisor may make grammatical changes related to the term change.

Sec. 52. **REPEALER.**

(a) Minnesota Statutes 2020, sections 254A.04; and 254B.14, subdivisions 1, 2, 3, 4, and 6, are repealed.

(b) Minnesota Statutes 2021 Supplement, section 254B.14, subdivision 5, is repealed.

ARTICLE 5
COMMUNITY SUPPORTS

Section 1. Minnesota Statutes 2020, section 245D.10, subdivision 3a, is amended to read:

Subd. 3a. **Service termination.** (a) The license holder must establish policies and procedures for service termination that promote continuity of care and service coordination with the person and the case manager and with other licensed caregivers, if any, who also provide support to the person. The policy must include the requirements specified in paragraphs (b) to (f).

(b) The license holder must permit each person to remain in the program or to continue receiving services and must not terminate services unless:

(1) the termination is necessary for the person's welfare and the ~~facility~~ license holder cannot meet the person's needs;

(2) the safety of the person ~~or~~, others in the program, or staff is endangered and positive support strategies were attempted and have not achieved and effectively maintained safety for the person or others;

(3) the health of the person ~~or~~, others in the program, or staff would otherwise be endangered;

(4) the ~~program~~ license holder has not been paid for services;

(5) the program or license holder ceases to operate;

(6) the person has been terminated by the lead agency from waiver eligibility; or

(7) for state-operated community-based services, the person no longer demonstrates complex behavioral needs that cannot be met by private community-based providers identified in section 252.50, subdivision 5, paragraph (a), clause (1).

(c) Prior to giving notice of service termination, the license holder must document actions taken to minimize or eliminate the need for termination. Action taken by the license holder must include, at a minimum:

(1) consultation with the person's support team or expanded support team to identify and resolve issues leading to issuance of the termination notice;

(2) a request to the case manager for intervention services identified in section 245D.03, subdivision 1, paragraph (c), clause (1), or other professional consultation or intervention

services to support the person in the program. This requirement does not apply to notices of service termination issued under paragraph (b), clauses (4) and (7); and

(3) for state-operated community-based services terminating services under paragraph (b), clause (7), the state-operated community-based services must engage in consultation with the person's support team or expanded support team to:

(i) identify that the person no longer demonstrates complex behavioral needs that cannot be met by private community-based providers identified in section 252.50, subdivision 5, paragraph (a), clause (1);

(ii) provide notice of intent to issue a termination of services to the lead agency when a finding has been made that a person no longer demonstrates complex behavioral needs that cannot be met by private community-based providers identified in section 252.50, subdivision 5, paragraph (a), clause (1);

(iii) assist the lead agency and case manager in developing a person-centered transition plan to a private community-based provider to ensure continuity of care; and

(iv) coordinate with the lead agency to ensure the private community-based service provider is able to meet the person's needs and criteria established in a person's person-centered transition plan.

If, based on the best interests of the person, the circumstances at the time of the notice were such that the license holder was unable to take the action specified in clauses (1) and (2), the license holder must document the specific circumstances and the reason for being unable to do so.

(d) The notice of service termination must meet the following requirements:

(1) the license holder must notify the person or the person's legal representative and the case manager in writing of the intended service termination. If the service termination is from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), the license holder must also notify the commissioner in writing; and

(2) the notice must include:

(i) the reason for the action;

(ii) except for a service termination under paragraph (b), clause (5), a summary of actions taken to minimize or eliminate the need for service termination or temporary service suspension as required under paragraph (c), and why these measures failed to prevent the termination or suspension;

(iii) the person's right to appeal the termination of services under section 256.045, subdivision 3, paragraph (a); and

(iv) the person's right to seek a temporary order staying the termination of services according to the procedures in section 256.045, subdivision 4a or 6, paragraph (c).

(e) Notice of the proposed termination of service, including those situations that began with a temporary service suspension, must be given at least 90 days prior to termination of services under paragraph (b), clause (7), 60 days prior to termination when a license holder is providing intensive supports and services identified in section 245D.03, subdivision 1, paragraph (c), and 30 days prior to termination for all other services licensed under this chapter. This notice may be given in conjunction with a notice of temporary service suspension under subdivision 3.

(f) During the service termination notice period, the license holder must:

(1) work with the support team or expanded support team to develop reasonable alternatives to protect the person and others and to support continuity of care;

(2) provide information requested by the person or case manager; and

(3) maintain information about the service termination, including the written notice of intended service termination, in the service recipient record.

(g) For notices issued under paragraph (b), clause (7), the lead agency shall provide notice to the commissioner and state-operated services at least 30 days before the conclusion of the 90-day termination period, if an appropriate alternative provider cannot be secured. Upon receipt of this notice, the commissioner and state-operated services shall reassess whether a private community-based service can meet the person's needs. If the commissioner determines that a private provider can meet the person's needs, state-operated services shall, if necessary, extend notice of service termination until placement can be made. If the commissioner determines that a private provider cannot meet the person's needs, state-operated services shall rescind the notice of service termination and re-engage with the lead agency in service planning for the person.

(h) For state-operated community-based services, the license holder shall prioritize the capacity created within the existing service site by the termination of services under paragraph (b), clause (7), to serve persons described in section 252.50, subdivision 5, paragraph (a), clause (1).

Sec. 2. Minnesota Statutes 2020, section 256.045, subdivision 3, is amended to read:

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

(1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food and Nutrition Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid;

(2) any patient or relative aggrieved by an order of the commissioner under section 252.27;

(3) a party aggrieved by a ruling of a prepaid health plan;

(4) except as provided under chapter 245C, any individual or facility determined by a lead investigative agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557;

(5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under chapter 260E is denied or not acted upon with reasonable promptness, regardless of funding source;

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under chapter 260E, after the individual or facility has exercised the right to administrative reconsideration under chapter 260E;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 260E.06, subdivision 1, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the

basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment;

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food and Nutrition Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt;

(12) a person issued a notice of service termination under section 245D.10, subdivision 3a, ~~from~~ by a licensed provider of any residential supports ~~and~~ or services ~~as defined~~ listed in section 245D.03, subdivision 1, ~~paragraph~~ paragraphs (b) and (c), ~~clause (3),~~ that is not otherwise subject to appeal under subdivision 4a;

(13) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914; or

(14) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

(i) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision 13, why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence.

Sec. 3. Minnesota Statutes 2020, section 256I.03, subdivision 6, is amended to read:

Subd. 6. **Medical assistance room and board rate.** "Medical assistance room and board rate" means an amount equal to ~~the medical assistance income standard~~ 81 percent of the federal poverty guideline for a single individual living alone in the community less the medical assistance personal needs allowance under section 256B.35. For the purposes of this section, the amount of the room and board rate that exceeds the medical assistance room and board rate is considered a remedial care cost. A remedial care cost may be used to meet a spenddown obligation under section 256B.056, subdivision 5. The medical assistance room and board rate is to be adjusted on the first day of January of each year.

ARTICLE 6
BEHAVIORAL HEALTH

Section 1. **[4.046] OPIOIDS, SUBSTANCE USE, AND ADDICTION SUBCABINET.**

Subdivision 1. **Subcabinet established; purposes.** The Opioids, Substance Use, and Addiction Subcabinet is established. The purposes of the subcabinet are to identify:

(1) challenges that exist within state government that create silos around addiction, treatment, prevention, and recovery; that limit access to treatment options or addiction-related services for all Minnesotans; and that prevent successful treatment outcomes;

(2) opportunities that exist within state government that support accessible and effective substance use disorder treatment options or addiction-related services;

(3) barriers and gaps in service for all Minnesotans seeking treatment for opioid or substance use disorder, particularly those barriers and gaps affecting members of communities disproportionately impacted by substance use and addiction;

(4) potential solutions to barriers and gaps identified in clause (3);

(5) how the state can address addiction as a chronic disease, emphasizing that there are multiple ways to enter sobriety; and

(6) policies and strategies that address prevention efforts, including addressing underlying causes of addiction and public awareness and education around the dangers of issues including but not limited to opioid abuse, use of fentanyl and other synthetic opioids, other substance use, excessive alcohol consumption, and addiction.

Subd. 2. **Subcabinet membership.** The subcabinet consists of the following members:

(1) the commissioner of human services;

(2) the commissioner of health;

(3) the commissioner of education;

(4) the commissioner of public safety;

(5) the commissioner of corrections;

(6) the commissioner of management and budget;

(7) the commissioner of higher education;

(8) the chair of the Interagency Council on Homelessness; and

(9) the governor's director of addiction and recovery, who shall serve as chair of the subcabinet.

Subd. 3. **Policy and strategy development.** The subcabinet must engage in the following duties related to the development of opioid use, substance use, and addiction policy and strategy:

(1) identify challenges and opportunities that exist relating to accessing treatment and support services and develop recommendations to overcome these barriers for all Minnesotans;

(2) with input from affected communities, develop policies and strategies that will reduce barriers and gaps in service for all Minnesotans seeking treatment for opioid or substance use disorder, particularly for those Minnesotans who are members of communities disproportionately impacted by substance use and addiction;

(3) develop policies and strategies that the state may adopt to expand Minnesota's recovery infrastructure, including detoxification or withdrawal management facilities, treatment facilities, and sober housing;

(4) identify innovative services and strategies for effective treatment and support;

(5) develop policies and strategies to expand services and support for people in Minnesota suffering from opioid or substance use disorder through partnership with the Opioid Epidemic Response Advisory Council and other relevant partnerships;

(6) develop policies and strategies for agencies to manage addiction and the relationship it has with co-occurring conditions;

(7) identify policies and strategies to address opioid or substance use disorder among Minnesotans experiencing homelessness; and

(8) submit recommendations to the legislature addressing opioid use, substance use, and addiction in Minnesota.

Subd. 4. **Public engagement.** The subcabinet must develop and implement a framework to ensure meaningful public engagement is conducted by the subcabinet's agencies and boards. The purpose of the framework is to:

(1) engage with and seek feedback from all affected Minnesotans, including members of the 11 Tribal Nations within Minnesota;

(2) build partnerships and shared understanding with all affected Minnesotans, including members of Tribal communities in urban areas, communities of color, local communities, and industries, including but not limited to the health and business sectors;

(3) provide a platform for dialogue about the needs and challenges of those in active addiction or in recovery and to identify effective solutions and how those solutions will impact the lives of people in Minnesota, including those who are members of communities disproportionately impacted by addiction, including opioid addiction; and

(4) gather and share ideas for how Minnesotans can get involved with and stay informed about addiction issues that matter to them.

Subd. 5. **Governor's Advisory Council on Opioids, Substance Use, and Addiction.** (a) The Governor's Advisory Council on Opioids, Substance Use, and Addiction is established to advise the subcabinet on the purposes and duties described in this section. The advisory council consists of up to 18 members appointed by the governor. The governor must seek representation from community leaders, individuals with direct experience with addiction, individuals providing treatment services, and other relevant stakeholders in making appointments to the council. The governor will appoint one member as chair of the advisory council.

(b) The advisory council must:

(1) meet up to four times per year to identify opportunities for and barriers to the development and implementation of policies and strategies to expand access to effective services for people in Minnesota suffering from addiction;

(2) examine what services and supports are needed in communities that are disproportionately impacted by the opioid epidemic; and

(3) provide opportunities for Minnesotans who have directly experienced addiction to address needs, challenges, and solutions.

(c) The terms, compensation, and removal of members of the advisory council are governed by section 15.059.

Subd. 6. **Addiction and recovery director.** The governor must appoint an addiction and recovery director, who shall serve as chair of the subcabinet. The director shall serve in the unclassified service and shall report to the governor. The director must:

(1) make efforts to break down silos and work across agencies to better target the state's role in addressing addiction, treatment, and recovery;

(2) assist in leading the subcabinet and the advisory council toward progress on measurable goals that track the state's efforts in combatting addiction; and

(3) establish and manage external partnerships and build relationships with communities, community leaders, and those who have direct experience with addiction to ensure that all voices of recovery are represented in the work of the subcabinet and advisory council.

Subd. 7. **Staff and administrative support.** The commissioner of human services, in coordination with other state agencies and boards as applicable, must provide staffing and administrative support to the addiction and recovery director, the subcabinet, and the advisory council established in this section.

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

Sec. 2. Minnesota Statutes 2020, section 13.46, subdivision 7, is amended to read:

Subd. 7. **Mental health data.** (a) Mental health data are private data on individuals and shall not be disclosed, except:

(1) pursuant to section 13.05, as determined by the responsible authority for the community mental health center, mental health division, or provider;

(2) pursuant to court order;

(3) pursuant to a statute specifically authorizing access to or disclosure of mental health data or as otherwise provided by this subdivision;

(4) to personnel of the welfare system working in the same program or providing services to the same individual or family to the extent necessary to coordinate services, provided that a health record may be disclosed only as provided under section 144.293;

(5) to a health care provider governed by sections 144.291 to 144.298, to the extent necessary to coordinate services; or

(6) with the consent of the client or patient.

(b) An agency of the welfare system may not require an individual to consent to the release of mental health data as a condition for receiving services or for reimbursing a community mental health center, mental health division of a county, or provider under contract to deliver mental health services.

(c) Notwithstanding section 245.69, subdivision 2, paragraph (f), or any other law to the contrary, ~~the responsible authority for~~ a community mental health center, mental health division of a county, or a mental health provider must disclose mental health data to a law enforcement agency if the law enforcement agency provides the name of a client or patient and communicates that the:

(1) client or patient is currently involved in ~~an emergency interaction with~~ a mental health crisis as defined in section 256B.0624, subdivision 2, paragraph (j), to which the law enforcement agency has responded; and

(2) data is necessary to protect the health or safety of the client or patient or of another person.

The scope of disclosure under this paragraph is limited to the minimum necessary for law enforcement to safely respond to the ~~emergency~~ mental health crisis. Disclosure under this paragraph may include~~, but is not limited to,~~ the name and telephone number of the psychiatrist, psychologist, therapist, mental health professional, practitioner, or case manager of the client or patient, if known; and strategies to address the mental health crisis. A law enforcement agency that obtains mental health data under this paragraph shall maintain a record of the requestor, the provider of the ~~information~~ data, and the client or patient name. Mental health data obtained by a law enforcement agency under this paragraph are private data on individuals and must not be used by the law enforcement agency for any other purpose. A law enforcement agency that obtains mental health data under this paragraph shall inform the subject of the data that mental health data was obtained.

(d) In the event of a request under paragraph (a), clause (6), a community mental health center, county mental health division, or provider must release mental health data to Criminal Mental Health Court personnel in advance of receiving a copy of a consent if the Criminal Mental Health Court personnel communicate that the:

(1) client or patient is a defendant in a criminal case pending in the district court;

(2) data being requested is limited to information that is necessary to assess whether the defendant is eligible for participation in the Criminal Mental Health Court; and

(3) client or patient has consented to the release of the mental health data and a copy of the consent will be provided to the community mental health center, county mental health division, or provider within 72 hours of the release of the data.

For purposes of this paragraph, "Criminal Mental Health Court" refers to a specialty criminal calendar of the Hennepin County District Court for defendants with mental illness and brain injury where a primary goal of the calendar is to assess the treatment needs of the defendants and to incorporate those treatment needs into voluntary case disposition plans. The data released pursuant to this paragraph may be used for the sole purpose of determining whether the person is eligible for participation in mental health court. This paragraph does not in any way limit or otherwise extend the rights of the court to obtain the release of mental health data pursuant to court order or any other means allowed by law.

Sec. 3. Minnesota Statutes 2020, section 144.294, subdivision 2, is amended to read:

Subd. 2. **Disclosure to law enforcement agency.** Notwithstanding section 144.293, subdivisions 2 and 4, a provider must disclose health records relating to a patient's mental health to a law enforcement agency if the law enforcement agency provides the name of the patient and communicates that the:

(1) patient is currently involved in ~~an emergency interaction with~~ a mental health crisis as defined in section 256B.0624, subdivision 2, paragraph (j), to which the law enforcement agency has responded; and

(2) disclosure of the records is necessary to protect the health or safety of the patient or of another person.

The scope of disclosure under this subdivision is limited to the minimum necessary for law enforcement to safely respond to the ~~emergency~~ mental health crisis. The disclosure may include the name and telephone number of the psychiatrist, psychologist, therapist, mental health professional, practitioner, or case manager of the patient, if known; and strategies to address the mental health crisis. A law enforcement agency that obtains health records under this subdivision shall maintain a record of the requestor, the provider of the information, and the patient's name. Health records obtained by a law enforcement agency under this subdivision are private data on individuals as defined in section 13.02, subdivision 12, and must not be used by law enforcement for any other purpose. A law enforcement agency that obtains health records under this subdivision shall inform the patient that health records were obtained.

Sec. 4. Minnesota Statutes 2021 Supplement, 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 or already in out-of-home placement in family foster settings as defined in chapter 245A and at risk of change in out-of-home placement or placement in a residential facility or other higher level of care. Allowable activities and expenses for respite care services are defined under subdivision 4. 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;

(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.

(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.

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

Sec. 5. Minnesota Statutes 2020, section 245.4889, is amended by adding a subdivision to read:

Subd. 4. **Respite care services.** Respite care services under subdivision 1, paragraph (b), clause (3), include hourly or overnight stays at a licensed foster home or with a qualified and approved family member or friend and may occur at a child's or provider's home. Respite care services may also include the following activities and expenses:

(1) recreational, sport, and nonsport extracurricular activities and programs for the child including camps, clubs, lessons, group outings, sports, or other activities and programs;

(2) family activities, camps, and retreats that the family does together and provide a break from the family's circumstance;

(3) cultural programs and activities for the child and family designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background; and

(4) costs of transportation, food, supplies, and equipment directly associated with approved respite care services and expenses necessary for the child and family to access and participate in respite care services.

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

Sec. 6. Minnesota Statutes 2020, section 245.713, subdivision 2, is amended to read:

Subd. 2. **Total funds available; allocation.** Funds granted to the state by the federal government under United States Code, title 42, sections 300X to 300X-9 each federal fiscal year for mental health services must be allocated as follows:

(a) Any amount set aside by the commissioner of human services for American Indian organizations within the state, which funds shall not duplicate any direct federal funding of American Indian organizations and which funds shall be at least 25 percent of the total federal allocation to the state for mental health services~~; provided that sufficient applications for funding are received by the commissioner which meet the specifications contained in requests for proposals~~. Money from this source may be used for special committees to advise the commissioner on mental health programs and services for American Indians and other minorities or underserved groups. For purposes of this subdivision, "American Indian organization" means an American Indian tribe or band or an organization providing mental health services that is legally incorporated as a nonprofit organization registered with the secretary of state and governed by a board of directors having at least a majority of American Indian directors.

(b) An amount not to exceed five percent of the federal block grant allocation for mental health services to be retained by the commissioner for administration.

(c) Any amount permitted under federal law which the commissioner approves for demonstration or research projects for severely disturbed children and adolescents, the underserved, special populations or multiply disabled mentally ill persons. The groups to be served, the extent and nature of services to be provided, the amount and duration of any grant awards are to be based on criteria set forth in the Alcohol, Drug Abuse and Mental Health Block Grant Law, United States Code, title 42, sections 300X to 300X-9, and on state policies and procedures determined necessary by the commissioner. Grant recipients must comply with applicable state and federal requirements and demonstrate fiscal and

program management capabilities that will result in provision of quality, cost-effective services.

(d) The amount required under federal law, for federally mandated expenditures.

(e) An amount not to exceed 15 percent of the federal block grant allocation for mental health services to be retained by the commissioner for planning and evaluation.

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

Sec. 7. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers services provided by a not-for-profit certified community behavioral health clinic (CCBHC) ~~services~~ that ~~meet~~ meets the requirements of section 245.735, subdivision 3.

(b) The commissioner shall reimburse CCBHCs on a ~~per-visit~~ per-day basis ~~under the prospective payment~~ for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical assistance payments as described in paragraph (c). The commissioner shall include a quality incentive payment in the ~~prospective payment~~ CCBHC daily bundled rate system as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC ~~prospective payment~~ daily bundled rate system.

(c) The commissioner shall ensure that the ~~prospective payment~~ CCBHC daily bundled rate system for CCBHC payments under medical assistance meets the following requirements:

(1) the ~~prospective payment~~ CCBHC daily bundled 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 CCBHC 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~~ when an eligible CCBHC ~~visit eligible for reimbursement~~ service is provided. 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~~ initial CCBHC daily bundled 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~~ established by the commissioner using a provider-specific rate based on the newly certified CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner shall rebase CCBHC rates once every three years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services;

(5) the commissioner shall provide for a 60-day appeals process after notice of the results of the rebasing;

(6) the ~~prospective payment~~ CCBHC daily bundled 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~~ CCBHC daily bundled rate system ~~rate~~ that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

(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~~ CCBHC daily bundled rate 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;

(8) the ~~prospective payment~~ CCBHC daily bundled rate for each CCBHC shall be updated by trending each provider-specific rate by the Medicare Economic Index 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. Estimated costs are subject to review by the commissioner. 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.

(d) Managed care plans and county-based purchasing plans shall reimburse CCBHC providers at the ~~prospective payment~~ CCBHC daily bundled 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~~ CCBHC daily bundled rate 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. 8. Minnesota Statutes 2020, section 256B.0941, is amended by adding a subdivision to read:

Subd. 2a. **Sleeping hours.** During normal sleeping hours, a psychiatric residential treatment facility provider must provide at least one staff person for every six residents present within a living unit. A provider must adjust sleeping-hour staffing levels based on the clinical needs of the residents in the facility.

Sec. 9. Minnesota Statutes 2021 Supplement, 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 trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

(c) "Crisis planning" has the meaning given in section 245.4871, subdivision 9a.

(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.

(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 team, under the treatment supervision of a mental health professional.

(f) "Standard diagnostic assessment" means the assessment described in 245I.10, subdivision 6.

(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 services through telehealth as defined under section 256B.0625, subdivision 3b. 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.

(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 individual treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (7).

(i) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.

~~(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 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.~~

~~(k)~~ (j) "Individual treatment plan" means the plan described in section 245I.10, subdivisions 7 and 8.

~~(l)~~ (k) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a 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)~~ (l) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

~~(n)~~ (m) "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

~~(o)~~ (n) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

~~(p)~~ (o) "Mental health service plan development" includes:

(1) ~~the~~ development~~, review,~~ and revision of a child's individual treatment plan~~, 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 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.

~~(q)~~ (p) "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)~~ (q) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.

~~(s)~~ (r) "Rehabilitative services" or "psychiatric rehabilitation services" means 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.

~~(t)~~ (s) "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)~~ (t) "Treatment supervision" means the supervision described in section 245I.06.

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. 10. Minnesota Statutes 2021 Supplement, 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 clinical trainee that is performed within one year before the initial start of service. The standard diagnostic assessment must:

(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;

(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

(3) be used in the development of the individual treatment plan.

(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.

(c) Children's therapeutic services and supports include development and rehabilitative services that support a child's developmental treatment needs.

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. 11. Minnesota Statutes 2021 Supplement, 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 planning. The commissioner shall recertify a provider entity ~~at least~~ every three years using the individual provider's certification anniversary or the calendar year end, whichever is later. The commissioner may approve a recertification extension, in the interest of sustaining services, when a certain date for recertification is identified. 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) The commissioner must provide the following to providers for the certification, recertification, and decertification processes:

(1) a structured listing of required provider certification criteria;

(2) a formal written letter with a determination of certification, recertification, or decertification, signed by the commissioner or the appropriate division director; and

(3) a formal written communication outlining the process for necessary corrective action and follow-up by the commissioner, if applicable.

~~(b)~~ (c) For purposes of this section, a provider entity must meet the standards in this section and chapter 245I, as required under 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.

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. 12. Minnesota Statutes 2021 Supplement, 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, 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. When required components of the standard diagnostic assessment are not provided in an outside or independent assessment or cannot be attained immediately, the provider entity must determine the missing information within 30 days and amend the child's standard diagnostic assessment or incorporate the information into the child's individual treatment plan;

(2) developing an individual treatment plan;

~~(3) developing an individual behavior plan that documents and describes interventions to be provided by the mental health behavioral aide. The individual behavior plan must include:~~

~~(i) detailed instructions on the psychosocial skills to be practiced;~~

~~(ii) time allocated to each 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)~~ (3) providing treatment supervision plans for staff according to section 245I.06. Treatment supervision does not include the authority to make or terminate court-ordered placements of the child. A treatment supervisor must be available for urgent consultation as required by the individual client's needs or the situation;

~~(5) meeting day treatment program conditions in items (i) and (ii):~~

~~(i) the 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) every 30 days, the 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;~~

~~(6) meeting the treatment supervision standards in items (i) and (ii) for all other services provided under CTSS:~~

~~(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~~

~~(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;~~

~~(7) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the 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 staff giving direction must begin with the goals on the 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 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 staff providing it to continuously evaluate the mental health behavioral aide's ability to carry out~~

~~the activities of the individual treatment plan and the individual behavior plan. When providing direction, the 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 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;~~

~~(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide; and~~

~~(vi) ensure~~ (4) requiring a mental health professional to determine the level of supervision for a behavioral health aide and to document and sign the supervision determination in the behavioral health aide's supervision plan;

(5) ensuring the immediate accessibility of a mental health professional, clinical trainee, or mental health practitioner to the behavioral aide during service delivery;

~~(8)~~ (6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

~~(9)~~ (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.

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. 13. Minnesota Statutes 2021 Supplement, 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) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health behavioral aide.

(c) A day treatment team must include ~~at least~~ one mental health professional or clinical trainee ~~and one mental health practitioner~~.

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. 14. Minnesota Statutes 2021 Supplement, 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) 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 team under the 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) 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 or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. ~~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 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)~~ (iii) 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, clinical trainee, or mental health practitioner must work with a group of three to eight clients; or

(B) any combination of two mental health professionals, clinical trainees, or mental health practitioners must work with a group of nine to 12 clients;

~~(vi)~~ (iv) 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)~~ (v) 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 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 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, 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) 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 approve the individual treatment plan. 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.

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. 15. Minnesota Statutes 2021 Supplement, 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) Required documentation must be completed for each individual provider and service modality for each day a child receives a service under subdivision 2, paragraph (b).

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 2021 Supplement, 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 who are eight years of age or older and under ~~26~~ 21 years of age 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 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" means the assessment described in section 245I.10, subdivision 6.

(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.

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

(f) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.

(g) "Substance use disorders" means one or more of the disorders defined in the diagnostic and statistical manual of mental disorders, current edition.

(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.

(i) "Treatment team" means all staff who provide services to recipients under this section.

(j) "Family peer specialist" means a staff person who is qualified under section 256B.0616.

Sec. 17. Minnesota Statutes 2021 Supplement, section 256B.0947, subdivision 3, is amended to read:

Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

(1) is eight years of age or older and under ~~26~~ 21 years of age;

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance use disorder, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a 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 during adulthood; and

(5) has had a recent standard diagnostic assessment 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. 18. Minnesota Statutes 2021 Supplement, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must meet the standards in this section and chapter 245I as required in section 245I.011, subdivision 5.

(b) The treatment team must have specialized training in providing services to the specific age group of youth that the team serves. An individual treatment team must serve youth who are: (1) at least eight years of age or older and under 16 years of age, or (2) at least 14 years of age or older and under ~~26~~ 21 years of age.

(c) 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) 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:

(i) a mental health professional who serves as team leader to provide administrative direction and 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 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 regarding 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 qualified according to section 245I.04, subdivision 6;

(vi) a mental health practitioner qualified according to section 245I.04, subdivision 4;

(vii) a case management service provider, as defined in section 245.4871, subdivision 4;

(viii) a housing access specialist; and

(ix) a family peer specialist as defined in subdivision 2, paragraph (j).

(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 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.

(d) The 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 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.

(e) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

(f) 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.

(g) 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.

(h) 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.

(i) A regional treatment team may serve multiple counties.

Sec. 19. Minnesota Statutes 2020, section 626.5571, subdivision 1, is amended to read:

Subdivision 1. **Establishment of team.** A county may establish a multidisciplinary adult protection team comprised of the director of the local welfare agency or designees, the county attorney or designees, the county sheriff or designees, and representatives of health care. In addition, representatives of mental health or other appropriate human service agencies, community corrections agencies, representatives from local tribal governments, local law enforcement agencies or designees thereof, and adult advocate groups may be added to the adult protection team.

Sec. 20. **[626.8477] MENTAL HEALTH AND HEALTH RECORDS; WRITTEN POLICY REQUIRED.**

The chief officer of every state and local law enforcement agency that seeks or uses mental health data under section 13.46, subdivision 7, paragraph (c), or health records under section 144.294, subdivision 2, must establish and enforce a written policy governing its use. At a minimum, the written policy must incorporate the requirements of sections 13.46, subdivision 7, paragraph (c), and 144.294, subdivision 2, and access procedures, retention policies, and data security safeguards that, at a minimum, meet the requirements of chapter 13 and any other applicable law.

Sec. 21. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 33, is amended to read:

Subd. 33. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	4,273,000	4,274,000
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.** $2,000,000 in fiscal year 2022 and $2,000,000 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. The general fund base for this appropriation is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025

(c) **Grant to Anoka County for Enhanced Treatment Program.** $125,000 in fiscal year 2023 is from the general fund for a grant to Anoka County for an enhanced treatment program for substance use disorder. This paragraph does not expire.

(d) **Base Level Adjustment.** The general fund base is $4,636,000 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.

Sec. 22. Laws 2021, First Special Session chapter 7, article 17, section 1, subdivision 2, is amended to read:

Subd. 2. **Eligibility.** An individual is eligible for the transition to community initiative if the individual does not meet eligibility criteria for the medical assistance program under section 256B.056 or 256B.057, but who meets at least one of the following criteria:

(1) the person otherwise meets the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(2) the person has met treatment objectives and no longer requires a hospital-level care or a secure treatment setting, but the person's discharge from the Anoka Metro Regional Treatment Center, the Minnesota Security Hospital, or a community behavioral health hospital would be substantially delayed without additional resources available through the transitions to community initiative;

(3) the person is in a community hospital ~~and on the waiting list for the Anoka Metro Regional Treatment Center~~, but alternative community living options would be appropriate for the person, and the person has received approval from the commissioner; or

(4)(i) the person is receiving customized living services reimbursed under section 256B.4914, 24-hour customized living services reimbursed under section 256B.4914, or community residential services reimbursed under section 256B.4914; (ii) the person expresses a desire to move; and (iii) the person has received approval from the commissioner.

Sec. 23. **REVIEW OF HUMAN SERVICES STRUCTURE; RECOMMENDATION FOR 2023 LEGISLATIVE SESSION.**

(a) No later than September 1, 2022, the addiction and recovery director must contract with a consultant to conduct an independent review of the structure of the Department of Human Services, with a focus on substance use disorder and mental health treatment access and service delivery. The review must be completed no later than December 31, 2022.

(b) In addition to the duties prescribed by Minnesota Statutes, section 4.046, the Opioids, Substance Use, and Addiction Subcabinet must submit a recommendation to the legislature for the creation of a permanent Office of Opioid Use, Substance Use, and Addiction, including proposed statutory language that establishes the office and provides initial goals. This recommendation must be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over opioid and substance use disorder treatment and prevention no later than December 31, 2022.

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

Sec. 24. **IMPACT ON EXECUTIVE ORDER.**

Sections 1 and 23 supersede the requirements of Executive Order No. 22-07, filed April 7, 2022. To the extent a conflict exists between that executive order and this act, the provisions of this act prevail.

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

Sec. 25. **REVISOR INSTRUCTION.**

The revisor of statutes shall change the terms "medication-assisted treatment" and "medication-assisted therapy" or similar terms to "substance use disorder treatment with medications for opioid use disorder" whenever the terms appear in Minnesota Statutes and Minnesota Rules. The revisor may make technical and other necessary grammatical changes related to the term change.

Sec. 26. **REPEALER.**

Minnesota Statutes 2020, section 256B.0943, subdivision 8a, is repealed.

EFFECTIVE DATE. This section 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 7
CONTINUING CARE FOR OLDER ADULTS POLICY

Section 1. Minnesota Statutes 2020, section 245A.14, subdivision 14, is amended to read:

Subd. 14. **Attendance records for publicly funded services.** (a) A child care center licensed under this chapter and according to Minnesota Rules, chapter 9503, must maintain documentation of actual attendance for each child receiving care for which the license holder is reimbursed by a governmental program. The records must be accessible to the commissioner during the program's hours of operation, they must be completed on the actual day of attendance, and they must include:

(1) the first and last name of the child;

(2) the time of day that the child was dropped off; and

(3) the time of day that the child was picked up.

(b) A family child care provider licensed under this chapter and according to Minnesota Rules, chapter 9502, must maintain documentation of actual attendance for each child

receiving care for which the license holder is reimbursed for the care of that child by a governmental program. The records must be accessible to the commissioner during the program's hours of operation, they must be completed on the actual day of attendance, and they must include:

(1) the first and last name of the child;

(2) the time of day that the child was dropped off; and

(3) the time of day that the child was picked up.

(c) An adult day services program licensed under this chapter and according to Minnesota Rules, parts 9555.5105 to 9555.6265, must maintain documentation of actual attendance for each adult day service recipient for which the license holder is reimbursed by a governmental program. The records must be accessible to the commissioner during the program's hours of operation, they must be completed on the actual day of attendance, and they must include:

(1) the first, middle, and last name of the recipient;

(2) the time of day that the recipient was dropped off; and

(3) the time of day that the recipient was picked up.

(d) ~~The commissioner shall not issue a correction for attendance record errors that occur before August 1, 2013.~~ Adult day services programs licensed under this chapter that are designated for remote adult day services must maintain documentation of actual participation for each adult day service recipient for whom the license holder is reimbursed by a governmental program. The records must be accessible to the commissioner during the program's hours of operation, must be completed on the actual day service is provided, and must include the:

(1) first, middle, and last name of the recipient;

(2) time of day the remote services started;

(3) time of day that the remote services ended; and

(4) means by which the remote services were provided, through audio remote services or through audio and video remote services.

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

Sec. 2. **[245A.70] REMOTE ADULT DAY SERVICES.**

(a) For the purposes of sections 245A.70 to 245A.75, the following terms have the meanings given.

(b) "Adult day care" and "adult day services" have the meanings given in section 245A.02, subdivision 2a.

(c) "Remote adult day services" means an individualized and coordinated set of services provided via live two-way communication by an adult day care or adult day services center.

(d) "Live two-way communication" means real-time audio or audio and video transmission of information between a participant and an actively involved staff member.

Sec. 3. **[245A.71] APPLICABILITY AND SCOPE.**

Subdivision 1. **Licensing requirements.** Adult day care centers or adult day services centers that provide remote adult day services must be licensed under this chapter and comply with the requirements set forth in this section.

Subd. 2. **Standards for licensure.** License holders seeking to provide remote adult day services must submit a request in the manner prescribed by the commissioner. Remote adult day services must not be delivered until approved by the commissioner. The designation to provide remote services is voluntary for license holders. Upon approval, the designation of approval for remote adult day services must be printed on the center's license, and identified on the commissioner's public website.

Subd. 3. **Federal requirements.** Adult day care centers or adult day services centers that provide remote adult day services to participants receiving alternative care under section 256B.0913, essential community supports under section 256B.0922, or home and community-based services waivers under chapter 256S or section 256B.092 or 256B.49 must comply with federally approved waiver plans.

Subd. 4. **Service limitations.** Remote adult day services must be provided during the days and hours of in-person services specified on the license of the adult day care center or adult day services center.

Sec. 4. **[245A.72] RECORD REQUIREMENTS.**

Adult day care centers and adult day services centers providing remote adult day services must comply with participant record requirements set forth in Minnesota Rules, part

9555.9660. The center must document how remote services will help a participant reach the short- and long-term objectives in the participant's plan of care.

Sec. 5. **[245A.73] REMOTE ADULT DAY SERVICES STAFF.**

Subdivision 1. **Staff ratios.** (a) A staff person who provides remote adult day services without two-way interactive video must only provide services to one participant at a time.

(b) A staff person who provides remote adult day services through two-way interactive video must not provide services to more than eight participants at one time.

Subd. 2. **Staff training.** A center licensed under section 245A.71 must document training provided to each staff person regarding the provision of remote services in the staff person's record. The training must be provided prior to a staff person delivering remote adult day services without supervision. The training must include:

(1) how to use the equipment, technology, and devices required to provide remote adult day services via live two-way communication;

(2) orientation and training on each participant's plan of care as directly related to remote adult day services; and

(3) direct observation by a manager or supervisor of the staff person while providing supervised remote service delivery sufficient to assess staff competency.

Sec. 6. **[245A.74] INDIVIDUAL SERVICE PLANNING.**

Subdivision 1. **Eligibility.** (a) A person must be eligible for and receiving in-person adult day services to receive remote adult day services from the same provider. The same provider must deliver both in-person adult day services and remote adult day services to a participant.

(b) The license holder must update the participant's plan of care according to Minnesota Rules, part 9555.9700.

(c) For a participant who chooses to receive remote adult day services, the license holder must document in the participant's plan of care the participant's proposed schedule and frequency for receiving both in-person and remote services. The license holder must also document in the participant's plan of care that remote services:

(1) are chosen as a service delivery method by the participant or the participant's legal representative;

(2) will meet the participant's assessed needs;

(3) are provided within the scope of adult day services; and

(4) will help the participant achieve identified short and long-term objectives specific to the provision of remote adult day services.

Subd. 2. **Participant daily service limitations.** In a 24-hour period, a participant may receive:

(1) a combination of in-person adult day services and remote adult day services on the same day but not at the same time;

(2) a combination of in-person and remote adult day services that does not exceed 12 hours in total; and

(3) up to six hours of remote adult day services.

Subd. 3. **Minimum in-person requirement.** A participant who receives remote services must receive services in-person as assigned in the participant's plan of care at least quarterly.

Sec. 7. **[245A.75] SERVICE AND PROGRAM REQUIREMENTS.**

Remote adult day services must be in the scope of adult day services provided in Minnesota Rules, part 9555.9710, subparts 3 to 7.

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

Sec. 8. Minnesota Statutes 2020, section 256R.02, subdivision 4, is amended to read:

Subd. 4. **Administrative costs.** "Administrative costs" means the identifiable costs for administering the overall activities of the nursing home. These costs include salaries and wages of the administrator, assistant administrator, business office employees, security guards, purchasing and inventory employees, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, all training except as specified in subdivision 17, voice and data communication or transmission, office supplies, property and liability insurance and other forms of insurance except insurance that is a fringe benefit under subdivision 22, personnel recruitment, legal services, accounting services, management or business consultants, data processing, information technology, website, central or home office costs, business meetings and seminars, postage, fees for professional organizations, subscriptions, security services, nonpromotional advertising, board of directors fees, working capital interest expense, bad debts, bad debt collection fees, and costs incurred for travel and ~~housing~~ lodging for persons

employed by a Minnesota-registered supplemental nursing services agency as defined in section 144A.70, subdivision 6.

Sec. 9. Minnesota Statutes 2020, section 256R.02, subdivision 17, is amended to read:

Subd. 17. **Direct care costs.** "Direct care costs" means costs for the wages of nursing administration, direct care registered nurses, licensed practical nurses, certified nursing assistants, trained medication aides, employees conducting training in resident care topics and associated fringe benefits and payroll taxes; services from a Minnesota-registered supplemental nursing services agency up to the maximum allowable charges under section 144A.74, excluding associated lodging and travel costs; supplies that are stocked at nursing stations or on the floor and distributed or used individually, including, but not limited to: rubbing alcohol or alcohol swabs, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, personal hygiene soap, medication cups, diapers, ~~plastic waste bags,~~ sanitary products, disposable thermometers, hypodermic needles and syringes, ~~clinical reagents or similar diagnostic agents,~~ drugs ~~that are not paid~~ not payable on a separate fee schedule by the medical assistance program or any other payer, and ~~technology related~~ clinical software costs specific to the provision of nursing care to residents, such as electronic charting systems; costs of materials used for resident care training, and training courses outside of the facility attended by direct care staff on resident care topics; and costs for nurse consultants, pharmacy consultants, and medical directors. Salaries and payroll taxes for nurse consultants who work out of a central office must be allocated proportionately by total resident days or by direct identification to the nursing facilities served by those consultants.

Sec. 10. Minnesota Statutes 2020, section 256R.02, subdivision 18, is amended to read:

Subd. 18. **Employer health insurance costs.** "Employer health insurance costs" means:

(1) premium expenses for group coverage;

(2) actual expenses incurred for self-insured plans, including ~~reinsurance;~~ actual claims paid, stop-loss premiums, and plan fees. Actual expenses incurred for self-insured plans does not include allowances for future funding unless the plan meets the Medicare requirements for reporting on a premium basis when the Medicare regulations define the actual costs; and

(3) employer contributions to employer-sponsored individual coverage health reimbursement arrangements as provided by Code of Federal Regulations, title 45, section

146.123, employee health reimbursement accounts, and health savings accounts. ~~Premium and expense costs and contributions are allowable for (1) all employees and (2) the spouse and dependents of those employees who are employed on average at least 30 hours per week.~~

Sec. 11. Minnesota Statutes 2020, section 256R.02, subdivision 22, is amended to read:

Subd. 22. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life, dental, workers' compensation, short- and long-term disability, long-term care insurance, accident insurance, supplemental insurance, legal assistance insurance, profit sharing, child care costs, health insurance costs not covered under subdivision 18, including costs associated with part-time employee family members or retirees, and pension and retirement plan contributions, except for the Public Employees Retirement Association costs.

Sec. 12. Minnesota Statutes 2020, section 256R.02, subdivision 29, is amended to read:

Subd. 29. **Maintenance and plant operations costs.** "Maintenance and plant operations costs" means the costs for the salaries and wages of the maintenance supervisor, engineers, heating-plant employees, and other maintenance employees and associated fringe benefits and payroll taxes. It also includes identifiable costs for maintenance and operation of the building and grounds, including, but not limited to, fuel, electricity, plastic waste bags, medical waste and garbage removal, water, sewer, supplies, tools, ~~and~~ repairs, and minor equipment not requiring capitalization under Medicare guidelines.

Sec. 13. Minnesota Statutes 2020, section 256R.02, is amended by adding a subdivision to read:

Subd. 32a. **Minor equipment.** "Minor equipment" means equipment that does not qualify as either fixed equipment or depreciable movable equipment as defined in section 256R.261.

Sec. 14. Minnesota Statutes 2020, section 256R.02, subdivision 42a, is amended to read:

Subd. 42a. **Real estate taxes.** "Real estate taxes" means the real estate tax liability shown on the annual property tax ~~statement~~ statements of the nursing facility for the reporting period. The term does not include personnel costs or fees for late payment.

Sec. 15. Minnesota Statutes 2020, section 256R.02, subdivision 48a, is amended to read:

Subd. 48a. **Special assessments.** "Special assessments" means the actual special assessments and related interest paid during the reporting period that are not voluntary costs.

The term does not include personnel costs ~~or~~, fees for late payment, or special assessments for projects that are reimbursed in the property rate.

Sec. 16. Minnesota Statutes 2020, section 256R.02, is amended by adding a subdivision to read:

Subd. 53. **Vested.** "Vested" means the existence of a legally fixed unconditional right to a present or future benefit.

Sec. 17. Minnesota Statutes 2020, section 256R.07, subdivision 1, is amended to read:

Subdivision 1. **Criteria.** A nursing facility ~~shall~~ must keep adequate documentation. In order to be adequate, documentation must:

(1) be maintained in orderly, well-organized files;

(2) not include documentation of more than one nursing facility in one set of files unless transactions may be traced by the commissioner to the nursing facility's annual cost report;

(3) include a paid invoice or copy of a paid invoice with date of purchase, vendor name and address, purchaser name and delivery destination address, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or nursing facilities. If any of the information is not available, the nursing facility ~~shall~~ must document its good faith attempt to obtain the information;

(4) include contracts, agreements, amortization schedules, mortgages, other debt instruments, and all other documents necessary to explain the nursing facility's costs or revenues; ~~and~~

(5) include signed and dated position descriptions; and

(6) be retained by the nursing facility to support the five most recent annual cost reports. The commissioner may extend the period of retention if the field audit was postponed because of inadequate record keeping or accounting practices as in section 256R.13, subdivisions 2 and 4, the records are necessary to resolve a pending appeal, or the records are required for the enforcement of sections 256R.04; 256R.05, subdivision 2; 256R.06, subdivisions 2, 6, and 7; 256R.08, subdivisions 1 ~~to~~ and 3; and 256R.09, subdivisions 3 and 4.

Sec. 18. Minnesota Statutes 2020, section 256R.07, subdivision 2, is amended to read:

Subd. 2. **Documentation of compensation.** Compensation for personal services, regardless of whether treated as identifiable costs or costs that are not identifiable, must be documented on payroll records. Payrolls must be supported by time and attendance or equivalent records for individual employees. Salaries and wages of employees which are allocated to more than one cost category must be supported by time distribution records. ~~The method used must produce a proportional distribution of actual time spent, or an accurate estimate of time spent performing assigned duties. The nursing facility that chooses to estimate time spent must use a statistically valid method. The compensation must reflect an amount proportionate to a full-time basis if the services are rendered on less than a full-time basis.~~ Salary allocations are allowable using the Medicare-approved allocation basis and methodology only if the salary costs cannot be directly determined, including when employees provide shared services to noncovered operations.

Sec. 19. Minnesota Statutes 2020, section 256R.07, subdivision 3, is amended to read:

Subd. 3. **Adequate documentation supporting nursing facility payrolls.** Payroll records supporting compensation costs claimed by nursing facilities must be supported by affirmative time and attendance records prepared by each individual at intervals of not more than one month. The requirements of this subdivision are met when documentation is provided under either clause (1) or (2) ~~as follows~~:

(1) the affirmative time and attendance record must identify the individual's name; the days worked during each pay period; the number of hours worked each day; and the number of hours taken each day by the individual for vacation, sick, and other leave. The affirmative time and attendance record must include a signed verification by the individual and the individual's supervisor, if any, that the entries reported on the record are correct; or

(2) if the affirmative time and attendance records identifying the individual's name, the days worked each pay period, the number of hours worked each day, and the number of hours taken each day by the individual for vacation, sick, and other leave are ~~placed on microfilm~~ stored electronically, equipment must be made available for viewing and printing ~~them, or if the records are stored as automated data, summary data must be available for viewing and printing~~ the records.

Sec. 20. Minnesota Statutes 2020, section 256R.08, subdivision 1, is amended to read:

Subdivision 1. **Reporting of financial statements.** (a) No later than February 1 of each year, a nursing facility ~~shall~~ must:

(1) provide the state agency with a copy of its audited financial statements or its working trial balance;

(2) provide the state agency with a statement of ownership for the facility;

(3) provide the state agency with separate, audited financial statements or working trial balances for every other facility owned in whole or in part by an individual or entity that has an ownership interest in the facility;

(4) upon request, provide the state agency with separate, audited financial statements or working trial balances for every organization with which the facility conducts business and which is owned in whole or in part by an individual or entity which has an ownership interest in the facility;

(5) provide the state agency with copies of leases, purchase agreements, and other documents related to the lease or purchase of the nursing facility; and

(6) upon request, provide the state agency with copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services which are claimed as allowable costs.

(b) Audited financial statements submitted under paragraph (a) must include a balance sheet, income statement, statement of the rate or rates charged to private paying residents, statement of retained earnings, statement of cash flows, notes to the financial statements, audited applicable supplemental information, and the public accountant's report. Public accountants must conduct audits in accordance with chapter 326A. The cost of an audit ~~shall~~ must not be an allowable cost unless the nursing facility submits its audited financial statements in the manner otherwise specified in this subdivision. A nursing facility must permit access by the state agency to the public accountant's audit work papers that support the audited financial statements submitted under paragraph (a).

(c) Documents or information provided to the state agency pursuant to this subdivision ~~shall~~ must be public unless prohibited by the Health Insurance Portability and Accountability Act or any other federal or state regulation. Data, notes, and preliminary drafts of reports created, collected, and maintained by the audit offices of government entities, or persons performing audits for government entities, and relating to an audit or investigation are confidential data on individuals or protected nonpublic data until the final report has been published or the audit or investigation is no longer being pursued actively, except that the data must be disclosed as required to comply with section 6.67 or 609.456.

(d) If the requirements of paragraphs (a) and (b) are not met, the reimbursement rate may be reduced to 80 percent of the rate in effect on the first day of the fourth calendar month after the close of the reporting period and the reduction ~~shall~~ must continue until the requirements are met.

Sec. 21. Minnesota Statutes 2020, section 256R.09, subdivision 2, is amended to read:

Subd. 2. **Reporting of statistical and cost information.** All nursing facilities ~~shall~~ must provide information annually to the commissioner on a form and in a manner determined by the commissioner. The commissioner may separately require facilities to submit in a manner specified by the commissioner documentation of statistical and cost information included in the report to ensure accuracy in establishing payment rates and to perform audit and appeal review functions under this chapter. The commissioner may also require nursing facilities to provide statistical and cost information for a subset of the items in the annual report on a semiannual basis. Nursing facilities ~~shall~~ must report only costs directly related to the operation of the nursing facility. The facility ~~shall~~ must not include costs which are separately reimbursed or reimbursable by residents, medical assistance, or other payors. Allocations of costs from central, affiliated, or corporate office and related organization transactions shall be reported according to sections 256R.07, subdivision 3, and 256R.12, subdivisions 1 to 7. The commissioner shall not grant facilities extensions to the filing deadline.

Sec. 22. Minnesota Statutes 2020, section 256R.09, subdivision 5, is amended to read:

Subd. 5. **Method of accounting.** (a) The accrual method of accounting in accordance with generally accepted accounting principles is the only method acceptable for purposes of satisfying the reporting requirements of this chapter. If a governmentally owned nursing facility demonstrates that the accrual method of accounting is not applicable to its accounts and that a cash or modified accrual method of accounting more accurately reports the nursing facility's financial operations, the commissioner shall permit the governmentally owned nursing facility to use a cash or modified accrual method of accounting.

(b) For reimbursement purposes, a provider must pay an accrued nonpayroll expense within 180 days following the end of the reporting period. A provider must not report on a subsequent cost report an expense disallowed by the commissioner under this paragraph for nonpayment unless the commissioner grants a specific exception to the 180-day rule for a documented contractual arrangement such as receivership, property tax installment payments, or pension contributions.

Sec. 23. Minnesota Statutes 2020, section 256R.10, is amended by adding a subdivision to read:

Subd. 8. **Employer health insurance costs.** (a) Employer health insurance costs are allowable for (1) all employees and (2) the spouse and dependents of those employees who are employed on average at least 30 hours per week.

(b) The commissioner must not treat employer contributions to employer-sponsored individual coverage health reimbursement arrangements as allowable costs if the facility does not provide the commissioner copies of the employer-sponsored individual coverage health reimbursement arrangement plan documents and documentation of any health insurance premiums and associated co-payments reimbursed under the arrangement. Documentation of reimbursements must denote any reimbursements for health insurance premiums or associated co-payments incurred by the spouses or dependents of employees who work on average less than 30 hours per week.

Sec. 24. Minnesota Statutes 2020, section 256R.13, subdivision 4, is amended to read:

Subd. 4. **Extended record retention requirements.** The commissioner shall extend the period for retention of records under section 256R.09, subdivision 3, for purposes of performing field audits as necessary to enforce sections 256R.04; 256R.05, subdivision 2; 256R.06, subdivisions 2, 6, and 7; 256R.08, subdivisions 1 ~~to~~ and 3; and 256R.09, subdivisions 3 and 4, with written notice to the facility postmarked no later than 90 days prior to the expiration of the record retention requirement.

Sec. 25. Minnesota Statutes 2020, section 256R.16, subdivision 1, is amended to read:

Subdivision 1. **Calculation of a quality score.** (a) The commissioner shall determine a quality score for each nursing facility using quality measures established in section 256B.439, according to methods determined by the commissioner in consultation with stakeholders and experts, and using the most recently available data as provided in the Minnesota Nursing Home Report Card. These methods ~~shall~~ must be exempt from the rulemaking requirements under chapter 14.

(b) For each quality measure, a score ~~shall~~ must be determined with the number of points assigned as determined by the commissioner using the methodology established according to this subdivision. The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner.

(c) The quality score ~~shall~~ must include up to 50 points related to the Minnesota quality indicators score derived from the minimum data set, up to 40 points related to the resident quality of life score derived from the consumer survey conducted under section 256B.439, subdivision 3, and up to ten points related to the state inspection results score.

(d) The commissioner, in cooperation with the commissioner of health, may adjust the formula in paragraph (c), or the methodology for computing the total quality score, ~~effective July 1 of any year,~~ with five months advance public notice. In changing the formula, the commissioner shall consider quality measure priorities registered by report card users, advice of stakeholders, and available research.

Sec. 26. Minnesota Statutes 2020, section 256R.17, subdivision 3, is amended to read:

Subd. 3. **Resident assessment schedule.** (a) Nursing facilities ~~shall~~ must conduct and submit case mix classification assessments according to the schedule established by the commissioner of health under section 144.0724, subdivisions 4 and 5.

(b) The case mix classifications established under section 144.0724, subdivision 3a, ~~shall be~~ are effective the day of admission for new admission assessments. The effective date for significant change assessments ~~shall be~~ is the assessment reference date. The effective date for annual and quarterly assessments ~~shall be~~ and significant corrections assessments is the first day of the month following assessment reference date.

Sec. 27. Minnesota Statutes 2020, section 256R.26, subdivision 1, is amended to read:

Subdivision 1. **Determination of limited undepreciated replacement cost.** A facility's limited URC is the lesser of:

(1) the facility's recognized URC from the appraisal; or

(2) the product of (i) the number of the facility's licensed beds three months prior to the beginning of the rate year, (ii) the construction cost per square foot value, and (iii) 1,000 square feet.

Sec. 28. Minnesota Statutes 2020, section 256R.261, subdivision 13, is amended to read:

Subd. 13. **Equipment allowance per bed value.** The equipment allowance per bed value is $10,000 adjusted annually for rate years beginning on or after January 1, 2021, by the percentage change indicated by the urban consumer price index for Minneapolis-St. Paul, as published by the Bureau of Labor Statistics (series ~~1967=100~~ 1982-84=100) for

the two previous Julys. The computation for this annual adjustment is based on the data that is publicly available on November 1 immediately preceding the start of the rate year.

Sec. 29. Minnesota Statutes 2020, section 256R.37, is amended to read:

256R.37 SCHOLARSHIPS.

~~(a) For the 27-month period beginning October 1, 2015, through December 31, 2017, the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing facility with no scholarship per diem that is requesting a scholarship per diem to be added to the external fixed payment rate to be used:~~

~~(1) for employee scholarships that satisfy the following requirements:~~

~~(i) scholarships are available to all employees who work an average of at least ten hours per week at the facility except the administrator, and to reimburse student loan expenses for newly hired registered nurses and licensed practical nurses, and training expenses for nursing assistants as specified in section 144A.611, subdivisions 2 and 4, who are newly hired; and~~

~~(ii) the course of study is expected to lead to career advancement with the facility or in long-term care, including medical care interpreter services and social work; and~~

~~(2) to provide job-related training in English as a second language.~~

~~(b) All facilities may annually request a rate adjustment under this section by submitting information to the commissioner on a schedule and in a form supplied by the commissioner. The commissioner shall allow a scholarship payment rate equal to the reported and allowable costs divided by resident days.~~

~~(c) In calculating the per diem under paragraph (b), the commissioner shall allow costs related to tuition, direct educational expenses, and reasonable costs as defined by the commissioner for child care costs and transportation expenses related to direct educational expenses.~~

~~(d) The rate increase under this section is an optional rate add-on that the facility must request from the commissioner in a manner prescribed by the commissioner. The rate increase must be used for scholarships as specified in this section.~~

~~(e) For instances in which a rate adjustment will be 15 cents or greater, nursing facilities that close beds during a rate year may request to have their scholarship adjustment under paragraph (b) recalculated by the commissioner for the remainder of the rate year to reflect the reduction in resident days compared to the cost report year.~~

(a) The commissioner shall provide a scholarship per diem rate calculated using the criteria in paragraphs (b) to (d). The per diem rate must be based on the allowable costs the facility paid for employee scholarships for any eligible employee, except the facility administrator, who works an average of at least ten hours per week in the licensed nursing facility building when the facility has paid expenses related to:

(1) an employee's course of study that is expected to lead to career advancement with the facility or in the field of long-term care;

(2) an employee's job-related training in English as a second language;

(3) the reimbursement of student loan expenses for newly hired registered nurses and licensed practical nurses; and

(4) the reimbursement of training, testing, and associated expenses for newly hired nursing assistants as specified in section 144A.611, subdivisions 2 and 4. The reimbursement of nursing assistant expenses under this clause is not subject to the ten-hour minimum work requirement under this paragraph.

(b) Allowable scholarship costs include: tuition, student loan reimbursement, other direct educational expenses, and reasonable costs for child care and transportation expenses directly related to education, as defined by the commissioner.

(c) The commissioner shall provide a scholarship per diem rate equal to the allowable scholarship costs divided by resident days. The commissioner shall compute the scholarship per diem rate annually and include the scholarship per diem rate in the external fixed costs payment rate.

(d) When the resulting scholarship per diem rate is 15 cents or more, nursing facilities that close beds during a rate year may request to have the scholarship rate recalculated. This recalculation is effective from the date of the bed closure through the remainder of the rate year and reflects the estimated reduction in resident days compared to the previous cost report year.

(e) Facilities seeking to have the facility's scholarship expenses recognized for the payment rate computation in section 256R.25 may apply annually by submitting information to the commissioner on a schedule and in a form supplied by the commissioner.

Sec. 30. Minnesota Statutes 2020, section 256R.39, is amended to read:

256R.39 QUALITY IMPROVEMENT INCENTIVE PROGRAM.

The commissioner shall develop a quality improvement incentive program in consultation with stakeholders. The annual funding pool available for quality improvement incentive payments ~~shall~~ must be equal to 0.8 percent of all operating payments, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under section 256R.48, critical access nursing facility program participation under section 256R.47, or performance-based incentive payment program participation under section 256R.38. ~~For the period from October 1, 2015, to December 31, 2016, rate adjustments provided under this section shall be effective for 15 months. Beginning January 1, 2017,~~ An annual rate ~~adjustments~~ adjustment provided under this section ~~shall~~ must be effective for one rate year.

Sec. 31. Minnesota Statutes 2021 Supplement, section 256S.205, is amended to read:

256S.205 CUSTOMIZED LIVING SERVICES; DISPROPORTIONATE SHARE RATE ADJUSTMENTS.

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

(b) "Application year" means a year in which a facility submits an application for designation as a disproportionate share facility.

(c) ~~"Assisted living facility" or "facility" means an assisted living facility licensed under chapter 144G~~ "Customized living resident" means a resident of a facility who is receiving either 24-hour customized living services or customized living services authorized under the elderly waiver, the brain injury waiver, or the community access for disability inclusion waiver.

(d) "Disproportionate share facility" means ~~an assisted living~~ a facility designated by the commissioner under subdivision 4.

(e) "Facility" means either an assisted living facility licensed under chapter 144G or a setting that is exempt from assisted living licensure under section 144G.08, subdivision 7, clauses (10) to (13).

(f) "Rate year" means January 1 to December 31 of the year following an application year.

Subd. 2. **Rate adjustment application.** ~~An assisted living~~ A facility may apply to the commissioner for designation as a disproportionate share facility. Applications must be submitted annually between ~~October~~ September 1 and ~~October 31~~ September 30. The applying facility must apply in a manner determined by the commissioner. The applying facility must document ~~as a percentage the census of elderly waiver participants~~ each of the following on the application:

(1) the number of customized living residents in the facility on September 1 of the application year, broken out by specific waiver program; and

(2) the total number of people residing in the facility on ~~October~~ September 1 of the application year.

Subd. 3. **Rate adjustment eligibility criteria.** Only facilities ~~with a census of at least 80 percent elderly waiver participants~~ satisfying all of the following conditions on ~~October~~ September 1 of the application year are eligible for designation as a disproportionate share facility:

(1) at least 83.5 percent of the residents of the facility are customized living residents; and

(2) at least 70 percent of the customized living residents are elderly waiver participants.

Subd. 4. **Designation as a disproportionate share facility.** (a) By ~~November~~ October 15 of each application year, the commissioner must designate as a disproportionate share facility a facility that complies with the application requirements of subdivision 2 and meets the eligibility criteria of subdivision 3.

(b) An annual designation is effective for one rate year.

Subd. 5. **Rate adjustment; rate floor.** (a) Notwithstanding the 24-hour customized living monthly service rate limits under section 256S.202, subdivision 2, and the component service rates established under section 256S.201, subdivision 4, the commissioner must establish a rate floor equal to $119 per resident per day for 24-hour customized living services provided to an elderly waiver participant in a designated disproportionate share facility ~~for the purpose of ensuring the minimal level of staffing required to meet the health and safety needs of elderly waiver participants~~.

(b) The commissioner must apply the rate floor to the services described in paragraph (a) provided during the rate year.

~~(b)~~ (c) The commissioner must adjust the rate floor ~~at least annually in the manner described under section 256S.18, subdivisions 5 and 6~~ by the same amount and at the same

time as any adjustment to the 24-hour customized living monthly service rate limits under section 256S.202, subdivision 2.

~~(c)~~ (d) The commissioner shall not implement the rate floor under this section if the customized living rates established under sections 256S.21 to 256S.215 will be implemented at 100 percent on January 1 of the year following an application year.

Subd. 6. **Budget cap disregard.** The value of the rate adjustment under this section must not be included in an elderly waiver client's monthly case mix budget cap.

EFFECTIVE DATE. This section is effective September 1, 2022, or upon federal approval, whichever is later, and applies to services provided on or after January 1, 2023, or on or after the date upon which federal approval is obtained, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 32. **REPEALER.**

Minnesota Statutes 2020, sections 245A.03, subdivision 5; and 256R.08, subdivision 2, and Minnesota Rules, part 9555.6255, are repealed.

ARTICLE 8
CHILD AND VULNERABLE ADULT PROTECTION

Section 1. Minnesota Statutes 2020, section 242.19, subdivision 2, is amended to read:

Subd. 2. **Dispositions.** When a child has been committed to the commissioner of corrections by a juvenile court, upon a finding of delinquency, the commissioner may for the purposes of treatment and rehabilitation:

(1) order the child's confinement to the Minnesota Correctional Facility-Red Wing, which shall accept the child, or to a group foster home under the control of the commissioner of corrections, or to private facilities or facilities established by law or incorporated under the laws of this state that may care for delinquent children;

(2) order the child's release on parole under such supervisions and conditions as the commissioner believes conducive to law-abiding conduct, treatment and rehabilitation;

(3) order reconfinement or renewed parole as often as the commissioner believes to be desirable;

(4) revoke or modify any order, except an order of discharge, as often as the commissioner believes to be desirable;

(5) discharge the child when the commissioner is satisfied that the child has been rehabilitated and that such discharge is consistent with the protection of the public;

(6) if the commissioner finds that the child is eligible for probation or parole and it appears from the commissioner's investigation that conditions in the child's or the guardian's home are not conducive to the child's treatment, rehabilitation, or law-abiding conduct, refer the child, together with the commissioner's findings, to a local social services agency or a licensed child-placing agency for placement in a foster care or, when appropriate, for initiation of child in need of protection or services proceedings as provided in sections 260C.001 to 260C.421. The commissioner of corrections shall reimburse local social services agencies for foster care costs they incur for the child while on probation or parole to the extent that funds for this purpose are made available to the commissioner by the legislature. The juvenile court ~~shall~~ may order the parents of a child on probation or parole to pay the costs of foster care under section 260B.331, subdivision 1, if the local social services agency has determined that requiring reimbursement is in the child's best interests, according to their ability to pay, and to the extent that the commissioner of corrections has not reimbursed the local social services agency.

Sec. 2. Minnesota Statutes 2020, section 260.012, is amended to read:

260.012 DUTY TO ENSURE PLACEMENT PREVENTION AND FAMILY REUNIFICATION; REASONABLE EFFORTS.

(a) Once a child alleged to be in need of protection or services is under the court's jurisdiction, the court shall ensure that reasonable efforts, including culturally appropriate services and practices, by the social services agency are made to prevent placement or to eliminate the need for removal and to reunite the child with the child's family at the earliest possible time, and the court must ensure that the responsible social services agency makes reasonable efforts to finalize an alternative permanent plan for the child as provided in paragraph (e). In determining reasonable efforts to be made with respect to a child and in making those reasonable efforts, the child's best interests, health, and safety must be of paramount concern. Reasonable efforts to prevent placement and for rehabilitation and reunification are always required except upon a determination by the court that a petition has been filed stating a prima facie case that:

(1) the parent has subjected a child to egregious harm as defined in section 260C.007, subdivision 14;

(2) the parental rights of the parent to another child have been terminated involuntarily;

(3) the child is an abandoned infant under section 260C.301, subdivision 2, paragraph (a), clause (2);

(4) the parent's custodial rights to another child have been involuntarily transferred to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law of another jurisdiction;

(5) the parent has committed sexual abuse as defined in section 260E.03, against the child or another child of the parent;

(6) the parent has committed an offense that requires registration as a predatory offender under section 243.166, subdivision 1b, paragraph (a) or (b); or

(7) the provision of services or further services for the purpose of reunification is futile and therefore unreasonable under the circumstances.

(b) When the court makes one of the prima facie determinations under paragraph (a), either permanency pleadings under section 260C.505, or a termination of parental rights petition under sections 260C.141 and 260C.301 must be filed. A permanency hearing under sections 260C.503 to 260C.521 must be held within 30 days of this determination.

(c) In the case of an Indian child, in proceedings under sections 260B.178, 260C.178, 260C.201, 260C.202, 260C.204, 260C.301, or 260C.503 to 260C.521, the juvenile court must make findings and conclusions consistent with the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901 et seq., as to the provision of active efforts. In cases governed by the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901, the responsible social services agency must provide active efforts as required under United States Code, title 25, section 1911(d).

(d) "Reasonable efforts to prevent placement" means:

(1) the agency has made reasonable efforts to prevent the placement of the child in foster care by working with the family to develop and implement a safety plan that is individualized to the needs of the child and the child's family and may include support persons from the child's extended family, kin network, and community; or

(2) the agency has demonstrated to the court that, given the particular circumstances of the child and family at the time of the child's removal, there are no services or efforts available ~~which~~ that could allow the child to safely remain in the home.

(e) "Reasonable efforts to finalize a permanent plan for the child" means due diligence by the responsible social services agency to:

(1) reunify the child with the parent or guardian from whom the child was removed;

(2) assess a noncustodial parent's ability to provide day-to-day care for the child and, where appropriate, provide services necessary to enable the noncustodial parent to safely provide the care, as required by section 260C.219;

(3) conduct a relative search to identify and provide notice to adult relatives, and engage relatives in case planning and permanency planning, as required under section 260C.221;

(4) consider placing the child with relatives in the order specified in section 260C.212, subdivision 2, paragraph (a);

~~(4)~~ (5) place siblings removed from their home in the same home for foster care or adoption, or transfer permanent legal and physical custody to a relative. Visitation between siblings who are not in the same foster care, adoption, or custodial placement or facility shall be consistent with section 260C.212, subdivision 2; and

~~(5)~~ (6) when the child cannot return to the parent or guardian from whom the child was removed, to plan for and finalize a safe and legally permanent alternative home for the child, and considers permanent alternative homes for the child inside or outside of the state, preferably with a relative in the order specified in section 260C.212, subdivision 2, paragraph (a), through adoption or transfer of permanent legal and physical custody of the child.

(f) Reasonable efforts are made upon the exercise of due diligence by the responsible social services agency to use culturally appropriate and available services to meet the individualized needs of the child and the child's family. Services may include those provided by the responsible social services agency and other culturally appropriate services available in the community. The responsible social services agency must select services for a child and the child's family by collaborating with the child's family and, if appropriate, the child. At each stage of the proceedings ~~where~~ when the court is required to review the appropriateness of the responsible social services agency's reasonable efforts as described in paragraphs (a), (d), and (e), the social services agency has the burden of demonstrating that:

(1) ~~it~~ the agency has made reasonable efforts to prevent placement of the child in foster care, including that the agency considered or established a safety plan according to paragraph (d), clause (1);

(2) ~~it~~ the agency has made reasonable efforts to eliminate the need for removal of the child from the child's home and to reunify the child with the child's family at the earliest possible time;

(3) the agency has made reasonable efforts to finalize a permanent plan for the child pursuant to paragraph (e);

~~(3) it~~ (4) the agency has made reasonable efforts to finalize an alternative permanent home for the child, and ~~considers~~ considered permanent alternative homes for the child ~~inside or outside~~ in or out of the state, preferably with a relative in the order specified in section 260C.212, subdivision 2, paragraph (a); or

~~(4)~~ (5) reasonable efforts to prevent placement and to reunify the child with the parent or guardian are not required. The agency may meet this burden by stating facts in a sworn petition filed under section 260C.141, by filing an affidavit summarizing the agency's reasonable efforts or facts that the agency believes demonstrate that there is no need for reasonable efforts to reunify the parent and child, or through testimony or a certified report required under juvenile court rules.

(g) Once the court determines that reasonable efforts for reunification are not required because the court has made one of the prima facie determinations under paragraph (a), the court may only require the agency to make reasonable efforts for reunification after a hearing according to section 260C.163, ~~where~~ if the court finds that there is not clear and convincing evidence of the facts upon which the court based ~~its~~ the court's prima facie determination. ~~In this case when~~ If there is clear and convincing evidence that the child is in need of protection or services, the court may find the child in need of protection or services and order any of the dispositions available under section 260C.201, subdivision 1. Reunification of a child with a parent is not required if the parent has been convicted of:

(1) a violation of, or an attempt or conspiracy to commit a violation of, sections 609.185 to 609.20; 609.222, subdivision 2; or 609.223 in regard to another child of the parent;

(2) a violation of section 609.222, subdivision 2; or 609.223, in regard to the child;

(3) a violation of, or an attempt or conspiracy to commit a violation of, United States Code, title 18, section 1111(a) or 1112(a), in regard to another child of the parent;

(4) committing sexual abuse as defined in section 260E.03, against the child or another child of the parent; or

(5) an offense that requires registration as a predatory offender under section 243.166, subdivision 1b, paragraph (a) or (b).

(h) The juvenile court, in proceedings under sections 260B.178, 260C.178, 260C.201, 260C.202, 260C.204, 260C.301, or 260C.503 to 260C.521, shall make findings and conclusions as to the provision of reasonable efforts. When determining whether reasonable

efforts have been made by the agency, the court shall consider whether services to the child and family were:

(1) selected in collaboration with the child's family and, if appropriate, the child;

(2) tailored to the individualized needs of the child and child's family;

~~(1)~~ (3) relevant to the safety ~~and~~, protection, and well-being of the child;

~~(2)~~ (4) adequate to meet the individualized needs of the child and family;

~~(3)~~ (5) culturally appropriate;

~~(4)~~ (6) available and accessible;

~~(5)~~ (7) consistent and timely; and

~~(6)~~ (8) realistic under the circumstances.

In the alternative, the court may determine that the provision of services or further services for the purpose of rehabilitation is futile and therefore unreasonable under the circumstances or that reasonable efforts are not required as provided in paragraph (a).

(i) This section does not prevent out-of-home placement for the treatment of a child with a mental disability when it is determined to be medically necessary as a result of the child's diagnostic assessment or the child's individual treatment plan indicates that appropriate and necessary treatment cannot be effectively provided outside of a residential or inpatient treatment program and the level or intensity of supervision and treatment cannot be effectively and safely provided in the child's home or community and it is determined that a residential treatment setting is the least restrictive setting that is appropriate to the needs of the child.

(j) If continuation of reasonable efforts to prevent placement or reunify the child with the parent or guardian from whom the child was removed is determined by the court to be inconsistent with the permanent plan for the child or upon the court making one of the prima facie determinations under paragraph (a), reasonable efforts must be made to place the child in a timely manner in a safe and permanent home and to complete whatever steps are necessary to legally finalize the permanent placement of the child.

(k) Reasonable efforts to place a child for adoption or in another permanent placement may be made concurrently with reasonable efforts to prevent placement or to reunify the child with the parent or guardian from whom the child was removed. When the responsible social services agency decides to concurrently make reasonable efforts for both reunification and permanent placement away from the parent under paragraph (a), the agency shall disclose

~~its~~ the agency's decision and both plans for concurrent reasonable efforts to all parties and the court. When the agency discloses ~~its~~ the agency's decision to proceed ~~on~~ with both plans for reunification and permanent placement away from the parent, the court's review of the agency's reasonable efforts shall include the agency's efforts under both plans.

Sec. 3. Minnesota Statutes 2020, section 260B.331, subdivision 1, is amended to read:

Subdivision 1. **Care, examination, or treatment.** (a)(1) Whenever legal custody of a child is transferred by the court to a local social services agency, or

(2) whenever legal custody is transferred to a person other than the local social services agency, but under the supervision of the local social services agency, and

(3) whenever a child is given physical or mental examinations or treatment under order of the court, and no provision is otherwise made by law for payment for the care, examination, or treatment of the child, these costs are a charge upon the welfare funds of the county in which proceedings are held upon certification of the judge of juvenile court.

(b) The court ~~shall~~ may order, and the local social services agency ~~shall~~ may require, the parents or custodian of a child, while the child is under the age of 18, to use ~~the total~~ income and resources attributable to the child for the period of care, examination, or treatment, except for clothing and personal needs allowance as provided in section 256B.35, to reimburse the county for the cost of care, examination, or treatment. Income and resources attributable to the child include, but are not limited to, Social Security benefits, Supplemental Security Income (SSI), veterans benefits, railroad retirement benefits and child support. When the child is over the age of 18, and continues to receive care, examination, or treatment, the court ~~shall~~ may order, and the local social services agency ~~shall~~ may require, reimbursement from the child for the cost of care, examination, or treatment from the income and resources attributable to the child less the clothing and personal needs allowance. The local social services agency shall determine whether requiring reimbursement, either through child support or parental fees, for the cost of care, examination, or treatment from income and resources attributable to the child is in the child's best interests. In determining whether to require reimbursement, the local social services agency shall consider:

(1) whether requiring reimbursement would compromise a parent's ability to meet the child's treatment and rehabilitation needs before the child returns to the parent's home;

(2) whether requiring reimbursement would compromise the parent's ability to meet the child's needs after the child returns home; and

(3) whether redirecting existing child support payments or changing the representative payee of social security benefits to the local social services agency would limit the parent's ability to maintain financial stability for the child upon the child's return home.

(c) If the income and resources attributable to the child are not enough to reimburse the county for the full cost of the care, examination, or treatment, the court ~~shall~~ may inquire into the ability of the parents to ~~support the child~~ reimburse the county for the cost of care, examination, or treatment and, after giving the parents a reasonable opportunity to be heard, the court ~~shall~~ may order, and the local social services agency ~~shall~~ may require, the parents to contribute to the cost of care, examination, or treatment of the child. ~~Except in delinquency cases where the victim is a member of the child's immediate family,~~ When determining the amount to be contributed by the parents, the court shall use a fee schedule based upon ability to pay that is established by the local social services agency and approved by the commissioner of human services. ~~In delinquency cases where the victim is a member of the child's immediate family,~~ The court shall ~~use the fee schedule but may also~~ take into account ~~the seriousness of the offense and any expenses which the parents have incurred as a result of the offense~~ any expenses that the parents may have incurred as a result of the offense, including but not limited to co-payments for mental health treatment and attorney fees. The income of a stepparent who has not adopted a child shall be excluded in calculating the parental contribution under this section. The local social services agency shall determine whether requiring reimbursement from the parents, either through child support or parental fees, for the cost of care, examination, or treatment from income and resources attributable to the child is in the child's best interests. In determining whether to require reimbursement, the local social services agency shall consider:

(1) whether requiring reimbursement would compromise a parent's ability to meet the child's treatment and rehabilitation needs before the child returns to the parent's home;

(2) whether requiring reimbursement would compromise the parent's ability to meet the child's needs after the child returns home; and

(3) whether requiring reimbursement would compromise the parent's ability to meet the needs of the family.

(d) If the local social services agency determines that requiring reimbursement is in the child's best interests, the court shall order the amount of reimbursement attributable to the parents or custodian, or attributable to the child, or attributable to both sources, withheld under chapter 518A from the income of the parents or the custodian of the child. A parent or custodian who fails to pay without good reason may be proceeded against for contempt,

or the court may inform the county attorney, who shall proceed to collect the unpaid sums, or both procedures may be used.

(e) If the court orders a physical or mental examination for a child, the examination is a medically necessary service for purposes of determining whether the service is covered by a health insurance policy, health maintenance contract, or other health coverage plan. Court-ordered treatment shall be subject to policy, contract, or plan requirements for medical necessity. Nothing in this paragraph changes or eliminates benefit limits, conditions of coverage, co-payments or deductibles, provider restrictions, or other requirements in the policy, contract, or plan that relate to coverage of other medically necessary services.

Sec. 4. Minnesota Statutes 2020, section 260C.001, subdivision 3, is amended to read:

Subd. 3. **Permanency, termination of parental rights, and adoption.** The purpose of the laws relating to permanency, termination of parental rights, and children who come under the guardianship of the commissioner of human services is to ensure that:

(1) when required and appropriate, reasonable efforts have been made by the social services agency to reunite the child with the child's parents in a home that is safe and permanent;

(2) if placement with the parents is not reasonably foreseeable, to secure for the child a safe and permanent placement according to the requirements of section 260C.212, subdivision 2, preferably ~~with adoptive parents~~ with a relative through an adoption or a transfer of permanent legal and physical custody or, if that is not possible or in the best interests of the child, ~~a fit and willing relative through transfer of permanent legal and physical custody to that relative~~ with a nonrelative caregiver through adoption; and

(3) when a child is under the guardianship of the commissioner of human services, reasonable efforts are made to finalize an adoptive home for the child in a timely manner.

Nothing in this section requires reasonable efforts to prevent placement or to reunify the child with the parent or guardian to be made in circumstances where the court has determined that the child has been subjected to egregious harm, when the child is an abandoned infant, the parent has involuntarily lost custody of another child through a proceeding under section 260C.515, subdivision 4, or similar law of another state, the parental rights of the parent to a sibling have been involuntarily terminated, or the court has determined that reasonable efforts or further reasonable efforts to reunify the child with the parent or guardian would be futile.

The paramount consideration in all proceedings for permanent placement of the child under sections 260C.503 to 260C.521, or the termination of parental rights is the best interests of the child. In proceedings involving an American Indian child, as defined in section 260.755, subdivision 8, the best interests of the child must be determined consistent with the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901, et seq.

Sec. 5. Minnesota Statutes 2020, section 260C.007, subdivision 27, is amended to read:

Subd. 27. **Relative.** "Relative" means a person related to the child by blood, marriage, or adoption; the legal parent, guardian, or custodian of the child's siblings; or an individual who is an important friend of the child or of the child's parent or custodian, including an individual with whom the child has resided or had significant contact or who has a significant relationship to the child or the child's parent or custodian.

Sec. 6. Minnesota Statutes 2020, section 260C.151, subdivision 6, is amended to read:

Subd. 6. **Immediate custody.** If the court makes individualized, explicit findings, based on the notarized petition or sworn affidavit, that there are reasonable grounds to believe that the child is in surroundings or conditions ~~which~~ that endanger the child's health, safety, or welfare that require that responsibility for the child's care and custody be immediately assumed by the responsible social services agency and that continuation of the child in the custody of the parent or guardian is contrary to the child's welfare, the court may order that the officer serving the summons take the child into immediate custody for placement of the child in foster care, preferably with a relative. In ordering that responsibility for the care, custody, and control of the child be assumed by the responsible social services agency, the court is ordering emergency protective care as that term is defined in the juvenile court rules.

Sec. 7. Minnesota Statutes 2020, section 260C.152, subdivision 5, is amended to read:

Subd. 5. **Notice to foster parents and preadoptive parents and relatives.** The foster parents, if any, of a child and any preadoptive parent or relative providing care for the child must be provided notice of and a right to be heard in any review or hearing to be held with respect to the child. Any other relative may also request, and must be granted, a notice and the ~~opportunity~~ right to be heard under this section. This subdivision does not require that a foster parent, preadoptive parent, ~~or~~ relative providing care for the child, or any other relative be made a party to a review or hearing solely on the basis of the notice and right to be heard.

Sec. 8. Minnesota Statutes 2020, section 260C.175, subdivision 2, is amended to read:

Subd. 2. **Notice to parent or custodian and child; emergency placement with relative.** ~~Whenever~~ (a) At the time that a peace officer takes a child into custody for relative placement or shelter care ~~or relative placement~~ pursuant to subdivision 1, section 260C.151, subdivision 5, or section 260C.154, the officer shall notify the child's parent or custodian and the child, if the child is ten years of age or older, that under section 260C.181, subdivision 2, the parent or custodian or the child may request ~~that~~ to place the child ~~be placed~~ with a relative ~~or a designated caregiver under chapter 257A~~ as defined in section 260C.007, subdivision 27, instead of in a shelter care facility.

(b) When a child who is not alleged to be delinquent is taken into custody pursuant to subdivision 1, clause (1) or (2), item (ii), and placement with an identified relative is requested, the peace officer shall coordinate with the responsible social services agency to ensure the child's safety and well-being and comply with section 260C.181, subdivision 2.

(c) The officer also shall give the parent or custodian of the child a list of names, addresses, and telephone numbers of social services agencies that offer child welfare services. If the parent or custodian was not present when the child was removed from the residence, the list shall be left with an adult on the premises or left in a conspicuous place on the premises if no adult is present. If the officer has reason to believe the parent or custodian is not able to read and understand English, the officer must provide a list that is written in the language of the parent or custodian. The list shall be prepared by the commissioner of human services. The commissioner shall prepare lists for each county and provide each county with copies of the list without charge. The list shall be reviewed annually by the commissioner and updated if it is no longer accurate. Neither the commissioner nor any peace officer or the officer's employer shall be liable to any person for mistakes or omissions in the list. The list does not constitute a promise that any agency listed will ~~in fact~~ assist the parent or custodian.

Sec. 9. Minnesota Statutes 2020, section 260C.176, subdivision 2, is amended to read:

Subd. 2. **Reasons for detention.** (a) If the child is not released as provided in subdivision 1, the person taking the child into custody shall notify the court as soon as possible of the detention of the child and the reasons for detention.

(b) No child taken into custody and placed in a relative's home or shelter care facility ~~or relative's home~~ by a peace officer pursuant to section 260C.175, subdivision 1, clause (1) or (2), item (ii), may be held in custody longer than 72 hours, excluding Saturdays, Sundays and holidays, unless a petition has been filed and the judge or referee determines

pursuant to section 260C.178 that the child shall remain in custody or unless the court has made a finding of domestic abuse perpetrated by a minor after a hearing under Laws 1997, chapter 239, article 10, sections 2 to 26, in which case the court may extend the period of detention for an additional seven days, within which time the social services agency shall conduct an assessment and shall provide recommendations to the court regarding voluntary services or file a child in need of protection or services petition.

Sec. 10. Minnesota Statutes 2020, section 260C.178, subdivision 1, is amended to read:

Subdivision 1. **Hearing and release requirements.** (a) If a child was taken into custody under section 260C.175, subdivision 1, clause (1) or (2), item (ii), the court shall hold a hearing within 72 hours of the time that the child was taken into custody, excluding Saturdays, Sundays, and holidays, to determine whether the child should continue to be in custody.

(b) Unless there is reason to believe that the child would endanger self or others or not return for a court hearing, or that the child's health or welfare would be immediately endangered, the child shall be released to the custody of a parent, guardian, custodian, or other suitable person, subject to reasonable conditions of release including, but not limited to, a requirement that the child undergo a chemical use assessment as provided in section 260C.157, subdivision 1.

(c) If the court determines that there is reason to believe that the child would endanger self or others or not return for a court hearing, or that the child's health or welfare would be immediately endangered if returned to the care of the parent or guardian who has custody and from whom the child was removed, the court shall order the child:

(1) into the care of the child's noncustodial parent and order the noncustodial parent to comply with any conditions that the court determines appropriate to ensure the safety and care of the child, including requiring the noncustodial parent to cooperate with paternity establishment proceedings if the noncustodial parent has not been adjudicated the child's father; or

(2) into foster care as defined in section 260C.007, subdivision 18, under the legal responsibility of the responsible social services agency or responsible probation or corrections agency for the purposes of protective care as that term is used in the juvenile court rules ~~or into the home of a noncustodial parent and order the noncustodial parent to comply with any conditions the court determines to be appropriate to the safety and care of the child, including cooperating with paternity establishment proceedings in the case of a man who has not been adjudicated the child's father~~. The court shall not give the responsible social

services legal custody and order a trial home visit at any time prior to adjudication and disposition under section 260C.201, subdivision 1, paragraph (a), clause (3), but may order the child returned to the care of the parent or guardian who has custody and from whom the child was removed and order the parent or guardian to comply with any conditions the court determines to be appropriate to meet the safety, health, and welfare of the child.

(d) In determining whether the child's health or welfare would be immediately endangered, the court shall consider whether the child would reside with a perpetrator of domestic child abuse.

(e) The court, before determining whether a child should be placed in or continue in foster care under the protective care of the responsible agency, shall also make a determination, consistent with section 260.012 as to whether reasonable efforts were made to prevent placement or whether reasonable efforts to prevent placement are not required. In the case of an Indian child, the court shall determine whether active efforts, according to section 260.762 and the Indian Child Welfare Act of 1978, United States Code, title 25, section 1912(d), were made to prevent placement. The court shall enter a finding that the responsible social services agency has made reasonable efforts to prevent placement when the agency establishes either:

(1) that ~~it~~ the agency has actually provided services or made efforts in an attempt to prevent the child's removal but that such services or efforts have not proven sufficient to permit the child to safely remain in the home; or

(2) that there are no services or other efforts that could be made at the time of the hearing that could safely permit the child to remain home or to return home. The court shall not make a reasonable efforts determination under this clause unless the court is satisfied that the agency has sufficiently demonstrated to the court that there were no services or other efforts that the agency was able to provide at the time of the hearing enabling the child to safely remain home or to safely return home. When reasonable efforts to prevent placement are required and there are services or other efforts that could be ordered ~~which~~ that would permit the child to safely return home, the court shall order the child returned to the care of the parent or guardian and the services or efforts put in place to ensure the child's safety. When the court makes a prima facie determination that one of the circumstances under paragraph (g) exists, the court shall determine that reasonable efforts to prevent placement and to return the child to the care of the parent or guardian are not required.

(f) If the court finds the social services agency's preventive or reunification efforts have not been reasonable but further preventive or reunification efforts could not permit the child

to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

~~(f)~~ (g) The court may not order or continue the foster care placement of the child unless the court makes explicit, individualized findings that continued custody of the child by the parent or guardian would be contrary to the welfare of the child and that placement is in the best interest of the child.

~~(g)~~ (h) At the emergency removal hearing, or at any time during the course of the proceeding, and upon notice and request of the county attorney, the court shall determine whether a petition has been filed stating a prima facie case that:

(1) the parent has subjected a child to egregious harm as defined in section 260C.007, subdivision 14;

(2) the parental rights of the parent to another child have been involuntarily terminated;

(3) the child is an abandoned infant under section 260C.301, subdivision 2, paragraph (a), clause (2);

(4) the parents' custodial rights to another child have been involuntarily transferred to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (e), clause (1); section 260C.515, subdivision 4; or a similar law of another jurisdiction;

(5) the parent has committed sexual abuse as defined in section 260E.03, against the child or another child of the parent;

(6) the parent has committed an offense that requires registration as a predatory offender under section 243.166, subdivision 1b, paragraph (a) or (b); or

(7) the provision of services or further services for the purpose of reunification is futile and therefore unreasonable.

~~(h)~~ (i) When a petition to terminate parental rights is required under section 260C.301, subdivision 4, or 260C.503, subdivision 2, but the county attorney has determined not to proceed with a termination of parental rights petition, and has instead filed a petition to transfer permanent legal and physical custody to a relative under section 260C.507, the court shall schedule a permanency hearing within 30 days of the filing of the petition.

~~(i)~~ (j) If the county attorney has filed a petition under section 260C.307, the court shall schedule a trial under section 260C.163 within 90 days of the filing of the petition except when the county attorney determines that the criminal case shall proceed to trial first under section 260C.503, subdivision 2, paragraph (c).

~~(j)~~ (k) If the court determines the child should be ordered into foster care and the child's parent refuses to give information to the responsible social services agency regarding the child's father or relatives of the child, the court may order the parent to disclose the names, addresses, telephone numbers, and other identifying information to the responsible social services agency for the purpose of complying with sections 260C.150, 260C.151, 260C.212, 260C.215, 260C.219, and 260C.221.

~~(k)~~ (l) If a child ordered into foster care has siblings, whether full, half, or step, who are also ordered into foster care, the court shall inquire of the responsible social services agency of the efforts to place the children together as required by section 260C.212, subdivision 2, paragraph (d), if placement together is in each child's best interests, unless a child is in placement for treatment or a child is placed with a previously noncustodial parent who is not a parent to all siblings. If the children are not placed together at the time of the hearing, the court shall inquire at each subsequent hearing of the agency's reasonable efforts to place the siblings together, as required under section 260.012. If any sibling is not placed with another sibling or siblings, the agency must develop a plan to facilitate visitation or ongoing contact among the siblings as required under section 260C.212, subdivision 1, unless it is contrary to the safety or well-being of any of the siblings to do so.

~~(l)~~ (m) When the court has ordered the child into the care of a noncustodial parent or in foster care ~~or into the home of a noncustodial parent~~, the court may order a chemical dependency evaluation, mental health evaluation, medical examination, and parenting assessment for the parent as necessary to support the development of a plan for reunification required under subdivision 7 and section 260C.212, subdivision 1, or the child protective services plan under section 260E.26, and Minnesota Rules, part 9560.0228.

Sec. 11. Minnesota Statutes 2020, section 260C.181, subdivision 2, is amended to read:

Subd. 2. **Least restrictive setting.** Notwithstanding the provisions of subdivision 1, if the child had been taken into custody pursuant to section 260C.175, subdivision 1, clause (1) or (2), item (ii), and is not alleged to be delinquent, the child shall be detained in the least restrictive setting consistent with the child's health and welfare and in closest proximity to the child's family as possible. Placement may be with a child's relative~~, a designated caregiver under chapter 257A,~~ or, if no placement is available with a relative, in a shelter care facility. The placing officer shall comply with this section and shall document why a less restrictive setting will or will not be in the best interests of the child for placement purposes.

Sec. 12. Minnesota Statutes 2020, section 260C.193, subdivision 3, is amended to read:

Subd. 3. **Best interests of the child.** (a) The policy of the state is to ensure that the best interests of children in foster care, who experience a transfer of permanent legal and physical custody to a relative under section 260C.515, subdivision 4, or adoption under this chapter, are met by:

(1) considering placement of a child with relatives in the order specified in section 260C.212, subdivision 2, paragraph (a); and

(2) requiring individualized determinations under section 260C.212, subdivision 2, paragraph (b), of the needs of the child and of how the selected home will serve the needs of the child.

(b) No later than three months after a child is ordered to be removed from the care of a parent in the hearing required under section 260C.202, the court shall review and enter findings regarding whether the responsible social services agency ~~made~~:

(1) ~~diligent efforts~~ exercised due diligence to identify ~~and~~, search for, notify, and engage relatives as required under section 260C.221; and

(2) made a placement consistent with section 260C.212, subdivision 2, that is based on an individualized determination ~~as required under section 260C.212, subdivision 2,~~ of the child's needs to select a home that meets the needs of the child.

(c) If the court finds that the agency has not ~~made efforts~~ exercised due diligence as required under section 260C.221, ~~and~~ the court shall order the agency to make reasonable efforts. If there is a relative who qualifies to be licensed to provide family foster care under chapter 245A, the court may order the child to be placed with the relative consistent with the child's best interests.

(d) If the agency's efforts under section 260C.221 are found by the court to be sufficient, the court shall order the agency to continue to appropriately engage relatives who responded to the notice under section 260C.221 in placement and case planning decisions and to appropriately engage relatives who subsequently come to the agency's attention. A court's finding that the agency has made reasonable efforts under this paragraph does not relieve the agency of the duty to continue notifying relatives who come to the agency's attention and engaging and considering relatives who respond to the notice under section 260C.221 in child placement and case planning decisions.

(e) If the child's birth parent ~~or parents~~ explicitly ~~request~~ requests that a specific relative ~~or important friend~~ not be considered for placement of the child, the court shall honor that

request if it is consistent with the best interests of the child and consistent with the requirements of section 260C.221. The court shall not waive relative search, notice, and consideration requirements, unless section 260C.139 applies. If the child's birth parent ~~or parents express~~ expresses a preference for placing the child in a foster or adoptive home of the same or a similar religious background ~~to~~ as that of the birth parent or parents, the court shall order placement of the child with an individual who meets the birth parent's religious preference.

(f) Placement of a child ~~cannot~~ must not be delayed or denied based on race, color, or national origin of the foster parent or the child.

(g) Whenever possible, siblings requiring foster care placement ~~should~~ shall be placed together unless it is determined not to be in the best interests of one or more of the siblings after weighing the benefits of separate placement against the benefits of sibling connections for each sibling. The agency shall consider section 260C.008 when making this determination. If siblings were not placed together according to section 260C.212, subdivision 2, paragraph (d), the responsible social services agency shall report to the court the efforts made to place the siblings together and why the efforts were not successful. If the court is not satisfied that the agency has made reasonable efforts to place siblings together, the court must order the agency to make further reasonable efforts. If siblings are not placed together, the court shall order the responsible social services agency to implement the plan for visitation among siblings required as part of the out-of-home placement plan under section 260C.212.

(h) This subdivision does not affect the Indian Child Welfare Act, United States Code, title 25, sections 1901 to 1923, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835.

Sec. 13. Minnesota Statutes 2020, section 260C.201, subdivision 1, is amended to read:

Subdivision 1. **Dispositions.** (a) If the court finds that the child is in need of protection or services or neglected and in foster care, ~~it~~ the court shall enter an order making any of the following dispositions of the case:

(1) place the child under the protective supervision of the responsible social services agency or child-placing agency in the home of a parent of the child under conditions prescribed by the court directed to the correction of the child's need for protection or services:

(i) the court may order the child into the home of a parent who does not otherwise have legal custody of the child, however, an order under this section does not confer legal custody on that parent;

(ii) if the court orders the child into the home of a father who is not adjudicated, the father must cooperate with paternity establishment proceedings regarding the child in the appropriate jurisdiction as one of the conditions prescribed by the court for the child to continue in the father's home; and

(iii) the court may order the child into the home of a noncustodial parent with conditions and may also order both the noncustodial and the custodial parent to comply with the requirements of a case plan under subdivision 2; or

(2) transfer legal custody to one of the following:

(i) a child-placing agency; or

(ii) the responsible social services agency. In making a foster care placement ~~for~~ of a child whose custody has been transferred under this subdivision, the agency shall make an individualized determination of how the placement is in the child's best interests using the placement consideration order for relatives~~,~~ and the best interest factors in section 260C.212, subdivision 2~~, paragraph (b)~~, and may include a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190; or

(3) order a trial home visit without modifying the transfer of legal custody to the responsible social services agency under clause (2). Trial home visit means the child is returned to the care of the parent or guardian from whom the child was removed for a period not to exceed six months. During the period of the trial home visit, the responsible social services agency:

(i) shall continue to have legal custody of the child, which means that the agency may see the child in the parent's home, at school, in a child care facility, or other setting as the agency deems necessary and appropriate;

(ii) shall continue to have the ability to access information under section 260C.208;

(iii) shall continue to provide appropriate services to both the parent and the child during the period of the trial home visit;

(iv) without previous court order or authorization, may terminate the trial home visit in order to protect the child's health, safety, or welfare and may remove the child to foster care;

(v) shall advise the court and parties within three days of the termination of the trial home visit when a visit is terminated by the responsible social services agency without a court order; and

(vi) shall prepare a report for the court when the trial home visit is terminated whether by the agency or court order ~~which~~ that describes the child's circumstances during the trial home visit and recommends appropriate orders, if any, for the court to enter to provide for the child's safety and stability. In the event a trial home visit is terminated by the agency by removing the child to foster care without prior court order or authorization, the court shall conduct a hearing within ten days of receiving notice of the termination of the trial home visit by the agency and shall order disposition under this subdivision or commence permanency proceedings under sections 260C.503 to 260C.515. The time period for the hearing may be extended by the court for good cause shown and if it is in the best interests of the child as long as the total time the child spends in foster care without a permanency hearing does not exceed 12 months;

(4) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a physical or mental disability or emotional disturbance as defined in section 245.4871, subdivision 15, the court may order the child's parent, guardian, or custodian to provide it. The court may order the child's health plan company to provide mental health services to the child. Section 62Q.535 applies to an order for mental health services directed to the child's health plan company. If the health plan, parent, guardian, or custodian fails or is unable to provide this treatment or care, the court may order it provided. Absent specific written findings by the court that the child's disability is the result of abuse or neglect by the child's parent or guardian, the court shall not transfer legal custody of the child for the purpose of obtaining special treatment or care solely because the parent is unable to provide the treatment or care. If the court's order for mental health treatment is based on a diagnosis made by a treatment professional, the court may order that the diagnosing professional not provide the treatment to the child if it finds that such an order is in the child's best interests; or

(5) if the court believes that the child has sufficient maturity and judgment and that it is in the best interests of the child, the court may order a child 16 years old or older to be allowed to live independently, either alone or with others as approved by the court under supervision the court considers appropriate, if the county board, after consultation with the court, has specifically authorized this dispositional alternative for a child.

(b) If the child was adjudicated in need of protection or services because the child is a runaway or habitual truant, the court may order any of the following dispositions in addition to or as alternatives to the dispositions authorized under paragraph (a):

(1) counsel the child or the child's parents, guardian, or custodian;

(2) place the child under the supervision of a probation officer or other suitable person in the child's own home under conditions prescribed by the court, including reasonable rules for the child's conduct and the conduct of the parents, guardian, or custodian, designed for the physical, mental, and moral well-being and behavior of the child;

(3) subject to the court's supervision, transfer legal custody of the child to one of the following:

(i) a reputable person of good moral character. No person may receive custody of two or more unrelated children unless licensed to operate a residential program under sections 245A.01 to 245A.16; or

(ii) a county probation officer for placement in a group foster home established under the direction of the juvenile court and licensed pursuant to section 241.021;

(4) require the child to pay a fine of up to $100. The court shall order payment of the fine in a manner that will not impose undue financial hardship upon the child;

(5) require the child to participate in a community service project;

(6) order the child to undergo a chemical dependency evaluation and, if warranted by the evaluation, order participation by the child in a drug awareness program or an inpatient or outpatient chemical dependency treatment program;

(7) if the court believes that it is in the best interests of the child or of public safety that the child's driver's license or instruction permit be canceled, the court may order the commissioner of public safety to cancel the child's license or permit for any period up to the child's 18th birthday. If the child does not have a driver's license or permit, the court may order a denial of driving privileges for any period up to the child's 18th birthday. The court shall forward an order issued under this clause to the commissioner, who shall cancel the license or permit or deny driving privileges without a hearing for the period specified by the court. At any time before the expiration of the period of cancellation or denial, the court may, for good cause, order the commissioner of public safety to allow the child to apply for a license or permit, and the commissioner shall so authorize;

(8) order that the child's parent or legal guardian deliver the child to school at the beginning of each school day for a period of time specified by the court; or

(9) require the child to perform any other activities or participate in any other treatment programs deemed appropriate by the court.

To the extent practicable, the court shall enter a disposition order the same day it makes a finding that a child is in need of protection or services or neglected and in foster care, but

in no event more than 15 days after the finding unless the court finds that the best interests of the child will be served by granting a delay. If the child was under eight years of age at the time the petition was filed, the disposition order must be entered within ten days of the finding and the court may not grant a delay unless good cause is shown and the court finds the best interests of the child will be served by the delay.

(c) If a child who is 14 years of age or older is adjudicated in need of protection or services because the child is a habitual truant and truancy procedures involving the child were previously dealt with by a school attendance review board or county attorney mediation program under section 260A.06 or 260A.07, the court shall order a cancellation or denial of driving privileges under paragraph (b), clause (7), for any period up to the child's 18th birthday.

(d) In the case of a child adjudicated in need of protection or services because the child has committed domestic abuse and been ordered excluded from the child's parent's home, the court shall dismiss jurisdiction if the court, at any time, finds the parent is able or willing to provide an alternative safe living arrangement for the child, as defined in Laws 1997, chapter 239, article 10, section 2.

(e) When a parent has complied with a case plan ordered under subdivision 6 and the child is in the care of the parent, the court may order the responsible social services agency to monitor the parent's continued ability to maintain the child safely in the home under such terms and conditions as the court determines appropriate under the circumstances.

Sec. 14. Minnesota Statutes 2020, section 260C.201, subdivision 2, is amended to read:

Subd. 2. **Written findings.** (a) Any order for a disposition authorized under this section shall contain written findings of fact to support the disposition and case plan ordered and shall also set forth in writing the following information:

(1) why the best interests and safety of the child are served by the disposition and case plan ordered;

(2) what alternative dispositions or services under the case plan were considered by the court and why such dispositions or services were not appropriate in the instant case;

(3) when legal custody of the child is transferred, the appropriateness of the particular placement made or to be made by the placing agency using the relative and sibling placement considerations and best interest factors in section 260C.212, subdivision 2~~, paragraph (b)~~, or the appropriateness of a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190;

(4) whether reasonable efforts to finalize the permanent plan for the child consistent with section 260.012 were made including reasonable efforts:

(i) to prevent the child's placement and to reunify the child with the parent or guardian from whom the child was removed at the earliest time consistent with the child's safety. The court's findings must include a brief description of what preventive and reunification efforts were made and why further efforts could not have prevented or eliminated the necessity of removal or that reasonable efforts were not required under section 260.012 or 260C.178, subdivision 1;

(ii) to identify and locate any noncustodial or nonresident parent of the child and to assess such parent's ability to provide day-to-day care of the child, and, where appropriate, provide services necessary to enable the noncustodial or nonresident parent to safely provide day-to-day care of the child as required under section 260C.219, unless such services are not required under section 260.012 or 260C.178, subdivision 1~~;~~. The court's findings must include a description of the agency's efforts to:

(A) identify and locate the child's noncustodial or nonresident parent;

(B) assess the noncustodial or nonresident parent's ability to provide day-to-day care of the child; and

(C) if appropriate, provide services necessary to enable the noncustodial or nonresident parent to safely provide the child's day-to-day care, including efforts to engage the noncustodial or nonresident parent in assuming care and responsibility of the child;

(iii) to make the diligent search for relatives and provide the notices required under section 260C.221; a finding made pursuant to a hearing under section 260C.202 that the agency has made diligent efforts to conduct a relative search and has appropriately engaged relatives who responded to the notice under section 260C.221 and other relatives, who came to the attention of the agency after notice under section 260C.221 was sent, in placement and case planning decisions fulfills the requirement of this item;

(iv) to identify and make a foster care placement of the child, considering the order in section 260C.212, subdivision 2, paragraph (a), in the home of an unlicensed relative, according to the requirements of section 245A.035, a licensed relative, or other licensed foster care provider, who will commit to being the permanent legal parent or custodian for the child in the event reunification cannot occur, but who will actively support the reunification plan for the child. If the court finds that the agency has not appropriately considered relatives for placement of the child, the court shall order the agency to comply with section 260C.212, subdivision 2, paragraph (a). The court may order the agency to

continue considering relatives for placement of the child regardless of the child's current placement setting; and

(v) to place siblings together in the same home or to ensure visitation is occurring when siblings are separated in foster care placement and visitation is in the siblings' best interests under section 260C.212, subdivision 2, paragraph (d); and

(5) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a mental disability or emotional disturbance as defined in section 245.4871, subdivision 15, the written findings shall also set forth:

(i) whether the child has mental health needs that must be addressed by the case plan;

(ii) what consideration was given to the diagnostic and functional assessments performed by the child's mental health professional and to health and mental health care professionals' treatment recommendations;

(iii) what consideration was given to the requests or preferences of the child's parent or guardian with regard to the child's interventions, services, or treatment; and

(iv) what consideration was given to the cultural appropriateness of the child's treatment or services.

(b) If the court finds that the social services agency's preventive or reunification efforts have not been reasonable but that further preventive or reunification efforts could not permit the child to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

(c) If the child has been identified by the responsible social services agency as the subject of concurrent permanency planning, the court shall review the reasonable efforts of the agency to develop a permanency plan for the child that includes a primary plan ~~which~~ that is for reunification with the child's parent or guardian and a secondary plan ~~which~~ that is for an alternative, legally permanent home for the child in the event reunification cannot be achieved in a timely manner.

Sec. 15. Minnesota Statutes 2020, section 260C.202, is amended to read:

260C.202 COURT REVIEW OF FOSTER CARE.

(a) If the court orders a child placed in foster care, the court shall review the out-of-home placement plan and the child's placement at least every 90 days as required in juvenile court rules to determine whether continued out-of-home placement is necessary and appropriate

or whether the child should be returned home. This review is not required if the court has returned the child home, ordered the child permanently placed away from the parent under sections 260C.503 to 260C.521, or terminated rights under section 260C.301. Court review for a child permanently placed away from a parent, including where the child is under guardianship of the commissioner, shall be governed by section 260C.607. When a child is placed in a qualified residential treatment program setting as defined in section 260C.007, subdivision 26d, the responsible social services agency must submit evidence to the court as specified in section 260C.712.

(b) No later than three months after the child's placement in foster care, the court shall review agency efforts to search for and notify relatives pursuant to section 260C.221, and order that the agency's efforts begin immediately, or continue, if the agency has failed to perform, or has not adequately performed, the duties under that section. The court must order the agency to continue to appropriately engage relatives who responded to the notice under section 260C.221 in placement and case planning decisions and to consider relatives for foster care placement consistent with section 260C.221. Notwithstanding a court's finding that the agency has made reasonable efforts to search for and notify relatives under section 260C.221, the court may order the agency to continue making reasonable efforts to search for, notify, engage ~~other~~, and consider relatives who came to the agency's attention after sending the initial notice under section 260C.221 ~~was sent~~.

(c) The court shall review the out-of-home placement plan and may modify the plan as provided under section 260C.201, subdivisions 6 and 7.

(d) When the court ~~orders transfer of~~ transfers the custody of a child to a responsible social services agency resulting in foster care or protective supervision with a noncustodial parent under subdivision 1, the court shall notify the parents of the provisions of sections 260C.204 and 260C.503 to 260C.521, as required under juvenile court rules.

(e) When a child remains in or returns to foster care pursuant to section 260C.451 and the court has jurisdiction pursuant to section 260C.193, subdivision 6, paragraph (c), the court shall at least annually conduct the review required under section 260C.203.

Sec. 16. Minnesota Statutes 2020, section 260C.203, is amended to read:

260C.203 ADMINISTRATIVE OR COURT REVIEW OF PLACEMENTS.

(a) Unless the court is conducting the reviews required under section 260C.202, there shall be an administrative review of the out-of-home placement plan of each child placed in foster care no later than 180 days after the initial placement of the child in foster care

and at least every six months thereafter if the child is not returned to the home of the parent or parents within that time. The out-of-home placement plan must be monitored and updated by the responsible social services agency at each administrative review. The administrative review shall be conducted by the responsible social services agency using a panel of appropriate persons at least one of whom is not responsible for the case management of, or the delivery of services to, either the child or the parents who are the subject of the review. The administrative review shall be open to participation by the parent or guardian of the child and the child, as appropriate.

(b) As an alternative to the administrative review required in paragraph (a), the court may, as part of any hearing required under the Minnesota Rules of Juvenile Protection Procedure, conduct a hearing to monitor and update the out-of-home placement plan pursuant to the procedure and standard in section 260C.201, subdivision 6, paragraph (d). The party requesting review of the out-of-home placement plan shall give parties to the proceeding notice of the request to review and update the out-of-home placement plan. A court review conducted pursuant to section 260C.141, subdivision 2; 260C.193; 260C.201, subdivision 1; 260C.202; 260C.204; 260C.317; or 260D.06 shall satisfy the requirement for the review so long as the other requirements of this section are met.

(c) As appropriate to the stage of the proceedings and relevant court orders, the responsible social services agency or the court shall review:

(1) the safety, permanency needs, and well-being of the child;

(2) the continuing necessity for and appropriateness of the placement, including whether the placement is consistent with the child's best interests and other placement considerations, including relative and sibling placement considerations under section 260C.212, subdivision 2;

(3) the extent of compliance with the out-of-home placement plan required under section 260C.212, subdivisions 1 and 1a, including services and resources that the agency has provided to the child and child's parents, services and resources that other agencies and individuals have provided to the child and child's parents, and whether the out-of-home placement plan is individualized to the needs of the child and child's parents;

(4) the extent of progress that has been made toward alleviating or mitigating the causes necessitating placement in foster care;

(5) the projected date by which the child may be returned to and safely maintained in the home or placed permanently away from the care of the parent or parents or guardian; and

(6) the appropriateness of the services provided to the child.

(d) When a child is age 14 or older:

(1) in addition to any administrative review conducted by the responsible social services agency, at the in-court review required under section 260C.317, subdivision 3, clause (3), or 260C.515, subdivision 5 or 6, the court shall review the independent living plan required under section 260C.212, subdivision 1, paragraph (c), clause (12), and the provision of services to the child related to the well-being of the child as the child prepares to leave foster care. The review shall include the actual plans related to each item in the plan necessary to the child's future safety and well-being when the child is no longer in foster care; and

(2) consistent with the requirements of the independent living plan, the court shall review progress toward or accomplishment of the following goals:

(i) the child has obtained a high school diploma or its equivalent;

(ii) the child has completed a driver's education course or has demonstrated the ability to use public transportation in the child's community;

(iii) the child is employed or enrolled in postsecondary education;

(iv) the child has applied for and obtained postsecondary education financial aid for which the child is eligible;

(v) the child has health care coverage and health care providers to meet the child's physical and mental health needs;

(vi) the child has applied for and obtained disability income assistance for which the child is eligible;

(vii) the child has obtained affordable housing with necessary supports, which does not include a homeless shelter;

(viii) the child has saved sufficient funds to pay for the first month's rent and a damage deposit;

(ix) the child has an alternative affordable housing plan, which does not include a homeless shelter, if the original housing plan is unworkable;

(x) the child, if male, has registered for the Selective Service; and

(xi) the child has a permanent connection to a caring adult.

Sec. 17. Minnesota Statutes 2020, section 260C.204, is amended to read:

260C.204 PERMANENCY PROGRESS REVIEW FOR CHILDREN IN FOSTER CARE FOR SIX MONTHS.

(a) When a child continues in placement out of the home of the parent or guardian from whom the child was removed, no later than six months after the child's placement the court shall conduct a permanency progress hearing to review:

(1) the progress of the case, the parent's progress on the case plan or out-of-home placement plan, whichever is applicable;

(2) the agency's reasonable, or in the case of an Indian child, active efforts for reunification and its provision of services;

(3) the agency's reasonable efforts to finalize the permanent plan for the child under section 260.012, paragraph (e), and to make a placement as required under section 260C.212, subdivision 2, in a home that will commit to being the legally permanent family for the child in the event the child cannot return home according to the timelines in this section; and

(4) in the case of an Indian child, active efforts to prevent the breakup of the Indian family and to make a placement according to the placement preferences under United States Code, title 25, chapter 21, section 1915.

(b) When a child is placed in a qualified residential treatment program setting as defined in section 260C.007, subdivision 26d, the responsible social services agency must submit evidence to the court as specified in section 260C.712.

(c) The court shall ensure that notice of the hearing is sent to any relative who:

(1) responded to the agency's notice provided under section 260C.221, indicating an interest in participating in planning for the child or being a permanency resource for the child and who has kept the court apprised of the relative's address; or

(2) asked to be notified of court proceedings regarding the child as is permitted in section 260C.152, subdivision 5.

(d)(1) If the parent or guardian has maintained contact with the child and is complying with the court-ordered out-of-home placement plan, and if the child would benefit from reunification with the parent, the court may either:

(i) return the child home, if the conditions ~~which~~ that led to the out-of-home placement have been sufficiently mitigated that it is safe and in the child's best interests to return home; or

(ii) continue the matter up to a total of six additional months. If the child has not returned home by the end of the additional six months, the court must conduct a hearing according to sections 260C.503 to 260C.521.

(2) If the court determines that the parent or guardian is not complying, is not making progress with or engaging with services in the out-of-home placement plan, or is not maintaining regular contact with the child as outlined in the visitation plan required as part of the out-of-home placement plan under section 260C.212, the court may order the responsible social services agency:

(i) to develop a plan for legally permanent placement of the child away from the parent;

(ii) to consider, identify, recruit, and support one or more permanency resources from the child's relatives and foster parent, consistent with section 260C.212, subdivision 2, paragraph (a), to be the legally permanent home in the event the child cannot be returned to the parent. Any relative or the child's foster parent may ask the court to order the agency to consider them for permanent placement of the child in the event the child cannot be returned to the parent. A relative or foster parent who wants to be considered under this item shall cooperate with the background study required under section 245C.08, if the individual has not already done so, and with the home study process required under chapter 245A for providing child foster care and for adoption under section 259.41. The home study referred to in this item shall be a single-home study in the form required by the commissioner of human services or similar study required by the individual's state of residence when the subject of the study is not a resident of Minnesota. The court may order the responsible social services agency to make a referral under the Interstate Compact on the Placement of Children when necessary to obtain a home study for an individual who wants to be considered for transfer of permanent legal and physical custody or adoption of the child; and

(iii) to file a petition to support an order for the legally permanent placement plan.

(e) Following the review under this section:

(1) if the court has either returned the child home or continued the matter up to a total of six additional months, the agency shall continue to provide services to support the child's return home or to make reasonable efforts to achieve reunification of the child and the parent as ordered by the court under an approved case plan;

(2) if the court orders the agency to develop a plan for the transfer of permanent legal and physical custody of the child to a relative, a petition supporting the plan shall be filed in juvenile court within 30 days of the hearing required under this section and a trial on the petition held within 60 days of the filing of the pleadings; or

(3) if the court orders the agency to file a termination of parental rights, unless the county attorney can show cause why a termination of parental rights petition should not be filed, a petition for termination of parental rights shall be filed in juvenile court within 30 days of the hearing required under this section and a trial on the petition held within 60 days of the filing of the petition.

Sec. 18. Minnesota Statutes 2021 Supplement, section 260C.212, subdivision 1, is amended to read:

Subdivision 1. **Out-of-home placement; plan.** (a) An out-of-home placement plan shall be prepared within 30 days after any child is placed in foster care by court order or a voluntary placement agreement between the responsible social services agency and the child's parent pursuant to section 260C.227 or chapter 260D.

(b) An out-of-home placement plan means a written document ~~which~~ individualized to the needs of the child and the child's parents or guardians that is prepared by the responsible social services agency jointly with ~~the parent or parents or guardian of the child~~ the child's parents or guardians and in consultation with the child's guardian ad litem~~,~~; the child's tribe, if the child is an Indian child~~,~~; the child's foster parent or representative of the foster care facility~~,~~; and, ~~where~~ when appropriate, the child. When a child is age 14 or older, the child may include two other individuals on the team preparing the child's out-of-home placement plan. The child may select one member of the case planning team to be designated as the child's advisor and to advocate with respect to the application of the reasonable and prudent parenting standards. The responsible social services agency may reject an individual selected by the child if the agency has good cause to believe that the individual would not act in the best interest of the child. For a child in voluntary foster care for treatment under chapter 260D, preparation of the out-of-home placement plan shall additionally include the child's mental health treatment provider. For a child 18 years of age or older, the responsible social services agency shall involve the child and the child's parents as appropriate. As appropriate, the plan shall be:

(1) submitted to the court for approval under section 260C.178, subdivision 7;

(2) ordered by the court, either as presented or modified after hearing, under section 260C.178, subdivision 7, or 260C.201, subdivision 6; and

(3) signed by the parent or parents or guardian of the child, the child's guardian ad litem, a representative of the child's tribe, the responsible social services agency, and, if possible, the child.

(c) The out-of-home placement plan shall be explained by the responsible social services agency to all persons involved in ~~its~~ the plan's implementation, including the child who has signed the plan, and shall set forth:

(1) a description of the foster care home or facility selected, including how the out-of-home placement plan is designed to achieve a safe placement for the child in the least restrictive, most family-like~~,~~ setting available ~~which~~ that is in close proximity to the home of the ~~parent or~~ child's parents or ~~guardian of the child~~ guardians when the case plan goal is reunification~~,~~; and how the placement is consistent with the best interests and special needs of the child according to the factors under subdivision 2, paragraph (b);

(2) the specific reasons for the placement of the child in foster care, and when reunification is the plan, a description of the problems or conditions in the home of the parent or parents ~~which~~ that necessitated removal of the child from home and the changes the parent or parents must make for the child to safely return home;

(3) a description of the services offered and provided to prevent removal of the child from the home and to reunify the family including:

(i) the specific actions to be taken by the parent or parents of the child to eliminate or correct the problems or conditions identified in clause (2), and the time period during which the actions are to be taken; and

(ii) the reasonable efforts, or in the case of an Indian child, active efforts to be made to achieve a safe and stable home for the child including social and other supportive services to be provided or offered to the parent or parents or guardian of the child, the child, and the residential facility during the period the child is in the residential facility;

(4) a description of any services or resources that were requested by the child or the child's parent, guardian, foster parent, or custodian since the date of the child's placement in the residential facility, and whether those services or resources were provided and if not, the basis for the denial of the services or resources;

(5) the visitation plan for the parent or parents or guardian, other relatives as defined in section 260C.007, subdivision 26b or 27, and siblings of the child if the siblings are not placed together in foster care, and whether visitation is consistent with the best interest of the child, during the period the child is in foster care;

(6) when a child cannot return to or be in the care of either parent, documentation of steps to finalize adoption as the permanency plan for the child through reasonable efforts to place the child for adoption pursuant to section 260C.605. At a minimum, the documentation must include consideration of whether adoption is in the best interests of the child, and child-specific recruitment efforts such as a relative search, consideration of relatives for adoptive placement, and the use of state, regional, and national adoption exchanges to facilitate orderly and timely placements in and outside of the state. A copy of this documentation shall be provided to the court in the review required under section 260C.317, subdivision 3, paragraph (b);

(7) when a child cannot return to or be in the care of either parent, documentation of steps to finalize the transfer of permanent legal and physical custody to a relative as the permanency plan for the child. This documentation must support the requirements of the kinship placement agreement under section 256N.22 and must include the reasonable efforts used to determine that it is not appropriate for the child to return home or be adopted, and reasons why permanent placement with a relative through a Northstar kinship assistance arrangement is in the child's best interest; how the child meets the eligibility requirements for Northstar kinship assistance payments; agency efforts to discuss adoption with the child's relative foster parent and reasons why the relative foster parent chose not to pursue adoption, if applicable; and agency efforts to discuss with the child's parent or parents the permanent transfer of permanent legal and physical custody or the reasons why these efforts were not made;

(8) efforts to ensure the child's educational stability while in foster care for a child who attained the minimum age for compulsory school attendance under state law and is enrolled full time in elementary or secondary school, or instructed in elementary or secondary education at home, or instructed in an independent study elementary or secondary program, or incapable of attending school on a full-time basis due to a medical condition that is documented and supported by regularly updated information in the child's case plan. Educational stability efforts include:

(i) efforts to ensure that the child remains in the same school in which the child was enrolled prior to placement or upon the child's move from one placement to another, including efforts to work with the local education authorities to ensure the child's educational stability and attendance; or

(ii) if it is not in the child's best interest to remain in the same school that the child was enrolled in prior to placement or move from one placement to another, efforts to ensure immediate and appropriate enrollment for the child in a new school;

(9) the educational records of the child including the most recent information available regarding:

(i) the names and addresses of the child's educational providers;

(ii) the child's grade level performance;

(iii) the child's school record;

(iv) a statement about how the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement; and

(v) any other relevant educational information;

(10) the efforts by the responsible social services agency to ensure the oversight and continuity of health care services for the foster child, including:

(i) the plan to schedule the child's initial health screens;

(ii) how the child's known medical problems and identified needs from the screens, including any known communicable diseases, as defined in section 144.4172, subdivision 2, shall be monitored and treated while the child is in foster care;

(iii) how the child's medical information shall be updated and shared, including the child's immunizations;

(iv) who is responsible to coordinate and respond to the child's health care needs, including the role of the parent, the agency, and the foster parent;

(v) who is responsible for oversight of the child's prescription medications;

(vi) how physicians or other appropriate medical and nonmedical professionals shall be consulted and involved in assessing the health and well-being of the child and determine the appropriate medical treatment for the child; and

(vii) the responsibility to ensure that the child has access to medical care through either medical insurance or medical assistance;

(11) the health records of the child including information available regarding:

(i) the names and addresses of the child's health care and dental care providers;

(ii) a record of the child's immunizations;

(iii) the child's known medical problems, including any known communicable diseases as defined in section 144.4172, subdivision 2;

(iv) the child's medications; and

(v) any other relevant health care information such as the child's eligibility for medical insurance or medical assistance;

(12) an independent living plan for a child 14 years of age or older, developed in consultation with the child. The child may select one member of the case planning team to be designated as the child's advisor and to advocate with respect to the application of the reasonable and prudent parenting standards in subdivision 14. The plan should include, but not be limited to, the following objectives:

(i) educational, vocational, or employment planning;

(ii) health care planning and medical coverage;

(iii) transportation including, where appropriate, assisting the child in obtaining a driver's license;

(iv) money management, including the responsibility of the responsible social services agency to ensure that the child annually receives, at no cost to the child, a consumer report as defined under section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report;

(v) planning for housing;

(vi) social and recreational skills;

(vii) establishing and maintaining connections with the child's family and community; and

(viii) regular opportunities to engage in age-appropriate or developmentally appropriate activities typical for the child's age group, taking into consideration the capacities of the individual child;

(13) for a child in voluntary foster care for treatment under chapter 260D, diagnostic and assessment information, specific services relating to meeting the mental health care needs of the child, and treatment outcomes;

(14) for a child 14 years of age or older, a signed acknowledgment that describes the child's rights regarding education, health care, visitation, safety and protection from exploitation, and court participation; receipt of the documents identified in section 260C.452; and receipt of an annual credit report. The acknowledgment shall state that the rights were explained in an age-appropriate manner to the child; and

(15) for a child placed in a qualified residential treatment program, the plan must include the requirements in section 260C.708.

(d) The parent or parents or guardian and the child each shall have the right to legal counsel in the preparation of the case plan and shall be informed of the right at the time of placement of the child. The child shall also have the right to a guardian ad litem. If unable to employ counsel from their own resources, the court shall appoint counsel upon the request of the parent or parents or the child or the child's legal guardian. The parent or parents may also receive assistance from any person or social services agency in preparation of the case plan.

(e) After the plan has been agreed upon by the parties involved or approved or ordered by the court, the foster parents shall be fully informed of the provisions of the case plan and shall be provided a copy of the plan.

(f) Upon the child's discharge from foster care, the responsible social services agency must provide the child's parent, adoptive parent, or permanent legal and physical custodian, and the child, if the child is 14 years of age or older, with a current copy of the child's health and education record. If a child meets the conditions in subdivision 15, paragraph (b), the agency must also provide the child with the child's social and medical history. The responsible social services agency may give a copy of the child's health and education record and social and medical history to a child who is younger than 14 years of age, if it is appropriate and if subdivision 15, paragraph (b), applies.

Sec. 19. Minnesota Statutes 2021 Supplement, section 260C.212, subdivision 2, is amended to read:

Subd. 2. **Placement decisions based on best interests of the child.** (a) The policy of the state of Minnesota is to ensure that the child's best interests are met by requiring an individualized determination of the needs of the child in consideration of paragraphs (a) to (f), and of how the selected placement will serve the current and future needs of the child being placed. The authorized child-placing agency shall place a child, released by court order or by voluntary release by the parent or parents, in a family foster home selected by considering placement with relatives ~~and important friends~~ in the following order:

(1) with an individual who is related to the child by blood, marriage, or adoption, including the legal parent, guardian, or custodian of the child's ~~siblings~~ sibling; or

(2) with an individual who is an important friend of the child or of the child's parent or custodian, including an individual with whom the child has resided or had significant contact or who has a significant relationship to the child or the child's parent or custodian.

~~(2) with an individual who is an important friend with whom the child has resided or had significant contact.~~

For an Indian child, the agency shall follow the order of placement preferences in the Indian Child Welfare Act of 1978, United States Code, title 25, section 1915.

(b) Among the factors the agency shall consider in determining the current and future needs of the child are the following:

(1) the child's current functioning and behaviors;

(2) the medical needs of the child;

(3) the educational needs of the child;

(4) the developmental needs of the child;

(5) the child's history and past experience;

(6) the child's religious and cultural needs;

(7) the child's connection with a community, school, and faith community;

(8) the child's interests and talents;

(9) the child's ~~relationship to current caretakers,~~ current and long-term needs regarding relationships with parents, siblings, ~~and~~ relatives, and other caretakers;

(10) the reasonable preference of the child, if the court, or the child-placing agency in the case of a voluntary placement, deems the child to be of sufficient age to express preferences; and

(11) for an Indian child, the best interests of an Indian child as defined in section 260.755, subdivision 2a.

When placing a child in foster care or in a permanent placement based on an individualized determination of the child's needs, the agency must not use one factor in this paragraph to the exclusion of all others, and the agency shall consider that the factors in paragraph (b) may be interrelated.

(c) Placement of a child cannot be delayed or denied based on race, color, or national origin of the foster parent or the child.

(d) Siblings should be placed together for foster care and adoption at the earliest possible time unless it is documented that a joint placement would be contrary to the safety or well-being of any of the siblings or unless it is not possible after reasonable efforts by the responsible social services agency. In cases where siblings cannot be placed together, the

agency is required to provide frequent visitation or other ongoing interaction between siblings unless the agency documents that the interaction would be contrary to the safety or well-being of any of the siblings.

(e) Except for emergency placement as provided for in section 245A.035, the following requirements must be satisfied before the approval of a foster or adoptive placement in a related or unrelated home: (1) a completed background study under section 245C.08; and (2) a completed review of the written home study required under section 260C.215, subdivision 4, clause (5), or 260C.611, to assess the capacity of the prospective foster or adoptive parent to ensure the placement will meet the needs of the individual child.

(f) The agency must determine whether colocation with a parent who is receiving services in a licensed residential family-based substance use disorder treatment program is in the child's best interests according to paragraph (b) and include that determination in the child's case plan under subdivision 1. The agency may consider additional factors not identified in paragraph (b). The agency's determination must be documented in the child's case plan before the child is colocated with a parent.

(g) The agency must establish a juvenile treatment screening team under section 260C.157 to determine whether it is necessary and appropriate to recommend placing a child in a qualified residential treatment program, as defined in section 260C.007, subdivision 26d.

Sec. 20. Minnesota Statutes 2020, section 260C.212, subdivision 4a, is amended to read:

Subd. 4a. **Monthly caseworker visits.** (a) Every child in foster care or on a trial home visit shall be visited by the child's caseworker or another person who has responsibility for visitation of the child on a monthly basis, with the majority of visits occurring in the child's residence. The responsible social services agency may designate another person responsible for monthly case visits. For the purposes of this section, the following definitions apply:

(1) "visit" is defined as a face-to-face contact between a child and the child's caseworker;

(2) "visited on a monthly basis" is defined as at least one visit per calendar month;

(3) "the child's caseworker" is defined as the person who has responsibility for managing the child's foster care placement case as assigned by the responsible social services agency;

(4) "another person" means the professional staff whom the responsible social services agency has assigned in the out-of-home placement plan or case plan. Another person must be professionally trained to assess the child's safety, permanency, well-being, and case progress. The agency may not designate the guardian ad litem, the child foster care provider,

residential facility staff, or a qualified individual as defined in section 260C.007, subdivision26b, as another person; and

(5) "the child's residence" is defined as the home where the child is residing, and can include the foster home, child care institution, or the home from which the child was removed if the child is on a trial home visit.

(b) Caseworker visits shall be of sufficient substance and duration to address issues pertinent to case planning and service delivery to ensure the safety, permanency, and well-being of the child, including whether the child is enrolled and attending school as required by law.

(c) Every effort shall be made by the responsible social services agency and professional staff to have the monthly visit with the child outside the presence of the child's parents, foster parents, or facility staff. There may be situations related to the child's needs when a caseworker visit cannot occur with the child alone. The reason the caseworker visit occurred in the presence of others must be documented in the case record and may include:

(1) that the child exhibits intense emotion or behavior indicating that visiting without the presence of the parent, foster parent, or facility staff would be traumatic for the child;

(2) that despite a caseworker's efforts, the child declines to visit with the caseworker outside the presence of the parent, foster parent, or facility staff; and

(3) that the child has a specific developmental delay, physical limitation, incapacity, medical device, or significant medical need, such that the parent, foster parent, or facility staff is required to be present with the child during the visit.

Sec. 21. Minnesota Statutes 2020, section 260C.221, is amended to read:

260C.221 RELATIVE SEARCH AND ENGAGEMENT; PLACEMENT CONSIDERATION.

Subdivision 1. **Relative search requirements.** (a) The responsible social services agency shall exercise due diligence to identify and notify adult relatives and current caregivers of a child's sibling, prior to placement or within 30 days after the child's removal from the parent, regardless of whether a child is placed in a relative's home, as required under subdivision 2. ~~The county agency shall consider placement with a relative under this section without delay and whenever the child must move from or be returned to foster care.~~ The relative search required by this section shall be comprehensive in scope. ~~After a finding that the agency has made reasonable efforts to conduct the relative search under this paragraph, the agency has the continuing responsibility to appropriately involve relatives,~~

~~who have responded to the notice required under this paragraph, in planning for the child and to continue to consider relatives according to the requirements of section 260C.212, subdivision 2. At any time during the course of juvenile protection proceedings, the court may order the agency to reopen its search for relatives when it is in the child's best interest to do so.~~

(b) The relative search required by this section shall include both maternal and paternal adult relatives of the child; all adult grandparents; all legal parents, guardians, or custodians of the child's siblings; and any other adult relatives suggested by the child's parents, subject to the exceptions due to family violence in subdivision 5, paragraph ~~(c)~~ (b). The search shall also include getting information from the child in an age-appropriate manner about who the child considers to be family members and important friends with whom the child has resided or had significant contact. The relative search required under this section must fulfill the agency's duties under the Indian Child Welfare Act regarding active efforts to prevent the breakup of the Indian family under United States Code, title 25, section 1912(d), and to meet placement preferences under United States Code, title 25, section 1915.

(c) The responsible social services agency has a continuing responsibility to search for and identify relatives of a child and send the notice to relatives that is required under subdivision 2, unless the court has relieved the agency of this duty under subdivision 5, paragraph (e).

Subd. 2. **Relative notice requirements.** (a) The agency may provide oral or written notice to a child's relatives. In the child's case record, the agency must document providing the required notice to each of the child's relatives. The responsible social services agency must notify relatives ~~must be notified~~:

(1) of the need for a foster home for the child, the option to become a placement resource for the child, the order of placement that the agency will consider under section 260C.212, subdivision 2, paragraph (a), and the possibility of the need for a permanent placement for the child;

(2) of their responsibility to keep the responsible social services agency and the court informed of their current address in order to receive notice in the event that a permanent placement is sought for the child and to receive notice of the permanency progress review hearing under section 260C.204. A relative who fails to provide a current address to the responsible social services agency and the court forfeits the right to receive notice of the possibility of permanent placement and of the permanency progress review hearing under section 260C.204, until the relative provides a current address to the responsible social

services agency and the court. A decision by a relative not to be identified as a potential permanent placement resource or participate in planning for the child ~~at the beginning of the case~~ shall not affect whether the relative is considered for placement of, or as a permanency resource for, the child with that relative ~~later~~ at any time in the case, and shall not be the sole basis for the court to rule out the relative as the child's placement or permanency resource;

(3) that the relative may participate in the care and planning for the child, as specified in subdivision 3, including that the opportunity for such participation may be lost by failing to respond to the notice sent under this subdivision~~. "Participate in the care and planning" includes, but is not limited to, participation in case planning for the parent and child, identifying the strengths and needs of the parent and child, supervising visits, providing respite and vacation visits for the child, providing transportation to appointments, suggesting other relatives who might be able to help support the case plan, and to the extent possible, helping to maintain the child's familiar and regular activities and contact with friends and relatives~~;

(4) of the family foster care licensing and adoption home study requirements, including how to complete an application and how to request a variance from licensing standards that do not present a safety or health risk to the child in the home under section 245A.04 and supports that are available for relatives and children who reside in a family foster home; ~~and~~

(5) of the relatives' right to ask to be notified of any court proceedings regarding the child, to attend the hearings, and of a relative's right ~~or opportunity~~ to be heard by the court as required under section 260C.152, subdivision 5~~.~~;

(6) that regardless of the relative's response to the notice sent under this subdivision, the agency is required to establish permanency for a child, including planning for alternative permanency options if the agency's reunification efforts fail or are not required; and

(7) that by responding to the notice, a relative may receive information about participating in a child's family and permanency team if the child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d.

(b) The responsible social services agency shall send the notice required under paragraph (a) to relatives who become known to the responsible social services agency, except for relatives that the agency does not contact due to safety reasons under subdivision 5, paragraph (b). The responsible social services agency shall continue to send notice to relatives

notwithstanding a court's finding that the agency has made reasonable efforts to conduct a relative search.

(c) The responsible social services agency is not required to send the notice under paragraph (a) to a relative who becomes known to the agency after an adoption placement agreement has been fully executed under section 260C.613, subdivision 1. If the relative wishes to be considered for adoptive placement of the child, the agency shall inform the relative of the relative's ability to file a motion for an order for adoptive placement under section 260C.607, subdivision 6.

Subd. 3. **Relative engagement requirements.** (a) A relative who responds to the notice under subdivision 2 has the opportunity to participate in care and planning for a child, which must not be limited based solely on the relative's prior inconsistent participation or nonparticipation in care and planning for the child. Care and planning for a child may include but is not limited to:

(1) participating in case planning for the child and child's parent, including identifying services and resources that meet the individualized needs of the child and child's parent. A relative's participation in case planning may be in person, via phone call, or by electronic means;

(2) identifying the strengths and needs of the child and child's parent;

(3) asking the responsible social services agency to consider the relative for placement of the child according to subdivision 4;

(4) acting as a support person for the child, the child's parents, and the child's current caregiver;

(5) supervising visits;

(6) providing respite care for the child and having vacation visits with the child;

(7) providing transportation;

(8) suggesting other relatives who may be able to participate in the case plan or that the agency may consider for placement of the child. The agency shall send a notice to each relative identified by other relatives according to subdivision 2, paragraph (b), unless a relative received this notice earlier in the case;

(9) helping to maintain the child's familiar and regular activities and contact with the child's friends and relatives, including providing supervision of the child at family gatherings and events; and

(10) participating in the child's family and permanency team if the child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d.

(b) The responsible social services agency shall make reasonable efforts to contact and engage relatives who respond to the notice required under this section. Upon a request by a relative or party to the proceeding, the court may conduct a review of the agency's reasonable efforts to contact and engage relatives who respond to the notice. If the court finds that the agency did not make reasonable efforts to contact and engage relatives who respond to the notice, the court may order the agency to make reasonable efforts to contact and engage relatives who respond to the notice in care and planning for the child.

Subd. 4. **Placement considerations.** (a) The responsible social services agency shall consider placing a child with a relative under this section without delay and when the child:

(1) enters foster care;

(2) must be moved from the child's current foster setting;

(3) must be permanently placed away from the child's parent; or

(4) returns to foster care after permanency has been achieved for the child.

(b) The agency shall consider placing a child with relatives:

(1) in the order specified in section 260C.212, subdivision 2, paragraph (a); and

(2) based on the child's best interests using the factors in section 260C.212, subdivision 2.

(c) The agency shall document how the agency considered relatives in the child's case record.

(d) Any relative who requests to be a placement option for a child in foster care has the right to be considered for placement of the child according to section 260C.212, subdivision 2, paragraph (a), unless the court finds that placing the child with a specific relative would endanger the child, sibling, parent, guardian, or any other family member under subdivision 5, paragraph (b).

(e) When adoption is the responsible social services agency's permanency goal for the child, the agency shall consider adoptive placement of the child with a relative in the order specified under section 260C.212, subdivision 2, paragraph (a).

Subd. 5. **Data disclosure; court review.** ~~(c)~~ (a) A responsible social services agency may disclose private data, as defined in section 13.02 and chapter 260E, to relatives of the child for the purpose of locating and assessing a suitable placement and may use any

reasonable means of identifying and locating relatives including the Internet or other electronic means of conducting a search. The agency shall disclose data that is necessary to facilitate possible placement with relatives and to ensure that the relative is informed of the needs of the child so the relative can participate in planning for the child and be supportive of services to the child and family.

(b) If the child's parent refuses to give the responsible social services agency information sufficient to identify the maternal and paternal relatives of the child, the agency shall ask the juvenile court to order the parent to provide the necessary information and shall use other resources to identify the child's maternal and paternal relatives. If a parent makes an explicit request that a specific relative not be contacted or considered for placement due to safety reasons, including past family or domestic violence, the agency shall bring the parent's request to the attention of the court to determine whether the parent's request is consistent with the best interests of the child ~~and~~. The agency shall not contact the specific relative when the juvenile court finds that contacting or placing the child with the specific relative would endanger the parent, guardian, child, sibling, or any family member. Unless section 260C.139 applies to the child's case, a court shall not waive or relieve the responsible social services agency of reasonable efforts to:

(1) conduct a relative search;

(2) notify relatives;

(3) contact and engage relatives in case planning; and

(4) consider relatives for placement of the child.

(c) Notwithstanding chapter 13, the agency shall disclose data to the court about particular relatives that the agency has identified, contacted, or considered for the child's placement for the court to review the agency's due diligence.

(d) At a regularly scheduled hearing not later than three months after the child's placement in foster care and as required in ~~section~~ sections 260C.193 and 260C.202, the agency shall report to the court:

(1) ~~its~~ the agency's efforts to identify maternal and paternal relatives of the child and to engage the relatives in providing support for the child and family, and document that the relatives have been provided the notice required under ~~paragraph (a)~~ subdivision 2; and

(2) ~~its~~ the agency's decision regarding placing the child with a relative as required under section 260C.212, subdivision 2~~, and to ask~~. If the responsible social services agency decides

that relative placement is not in the child's best interests at the time of the hearing, the agency shall inform the court of the agency's decision, including:

(i) why the agency decided against relative placement of the child; and

(ii) the agency's efforts to engage relatives ~~to visit or maintain contact with the child in order~~ as required under subdivision 3 to support family connections for the child~~, when placement with a relative is not possible or appropriate~~.

~~(e) Notwithstanding chapter 13, the agency shall disclose data about particular relatives identified, searched for, and contacted for the purposes of the court's review of the agency's due diligence.~~

~~(f)~~ (e) When the court is satisfied that the agency has exercised due diligence to identify relatives and provide the notice required in ~~paragraph (a)~~ subdivision 2, the court may find that the agency made reasonable efforts ~~have been made~~ to conduct a relative search to identify and provide notice to adult relatives as required under section 260.012, paragraph (e), clause (3). A finding under this paragraph does not relieve the responsible social services agency of the ongoing duty to contact, engage, and consider relatives under this section nor is it a basis for the court to rule out any relative from being a foster care or permanent placement option for the child. The agency has the continuing responsibility to:

(1) involve relatives who respond to the notice in planning for the child; and

(2) continue considering relatives for the child's placement while taking the child's short- and long-term permanency goals into consideration, according to the requirements of section 260C.212, subdivision 2.

(f) At any time during the course of juvenile protection proceedings, the court may order the agency to reopen the search for relatives when it is in the child's best interests.

(g) If the court is not satisfied that the agency has exercised due diligence to identify relatives and provide the notice required in ~~paragraph (a)~~ subdivision 2, the court may order the agency to continue its search and notice efforts and to report back to the court.

~~(g) When the placing agency determines that permanent placement proceedings are necessary because there is a likelihood that the child will not return to a parent's care, the agency must send the notice provided in paragraph (h), may ask the court to modify the duty of the agency to send the notice required in paragraph (h), or may ask the court to completely relieve the agency of the requirements of paragraph (h). The relative notification requirements of paragraph (h) do not apply when the child is placed with an appropriate relative or a foster home that has committed to adopting the child or taking permanent legal~~

~~and physical custody of the child and the agency approves of that foster home for permanent placement of the child. The actions ordered by the court under this section must be consistent with the best interests, safety, permanency, and welfare of the child.~~

(h) ~~Unless required under the Indian Child Welfare Act or relieved of this duty by the court under paragraph (f),~~ When the agency determines that it is necessary to prepare for permanent placement determination proceedings, or in anticipation of filing a termination of parental rights petition, the agency shall send notice to ~~the~~ relatives who responded to a notice under this section sent at any time during the case, any adult with whom the child is currently residing, any adult with whom the child has resided for one year or longer in the past, and any adults who have maintained a relationship or exercised visitation with the child as identified in the agency case plan. The notice must state that a permanent home is sought for the child and that the individuals receiving the notice may indicate to the agency their interest in providing a permanent home. The notice must state that within 30 days of receipt of the notice an individual receiving the notice must indicate to the agency the individual's interest in providing a permanent home for the child or that the individual may lose the opportunity to be considered for a permanent placement. A relative's failure to respond or timely respond to the notice is not a basis for ruling out the relative from being a permanent placement option for the child, should the relative request to be considered for permanent placement at a later date.

Sec. 22. Minnesota Statutes 2020, section 260C.331, subdivision 1, is amended to read:

Subdivision 1. **Care, examination, or treatment.** (a) Except where parental rights are terminated,

(1) whenever legal custody of a child is transferred by the court to a responsible social services agency,

(2) whenever legal custody is transferred to a person other than the responsible social services agency, but under the supervision of the responsible social services agency, or

(3) whenever a child is given physical or mental examinations or treatment under order of the court, and no provision is otherwise made by law for payment for the care, examination, or treatment of the child, these costs are a charge upon the welfare funds of the county in which proceedings are held upon certification of the judge of juvenile court.

(b) The court ~~shall~~ may order, and the responsible social services agency ~~shall~~ may require, the parents or custodian of a child, while the child is under the age of 18, to use ~~the total~~ income and resources attributable to the child for the period of care, examination, or

treatment, except for clothing and personal needs allowance as provided in section 256B.35, to reimburse the county for the cost of care, examination, or treatment. Income and resources attributable to the child include, but are not limited to, Social Security benefits, Supplemental Security Income (SSI), veterans benefits, railroad retirement benefits and child support. When the child is over the age of 18, and continues to receive care, examination, or treatment, the court ~~shall~~ may order, and the responsible social services agency ~~shall~~ may require, reimbursement from the child for the cost of care, examination, or treatment from the income and resources attributable to the child less the clothing and personal needs allowance. Income does not include earnings from a child over the age of 18 who is working as part of a plan under section 260C.212, subdivision 1, paragraph (c), clause (12), to transition from foster care, or the income and resources ~~from sources other than Supplemental Security Income and child support~~ that are needed to complete the requirements listed in section 260C.203. The responsible social services agency shall determine whether requiring reimbursement, either through child support or parental fees, for the cost of care, examination, or treatment from the parents or custodian of a child is in the child's best interests. In determining whether to require reimbursement, the responsible social services agency shall consider:

(1) whether requiring reimbursement would compromise the parent's ability to meet the requirements of the reunification plan;

(2) whether requiring reimbursement would compromise the parent's ability to meet the child's needs after reunification; and

(3) whether redirecting existing child support payments or changing the representative payee of social security benefits to the responsible social services agency would limit the parent's ability to maintain financial stability for the child.

(c) If the income and resources attributable to the child are not enough to reimburse the county for the full cost of the care, examination, or treatment, the court ~~shall~~ may inquire into the ability of the parents to ~~support the child~~ reimburse the county for the cost of care, examination, or treatment and, after giving the parents a reasonable opportunity to be heard, the court ~~shall~~ may order, and the responsible social services agency ~~shall~~ may require, the parents to contribute to the cost of care, examination, or treatment of the child. When determining the amount to be contributed by the parents, the court shall use a fee schedule based upon ability to pay that is established by the responsible social services agency and approved by the commissioner of human services. The income of a stepparent who has not adopted a child shall be excluded in calculating the parental contribution under this section. In determining whether to require reimbursement, the responsible social services agency shall consider:

(1) whether requiring reimbursement would compromise the parent's ability to meet the requirements of the reunification plan;

(2) whether requiring reimbursement would compromise the parent's ability to meet the child's needs after reunification; and

(3) whether requiring reimbursement would compromise the parent's ability to meet the needs of the family.

(d) If the responsible social services agency determines that reimbursement is in the child's best interest, the court shall order the amount of reimbursement attributable to the parents or custodian, or attributable to the child, or attributable to both sources, withheld under chapter 518A from the income of the parents or the custodian of the child. A parent or custodian who fails to pay without good reason may be proceeded against for contempt, or the court may inform the county attorney, who shall proceed to collect the unpaid sums, or both procedures may be used.

(e) If the court orders a physical or mental examination for a child, the examination is a medically necessary service for purposes of determining whether the service is covered by a health insurance policy, health maintenance contract, or other health coverage plan. Court-ordered treatment shall be subject to policy, contract, or plan requirements for medical necessity. Nothing in this paragraph changes or eliminates benefit limits, conditions of coverage, co-payments or deductibles, provider restrictions, or other requirements in the policy, contract, or plan that relate to coverage of other medically necessary services.

(f) Notwithstanding paragraph (b), (c), or (d), a parent, custodian, or guardian of the child is not required to use income and resources attributable to the child to reimburse the county for costs of care and is not required to contribute to the cost of care of the child during any period of time when the child is returned to the home of that parent, custodian, or guardian pursuant to a trial home visit under section 260C.201, subdivision 1, paragraph (a).

Sec. 23. Minnesota Statutes 2020, section 260C.513, is amended to read:

260C.513 PERMANENCY DISPOSITIONS WHEN CHILD CANNOT RETURN HOME.

(a) ~~Termination of parental rights and adoption, or guardianship to the commissioner of human services through a consent to adopt, are preferred permanency options for a child who cannot return home. If the court finds that termination of parental rights and guardianship to the commissioner is not in the child's best interests, the court may transfer permanent~~

~~legal and physical custody of the child to a relative when that order is in the child's best interests.~~ For a child who cannot return home, a permanency placement with a relative is preferred. A permanency placement with a relative includes termination of parental rights and adoption by a relative, guardianship to the commissioner of human services through a consent to adopt with a relative, or a transfer of permanent legal and physical custody to a relative. The court must consider the best interests of the child and section 260C.212, subdivision 2, paragraph (a), when making a permanency determination.

(b) When the court has determined that permanent placement of the child away from the parent is necessary, the court shall consider permanent alternative homes that are available both inside and outside the state.

Sec. 24. Minnesota Statutes 2021 Supplement, section 260C.605, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** (a) Reasonable efforts to finalize the adoption of a child under the guardianship of the commissioner shall be made by the responsible social services agency responsible for permanency planning for the child.

(b) Reasonable efforts to make a placement in a home according to the placement considerations under section 260C.212, subdivision 2, with a relative or foster parent who will commit to being the permanent resource for the child in the event the child cannot be reunified with a parent are required under section 260.012 and may be made concurrently with reasonable, or if the child is an Indian child, active efforts to reunify the child with the parent.

(c) Reasonable efforts under paragraph (b) must begin as soon as possible when the child is in foster care under this chapter, but not later than the hearing required under section 260C.204.

(d) Reasonable efforts to finalize the adoption of the child include:

(1) considering the child's preference for an adoptive family;

~~(1)~~ (2) using age-appropriate engagement strategies to plan for adoption with the child;

~~(2)~~ (3) identifying an appropriate prospective adoptive parent for the child by updating the child's identified needs using the factors in section 260C.212, subdivision 2;

~~(3)~~ (4) making an adoptive placement that meets the child's needs by:

(i) completing or updating the relative search required under section 260C.221 and giving notice of the need for an adoptive home for the child to:

(A) relatives who have kept the agency or the court apprised of their whereabouts ~~and who have indicated an interest in adopting the child~~; or

(B) relatives of the child who are located in an updated search;

(ii) an updated search is required whenever:

(A) there is no identified prospective adoptive placement for the child notwithstanding a finding by the court that the agency made diligent efforts under section 260C.221, in a hearing required under section 260C.202;

(B) the child is removed from the home of an adopting parent; or

(C) the court determines that a relative search by the agency is in the best interests of the child;

(iii) engaging the child's relatives or current or former foster ~~parent and the child's relatives identified as an adoptive resource during the search conducted under section 260C.221,~~ parents to commit to being the prospective adoptive parent of the child, and considering the child's relatives for adoptive placement of the child in the order specified under section 260C.212, subdivision 2, paragraph (a); or

(iv) when there is no identified prospective adoptive parent:

(A) registering the child on the state adoption exchange as required in section 259.75 unless the agency documents to the court an exception to placing the child on the state adoption exchange reported to the commissioner;

(B) reviewing all families with approved adoption home studies associated with the responsible social services agency;

(C) presenting the child to adoption agencies and adoption personnel who may assist with finding an adoptive home for the child;

(D) using newspapers and other media to promote the particular child;

(E) using a private agency under grant contract with the commissioner to provide adoption services for intensive child-specific recruitment efforts; and

(F) making any other efforts or using any other resources reasonably calculated to identify a prospective adoption parent for the child;

~~(4)~~ (5) updating and completing the social and medical history required under sections 260C.212, subdivision 15, and 260C.609;

~~(5)~~ (6) making, and keeping updated, appropriate referrals required by section 260.851, the Interstate Compact on the Placement of Children;

~~(6)~~ (7) giving notice regarding the responsibilities of an adoptive parent to any prospective adoptive parent as required under section 259.35;

~~(7)~~ (8) offering the adopting parent the opportunity to apply for or decline adoption assistance under chapter 256N;

~~(8)~~ (9) certifying the child for adoption assistance, assessing the amount of adoption assistance, and ascertaining the status of the commissioner's decision on the level of payment if the adopting parent has applied for adoption assistance;

~~(9)~~ (10) placing the child with siblings. If the child is not placed with siblings, the agency must document reasonable efforts to place the siblings together, as well as the reason for separation. The agency may not cease reasonable efforts to place siblings together for final adoption until the court finds further reasonable efforts would be futile or that placement together for purposes of adoption is not in the best interests of one of the siblings; and

~~(10)~~ (11) working with the adopting parent to file a petition to adopt the child and with the court administrator to obtain a timely hearing to finalize the adoption.

Sec. 25. Minnesota Statutes 2020, section 260C.607, subdivision 2, is amended to read:

Subd. 2. **Notice.** Notice of review hearings shall be given by the court to:

(1) the responsible social services agency;

(2) the child, if the child is age ten and older;

(3) the child's guardian ad litem;

(4) counsel appointed for the child pursuant to section 260C.163, subdivision 3;

(5) relatives of the child who have kept the court informed of their whereabouts as required in section 260C.221 and who have responded to the agency's notice under section 260C.221, ~~indicating a willingness to provide an adoptive home for the child~~ unless the relative has been previously ruled out by the court as a suitable ~~foster parent or~~ permanency resource for the child;

(6) the current foster or adopting parent of the child;

(7) any foster or adopting parents of siblings of the child; and

(8) the Indian child's tribe.

Sec. 26. Minnesota Statutes 2020, section 260C.607, subdivision 5, is amended to read:

Subd. 5. **Required placement by responsible social services agency.** (a) No petition for adoption shall be filed for a child under the guardianship of the commissioner unless the child sought to be adopted has been placed for adoption with the adopting parent by the responsible social services agency as required under section 260C.613, subdivision 1. The court may order the agency to make an adoptive placement using standards and procedures under subdivision 6.

(b) Any relative or the child's foster parent who believes the responsible agency has not reasonably considered the relative's or foster parent's request to be considered for adoptive placement as required under section 260C.212, subdivision 2, and who wants to be considered for adoptive placement of the child shall bring a request for consideration to the attention of the court during a review required under this section. The child's guardian ad litem and the child may also bring a request for a relative or the child's foster parent to be considered for adoptive placement. After hearing from the agency, the court may order the agency to take appropriate action regarding the relative's or foster parent's request for consideration under section 260C.212, subdivision 2, paragraph (b).

Sec. 27. Minnesota Statutes 2021 Supplement, section 260C.607, subdivision 6, is amended to read:

Subd. 6. **Motion and hearing to order adoptive placement.** (a) At any time after the district court orders the child under the guardianship of the commissioner of human services, but not later than 30 days after receiving notice required under section 260C.613, subdivision 1, paragraph (c), that the agency has made an adoptive placement, a relative or the child's foster parent may file a motion for an order for adoptive placement of a child who is under the guardianship of the commissioner if the relative or the child's foster parent:

(1) has an adoption home study under section 259.41 or 260C.611 approving the relative or foster parent for adoption ~~and has~~. If the relative or foster parent does not have an adoption home study, an affidavit attesting to efforts to complete an adoption home study may be filed with the motion instead. The affidavit must be signed by the relative or foster parent and the responsible social services agency or licensed child-placing agency completing the adoption home study. The relative or foster parent must also have been a resident of Minnesota for at least six months before filing the motion; the court may waive the residency requirement for the moving party if there is a reasonable basis to do so; or

(2) is not a resident of Minnesota, but has an approved adoption home study by an agency licensed or approved to complete an adoption home study in the state of the individual's

residence and the study is filed with the motion for adoptive placement. If the relative or foster parent does not have an adoption home study in the relative or foster parent's state of residence, an affidavit attesting to efforts to complete an adoption home study may be filed with the motion instead. The affidavit must be signed by the relative or foster parent and the agency completing the adoption home study.

(b) The motion shall be filed with the court conducting reviews of the child's progress toward adoption under this section. The motion and supporting documents must make a prima facie showing that the agency has been unreasonable in failing to make the requested adoptive placement. The motion must be served according to the requirements for motions under the Minnesota Rules of Juvenile Protection Procedure and shall be made on all individuals and entities listed in subdivision 2.

(c) If the motion and supporting documents do not make a prima facie showing for the court to determine whether the agency has been unreasonable in failing to make the requested adoptive placement, the court shall dismiss the motion. If the court determines a prima facie basis is made, the court shall set the matter for evidentiary hearing.

(d) At the evidentiary hearing, the responsible social services agency shall proceed first with evidence about the reason for not making the adoptive placement proposed by the moving party. When the agency presents evidence regarding the child's current relationship with the identified adoptive placement resource, the court must consider the agency's efforts to support the child's relationship with the moving party consistent with section 260C.221. The moving party then has the burden of proving by a preponderance of the evidence that the agency has been unreasonable in failing to make the adoptive placement.

(e) The court shall review and enter findings regarding whether the agency, in making an adoptive placement decision for the child:

(1) considered relatives for adoptive placement in the order specified under section 260C.212, subdivision 2, paragraph (a); and

(2) assessed how the identified adoptive placement resource and the moving party are each able to meet the child's current and future needs, based on an individualized determination of the child's needs, as required under sections 260C.212, subdivision 2, and 260C.613, subdivision 1, paragraph (b).

~~(e)~~ (f) At the conclusion of the evidentiary hearing, if the court finds that the agency has been unreasonable in failing to make the adoptive placement and that the ~~relative or the child's foster parent~~ moving party is the most suitable adoptive home to meet the child's needs using the factors in section 260C.212, subdivision 2, paragraph (b), the court may:

(1) order the responsible social services agency to make an adoptive placement in the home of the ~~relative or the child's foster parent.~~ moving party if the moving party has an approved adoption home study; or

(2) order the responsible social services agency to place the child in the home of the moving party upon approval of an adoption home study. The agency must promote and support the child's ongoing visitation and contact with the moving party until the child is placed in the moving party's home. The agency must provide an update to the court after 90 days, including progress and any barriers encountered. If the moving party does not have an approved adoption home study within 180 days, the moving party and the agency must inform the court of any barriers to obtaining the approved adoption home study during a review hearing under this section. If the court finds that the moving party is unable to obtain an approved adoption home study, the court must dismiss the order for adoptive placement under this subdivision and order the agency to continue making reasonable efforts to finalize the adoption of the child as required under section 260C.605.

~~(f)~~ (g) If, in order to ensure that a timely adoption may occur, the court orders the responsible social services agency to make an adoptive placement under this subdivision, the agency shall:

(1) make reasonable efforts to obtain a fully executed adoption placement agreement, including assisting the moving party with the adoption home study process;

(2) work with the moving party regarding eligibility for adoption assistance as required under chapter 256N; and

(3) if the moving party is not a resident of Minnesota, timely refer the matter for approval of the adoptive placement through the Interstate Compact on the Placement of Children.

~~(g)~~ (h) Denial or granting of a motion for an order for adoptive placement after an evidentiary hearing is an order which may be appealed by the responsible social services agency, the moving party, the child, when age ten or over, the child's guardian ad litem, and any individual who had a fully executed adoption placement agreement regarding the child at the time the motion was filed if the court's order has the effect of terminating the adoption placement agreement. An appeal shall be conducted according to the requirements of the Rules of Juvenile Protection Procedure.

Sec. 28. Minnesota Statutes 2020, section 260C.613, subdivision 1, is amended to read:

Subdivision 1. **Adoptive placement decisions.** (a) The responsible social services agency has exclusive authority to make an adoptive placement of a child under the guardianship of

the commissioner. The child shall be considered placed for adoption when the adopting parent, the agency, and the commissioner have fully executed an adoption placement agreement on the form prescribed by the commissioner.

(b) The responsible social services agency shall use an individualized determination of the child's current and future needs, pursuant to section 260C.212, subdivision 2, paragraph (b), to determine the most suitable adopting parent for the child in the child's best interests. The responsible social services agency must consider adoptive placement of the child with relatives in the order specified in section 260C.212, subdivision 2, paragraph (a).

(c) The responsible social services agency shall notify the court and parties entitled to notice under section 260C.607, subdivision 2, when there is a fully executed adoption placement agreement for the child.

(d) In the event an adoption placement agreement terminates, the responsible social services agency shall notify the court, the parties entitled to notice under section 260C.607, subdivision 2, and the commissioner that the agreement and the adoptive placement have terminated.

Sec. 29. Minnesota Statutes 2020, section 260C.613, subdivision 5, is amended to read:

Subd. 5. **Required record keeping.** The responsible social services agency shall document, in the records required to be kept under section 259.79, the reasons for the adoptive placement decision regarding the child, including the individualized determination of the child's needs based on the factors in section 260C.212, subdivision 2, paragraph (b)~~,~~; the agency's consideration of relatives in the order specified in section 260C.212, subdivision 2, paragraph (a); and the assessment of how the selected adoptive placement meets the identified needs of the child. The responsible social services agency shall retain in the records required to be kept under section 259.79, copies of all out-of-home placement plans made since the child was ordered under guardianship of the commissioner and all court orders from reviews conducted pursuant to section 260C.607.

Sec. 30. Minnesota Statutes 2021 Supplement, 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. When it is possible and the report alleges substantial child endangerment or sexual abuse, the local welfare agency is not required to provide notice

before conducting the initial face-to-face contact with the child and the child's primary caregiver.

(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. 31. Minnesota Statutes 2020, section 260E.22, subdivision 2, is amended to read:

Subd. 2. **Child interview procedure.** (a) The interview may take place at school or at any facility or other place where the alleged victim or other children might be found or the child may be transported to, and the interview may be conducted at a place appropriate for the interview of a child designated by the local welfare agency or law enforcement agency.

(b) When it is possible and the report alleges substantial child endangerment or sexual abuse, the interview may take place outside the presence of the alleged offender ~~or parent, legal custodian, guardian, or school official.~~ and may take place prior to any interviews of the alleged offender.

~~(c) For a family assessment, it is the preferred practice to request a parent or guardian's permission to interview the child before conducting the child interview, unless doing so would compromise the safety assessment.~~

Sec. 32. Minnesota Statutes 2020, section 260E.24, subdivision 2, is amended to read:

Subd. 2. **Determination after family assessment.** After conducting a family assessment, the local welfare agency shall determine whether child protective services are needed to address the safety of the child and other family members and the risk of subsequent maltreatment. The local welfare agency must document the information collected under section 260E.20, subdivision 3, related to the completed family assessment in the child's or family's case notes.

Sec. 33. Minnesota Statutes 2020, section 477A.0126, is amended by adding a subdivision to read:

Subd. 3a. **Transfer of withheld aid amounts.** (a) For aid payable in 2023 and later, the commissioner must transfer the total amount of the aid reductions under subdivision 3, paragraph (d), for that year to the Board of Regents of the University of Minnesota for the Tribal and Training Certification Partnership in the College of Education and Human Service Professions at the University of Minnesota, Duluth.

(b) In order to support consistent training and county compliance with the Indian Child Welfare Act and the Minnesota Indian Family Preservation Act, the Tribal Training and Certification Partnership must use funds transferred under this subdivision to (1) enhance training on the Indian Child Welfare Act and Minnesota Indian Family Preservation Act for county workers and state guardians ad litem, and (2) build indigenous child welfare training for the Tribal child welfare workforce.

EFFECTIVE DATE. This section is effective for aid payable in 2023 and later.

Sec. 34. Minnesota Statutes 2020, section 477A.0126, subdivision 7, is amended to read:

Subd. 7. **Appropriation.** (a) $5,000,000 is annually appropriated to the commissioner of revenue from the general fund to pay aid and make transfers required under this section.

(b) $390,000 is appropriated annually from the general fund to the commissioner of human services to implement subdivision 6.

EFFECTIVE DATE. This section is effective for aid payable in 2023 and later.

Sec. 35. Minnesota Statutes 2020, section 518.17, subdivision 1, is amended to read:

Subdivision 1. **Best interests of the child.** (a) In evaluating the best interests of the child for purposes of determining issues of custody and parenting time, the court must consider and evaluate all relevant factors, including:

(1) a child's physical, emotional, cultural, spiritual, and other needs, and the effect of the proposed arrangements on the child's needs and development;

(2) any special medical, mental health, developmental disability, or educational needs that the child may have that may require special parenting arrangements or access to recommended services;

(3) the reasonable preference of the child, if the court deems the child to be of sufficient ability, age, and maturity to express an independent, reliable preference;

(4) whether domestic abuse, as defined in section 518B.01, has occurred in the parents' or either parent's household or relationship; the nature and context of the domestic abuse; and the implications of the domestic abuse for parenting and for the child's safety, well-being, and developmental needs;

(5) any physical, mental, or chemical health issue of a parent that affects the child's safety or developmental needs;

(6) the history and nature of each parent's participation in providing care for the child;

(7) the willingness and ability of each parent to provide ongoing care for the child; to meet the child's ongoing developmental, emotional, spiritual, and cultural needs; and to maintain consistency and follow through with parenting time;

(8) the effect on the child's well-being and development of changes to home, school, and community;

(9) the effect of the proposed arrangements on the ongoing relationships between the child and each parent, siblings, and other significant persons in the child's life;

(10) the benefit to the child in maximizing parenting time with both parents and the detriment to the child in limiting parenting time with either parent;

(11) except in cases in which domestic abuse as described in clause (4) has occurred, the disposition of each parent to support the child's relationship with the other parent and to encourage and permit frequent and continuing contact between the child and the other parent; and

(12) the willingness and ability of parents to cooperate in the rearing of their child; to maximize sharing information and minimize exposure of the child to parental conflict; and to utilize methods for resolving disputes regarding any major decision concerning the life of the child.

(b) Clauses (1) to (9) govern the application of the best interests of the child factors by the court:

(1) The court must make detailed findings on each of the factors in paragraph (a) based on the evidence presented and explain how each factor led to its conclusions and to the determination of custody and parenting time. The court may not use one factor to the exclusion of all others, and the court shall consider that the factors may be interrelated.

(2) The court shall consider that it is in the best interests of the child to promote the child's healthy growth and development through safe, stable, nurturing relationships between a child and both parents.

(3) The court shall consider both parents as having the capacity to develop and sustain nurturing relationships with their children unless there are substantial reasons to believe otherwise. In assessing whether parents are capable of sustaining nurturing relationships with their children, the court shall recognize that there are many ways that parents can respond to a child's needs with sensitivity and provide the child love and guidance, and these may differ between parents and among cultures.

(4) The court shall not consider conduct of a party that does not affect the party's relationship with the child.

(5) Disability alone, as defined in section 363A.03, of a proposed custodian or the child shall not be determinative of the custody of the child.

(6) The court shall consider evidence of a violation of section 609.507 in determining the best interests of the child.

(7) There is no presumption for or against joint physical custody, except as provided in clause (9).

(8) Joint physical custody does not require an absolutely equal division of time.

(9) The court shall use a rebuttable presumption that upon request of either or both parties, joint legal custody is in the best interests of the child. However, the court shall use a rebuttable presumption that joint legal custody or joint physical custody is not in the best interests of the child if domestic abuse, as defined in section 518B.01, has occurred between the parents. In determining whether the presumption is rebutted, the court shall consider

the nature and context of the domestic abuse and the implications of the domestic abuse for parenting and for the child's safety, well-being, and developmental needs. Disagreement alone over whether to grant sole or joint custody does not constitute an inability of parents to cooperate in the rearing of their children as referenced in paragraph (a), clause (12).

(c) In a proceeding involving the custodial responsibility of a service member's child, a court may not consider only a parent's past deployment or possible future deployment in determining the best interests of the child. For purposes of this paragraph, "custodial responsibility" has the meaning given in section 518E.102, paragraph (f).

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

Sec. 36. Minnesota Statutes 2020, section 518A.43, subdivision 1, is amended to read:

Subdivision 1. **General factors.** Among other reasons, deviation from the presumptive child support obligation computed under section 518A.34 is intended to encourage prompt and regular payments of child support and to prevent either parent or the joint children from living in poverty. In addition to the child support guidelines and other factors used to calculate the child support obligation under section 518A.34, the court must take into consideration the following factors in setting or modifying child support or in determining whether to deviate upward or downward from the presumptive child support obligation:

(1) all earnings, income, circumstances, and resources of each parent, including real and personal property, but excluding income from excess employment of the obligor or obligee that meets the criteria of section 518A.29, paragraph (b);

(2) the extraordinary financial needs and resources, physical and emotional condition, and educational needs of the child to be supported;

(3) the standard of living the child would enjoy if the parents were currently living together, but recognizing that the parents now have separate households;

(4) whether the child resides in a foreign country for more than one year that has a substantially higher or lower cost of living than this country;

(5) which parent receives the income taxation dependency exemption and the financial benefit the parent receives from it;

(6) the parents' debts as provided in subdivision 2; ~~and~~

(7) the obligor's total payments for court-ordered child support exceed the limitations set forth in section 571.922~~.~~; and

(8) in cases involving court-ordered out-of-home placement, whether ordering and redirecting a child support obligation to reimburse the county for the cost of care, examination, or treatment would compromise the parent's ability to meet the requirements of a reunification plan or the parent's ability to meet the child's needs after reunification.

Sec. 37. Minnesota Statutes 2020, section 626.557, subdivision 4, is amended to read:

Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter shall immediately make ~~an oral~~ a report to the common entry point. ~~The common entry point may accept electronic reports submitted through a web-based reporting system established by the commissioner. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports.~~ To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, to the extent necessary to comply with this subdivision.

(b) A boarding care home that is licensed under sections 144.50 to 144.58 and certified under Title 19 of the Social Security Act, a nursing home that is licensed under section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under Code of Federal Regulations, title 42, section 482.66, may submit a report electronically to the common entry point instead of submitting an oral report. The report may be a duplicate of the initial report the facility submits electronically to the commissioner of health to comply with the reporting requirements under Code of Federal Regulations, title 42, section 483.12. The commissioner of health may modify these reporting requirements to include items required under paragraph (a) that are not currently included in the electronic reporting form.

Sec. 38. Minnesota Statutes 2020, section 626.557, subdivision 9, is amended to read:

Subd. 9. **Common entry point designation.** (a) ~~Each county board shall designate a common entry point for reports of suspected maltreatment, for use until the commissioner of human services establishes a common entry point. Two or more county boards may jointly designate a single common entry point.~~ The commissioner of human services shall

establish a common entry point ~~effective July 1, 2015~~. The common entry point is the unit responsible for receiving the report of suspected maltreatment under this section.

(b) The common entry point must be available 24 hours per day to take calls from reporters of suspected maltreatment. The common entry point shall use a standard intake form that includes:

(1) the time and date of the report;

(2) the name, relationship, and identifying and contact information for the person believed to be a vulnerable adult and the individual or facility alleged responsible for maltreatment;

(3) the name, ~~address, and telephone number of the person reporting;~~ relationship, and contact information for the:

(i) reporter;

(ii) initial reporter, witnesses, and persons who may have knowledge about the maltreatment; and

(iii) legal surrogate and persons who may provide support to the vulnerable adult;

(4) the basis of vulnerability for the vulnerable adult;

~~(3)~~ (5) the time, date, and location of the incident;

~~(4) the names of the persons involved, including but not limited to, perpetrators, alleged victims, and witnesses;~~

~~(5) whether there was a risk of imminent danger to the alleged victim;~~

(6) the immediate safety risk to the vulnerable adult;

~~(6)~~ (7) a description of the suspected maltreatment;

~~(7) the disability, if any, of the alleged victim;~~

~~(8) the relationship of the alleged perpetrator to the alleged victim;~~

(8) the impact of the suspected maltreatment on the vulnerable adult;

(9) whether a facility was involved and, if so, which agency licenses the facility;

~~(10) any action taken by the common entry point;~~

~~(11) whether law enforcement has been notified;~~

(10) the actions taken to protect the vulnerable adult;

(11) the required notifications and referrals made by the common entry point; and

(12) whether the reporter wishes to receive notification of the ~~initial and final reports; and~~ disposition.

~~(13) if the report is from a facility with an internal reporting procedure, the name, mailing address, and telephone number of the person who initiated the report internally.~~

(c) The common entry point is not required to complete each item on the form prior to dispatching the report to the appropriate lead investigative agency.

(d) The common entry point shall immediately report to a law enforcement agency any incident in which there is reason to believe a crime has been committed.

(e) If a report is initially made to a law enforcement agency or a lead investigative agency, those agencies shall take the report on the appropriate common entry point intake forms and immediately forward a copy to the common entry point.

(f) The common entry point staff must receive training on how to screen and dispatch reports efficiently and in accordance with this section.

(g) The commissioner of human services shall maintain a centralized database for the collection of common entry point data, lead investigative agency data including maltreatment report disposition, and appeals data. The common entry point shall have access to the centralized database and must log the reports into the database ~~and immediately identify and locate prior reports of abuse, neglect, or exploitation~~.

(h) When appropriate, the common entry point staff must refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might resolve the reporter's concerns.

(i) A common entry point must be operated in a manner that enables the commissioner of human services to:

(1) track critical steps in the reporting, evaluation, referral, response, disposition, and investigative process to ensure compliance with all requirements for all reports;

(2) maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation;

(3) serve as a resource for the evaluation, management, and planning of preventative and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation;

(4) set standards, priorities, and policies to maximize the efficiency and effectiveness of the common entry point; and

(5) track and manage consumer complaints related to the common entry point.

(j) The commissioners of human services and health shall collaborate on the creation of a system for referring reports to the lead investigative agencies. This system shall enable the commissioner of human services to track critical steps in the reporting, evaluation, referral, response, disposition, investigation, notification, determination, and appeal processes.

Sec. 39. Minnesota Statutes 2020, section 626.557, subdivision 9b, is amended to read:

Subd. 9b. **Response to reports.** Law enforcement is the primary agency to conduct investigations of any incident in which there is reason to believe a crime has been committed. Law enforcement shall initiate a response immediately. If the common entry point notified a county agency for emergency adult protective services, law enforcement shall cooperate with that county agency when both agencies are involved and shall exchange data to the extent authorized in subdivision 12b, paragraph (g). County adult protection shall initiate a response immediately. Each lead investigative agency shall complete the investigative process for reports within its jurisdiction. A lead investigative agency, county, adult protective agency, licensed facility, or law enforcement agency shall cooperate with other agencies in the provision of protective services, coordinating its investigations, and assisting another agency within the limits of its resources and expertise and shall exchange data to the extent authorized in subdivision 12b, paragraph (g). The lead investigative agency shall obtain the results of any investigation conducted by law enforcement officials. The lead investigative agency has the right to enter facilities and inspect and copy records as part of investigations. The lead investigative agency has access to not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, that are maintained by facilities to the extent necessary to conduct its investigation. Each lead investigative agency shall develop guidelines for prioritizing reports for investigation. When a county acts as a lead investigative agency, the county shall make guidelines available to the public regarding which reports the county prioritizes for investigation and adult protective services.

Sec. 40. Minnesota Statutes 2020, section 626.557, subdivision 9c, is amended to read:

Subd. 9c. **Lead investigative agency; notifications, dispositions, determinations.** (a) Upon request of the reporter, the lead investigative agency shall notify the reporter that it has received the report, and provide information on the initial disposition of the report within five business days of receipt of the report, provided that the notification will not endanger the vulnerable adult or hamper the investigation.

(b) In making the initial disposition of a report alleging maltreatment of a vulnerable adult, the lead investigative agency may consider previous reports of suspected maltreatment and may request and consider public information, records maintained by a lead investigative agency or licensed providers, and information from any person who may have knowledge regarding the alleged maltreatment and the basis for the adult's vulnerability.

(c) When the county social service agency does not accept a report for adult protective services or investigation, the agency may offer assistance to the reporter or the person who was the subject of the report.

(d) While investigating reports and providing adult protective services, the lead investigative agency may coordinate with entities identified under subdivision 12b, paragraph (g), and may coordinate with support persons to safeguard the welfare of the vulnerable adult and prevent further maltreatment of the vulnerable adult.

~~(b)~~ (e) Upon conclusion of every investigation it conducts, the lead investigative agency shall make a final disposition as defined in section 626.5572, subdivision 8.

~~(c)~~ (f) When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead investigative agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

~~(d)~~ (g) When substantiated maltreatment is determined to have been committed by an individual who is also the facility license holder, both the individual and the facility must be determined responsible for the maltreatment, and both the background study disqualification standards under section 245C.15, subdivision 4, and the licensing actions under section 245A.06 or 245A.07 apply.

~~(e)~~ (h) The lead investigative agency shall complete its final disposition within 60 calendar days. If the lead investigative agency is unable to complete its final disposition within 60 calendar days, the lead investigative agency shall notify the following persons provided that the notification will not endanger the vulnerable adult or hamper the investigation: (1) the vulnerable adult or the vulnerable adult's guardian or health care agent, when known, if the lead investigative agency knows them to be aware of the investigation; and (2) the facility, where applicable. The notice shall contain the reason for the delay and the projected completion date. If the lead investigative agency is unable to complete its final disposition by a subsequent projected completion date, the lead investigative agency shall again notify the vulnerable adult or the vulnerable adult's guardian or health care agent, when known if the lead investigative agency knows them to be aware of the investigation, and the facility, where applicable, of the reason for the delay and the revised projected completion date provided that the notification will not endanger the vulnerable adult or hamper the investigation. The lead investigative agency must notify the health care agent of the vulnerable adult only if the health care agent's authority to make health care decisions for the vulnerable adult is currently effective under section 145C.06 and not suspended under section 524.5-310 and the investigation relates to a duty assigned to the health care agent by the principal. A lead investigative agency's inability to complete the final disposition within 60 calendar days or by any projected completion date does not invalidate the final disposition.

~~(f) Within ten calendar days of completing the final disposition~~ (i) When the lead investigative agency is the Department of Health or the Department of Human Services, the lead investigative agency shall provide a copy of the public investigation memorandum under subdivision 12b, paragraph (b), clause (1), ~~when required to be completed under this section,~~ within ten calendar days of completing the final disposition to the following persons:

(1) the vulnerable adult, or the vulnerable adult's guardian or health care agent, if known, unless the lead investigative agency knows that the notification would endanger the well-being of the vulnerable adult;

(2) the reporter, if the reporter requested notification when making the report, provided this notification would not endanger the well-being of the vulnerable adult;

(3) the ~~alleged perpetrator~~ person or facility alleged responsible for maltreatment, if known;

(4) the facility; and

(5) the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities, as appropriate.

(j) When the lead investigative agency is a county agency, within ten calendar days of completing the final disposition, the lead investigative agency shall provide notification of the final disposition to the following persons:

(1) the vulnerable adult, or the vulnerable adult's guardian or health care agent, if known, when the allegation is applicable to the authority of the vulnerable adult's guardian or health care agent, unless the agency knows that the notification would endanger the well-being of the vulnerable adult;

(2) the individual determined responsible for maltreatment, if known; and

(3) when the alleged incident involves a personal care assistant or provider agency, the personal care provider organization under section 256B.0659. Upon implementation of Community First Services and Supports (CFSS), this notification requirement applies to the CFSS support worker or CFSS agency under section 256B.85.

~~(g)~~ (k) If, as a result of a reconsideration, review, or hearing, the lead investigative agency changes the final disposition, or if a final disposition is changed on appeal, the lead investigative agency shall notify the parties specified in paragraph ~~(f)~~ (k).

~~(h)~~ (l) The lead investigative agency shall notify the vulnerable adult who is the subject of the report or the vulnerable adult's guardian or health care agent, if known, and any person or facility determined to have maltreated a vulnerable adult, of their appeal or review rights under this section or section 256.021.

~~(i)~~ (m) The lead investigative agency shall routinely provide investigation memoranda for substantiated reports to the appropriate licensing boards. These reports must include the names of substantiated perpetrators. The lead investigative agency may not provide investigative memoranda for inconclusive or false reports to the appropriate licensing boards unless the lead investigative agency's investigation gives reason to believe that there may have been a violation of the applicable professional practice laws. If the investigation memorandum is provided to a licensing board, the subject of the investigation memorandum shall be notified and receive a summary of the investigative findings.

~~(j)~~ (n) In order to avoid duplication, licensing boards shall consider the findings of the lead investigative agency in their investigations if they choose to investigate. This does not preclude licensing boards from considering other information.

~~(k)~~ (o) The lead investigative agency must provide to the commissioner of human services its final dispositions, including the names of all substantiated perpetrators. The commissioner of human services shall establish records to retain the names of substantiated perpetrators.

Sec. 41. Minnesota Statutes 2020, section 626.557, subdivision 9d, is amended to read:

Subd. 9d. **Administrative reconsideration; review panel.** (a) Except as provided under paragraph (e), any individual or facility which a lead investigative agency determines has maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead investigative agency's determination, who contests the lead investigative agency's final disposition of an allegation of maltreatment, may request the lead investigative agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead investigative agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's guardian or health care agent. If mailed, the request for reconsideration must be postmarked and sent to the lead investigative agency within 15 calendar days of the individual's or facility's receipt of the final disposition. If the request for reconsideration is made by personal service, it must be received by the lead investigative agency within 15 calendar days of the individual's or facility's receipt of the final disposition. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted in writing within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the lead investigative agency within 30 calendar days of the individual's receipt of the notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the lead investigative agency within 30 calendar days after the individual's receipt of the notice of disqualification.

(b) Except as provided under paragraphs (e) and (f), if the lead investigative agency denies the request or fails to act upon the request within 15 working days after receiving

the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045, may submit to the commissioner of human services a written request for a hearing under that statute. The vulnerable adult, or an interested person acting on behalf of the vulnerable adult, may request a review by the Vulnerable Adult Maltreatment Review Panel under section 256.021 if the lead investigative agency denies the request or fails to act upon the request, or if the vulnerable adult or interested person contests a reconsidered disposition. The Vulnerable Adult Maltreatment Review Panel shall not conduct a review if the interested person making the request on behalf of the vulnerable adult is also the individual or facility alleged responsible for the maltreatment of the vulnerable adult. The lead investigative agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the lead investigative agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered disposition. The request must specifically identify the aspects of the lead investigative agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the lead investigative agency changes the final disposition, it shall notify the parties specified in subdivision 9c, paragraph ~~(f)~~ (i).

(d) For purposes of this subdivision, "interested person acting on behalf of the vulnerable adult" means a person designated in writing by the vulnerable adult to act on behalf of the vulnerable adult, or a legal guardian or conservator or other legal representative, a proxy or health care agent appointed under chapter 145B or 145C, or an individual who is related to the vulnerable adult, as defined in section 245A.02, subdivision 13.

(e) If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied and the individual remains disqualified following a reconsideration decision, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for

under section 245A.08, the scope of the contested case hearing must include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing must not be conducted under section 256.045. Except for family child care and child foster care, reconsideration of a maltreatment determination under this subdivision, and reconsideration of a disqualification under section 245C.22, must not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination or disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 260E.33 and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 260E.33, and 626.557, subdivision 9d.

If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) Until August 1, 2002, an individual or facility that was determined by the commissioner of human services or the commissioner of health to be responsible for neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August 1, 2001, that believes that the finding of neglect does not meet an amended definition of neglect may request a reconsideration of the determination of neglect. The commissioner of human services or the commissioner of health shall mail a notice to the last known address of individuals who are eligible to seek this reconsideration. The request for reconsideration must state how the established findings no longer meet the elements of the definition of neglect. The commissioner shall review the request for reconsideration and make a determination within 15 calendar days. The commissioner's decision on this reconsideration is the final agency action.

(1) For purposes of compliance with the data destruction schedule under subdivision 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, the date of the original finding of a substantiated maltreatment must be used to calculate the destruction date.

(2) For purposes of any background studies under chapter 245C, when a determination of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, any prior disqualification of the individual under chapter 245C that was based on this determination of maltreatment shall be rescinded, and for future background studies under chapter 245C the commissioner must not use the previous determination of substantiated maltreatment as a basis for disqualification or as a basis for referring the individual's maltreatment history to a health-related licensing board under section 245C.31.

Sec. 42. Minnesota Statutes 2020, section 626.557, subdivision 10, is amended to read:

Subd. 10. **Duties of county social service agency.** (a) When the common entry point refers a report to the county social service agency as the lead investigative agency or makes a referral to the county social service agency for emergency adult protective services, or when another lead investigative agency requests assistance from the county social service agency for adult protective services, the county social service agency shall immediately assess and offer emergency and continuing protective social services for purposes of preventing further maltreatment and for safeguarding the welfare of the maltreated vulnerable adult. The county shall use ~~a~~ standardized ~~tool~~ tools and the data system made available by the commissioner. The information entered by the county into the standardized tool must be accessible to the Department of Human Services. In cases of suspected sexual abuse, the county social service agency shall immediately arrange for and make available to the vulnerable adult appropriate medical examination and treatment. When necessary in order to protect the vulnerable adult from further harm, the county social service agency shall seek authority to remove the vulnerable adult from the situation in which the maltreatment occurred. The county social service agency may also investigate to determine whether the conditions which resulted in the reported maltreatment place other vulnerable adults in jeopardy of being maltreated and offer protective social services that are called for by its determination.

(b) Within five business days of receipt of a report screened in by the county social service agency for investigation, the county social service agency shall determine whether, in addition to an assessment and services for the vulnerable adult, to also conduct an

investigation for final disposition of the individual or facility alleged to have maltreated the vulnerable adult.

(c) The county social service agency must investigate for a final disposition the individual or facility alleged to have maltreated a vulnerable adult for each report accepted as lead investigative agency involving an allegation of abuse, caregiver neglect that resulted in harm to the vulnerable adult, financial exploitation that may be criminal, or an allegation against a caregiver under chapter 256B.

(d) An investigating county social service agency must make a final disposition for any allegation when the county social service agency determines that a final disposition may safeguard a vulnerable adult or may prevent further maltreatment.

(e) If the county social service agency learns of an allegation listed in paragraph (c) after the determination in paragraph (a), the county social service agency must change the initial determination and conduct an investigation for final disposition of the individual or facility alleged to have maltreated the vulnerable adult.

~~(b)~~ (f) County social service agencies may enter facilities and inspect and copy records as part of an investigation. The county social service agency has access to not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, that are maintained by facilities to the extent necessary to conduct its investigation. The inquiry is not limited to the written records of the facility, but may include every other available source of information.

~~(c)~~ (g) When necessary in order to protect a vulnerable adult from serious harm, the county social service agency shall immediately intervene on behalf of that adult to help the family, vulnerable adult, or other interested person by seeking any of the following:

(1) a restraining order or a court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to section 518B.01;

(2) the appointment of a guardian or conservator pursuant to sections 524.5-101 to 524.5-502, or guardianship or conservatorship pursuant to chapter 252A;

(3) replacement of a guardian or conservator suspected of maltreatment and appointment of a suitable person as guardian or conservator, pursuant to sections 524.5-101 to 524.5-502; or

(4) a referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under chapter 609.

The expenses of legal intervention must be paid by the county in the case of indigent persons, under section 524.5-502 and chapter 563.

In proceedings under sections 524.5-101 to 524.5-502, if a suitable relative or other person is not available to petition for guardianship or conservatorship, a county employee shall present the petition with representation by the county attorney. The county shall contract with or arrange for a suitable person or organization to provide ongoing guardianship services. If the county presents evidence to the court exercising probate jurisdiction that it has made a diligent effort and no other suitable person can be found, a county employee may serve as guardian or conservator. The county shall not retaliate against the employee for any action taken on behalf of the ~~ward or protected~~ person subject to guardianship or conservatorship, even if the action is adverse to the county's interest. Any person retaliated against in violation of this subdivision shall have a cause of action against the county and shall be entitled to reasonable attorney fees and costs of the action if the action is upheld by the court.

Sec. 43. Minnesota Statutes 2020, section 626.557, subdivision 10b, is amended to read:

Subd. 10b. **Investigations; guidelines.** (a) Each lead investigative agency shall develop guidelines for prioritizing reports for investigation.

(b) When investigating a report, the lead investigative agency shall conduct the following activities~~,~~ as appropriate:

(1) interview of the ~~alleged victim~~ vulnerable adult;

(2) interview of the reporter and others who may have relevant information;

(3) interview of the ~~alleged perpetrator~~ individual or facility alleged responsible for maltreatment; and

~~(4) examination of the environment surrounding the alleged incident;~~

~~(5)~~ (4) review of records and pertinent documentation of the alleged incident~~; and~~.

~~(6) consultation with professionals.~~

(c) The lead investigative agency shall conduct the following activities as appropriate to further the investigation, to prevent further maltreatment, or to safeguard the vulnerable adult:

(1) examining the environment surrounding the alleged incident;

(2) consulting with professionals; and

(3) communicating with state, federal, tribal, and other agencies including:

(i) service providers;

(ii) case managers;

(iii) ombudsmen; and

(iv) support persons for the vulnerable adult.

(d) The lead investigative agency may decide not to conduct an interview of a vulnerable adult, reporter, or witness under paragraph (b) if:

(1) the vulnerable adult, reporter, or witness declines to have an interview with the agency or is unable to be contacted despite the agency's diligent attempts;

(2) an interview of the vulnerable adult or reporter was conducted by law enforcement or a professional trained in forensic interview and an additional interview will not further the investigation;

(3) an interview of the witness will not further the investigation; or

(4) the agency has a reason to believe that the interview will endanger the vulnerable adult.

Sec. 44. Minnesota Statutes 2020, section 626.557, subdivision 12b, is amended to read:

Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a lead investigative agency, the county social service agency shall maintain appropriate records. Data collected by the county social service agency under this section while providing adult protective services are welfare data under section 13.46. Investigative data collected under this section are confidential data on individuals or protected nonpublic data as defined under section 13.02. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph (c).

Data maintained by the common entry point are confidential data on individuals or protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the common entry point shall maintain data for three calendar years after date of receipt and then destroy the data unless otherwise directed by federal requirements.

(b) The commissioners of health and human services shall prepare an investigation memorandum for each report alleging maltreatment investigated under this section. County

social service agencies must maintain private data on individuals but are not required to prepare an investigation memorandum. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02. Upon completion of the investigation, the data are classified as provided in clauses (1) to (3) and paragraph (c).

(1) The investigation memorandum must contain the following data, which are public:

(i) the name of the facility investigated;

(ii) a statement of the nature of the alleged maltreatment;

(iii) pertinent information obtained from medical or other records reviewed;

(iv) the identity of the investigator;

(v) a summary of the investigation's findings;

(vi) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;

(vii) a statement of any action taken by the facility;

(viii) a statement of any action taken by the lead investigative agency; and

(ix) when a lead investigative agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.

The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data listed in clause (2).

(2) Data on individuals collected and maintained in the investigation memorandum are private data, including:

(i) the name of the vulnerable adult;

(ii) the identity of the individual alleged to be the perpetrator;

(iii) the identity of the individual substantiated as the perpetrator; and

(iv) the identity of all individuals interviewed as part of the investigation.

(3) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.

(c) ~~After the assessment or investigation is completed,~~ The name of the reporter must be confidential. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.

(d) Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services must be maintained under the following schedule and then destroyed unless otherwise directed by federal requirements:

(1) data from reports determined to be false, maintained for three years after the finding was made;

(2) data from reports determined to be inconclusive, maintained for four years after the finding was made;

(3) data from reports determined to be substantiated, maintained for seven years after the finding was made; and

(4) data from reports which were not investigated by a lead investigative agency and for which there is no final disposition, maintained for three years from the date of the report.

(e) The commissioners of health and human services shall annually publish on their websites the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. On a biennial basis, the commissioners of health and human services shall jointly report the following information to the legislature and the governor:

(1) the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigations under this section, the resolution of those investigations, and which of the two lead agencies was responsible;

(2) trends about types of substantiated maltreatment found in the reporting period;

(3) if there are upward trends for types of maltreatment substantiated, recommendations for addressing and responding to them;

(4) efforts undertaken or recommended to improve the protection of vulnerable adults;

(5) whether and where backlogs of cases result in a failure to conform with statutory time frames and recommendations for reducing backlogs if applicable;

(6) recommended changes to statutes affecting the protection of vulnerable adults; and

(7) any other information that is relevant to the report trends and findings.

(f) Each lead investigative agency must have a record retention policy.

(g) Lead investigative agencies, county agencies responsible for adult protective services, prosecuting authorities, and law enforcement agencies may exchange not public data, as defined in section 13.02, with a tribal agency, facility, service provider, vulnerable adult, primary support person for a vulnerable adult, state licensing board, federal or state agency, the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities, if the agency or authority ~~requesting~~ providing the data determines that the data are pertinent and necessary ~~to the requesting agency in initiating, furthering, or completing~~ to prevent further maltreatment of a vulnerable adult, to safeguard a vulnerable adult, or for an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, and licensing agencies investigating the alleged maltreatment under this section. The lead investigative agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section. Notwithstanding section 138.17, upon completion of the review, not public data received by the review panel must be destroyed.

(h) Each lead investigative agency shall keep records of the length of time it takes to complete its investigations.

(i) A lead investigative agency may notify other affected parties and their authorized representative if the lead investigative agency has reason to believe maltreatment has occurred and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

(j) Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead investigative agency may not provide any notice unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

Sec. 45. Minnesota Statutes 2020, section 626.5571, subdivision 1, is amended to read:

Subdivision 1. **Establishment of team.** A county may establish a multidisciplinary adult protection team comprised of the director of the local welfare agency or designees, the

county attorney or designees, the county sheriff or designees, and representatives of health care. In addition, representatives of mental health or other appropriate human service agencies, representatives from local tribal governments, ~~and~~ adult advocate groups, and any other organization with relevant expertise may be added to the adult protection team.

Sec. 46. Minnesota Statutes 2020, section 626.5571, subdivision 2, is amended to read:

Subd. 2. **Duties of team.** A multidisciplinary adult protection team may provide public and professional education, develop resources for prevention, intervention, and treatment, and provide case consultation to the local welfare agency to better enable the agency to carry out its ~~adult protection~~ functions under section 626.557 and to meet the community's needs ~~for adult protection services~~. Case consultation may be performed by a committee of the team composed of the team members representing social services, law enforcement, the county attorney, health care, and persons directly involved in an individual case as determined by the case consultation committee. Case consultation ~~is~~ includes a case review process that results in recommendations about services to be provided to the identified adult and family.

Sec. 47. Minnesota Statutes 2020, section 626.5572, subdivision 2, is amended to read:

Subd. 2. **Abuse.** "Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult~~; and~~ unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

~~(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.~~

(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

(e) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C or 252A, or section 253B.03 or 524.5-313, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult or, where permitted under law, to provide nutrition and hydration parenterally or through intubation. This paragraph does not enlarge or diminish rights otherwise held under law by:

(1) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(2) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct.

(f) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult.

(g) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(1) a person, including a facility staff person, when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(2) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship.

Sec. 48. Minnesota Statutes 2020, section 626.5572, subdivision 4, is amended to read:

Subd. 4. **Caregiver.** "Caregiver" means an individual or facility who has responsibility for all or a portion of the care of a vulnerable adult ~~as a result of a family relationship, or who has assumed responsibility for all or a portion of the care of a vulnerable adult~~ voluntarily, by contract, or by agreement. Caregiver does not include an unpaid caregiver who provides incidental care.

Sec. 49. Minnesota Statutes 2020, section 626.5572, subdivision 17, is amended to read:

Subd. 17. **Neglect.** ~~"Neglect" means:~~ Neglect means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) ~~The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult~~ "Self-neglect" means neglect by a vulnerable adult of the vulnerable adult's own food, clothing, shelter, health care, or other services that are not the responsibility of a caregiver which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort ~~considering the physical or mental capacity or dysfunction of the vulnerable adult~~.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or

(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;

(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;

(iii) the error is not part of a pattern of errors by the individual;

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

(d) Nothing in this definition requires a caregiver, if regulated, to provide services in excess of those required by the caregiver's license, certification, registration, or other regulation.

(e) If the findings of an investigation by a lead investigative agency result in a determination of substantiated maltreatment for the sole reason that the actions required of a facility under paragraph (c), clause (5), item (iv), (v), or (vi), were not taken, then the facility is subject to a correction order. An individual will not be found to have neglected or maltreated the vulnerable adult based solely on the facility's not having taken the actions required under paragraph (c), clause (5), item (iv), (v), or (vi). This must not alter the lead investigative agency's determination of mitigating factors under section 626.557, subdivision 9c, paragraph ~~(e)~~ (f).

Sec. 50. Laws 2021, First Special Session chapter 7, article 10, section 1, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective June 1, ~~2022~~ 2023.

Sec. 51. Laws 2021, First Special Session chapter 7, article 10, section 3, is amended to read:

Sec. 3. **LEGISLATIVE TASK FORCE; CHILD PROTECTION.**

(a) A legislative task force is created to~~:~~

~~(1) review the efforts being made to implement the recommendations of the Governor's Task Force on the Protection of Children;~~

~~(2) expand the efforts into related areas of the child welfare system;~~

~~(3) work with the commissioner of human services and community partners to establish and evaluate child protection grants to address disparities in child welfare pursuant to Minnesota Statutes, section 256E.28;~~

~~(4) review and recommend alternatives to law enforcement responding to a maltreatment report by removing the child and evaluate situations in which it may be appropriate for a social worker or other child protection worker to remove the child from the home;~~

~~(5) evaluate current statutes governing mandatory reporters, consider the modification of mandatory reporting requirements for private or public youth recreation programs, and, if necessary, introduce legislation by February 15, 2022, to implement appropriate modifications;~~

~~(6) evaluate and consider the intersection of educational neglect and the child protection system; and~~

~~(7)~~ identify ~~additional~~ areas within the child welfare system that need to be addressed by the legislature.

(b) Members of the legislative task force shall include:

(1) six members from the house of representatives appointed by the speaker of the house, including three from the majority party and three from the minority party; and

(2) six members from the senate, including three members appointed by the senate majority leader and three members appointed by the senate minority leader.

(c) Members of the task force shall serve a term that expires on December 31 of the ~~even-numbered~~ odd-numbered year following the year they are appointed. The speaker of the house and the majority leader of the senate shall each appoint a chair and vice-chair from the membership of the task force. The chair shall rotate after each meeting. The task force must meet at least quarterly.

(d) Initial appointments to the task force shall be made by July 15, ~~2021~~ 2022. The chair shall convene the first meeting of the task force by August 15, ~~2021~~ 2022.

(e) The task force may provide oversight and monitoring of:

(1) the efforts by the Department of Human Services, counties, and Tribes to implement laws related to child protection;

(2) efforts by the Department of Human Services, counties, and Tribes to implement the recommendations of the Governor's Task Force on the Protection of Children;

(3) efforts by agencies including but not limited to the Department of Education, the Housing Finance Agency, the Department of Corrections, and the Department of Public Safety, to work with the Department of Human Services to assure safety and well-being for children at risk of harm or children in the child welfare system; and

(4) efforts by the Department of Human Services, other agencies, counties, and Tribes to implement best practices to ensure every child is protected from maltreatment and neglect and to ensure every child has the opportunity for healthy development.

~~(f) The task force, in cooperation with the commissioner of human services, shall issue a report to the legislature and governor by February 1, 2024. The report must contain information on the progress toward implementation of changes to the child protection system, recommendations for additional legislative changes and procedures affecting child protection and child welfare, and funding needs to implement recommended changes.~~

~~(g)~~ (f) This section expires December 31, ~~2024~~ 2025.

ARTICLE 9
ECONOMIC ASSISTANCE

Section 1. 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.

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

Sec. 2. Minnesota Statutes 2020, section 256E.36, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

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

(c) "Eligible organization" means a local governmental unit, federally recognized Tribal Nation, or nonprofit organization providing or seeking to provide emergency services for homeless persons.

(d) "Emergency services" means:

(1) providing emergency shelter for homeless persons; and

(2) assisting homeless persons in obtaining essential services, including:

(i) access to permanent housing;

(ii) medical and psychological help;

(iii) employment counseling and job placement;

(iv) substance abuse treatment;

(v) financial assistance available from other programs;

(vi) emergency child care;

(vii) transportation; and

(viii) other services needed to stabilize housing.

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

Sec. 3. Minnesota Statutes 2020, section 256P.04, subdivision 11, is amended to read:

Subd. 11. **Participant's completion of household report form.** (a) When a participant is required to complete a household report form, the following paragraphs apply.

(b) If the agency receives an incomplete household report form, the agency must immediately ~~return the incomplete form and clearly state what the participant must do for the form to be complete~~ contact the participant 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 participant if a complete household report form is not received by the agency. The automated notice must be mailed to the participant by approximately the 16th of the month. When a participant submits an incomplete form on or after the date a notice of proposed termination has been sent, the termination is valid unless the participant submits a complete form before the end of the month.

(d) The submission of a household report form is considered to have continued the participant's application for assistance if a complete household report form is received within a calendar month after the month in which the form was due. Assistance shall be paid for the period beginning with the first day of that calendar month.

(e) An agency must allow good cause exemptions for a participant required to complete a household report form when any of the following factors cause a participant to fail to

submit a completed household report form before the end of the month in which the form is due:

(1) an employer delays completion of employment verification;

(2) the agency does not help a participant complete the household report form when the participant asks for help;

(3) a participant does not receive a household report form due to a mistake on the part of the department or the agency or a reported change in address;

(4) a participant is ill or physically or mentally incapacitated; or

(5) some other circumstance occurs that a participant could not avoid with reasonable care which prevents the participant from providing a completed household report form before the end of the month in which the form is due.

Sec. 4. Minnesota Statutes 2021 Supplement, 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;

(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 the nonrecurring income is: (A) from tax refunds, tax rebates, or tax credits; (B) a reimbursement, rebate, award, grant, or refund of personal or real property or costs or losses incurred when these payments are made by: a public agency; a court; solicitations through public appeal; a federal, state, or local unit of government; or a disaster assistance organization; (C) provided as an in-kind benefit; or (D) earmarked and used for the purpose for which it was intended, subject to verification requirements under section 256P.04;

(x) retirement benefits;

(xi) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I, and 256J;

(xii) Tribal per capita payments unless excluded by federal and state law;

~~(xiii) 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;

~~(xvii)~~ (xvi) spousal support; and

~~(xviii)~~ (xvii) workers' compensation.

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

Sec. 5. Minnesota Statutes 2020, section 268.19, subdivision 1, is amended to read:

Subdivision 1. **Use of data.** (a) Except as provided by this section, data gathered from any person under the administration of the Minnesota Unemployment Insurance Law are private data on individuals or nonpublic data not on individuals as defined in section 13.02, subdivisions 9 and 12, and may not be disclosed except according to a district court order or section 13.05. A subpoena is not considered a district court order. These data may be disseminated to and used by the following agencies without the consent of the subject of the data:

(1) state and federal agencies specifically authorized access to the data by state or federal law;

(2) any agency of any other state or any federal agency charged with the administration of an unemployment insurance program;

(3) any agency responsible for the maintenance of a system of public employment offices for the purpose of assisting individuals in obtaining employment;

(4) the public authority responsible for child support in Minnesota or any other state in accordance with section 256.978;

(5) human rights agencies within Minnesota that have enforcement powers;

(6) the Department of Revenue to the extent necessary for its duties under Minnesota laws;

(7) public and private agencies responsible for administering publicly financed assistance programs for the purpose of monitoring the eligibility of the program's recipients;

(8) the Department of Labor and Industry and the Commerce Fraud Bureau in the Department of Commerce for uses consistent with the administration of their duties under Minnesota law;

(9) the Department of Human Services and the Office of Inspector General and its agents within the Department of Human Services, including county fraud investigators, for investigations related to recipient or provider fraud and employees of providers when the provider is suspected of committing public assistance fraud;

(10) local and state welfare agencies for monitoring the eligibility of the data subject for assistance programs, or for any employment or training program administered by those agencies, whether alone, in combination with another welfare agency, or in conjunction with the department or to monitor and evaluate the statewide Minnesota family investment program and other cash assistance programs, the Supplemental Nutrition Assistance Program, and the Supplemental Nutrition Assistance Program Employment and Training program by providing data on recipients and former recipients of Supplemental Nutrition Assistance Program (SNAP) benefits, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B or 256L or formerly codified under chapter 256D;

(11) local and state welfare agencies for the purpose of identifying employment, wages, and other information to assist in the collection of an overpayment debt in an assistance program;

(12) local, state, and federal law enforcement agencies for the purpose of ascertaining the last known address and employment location of an individual who is the subject of a criminal investigation;

(13) the United States Immigration and Customs Enforcement has access to data on specific individuals and specific employers provided the specific individual or specific employer is the subject of an investigation by that agency;

(14) the Department of Health for the purposes of epidemiologic investigations;

(15) the Department of Corrections for the purposes of case planning and internal research for preprobation, probation, and postprobation employment tracking of offenders sentenced to probation and preconfinement and postconfinement employment tracking of committed offenders;

(16) the state auditor to the extent necessary to conduct audits of job opportunity building zones as required under section 469.3201; and

(17) the Office of Higher Education for purposes of supporting program improvement, system evaluation, and research initiatives including the Statewide Longitudinal Education Data System.

(b) Data on individuals and employers that are collected, maintained, or used by the department in an investigation under section 268.182 are confidential as to data on individuals and protected nonpublic data not on individuals as defined in section 13.02, subdivisions 3 and 13, and must not be disclosed except under statute or district court order or to a party named in a criminal proceeding, administrative or judicial, for preparation of a defense.

(c) Data gathered by the department in the administration of the Minnesota unemployment insurance program must not be made the subject or the basis for any suit in any civil proceedings, administrative or judicial, unless the action is initiated by the department.

Sec. 6. **DIRECTION TO COMMISSIONER; SNAP VERIFICATION OF FEDERAL WORK REQUIREMENTS.**

No later than December 1, 2022, the commissioner of human services shall issue guidance to local agencies that administer the Supplemental Nutrition Assistance Program (SNAP) regarding local agency responsibilities for verification of federal work requirements for SNAP recipients.

Sec. 7. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber each section of Minnesota Statutes listed in column A with the number listed in column B. The revisor shall also make necessary grammatical and cross-reference changes consistent with the renumbering.

Column A	Column B
256D.051, subdivision 20	256D.60, subdivision 1
256D.051, subdivision 21	256D.60, subdivision 2
256D.051, subdivision 22	256D.60, subdivision 3
256D.051, subdivision 23	256D.60, subdivision 4
256D.051, subdivision 24	256D.60, subdivision 5
256D.0512	256D.61
256D.0515	256D.62
256D.0516	256D.63
256D.053	256D.64

Sec. 8. **REPEALER.**

Minnesota Statutes 2020, section 256D.055, is repealed.

ARTICLE 10
DIRECT CARE AND TREATMENT POLICY

Section 1. Minnesota Statutes 2020, section 253B.18, subdivision 6, is amended to read:

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

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

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

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

(3) the need for continued institutionalization;

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

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

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

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

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

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

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

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

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

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

(i) The committed person must be provided a copy of the revocation report and informed, orally and in writing, of the rights of a committed person under this section. The revocation report must be served upon the committed person, the committed person's counsel, and the

designated agency. The report must outline the specific reasons for the revocation, including but not limited to the specific facts upon which the revocation is based.

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

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

Sec. 2. Minnesota Statutes 2021 Supplement, section 256.01, subdivision 42, is amended to read:

Subd. 42. **Expiration of report mandates.** (a) If the submission of a report by the commissioner of human services to the legislature is mandated by statute and the enabling legislation does not include a date for the submission of a final report or an expiration date, the mandate to submit the report shall expire in accordance with this section.

(b) If the mandate requires the submission of an annual or more frequent report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1, 2023. If the mandate requires the submission of a biennial or less frequent report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1, 2024.

(c) Any reporting mandate enacted on or after January 1, 2021, shall expire three years after the date of enactment if the mandate requires the submission of an annual or more frequent report and shall expire five years after the date of enactment if the mandate requires the submission of a biennial or less frequent report unless the enacting legislation provides for a different expiration date.

(d) By January 15 of each year, the commissioner shall submit a list ~~to the chairs and ranking minority members of the legislative committees with jurisdiction over human services by February 15 of each year, beginning February 15, 2022,~~ of all reports set to expire during the following calendar year ~~in accordance with this section~~ to the chairs and ranking minority members of the legislative committees with jurisdiction over human services. Notwithstanding paragraph (c), this paragraph does not expire.

Sec. 3. Laws 2009, chapter 79, article 13, section 3, subdivision 10, as amended by Laws 2009, chapter 173, article 2, section 1, is amended to read:

Subd. 10. **State-Operated Services**

The amounts that may be spent from the appropriation for each purpose are as follows:

Transfer Authority Related to State-Operated Services. Money appropriated to finance state-operated services may be transferred between the fiscal years of the biennium with the approval of the commissioner of finance.

County Past Due Receivables. The commissioner is authorized to withhold county federal administrative reimbursement when the county of financial responsibility for cost-of-care payments due the state under Minnesota Statutes, section 246.54 or 253B.045, is 90 days past due. The commissioner shall deposit the withheld federal administrative earnings for the county into the general fund to settle the claims with the county of financial responsibility. The process for withholding funds is governed by Minnesota Statutes, section 256.017.

~~**Forecast and Census Data.** The commissioner shall include census data and fiscal projections for state-operated services and Minnesota sex offender services with the November and February budget forecasts. Notwithstanding any contrary provision in this article, this paragraph shall not expire~~.

(a) Adult Mental Health Services	106,702,000	107,201,000

Appropriation Limitation. No part of the appropriation in this article to the

commissioner for mental health treatment services provided by state-operated services shall be used for the Minnesota sex offender program.

Community Behavioral Health Hospitals. Under Minnesota Statutes, section 246.51, subdivision 1, a determination order for the clients served in a community behavioral health hospital operated by the commissioner of human services is only required when a client's third-party coverage has been exhausted.

Base Adjustment. The general fund base is decreased by $500,000 for fiscal year 2012 and by $500,000 for fiscal year 2013.

(b) Minnesota Sex Offender Services

	Appropriations by Fund	
General	38,348,000	67,503,000
Federal Fund	26,495,000	0

Use of Federal Stabilization Funds. Of this appropriation, $26,495,000 in fiscal year 2010 is from the fiscal stabilization account in the federal fund to the commissioner. This appropriation must not be used for any activity or service for which federal reimbursement is claimed. This is a onetime appropriation.

(c) Minnesota Security Hospital and METO Services

	Appropriations by Fund	
General	230,000	83,735,000
Federal Fund	83,505,000	0

Minnesota Security Hospital. For the purposes of enhancing the safety of the public, improving supervision, and enhancing

community-based mental health treatment, state-operated services may establish additional community capacity for providing treatment and supervision of clients who have been ordered into a less restrictive alternative of care from the state-operated services transitional services program consistent with Minnesota Statutes, section 246.014.

Use of Federal Stabilization Funds. $83,505,000 in fiscal year 2010 is appropriated from the fiscal stabilization account in the federal fund to the commissioner. This appropriation must not be used for any activity or service for which federal reimbursement is claimed. This is a onetime appropriation.

Sec. 4. **REPEALER.**

Minnesota Statutes 2020, sections 246.0136; 252.025, subdivision 7; and 252.035, are repealed.

ARTICLE 11
PREVENTING HOMELESSNESS

Section 1. Minnesota Statutes 2020, section 256E.33, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Transitional housing" means housing designed for independent living and provided to a homeless person or family at a rental rate of at least 25 percent of the family income for a period of up to ~~24~~ 36 months. If a transitional housing program is associated with a licensed facility or shelter, it must be located in a separate facility or a specified section of the main facility where residents can be responsible for their own meals and other daily needs.

(c) "Support services" means an assessment service that identifies the needs of individuals for independent living and arranges or provides for the appropriate educational, social, legal, advocacy, child care, employment, financial, health care, or information and referral services to meet these needs.

Sec. 2. Minnesota Statutes 2020, section 256E.33, subdivision 2, is amended to read:

Subd. 2. **Establishment and administration.** A transitional housing program is established to be administered by the commissioner. The commissioner may make grants to eligible recipients or enter into agreements with community action agencies or other public or private nonprofit agencies to make grants to eligible recipients to initiate, maintain, or expand programs to provide transitional housing and support services for persons in need of transitional housing, which may include up to six months of follow-up support services for persons who complete transitional housing as they stabilize in permanent housing. The commissioner must ensure that money appropriated to implement this section is distributed as soon as practicable. The commissioner may make grants directly to eligible recipients. The commissioner may extend use ~~up to ten percent of the appropriation available for~~ of this program for persons needing assistance longer than ~~24~~ 36 months.

Sec. 3. Minnesota Statutes 2020, section 256K.45, subdivision 6, is amended to read:

Subd. 6. **Funding.** Funds appropriated for this section may be expended on programs described under subdivisions 3 to 5 and 7, technical assistance, and capacity building to meet the greatest need on a statewide basis. The commissioner will provide outreach, technical assistance, and program development support to increase capacity to new and existing service providers to better meet needs statewide, particularly in areas where services for homeless youth have not been established, especially in greater Minnesota.

Sec. 4. Minnesota Statutes 2020, section 256K.45, is amended by adding a subdivision to read:

Subd. 7. **Provider repair or improvement grants.** (a) Providers that serve homeless youth under this section may apply for a grant of up to $200,000 under this subdivision to make minor or mechanical repairs or improvements to a facility providing services to homeless youth or youth at risk of homelessness.

(b) Grant applications under this subdivision must include a description of the repairs or improvements and the estimated cost of the repairs or improvements.

(c) Grantees under this subdivision cannot receive grant funds under this subdivision for two consecutive years.

Sec. 5. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 24, is amended to read:

Subd. 24. **Grant Programs; Children and Economic Support Grants**	29,740,000	29,740,000

(a) **Minnesota Food Assistance Program.** Unexpended funds for the Minnesota food assistance program for fiscal year 2022 do not cancel but are available in fiscal year 2023.

(b) **Base Level Adjustment; Provider Repair Grants.** The general fund base includes $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 for provider repair or improvement grants under Minnesota Statutes, section 256K.45, subdivision 7.

Sec. 6. Laws 2021, First Special Session chapter 8, article 6, section 1, subdivision 7, is amended to read:

Subd. 7. **Report.** (a) No later than February 1, 2022, the task force shall submit an initial report to the chairs and ranking minority members of the house of representatives and senate committees and divisions with jurisdiction over housing and preventing homelessness on its findings and recommendations.

(b) No later than ~~August 31~~ December 15, 2022, the task force shall submit a final report to the chairs and ranking minority members of the house of representatives and senate committees and divisions with jurisdiction over housing and preventing homelessness on its findings and recommendations.

ARTICLE 12

DEPARTMENT OF HUMAN SERVICES LICENSING AND OPERATIONS POLICY

Section 1. Minnesota Statutes 2020, section 245A.02, subdivision 5a, is amended to read:

Subd. 5a. **Controlling individual.** (a) "Controlling individual" means an owner of a program or service provider licensed under this chapter and the following individuals, if applicable:

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

(2) the individual designated as the authorized agent under section 245A.04, subdivision 1, paragraph (b);

(3) the individual designated as the compliance officer under section 256B.04, subdivision 21, paragraph (g); ~~and~~

(4) each managerial official whose responsibilities include the direction of the management or policies of a program~~.~~; and

(5) the individual designated as the primary provider of care for a special family child care program under section 245A.14, subdivision 4, paragraph (i).

(b) Controlling individual does not include:

(1) a bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity operates a program directly or through a subsidiary;

(2) an individual who is a state or federal official, or state or federal employee, or a member or employee of the governing body of a political subdivision of the state or federal government that operates one or more programs, unless the individual is also an officer, owner, or managerial official of the program, receives remuneration from the program, or owns any of the beneficial interests not excluded in this subdivision;

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

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

(ii) whose transactions are exempt under section 80A.46, clause (2);

(4) an individual who is a member of an organization exempt from taxation under section 290.05, unless the individual is also an officer, owner, or managerial official of the program or owns any of the beneficial interests not excluded in this subdivision. This clause does not exclude from the definition of controlling individual an organization that is exempt from taxation; or

(5) an employee stock ownership plan trust, or a participant or board member of an employee stock ownership plan, unless the participant or board member is a controlling individual according to paragraph (a).

(c) For purposes of this subdivision, "managerial official" means an individual who has the decision-making authority related to the operation of the program, and the responsibility for the ongoing management of or direction of the policies, services, or employees of the program. A site director who has no ownership interest in the program is not considered to be a managerial official for purposes of this definition.

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

Sec. 2. Minnesota Statutes 2021 Supplement, section 245A.14, subdivision 4, is amended to read:

Subd. 4. **Special family 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 child care or group family 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) Notwithstanding Minnesota Rules, part 9502.0335, subpart 12, the commissioner may issue up to four licenses to an organization licensed under paragraph (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) For licenses issued under paragraph (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 paragraph (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~~.~~; and

(5) is authorized to communicate with the county licensing agency and the department on matters related to licensing.

(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.

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

Sec. 3. Minnesota Statutes 2020, section 245A.1443, is amended to read:

245A.1443 ~~CHEMICAL DEPENDENCY~~ SUBSTANCE USE DISORDER TREATMENT LICENSED PROGRAMS THAT SERVE PARENTS WITH THEIR CHILDREN.

Subdivision 1. **Application.** This section applies to ~~chemical dependency~~ residential substance use disorder treatment facilities that are licensed under this chapter and ~~Minnesota Rules,~~ chapter ~~9530,~~ 245G and that provide services in accordance with section 245G.19.

Subd. 2. **Requirements for providing education.** (a) 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 to comply with this requirement. At a minimum, the education must address:

(1) instruction that a child or infant should never be left unattended around water, a tub should be filled with only two to four inches of water for infants, and 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 ~~dangers~~ risks of co-sleeping.

(b) 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. If the parent refuses to comply, program staff must provide additional education to the parent ~~at appropriate intervals, at least weekly~~ 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.

Subd. 3. **Parental supervision of children.** (a) On or before the date of a child's initial physical presence at the facility, the license holder must ~~complete and~~ document ~~an assessment of~~ the parent's capacity to meet the health and safety needs of the child while on the facility premises~~, including identifying circumstances when the parent may be unable to adequately care for their child due to~~ considering the following factors:

(1) the parent's physical ~~or~~ and mental health;

(2) the parent being under the influence of drugs, alcohol, medications, or other chemicals;

~~(3) the parent being unable to provide appropriate supervision for the child; or~~

(3) the child's physical and mental health; and

(4) any other information available to the license holder that indicates the parent may not be able to adequately care for the child.

(b) The license holder must have written procedures specifying the actions to be taken by staff if a parent is or becomes unable to adequately care for the parent's child.

(c) If the parent refuses to comply with the safeguards described in subdivision 2 or is unable to adequately care for the child, the license holder must develop a parental supervision plan in conjunction with the client. The plan must account for any factors in paragraph (a) 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.

Subd. 4. **Alternative supervision arrangements.** 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 client 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 client occurs. The procedure for approval must include an assessment of the nonparental client's capacity to assume the supervisory responsibilities using the criteria in subdivision 3. The license holder must document the license holder's approval of the supervisory arrangement and the assessment of the nonparental client's capacity to supervise the child, and must keep this documentation in the file of the parent of the child being supervised.

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

Sec. 4. Minnesota Statutes 2020, section 245F.15, subdivision 1, is amended to read:

Subdivision 1. **Qualifications for all staff who have direct patient contact.** ~~(a)~~ All staff who have direct patient contact must be at least 18 years of age ~~and must, at the time of hiring, document that they meet the requirements in paragraph (b), (c), or (d)~~.

~~(b) Program directors, supervisors, nurses, and alcohol and drug counselors must be free of substance use problems for at least two years immediately preceding their hiring and must sign a statement attesting to that fact.~~

~~(c) Recovery peers must be free of substance use problems for at least one year immediately preceding their hiring and must sign a statement attesting to that fact.~~

~~(d) Technicians and other support staff must be free of substance use problems for at least six months immediately preceding their hiring and must sign a statement attesting to that fact.~~

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

Sec. 5. Minnesota Statutes 2020, section 245F.16, subdivision 1, is amended to read:

Subdivision 1. **Policy requirements.** A license holder must have written personnel policies and must make them available to staff members at all times. The personnel policies must:

(1) ensure that a staff member's retention, promotion, job assignment, or pay are not affected by a good-faith communication between the staff member and the Department of Human Services, Department of Health, Ombudsman for Mental Health and Developmental Disabilities, law enforcement, or local agencies that investigate complaints regarding patient rights, health, or safety;

(2) include a job description for each position that specifies job responsibilities, degree of authority to execute job responsibilities, standards of job performance related to specified job responsibilities, and qualifications;

(3) provide for written job performance evaluations for staff members of the license holder at least annually;

(4) describe ~~behavior that constitutes grounds~~ the process for disciplinary action, suspension, or dismissal~~, including policies that address substance use problems and meet the requirements of section 245F.15, subdivisions 1 and 2. The policies and procedures must list behaviors or incidents that are considered substance use problems. The list must include:~~ of a staff person for violating the drug and alcohol policy described in section 245A.04, subdivision 1, paragraph (c);

~~(i) receiving treatment for substance use disorder within the period specified for the position in the staff qualification requirements;~~

~~(ii) substance use that has a negative impact on the staff member's job performance;~~

~~(iii) substance use that affects the credibility of treatment services with patients, referral sources, or other members of the community; and~~

~~(iv) symptoms of intoxication or withdrawal on the job;~~

(5) include policies prohibiting personal involvement with patients and policies prohibiting patient maltreatment as specified under sections 245A.65, 626.557, and 626.5572 and chapters 260E and 604;

(6) include a chart or description of organizational structure indicating the lines of authority and responsibilities;

(7) include a written plan for new staff member orientation that, at a minimum, includes training related to the specific job functions for which the staff member was hired, program policies and procedures, patient needs, and the areas identified in subdivision 2, paragraphs (b) to (e); and

(8) include a policy on the confidentiality of patient information.

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

Sec. 6. Minnesota Statutes 2020, section 245G.01, subdivision 4, is amended to read:

Subd. 4. **Alcohol and drug counselor.** "Alcohol and drug counselor" ~~has the meaning given in section 148F.01, subdivision 5~~ means a person who is qualified according to section 245G.11, subdivision 5.

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

Sec. 7. Minnesota Statutes 2020, section 245G.01, subdivision 17, is amended to read:

Subd. 17. **Licensed professional in private practice.** (a) "Licensed professional in private practice" means an individual who:

(1) is licensed under chapter 148F, or is exempt from licensure under that chapter but is otherwise licensed to provide alcohol and drug counseling services;

(2) practices solely within the permissible scope of the individual's license as defined in the law authorizing licensure; and

(3) does not affiliate with other licensed or unlicensed professionals to provide alcohol and drug counseling services. ~~Affiliation does not include conferring with another professional or making a client referral.~~

(b) For purposes of this subdivision, affiliate includes but is not limited to:

(1) using the same electronic record system as another professional, except when the system prohibits each professional from accessing the records of another professional;

(2) advertising the services of more than one professional together;

(3) accepting client referrals made to a group of professionals;

(4) providing services to another professional's clients when that professional is absent; or

(5) appearing in any way to be a group practice or program.

(c) For purposes of this subdivision, affiliate does not include:

(1) conferring with another professional;

(2) making a client referral to another professional;

(3) contracting with the same agency as another professional for billing services;

(4) using the same waiting area for clients in an office as another professional; or

(5) using the same receptionist as another professional if the receptionist supports each professional independently.

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

Sec. 8. Minnesota Statutes 2020, section 245G.06, is amended by adding a subdivision to read:

Subd. 2a. **Documentation of treatment services.** The license holder must ensure that the staff member who provides the treatment service documents in the client record the date, type, and amount of each treatment service provided to a client and the client's response to each treatment service within seven days of providing the treatment service.

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

Sec. 9. Minnesota Statutes 2020, section 245G.06, is amended by adding a subdivision to read:

Subd. 2b. **Client record documentation requirements.** (a) The license holder must document in the client record any significant event that occurs at the program on the day the event occurs. A significant event is an event that impacts the client's relationship with other clients, staff, or the client's family, or the client's treatment plan.

(b) A residential treatment program must document in the client record the following items on the day that each occurs:

(1) medical and other appointments the client attended;

(2) concerns related to medications that are not documented in the medication administration record; and

(3) concerns related to attendance for treatment services, including the reason for any client absence from a treatment service.

(c) Each entry in a client's record must be accurate, legible, signed, dated, and include the job title or position of the staff person that made the entry. A late entry must be clearly labeled "late entry." A correction to an entry must be made in a way in which the original entry can still be read.

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

Sec. 10. Minnesota Statutes 2020, section 245G.06, subdivision 3, is amended to read:

Subd. 3. ~~**Documentation of treatment services;**~~ **Treatment plan review.** ~~(a) A review of all treatment services must be documented weekly and include a review of:~~

~~(1) care coordination activities;~~

~~(2) medical and other appointments the client attended;~~

~~(3) issues related to medications that are not documented in the medication administration record; and~~

~~(4) issues related to attendance for treatment services, including the reason for any client absence from a treatment service.~~

~~(b) A note must be entered immediately following any significant event. A significant event is an event that impacts the client's relationship with other clients, staff, the client's family, or the client's treatment plan.~~

~~(c)~~ A treatment plan review must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the ~~staff member providing the service~~ alcohol and drug counselor responsible for the client's treatment plan. The review must indicate the span of time covered by the review and each of the six dimensions listed in section 245G.05, subdivision 2, paragraph (c). The review must:

~~(1) indicate the date, type, and amount of each treatment service provided and the client's response to each service;~~

~~(2)~~ (1) address each goal in the treatment plan and whether the methods to address the goals are effective;

~~(3)~~ (2) include monitoring of any physical and mental health problems;

~~(4)~~ (3) document the participation of others;

~~(5)~~ (4) document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change; and

~~(6)~~ (5) include a review and evaluation of the individual abuse prevention plan according to section 245A.65.

~~(d) Each entry in a client's record must be accurate, legible, signed, and dated. A late entry must be clearly labeled "late entry." A correction to an entry must be made in a way in which the original entry can still be read.~~

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

Sec. 11. Minnesota Statutes 2020, section 245G.08, subdivision 5, is amended to read:

Subd. 5. **Administration of medication and assistance with self-medication.** (a) A license holder must meet the requirements in this subdivision if a service provided includes the administration of medication.

(b) A staff member, other than a licensed practitioner or nurse, who is delegated by a licensed practitioner or a registered nurse the task of administration of medication or assisting with self-medication, must:

(1) successfully complete a medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution. A staff member's completion of the course must be documented in writing and placed in the staff member's personnel file;

(2) be trained according to a formalized training program that is taught by a registered nurse and offered by the license holder. The training must include the process for administration of naloxone, if naloxone is kept on site. A staff member's completion of the training must be documented in writing and placed in the staff member's personnel records; or

(3) demonstrate to a registered nurse competency to perform the delegated activity. A registered nurse must be employed or contracted to develop the policies and procedures for administration of medication or assisting with self-administration of medication, or both.

(c) A registered nurse must provide supervision as defined in section 148.171, subdivision 23. The registered nurse's supervision must include, at a minimum, monthly on-site supervision or more often if warranted by a client's health needs. The policies and procedures must include:

(1) a provision that a delegation of administration of medication is limited to a method a staff member has been trained to administer and limited to ~~the administration of~~:

(i) a medication that is administered orally, topically, or as a suppository, an eye drop, an ear drop, ~~or~~ an inhalant, or an intranasal; and

(ii) an intramuscular injection of naloxone or epinephrine;

(2) a provision that each client's file must include documentation indicating whether staff must conduct the administration of medication or the client must self-administer medication, or both;

(3) a provision that a client may carry emergency medication such as nitroglycerin as instructed by the client's physician or advanced practice registered nurse;

(4) a provision for the client to self-administer medication when a client is scheduled to be away from the facility;

(5) a provision that if a client self-administers medication when the client is present in the facility, the client must self-administer medication under the observation of a trained staff member;

(6) a provision that when a license holder serves a client who is a parent with a child, the parent may only administer medication to the child under a staff member's supervision;

(7) requirements for recording the client's use of medication, including staff signatures with date and time;

(8) guidelines for when to inform a nurse of problems with self-administration of medication, including a client's failure to administer, refusal of a medication, adverse reaction, or error; and

(9) procedures for acceptance, documentation, and implementation of a prescription, whether written, verbal, telephonic, or electronic.

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

Sec. 12. Minnesota Statutes 2020, section 245G.09, subdivision 3, is amended to read:

Subd. 3. **Contents.** Client records must contain the following:

(1) documentation that the client was given information on client rights and responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan required under section 245A.65, subdivision 2, paragraph (a), clause (4). If the client has an opioid use disorder, the record

must contain documentation that the client was provided educational information according to section 245G.05, subdivision 1, paragraph (b);

(2) an initial services plan completed according to section 245G.04;

(3) a comprehensive assessment completed according to section 245G.05;

(4) an assessment summary completed according to section 245G.05, subdivision 2;

(5) an individual abuse prevention plan according to sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

(6) an individual treatment plan according to section 245G.06, subdivisions 1 and 2;

(7) documentation of treatment services, significant events, appointments, concerns, and treatment plan ~~review~~ reviews according to section 245G.06, ~~subdivision~~ subdivisions 2a, 2b, and 3; and

(8) a summary at the time of service termination according to section 245G.06, subdivision 4.

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

Sec. 13. Minnesota Statutes 2020, section 245G.11, subdivision 1, is amended to read:

Subdivision 1. **General qualifications.** (a) All staff members who have direct contact must be 18 years of age or older. ~~At the time of employment, each staff member must meet the qualifications in this subdivision. For purposes of this subdivision, "problematic substance use" means a behavior or incident listed by the license holder in the personnel policies and procedures according to section 245G.13, subdivision 1, clause (5).~~

~~(b) A treatment director, supervisor, nurse, counselor, student intern, or other professional must be free of problematic substance use for at least the two years immediately preceding employment and must sign a statement attesting to that fact.~~

~~(c) A paraprofessional, recovery peer, or any other staff member with direct contact must be free of problematic substance use for at least one year immediately preceding employment and must sign a statement attesting to that fact.~~

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

Sec. 14. Minnesota Statutes 2020, section 245G.11, subdivision 10, is amended to read:

Subd. 10. **Student interns.** A qualified staff member must supervise and be responsible for a treatment service performed by a student intern and must review and sign each

assessment, ~~progress note, and~~ individual treatment plan, and treatment plan review prepared by a student intern. A student intern must receive the orientation and training required in section 245G.13, subdivisions 1, clause (7), and 2. No more than 50 percent of the treatment staff may be students or licensing candidates with time documented to be directly related to the provision of treatment services for which the staff are authorized.

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

Sec. 15. Minnesota Statutes 2020, section 245G.13, subdivision 1, is amended to read:

Subdivision 1. **Personnel policy requirements.** A license holder must have written personnel policies that are available to each staff member. The personnel policies must:

(1) ensure that staff member retention, promotion, job assignment, or pay are not affected by a good faith communication between a staff member and the department, the Department of Health, the ombudsman for mental health and developmental disabilities, law enforcement, or a local agency for the investigation of a complaint regarding a client's rights, health, or safety;

(2) contain a job description for each staff member position specifying responsibilities, degree of authority to execute job responsibilities, and qualification requirements;

(3) provide for a job performance evaluation based on standards of job performance conducted on a regular and continuing basis, including a written annual review;

(4) describe behavior that constitutes grounds for disciplinary action, suspension, or dismissal, including ~~policies that address staff member problematic substance use and the requirements of section 245G.11, subdivision 1,~~ policies prohibiting personal involvement with a client in violation of chapter 604, and policies prohibiting client abuse described in sections 245A.65, 626.557, and 626.5572, and chapter 260E;

~~(5) identify how the program will identify whether behaviors or incidents are problematic substance use, including a description of how the facility must address:~~

~~(i) receiving treatment for substance use within the period specified for the position in the staff qualification requirements, including medication-assisted treatment;~~

~~(ii) substance use that negatively impacts the staff member's job performance;~~

~~(iii) substance use that affects the credibility of treatment services with a client, referral source, or other member of the community;~~

~~(iv) symptoms of intoxication or withdrawal on the job; and~~

~~(v) the circumstances under which an individual who participates in monitoring by the health professional services program for a substance use or mental health disorder is able to provide services to the program's clients;~~

(5) describe the process for disciplinary action, suspension, or dismissal of a staff person for violating the drug and alcohol policy described in section 245A.04, subdivision 1, paragraph (c);

(6) include a chart or description of the organizational structure indicating lines of authority and responsibilities;

(7) include orientation within 24 working hours of starting for each new staff member based on a written plan that, at a minimum, must provide training related to the staff member's specific job responsibilities, policies and procedures, client confidentiality, HIV minimum standards, and client needs; and

(8) include policies outlining the license holder's response to a staff member with a behavior problem that interferes with the provision of treatment service.

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

Sec. 16. Minnesota Statutes 2020, section 245G.20, is amended to read:

245G.20 LICENSE HOLDERS SERVING PERSONS WITH CO-OCCURRING DISORDERS.

A license holder specializing in the treatment of a person with co-occurring disorders must:

(1) demonstrate that staff levels are appropriate for treating a client with a co-occurring disorder, and that there are adequate staff members with mental health training;

(2) have continuing access to a medical provider with appropriate expertise in prescribing psychotropic medication;

(3) have a mental health professional available for staff member supervision and consultation;

(4) determine group size, structure, and content considering the special needs of a client with a co-occurring disorder;

(5) have documentation of active interventions to stabilize mental health symptoms present in the individual treatment plans and ~~progress notes~~ treatment plan reviews;

(6) have continuing documentation of collaboration with continuing care mental health providers, and involvement of the providers in treatment planning meetings;

(7) have available program materials adapted to a client with a mental health problem;

(8) have policies that provide flexibility for a client who may lapse in treatment or may have difficulty adhering to established treatment rules as a result of a mental illness, with the goal of helping a client successfully complete treatment; and

(9) have individual psychotherapy and case management available during treatment service.

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

Sec. 17. Minnesota Statutes 2020, section 245G.22, subdivision 7, is amended to read:

Subd. 7. **Restrictions for unsupervised use of methadone hydrochloride.** (a) If a medical director or prescribing practitioner assesses and determines that a client meets the criteria in subdivision 6 and may be dispensed a medication used for the treatment of opioid addiction, the restrictions in this subdivision must be followed when the medication to be dispensed is methadone hydrochloride. The results of the assessment must be contained in the client file. The number of unsupervised use medication doses per week in paragraphs (b) to (d) is in addition to the number of unsupervised use medication doses a client may receive for days the clinic is closed for business as allowed by subdivision 6, paragraph (a).

(b) During the first 90 days of treatment, the unsupervised use medication supply must be limited to a maximum of a single dose each week and the client shall ingest all other doses under direct supervision.

(c) In the second 90 days of treatment, the unsupervised use medication supply must be limited to two doses per week.

(d) In the third 90 days of treatment, the unsupervised use medication supply must not exceed three doses per week.

(e) In the remaining months of the first year, a client may be given a maximum six-day unsupervised use medication supply.

(f) After one year of continuous treatment, a client may be given a maximum two-week unsupervised use medication supply.

(g) After two years of continuous treatment, a client may be given a maximum one-month unsupervised use medication supply, but must make monthly visits to the program.

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

Sec. 18. Laws 2020, First Special Session chapter 7, section 1, subdivision 5, as amended by Laws 2021, First Special Session chapter 7, article 2, section 73, is amended to read:

Subd. 5. **Waivers and modifications; extension ~~for 365 days~~.** (a) 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 365 days after the peacetime emergency ends~~ until January 1, 2023.

(b) Under the extension of the waiver in paragraph (a), mandatory direct contact supervision requirements are waived to allow the commissioner to permit an individual to work without supervision while that individual's background study is being processed, on a case-by-case basis and as permitted under federal law and regulation, while providers transition from name and date of birth background studies of only Minnesota records to fingerprint-based background studies.

(c) The commissioner shall conduct a name and date of birth background study of only Minnesota records for an individual who has direct contact with persons served in any program licensed by the commissioner that is not authorized to conduct fingerprint-based national criminal history record checks, until federal approval is obtained for fingerprint-based national criminal history record checks and necessary NETStudy 2.0 system changes following federal approval have been completed. A name and date of birth background study of only Minnesota records conducted under this paragraph shall remain valid until three months after the commissioner begins conducting fingerprint-based national criminal history record checks.

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

Sec. 19. **CHILD CARE REGULATION MODERNIZATION; PILOT PROJECTS.**

The commissioner of human services may conduct and administer pilot projects to test methods and procedures for the projects to modernize regulation of child care centers and family child care allowed under Laws 2021, First Special Session chapter 7, article 2, sections 75 and 81. To carry out the pilot projects, the commissioner of human services may, by issuing a commissioner's order, waive enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The commissioner's order

establishing the waiver must provide alternative methods and procedures of administration and must not be in conflict with the basic purposes, coverage, or benefits provided by law. Pilot projects must comply with the requirements of the child care and development fund plan.

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

Sec. 20. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; AMENDING CHILDREN'S RESIDENTIAL FACILITY AND DETOXIFICATION PROGRAM RULES.**

(a) The commissioner of human services must amend Minnesota Rules, part 2960.0460, to remove all references to repealed Minnesota Rules, part 2960.0460, subpart 2.

(b) The commissioner must amend Minnesota Rules, part 2960.0470, to require license holders to have written personnel policies that describe the process for disciplinary action, suspension, or dismissal of a staff person for violating the drug and alcohol policy described in Minnesota Statutes, section 245A.04, subdivision 1, paragraph (c), and Minnesota Rules, part 2960.0030, subpart 9.

(c) The commissioner must amend Minnesota Rules, part 9530.6565, subpart 1, to remove items A and B and the documentation requirement that references these items.

(d) The commissioner must amend Minnesota Rules, part 9530.6570, subpart 1, item D, to remove the existing language and insert language to require license holders to have written personnel policies that describe the process for disciplinary action, suspension, or dismissal of a staff person for violating the drug and alcohol policy described in Minnesota Statutes, section 245A.04, subdivision 1, paragraph (c).

(e) For purposes of this section, the commissioner may use the good cause exempt process under Minnesota Statutes, section 14.388, subdivision 1, clause (3), and Minnesota Statutes, section 14.386, does not apply.

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

Sec. 21. **REPEALER.**

(a) Minnesota Statutes 2020, sections 245F.15, subdivision 2; and 245G.11, subdivision 2, are repealed.

(b) Minnesota Rules, parts 2960.0460, subpart 2; and 9530.6565, subpart 2, are repealed.

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

ARTICLE 13
MISCELLANEOUS

Section 1. Minnesota Statutes 2020, section 34A.01, subdivision 4, is amended to read:

Subd. 4. **Food.** "Food" means every ingredient used for, entering into the consumption of, or used or intended for use in the preparation of food, drink, confectionery, or condiment for humans or other animals, whether simple, mixed, or compound; and articles used as components of these ingredients, except that edible cannabinoid products, as defined in section 151.72, subdivision 1, paragraph (c), are not food.

Sec. 2. Minnesota Statutes 2020, section 137.68, is amended to read:

137.68 MINNESOTA RARE DISEASE ADVISORY COUNCIL ~~ON RARE DISEASES~~.

Subdivision 1. **Establishment.** ~~The University of Minnesota is requested to establish~~ There is established an advisory council on rare diseases to provide advice on policies, access, equity, research, diagnosis, treatment, and education related to rare diseases. The advisory council is established in honor of Chloe Barnes and her experiences in the health care system. For purposes of this section, "rare disease" has the meaning given in United States Code, title 21, section 360bb. The council shall be called the ~~Chloe Barnes Advisory Council on Rare Diseases~~ Minnesota Rare Disease Advisory Council. The Council on Disability shall provide meeting and office space and administrative support to the advisory council but does not have authority over the work of the advisory council.

Subd. 2. **Membership.** (a) The advisory council ~~may~~ shall consist of at least 17 public members who reflect statewide representation. Except for initial members, members are appointed by ~~the Board of Regents or a designee~~ the governor according to paragraph (b) ~~and~~. Four members of the legislature are appointed according to paragraph (c).

(b) ~~The Board of Regents or a designee is requested to~~ The governor shall appoint at least the following public members according to section 15.0597:

(1) three physicians licensed and practicing in the state with experience researching, diagnosing, or treating rare diseases, including one specializing in pediatrics;

(2) one registered nurse or advanced practice registered nurse licensed and practicing in the state with experience treating rare diseases;

(3) at least two hospital administrators, or their designees, from hospitals in the state that provide care to persons diagnosed with a rare disease. One administrator or designee

appointed under this clause must represent a hospital in which the scope of service focuses on rare diseases of pediatric patients;

(4) three persons age 18 or older who either have a rare disease or are a caregiver of a person with a rare disease. One person appointed under this clause must reside in rural Minnesota;

(5) a representative of a rare disease patient organization that operates in the state;

(6) a social worker with experience providing services to persons diagnosed with a rare disease;

(7) a pharmacist with experience with drugs used to treat rare diseases;

(8) a dentist licensed and practicing in the state with experience treating rare diseases;

(9) a representative of the biotechnology industry;

(10) a representative of health plan companies;

(11) a medical researcher with experience conducting research on rare diseases; ~~and~~

(12) a genetic counselor with experience providing services to persons diagnosed with a rare disease or caregivers of those persons~~.~~; and

(13) representatives with other areas of expertise as identified by the advisory council.

(c) The advisory council shall include two members of the senate, one appointed by the majority leader and one appointed by the minority leader; and two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader. Members appointed under this paragraph serve until their successors are appointed.

(d) The commissioner of health or a designee, a representative of Mayo Medical School, and a representative of the University of Minnesota Medical School shall serve as ex officio, nonvoting members of the advisory council.

(e) ~~Initial appointments to the advisory council shall be made no later than September 1, 2019.~~ Members appointed according to paragraph (b) shall serve for a term of three years, except ~~that~~ the initial members appointed according to paragraph (b) ~~shall have an initial term of two, three, or four years determined by lot by the chairperson~~. Members appointed according to paragraph (b) shall serve until their successors have been appointed.

(f) Members may be reappointed for up to two full additional terms according to the advisory council's operating procedures.

(g) Members may be removed as provided in section 15.059, subdivision 4.

(h) Public members serve without compensation, but may have expenses reimbursed as provided in section 15.059, subdivision 3. Legislative members may receive per diem according to the rules of their respective bodies.

Subd. 3. **Meetings.** ~~The Board of Regents or a designee is requested to convene the first meeting of the advisory council no later than October 1, 2019.~~ The advisory council shall meet at the call of the chairperson or at the request of a majority of advisory council members. Meetings of the advisory council are subject to section 13D.01, and notice of its meetings is governed by section 13D.04.

Subd. 3a. **Chairperson; executive director; staff; executive committee.** (a) The advisory council shall elect a chairperson and other officers as it deems necessary and in accordance with the advisory council's operating procedures.

(b) The advisory council shall be governed by an executive committee elected by the members of the advisory council. One member of the executive committee must be the advisory council chairperson.

(c) The advisory council shall appoint an executive director. The executive director serves as an ex officio nonvoting member of the executive committee. The advisory council may delegate to the executive director any powers and duties under this section that do not require advisory council approval. The executive director serves in the unclassified service and may be removed at any time by a majority vote of the advisory council. The executive director may employ and direct staff necessary to carry out advisory council mandates, policies, activities, and objectives.

(d) The executive committee may appoint additional subcommittees and work groups as necessary to fulfill the duties of the advisory council.

Subd. 4. **Duties.** (a) The advisory council's duties may include, but are not limited to:

(1) in conjunction with the state's medical schools, the state's schools of public health, and hospitals in the state that provide care to persons diagnosed with a rare disease, developing resources or recommendations relating to quality of and access to treatment and services in the state for persons with a rare disease, including but not limited to:

(i) a list of existing, publicly accessible resources on research, diagnosis, treatment, and education relating to rare diseases;

(ii) identifying best practices for rare disease care implemented in other states, at the national level, and at the international level that will improve rare disease care in the state and seeking opportunities to partner with similar organizations in other states and countries;

(iii) identifying and addressing problems faced by patients with a rare disease when changing health plans, including recommendations on how to remove obstacles faced by these patients to finding a new health plan and how to improve the ease and speed of finding a new health plan that meets the needs of patients with a rare disease; ~~and~~

(iv) identifying and addressing barriers faced by patients with a rare disease to obtaining care, caused by prior authorization requirements in private and public health plans; and

~~(iv)~~ (v) identifying, recommending, and implementing best practices to ensure health care providers are adequately informed of the most effective strategies for recognizing and treating rare diseases; ~~and~~

(2) advising, consulting, and cooperating with the Department of Health, including the Advisory Committee on Heritable and Congenital Disorders~~.~~; the Department of Human Services, including the Drug Utilization Review Board and the Drug Formulary Committee; and other agencies of state government in developing recommendations, information, and programs for the public and the health care community relating to diagnosis, treatment, and awareness of rare diseases~~.~~;

(3) advising on policy issues and advancing policy initiatives at the state and federal levels; and

(4) receiving funds and issuing grants.

(b) The advisory council shall collect additional topic areas for study and evaluation from the general public. In order for the advisory council to study and evaluate a topic, the topic must be approved for study and evaluation by the advisory council.

(c) Legislative members may not deliberate about or vote on decisions related to the issuance of grants of state money.

Subd. 5. **Conflict of interest.** Advisory council members are subject to the ~~Board of Regents policy on conflicts~~ advisory council's conflict of interest policy as outlined in the advisory council's operating procedures.

Subd. 6. **Annual report.** By January 1 of each year, beginning January 1, 2020, the advisory council shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over higher education and health care policy on the advisory

council's activities under subdivision 4 and other issues on which the advisory council may choose to report.

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

Sec. 3. Minnesota Statutes 2020, section 151.72, subdivision 1, is amended to read:

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

(b) "Certified hemp" means hemp plants that have been tested and found to meet the requirements of chapter 18K and the rules adopted thereunder.

(c) "Edible cannabinoid product" means any product that is intended to be eaten or consumed as a beverage by humans, contains a cannabinoid in combination with food ingredients, and is not a drug.

~~(b)~~ (d) "Hemp" has the meaning given to "industrial hemp" in section 18K.02, subdivision 3.

(e) "Label" has the meaning given in section 151.01, subdivision 18.

~~(c)~~ (f) "Labeling" means all labels and other written, printed, or graphic matter that are:

(1) affixed to the immediate container in which a product regulated under this section is sold; ~~or~~

(2) provided, in any manner, with the immediate container, including but not limited to outer containers, wrappers, package inserts, brochures, or pamphlets~~.~~; or

(3) provided on that portion of a manufacturer's website that is linked by a scannable barcode or matrix barcode.

(g) "Matrix barcode" means a code that stores data in a two-dimensional array of geometrically shaped dark and light cells capable of being read by the camera on a smartphone or other mobile device.

(h) "Nonintoxicating cannabinoid" means substances extracted from certified hemp plants that do not produce intoxicating effects when consumed by any route of administration.

Sec. 4. Minnesota Statutes 2020, section 151.72, subdivision 2, is amended to read:

Subd. 2. **Scope.** (a) This section applies to the sale of any product that contains ~~nonintoxicating~~ cannabinoids extracted from hemp ~~other than food~~ and that is an edible

cannabinoid product or is intended for human or animal consumption by any route of administration.

(b) This section does not apply to any product dispensed by a registered medical cannabis manufacturer pursuant to sections 152.22 to 152.37.

(c) The board must have no authority over food products, as defined in section 34A.01, subdivision 4, that do not contain cannabinoids extracted or derived from hemp.

Sec. 5. Minnesota Statutes 2020, section 151.72, subdivision 3, is amended to read:

Subd. 3. **Sale of cannabinoids derived from hemp.** (a) Notwithstanding any other section of this chapter, a product containing nonintoxicating cannabinoids, including an edible cannabinoid product, may be sold for human or animal consumption only if all of the requirements of this section are met, provided that a product sold for human or animal consumption does not contain more than 0.3 percent of any tetrahydrocannabinol and an edible cannabinoid product does not contain an amount of any tetrahydrocannabinol that exceeds the limits established in subdivision 5a, paragraph (f).

(b) No other substance extracted or otherwise derived from hemp may be sold for human consumption if the substance is intended:

(1) for external or internal use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or other animals; or

(2) to affect the structure or any function of the bodies of humans or other animals.

(c) No product containing any cannabinoid or tetrahydrocannabinol extracted or otherwise derived from hemp may be sold to any individual who is under the age of 21.

(d) Products that meet the requirements of this section are not controlled substances under section 152.02.

Sec. 6. Minnesota Statutes 2020, section 151.72, subdivision 4, is amended to read:

Subd. 4. **Testing requirements.** (a) A manufacturer of a product regulated under this section must submit representative samples of the product to an independent, accredited laboratory in order to certify that the product complies with the standards adopted by the board. Testing must be consistent with generally accepted industry standards for herbal and botanical substances, and, at a minimum, the testing must confirm that the product:

(1) contains the amount or percentage of cannabinoids that is stated on the label of the product;

(2) does not contain more than trace amounts of any mold, residual solvents, pesticides, fertilizers, or heavy metals; and

(3) does not contain ~~a delta-9 tetrahydrocannabinol concentration that exceeds the concentration permitted for industrial hemp as defined in section 18K.02, subdivision 3~~ more than 0.3 percent of any tetrahydrocannabinol.

(b) Upon the request of the board, the manufacturer of the product must provide the board with the results of the testing required in this section.

(c) Testing of the hemp from which the nonintoxicating cannabinoid was derived, or possession of a certificate of analysis for such hemp, does not meet the testing requirements of this section.

Sec. 7. Minnesota Statutes 2021 Supplement, section 151.72, subdivision 5, is amended to read:

Subd. 5. **Labeling requirements.** (a) A product regulated under this section must bear a label that contains, at a minimum:

(1) the name, location, contact phone number, and website of the manufacturer of the product;

(2) the name and address of the independent, accredited laboratory used by the manufacturer to test the product; and

(3) an accurate statement of the amount or percentage of cannabinoids found in each unit of the product meant to be consumed~~; or~~.

~~(4) instead of the information required in clauses (1) to (3), a scannable bar code or QR code that links to the manufacturer's website.~~

(b) The information in paragraph (a) may be provided on an outer package if the immediate container that holds the product is too small to contain all of the information.

(c) The information required in paragraph (a) may be provided through the use of a scannable barcode or matrix barcode that links to a page on the manufacturer's website if that page contains all of the information required by this subdivision.

(d) The label must also include a statement stating that ~~this~~ the product does not claim to diagnose, treat, cure, or prevent any disease and has not been evaluated or approved by the United States Food and Drug Administration (FDA) unless the product has been so approved.

~~(b)~~ (e) The information required ~~to be on the label~~ by this subdivision must be prominently and conspicuously placed ~~and~~ on the label or displayed on the website in terms that can be easily read and understood by the consumer.

~~(c)~~ (f) The ~~label~~ labeling must not contain any claim that the product may be used or is effective for the prevention, treatment, or cure of a disease or that it may be used to alter the structure or function of human or animal bodies, unless the claim has been approved by the FDA.

Sec. 8. Minnesota Statutes 2020, section 151.72, is amended by adding a subdivision to read:

Subd. 5a. **Additional requirements for edible cannabinoid products.** (a) In addition to the testing and labeling requirements under subdivisions 4 and 5, an edible cannabinoid must meet the requirements of this subdivision.

(b) An edible cannabinoid product must not:

(1) bear the likeness or contain cartoon-like characteristics of a real or fictional person, animal, or fruit that appeals to children;

(2) be modeled after a brand of products primarily consumed by or marketed to children;

(3) be made by applying an extracted or concentrated hemp-derived cannabinoid to a commercially available candy or snack food item;

(4) contain an ingredient, other than a hemp-derived cannabinoid, that is not approved by the United States Food and Drug Administration for use in food;

(5) be packaged in a way that resembles the trademarked, characteristic, or product-specialized packaging of any commercially available food product; or

(6) be packaged in a container that includes a statement, artwork, or design that could reasonably mislead any person to believe that the package contains anything other than an edible cannabinoid product.

(c) An edible cannabinoid product must be prepackaged in packaging or a container that is child-resistant, tamper-evident, and opaque or placed in packaging or a container that is child-resistant, tamper-evident, and opaque at the final point of sale to a customer. The requirement that packaging be child-resistant does not apply to an edible cannabinoid product that is intended to be consumed as a beverage and which contains no more than a trace amount of any tetrahydrocannabinol.

(d) If an edible cannabinoid product is intended for more than a single use or contains multiple servings, each serving must be indicated by scoring, wrapping, or other indicators designating the individual serving size.

(e) A label containing at least the following information must be affixed to the packaging or container of all edible cannabinoid products sold to consumers:

(1) the serving size;

(2) the cannabinoid profile per serving and in total;

(3) a list of ingredients, including identification of any major food allergens declared by name; and

(4) the following statement: "Keep this product out of reach of children."

(f) An edible cannabinoid product must not contain more than five milligrams of any tetrahydrocannabinol in a single serving, or more than a total of 50 milligrams of any tetrahydrocannabinol per package.

Sec. 9. Minnesota Statutes 2020, section 151.72, subdivision 6, is amended to read:

Subd. 6. **Enforcement.** (a) A product ~~sold~~ regulated under this section, including an edible cannabinoid product, shall be considered an adulterated drug if:

(1) it consists, in whole or in part, of any filthy, putrid, or decomposed substance;

(2) it has been produced, prepared, packed, or held under unsanitary conditions where it may have been rendered injurious to health, or where it may have been contaminated with filth;

(3) its container is composed, in whole or in part, of any poisonous or deleterious substance that may render the contents injurious to health;

(4) it contains any food additives, color additives, or excipients that have been found by the FDA to be unsafe for human or animal consumption; ~~or~~

(5) it contains an amount or percentage of nonintoxicating cannabinoids that is different than the amount or percentage stated on the label~~.~~;

(6) it contains more than 0.3 percent of any tetrahydrocannabinol or, if the product is an edible cannabinoid product, an amount of tetrahydrocannabinol that exceeds the limits established in subdivision 5a, paragraph (f); or

(7) it contains more than trace amounts of mold, residual solvents, pesticides, fertilizers, or heavy metals.

(b) A product ~~sold~~ regulated under this section shall be considered a misbranded drug if the product's labeling is false or misleading in any manner or in violation of the requirements of this section.

(c) The board's authority to issue cease and desist orders under section 151.06; to embargo adulterated and misbranded drugs under section 151.38; and to seek injunctive relief under section 214.11, extends to any violation of this section.

Sec. 10. 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, 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) tetrahydrocannabinols naturally contained in a plant of the genus Cannabis, except that tetrahydrocannabinols do not include any material, compound, mixture, or preparation that qualifies as industrial hemp as defined in section 18K.02, subdivision 3; 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) 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, 2022, and applies to crimes committed on or after that date.

Sec. 11. Minnesota Statutes 2021 Supplement, section 363A.50, is amended to read:

363A.50 NONDISCRIMINATION IN ACCESS TO TRANSPLANTS.

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

(b) "Anatomical gift" has the meaning given in section 525A.02, subdivision 4.

(c) "Auxiliary aids and services" include, but are not limited to:

(1) qualified interpreters or other effective methods of making aurally delivered materials available to individuals with hearing impairments and to non-English-speaking individuals;

(2) qualified readers, taped texts, texts in accessible electronic format, or other effective methods of making visually delivered materials available to individuals with visual impairments;

(3) the provision of information in a format that is accessible for individuals with cognitive, neurological, developmental, intellectual, or physical disabilities;

(4) the provision of supported decision-making services; and

(5) the acquisition or modification of equipment or devices.

(d) "Covered entity" means:

(1) any licensed provider of health care services, including licensed health care practitioners, hospitals, nursing facilities, laboratories, intermediate care facilities, psychiatric

residential treatment facilities, institutions for individuals with intellectual or developmental disabilities, and prison health centers; or

(2) any entity responsible for matching anatomical gift donors to potential recipients.

(e) "Disability" has the meaning given in section 363A.03, subdivision 12.

(f) "Organ transplant" means the transplantation or infusion of a part of a human body into the body of another for the purpose of treating or curing a medical condition.

(g) "Qualified individual" means an individual who, with or without available support networks, the provision of auxiliary aids and services, or reasonable modifications to policies or practices, meets the essential eligibility requirements for the receipt of an anatomical gift.

(h) "Reasonable modifications" include, but are not limited to:

(1) communication with individuals responsible for supporting an individual with postsurgical and post-transplantation care, including medication; and

(2) consideration of support networks available to the individual, including family, friends, and home and community-based services, including home and community-based services funded through Medicaid, Medicare, another health plan in which the individual is enrolled, or any program or source of funding available to the individual, in determining whether the individual is able to comply with post-transplant medical requirements.

(i) "Supported decision making" has the meaning given in section 524.5-102, subdivision 16a.

Subd. 2. **Prohibition of discrimination.** (a) A covered entity may not, on the basis of a qualified individual's race, ethnicity, mental disability, or physical disability:

(1) deem an individual ineligible to receive an anatomical gift or organ transplant;

(2) deny medical or related organ transplantation services, including evaluation, surgery, counseling, and postoperative treatment and care;

(3) refuse to refer the individual to a transplant center or other related specialist for the purpose of evaluation or receipt of an anatomical gift or organ transplant;

(4) refuse to place an individual on an organ transplant waiting list or place the individual at a lower-priority position on the list than the position at which the individual would have been placed if not for the individual's race, ethnicity, or disability; or

(5) decline insurance coverage for any procedure associated with the receipt of the anatomical gift or organ transplant, including post-transplantation and postinfusion care.

(b) Notwithstanding paragraph (a), a covered entity may take an individual's disability into account when making treatment or coverage recommendations or decisions, solely to the extent that the physical or mental disability has been found by a physician, following an individualized evaluation of the potential recipient to be medically significant to the provision of the anatomical gift or organ transplant. The provisions of this section may not be deemed to require referrals or recommendations for, or the performance of, organ transplants that are not medically appropriate given the individual's overall health condition.

(c) If an individual has the necessary support system to assist the individual in complying with post-transplant medical requirements, an individual's inability to independently comply with those requirements may not be deemed to be medically significant for the purposes of paragraph (b).

(d) A covered entity must make reasonable modifications to policies, practices, or procedures, when such modifications are necessary to make services such as transplantation-related counseling, information, coverage, or treatment available to qualified individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such services.

(e) A covered entity must take such steps as may be necessary to ensure that no qualified individual with a disability is denied services such as transplantation-related counseling, information, coverage, or treatment because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the services being offered or result in an undue burden. A covered entity is not required to provide supported decision-making services.

(f) A covered entity must otherwise comply with the requirements of Titles II and III of the Americans with Disabilities Act of 1990, the Americans with Disabilities Act Amendments Act of 2008, and the Minnesota Human Rights Act.

(g) The provisions of this section apply to each part of the organ transplant process.

Subd. 3. **Remedies.** In addition to all other remedies available under this chapter, any individual who has been subjected to discrimination in violation of this section may initiate a civil action in a court of competent jurisdiction to enjoin violations of this section.

Sec. 12. **INITIAL MEMBERS AND FIRST MEETING; MINNESOTA RARE DISEASE ADVISORY COUNCIL.**

Public members serving on the University of Minnesota's Advisory Council on Rare Diseases on June 30, 2022, are the initial public members of the Minnesota Rare Disease Advisory Council. The terms of the members begin on July 1, 2022. The governor must designate six members to serve a two-year term; six members to serve a three-year term; and five members to serve a four-year term. The governor may appoint additional members under Minnesota Statutes, section 137.68, subdivision 2, paragraph (b), clause (13), and must set their terms so that roughly one-third of the members' terms expire after two years, one-third after three years, and one-third after four years. Legislative members of the University of Minnesota's Advisory Council on Rare Disease serve on the Minnesota Rare Disease Advisory Council until appointing authorities appoint successors. The person serving as chair of the executive subcommittee of the University of Minnesota's Advisory Council on Rare Diseases shall convene the first meeting of the Minnesota Rare Disease Advisory Council by September 1, 2022.

Sec. 13. **APPROPRIATIONS.**

In accordance with Minnesota Statutes, section 15.039, subdivision 6, the unexpended balance of money appropriated from the general fund to the Board of Regents of the University of Minnesota for purposes of the advisory council on rare diseases under Minnesota Statutes, section 137.68, shall be under the control of the Minnesota Rare Disease Advisory Council and the Council on Disability.

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

Sec. 14. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber as Minnesota Statutes, section 256.4835, the Minnesota Rare Disease Advisory Council that is currently coded as Minnesota Statutes, section 137.68. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

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

ARTICLE 14
MANDATED REPORTS

Section 1. Minnesota Statutes 2020, section 62J.692, subdivision 5, is amended to read:

Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must sign and submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible training site. If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(b) The reports must provide verification of the distribution of the funds and must include:

(1) the total number of eligible trainee FTEs in each clinical medical education program;

(2) the name of each funded program and, for each program, the dollar amount distributed to each training site and a training site expenditure report;

(3) documentation of any discrepancies between the initial grant distribution notice included in the commissioner's approval letter and the actual distribution;

(4) a statement by the sponsoring institution stating that the completed grant verification report is valid and accurate; and

(5) other information the commissioner deems appropriate to evaluate the effectiveness of the use of funds for medical education.

(c) Each year, the commissioner shall provide an annual summary report to the legislature on the implementation of this section. This report is exempt from section 144.05, subdivision 7.

Sec. 2. Minnesota Statutes 2020, section 62Q.37, subdivision 7, is amended to read:

Subd. 7. **Human services.** ~~(a)~~ The commissioner of human services shall implement this section in a manner that is consistent with applicable federal laws and regulations and that avoids the duplication of review activities performed by a nationally recognized independent organization.

~~(b) By December 31 of each year, the commissioner shall submit to the legislature a written report identifying the number of audits performed by a nationally recognized~~

~~independent organization that were accepted, partially accepted, or rejected by the commissioner under this section. The commissioner shall provide the rationale for partial acceptance or rejection. If the rationale for the partial acceptance or rejection was based on the commissioner's determination that the standards used in the audit were not equivalent to state law, regulation, or contract requirement, the report must document the variances between the audit standards and the applicable state requirements.~~

Sec. 3. Minnesota Statutes 2020, section 144.193, is amended to read:

144.193 INVENTORY OF BIOLOGICAL AND HEALTH DATA.

By February 1, 2014, and annually after that date, the commissioner shall prepare an inventory of biological specimens, registries, and health data and databases collected or maintained by the commissioner. In addition to the inventory, the commissioner shall provide the schedules for storage of health data and biological specimens. The inventories must be listed in reverse chronological order beginning with the year 2012. The commissioner shall make the inventory and schedules available on the department's website ~~and submit the inventory and schedules to the chairs and ranking minority members of the committees of the legislature with jurisdiction over health policy and data practices issues~~.

Sec. 4. Minnesota Statutes 2020, section 144.4199, subdivision 8, is amended to read:

Subd. 8. **Report.** By January 15 of each year, the commissioner shall submit a report to the chairs and ranking minority members of the house of representatives Ways and Means Committee, the senate Finance Committee, and the house of representatives and senate committees with jurisdiction over health and human services finance, detailing expenditures made in the previous calendar year from the public health response contingency account. This report is exempt from section 144.05, subdivision 7.

Sec. 5. Minnesota Statutes 2020, section 144A.10, subdivision 17, is amended to read:

Subd. 17. **Agency quality improvement program; annual report on survey process.** (a) The commissioner shall establish a quality improvement program for the nursing facility survey and complaint processes. The commissioner must regularly consult with consumers, consumer advocates, and representatives of the nursing home industry and representatives of nursing home employees in implementing the program. The commissioner, through the quality improvement program, shall submit to the legislature an annual survey and certification quality improvement report, beginning December 15, 2004, and each December 15 thereafter. This report is exempt from section 144.05, subdivision 7.

(b) The report must include, but is not limited to, an analysis of:

(1) the number, scope, and severity of citations by region within the state;

(2) cross-referencing of citations by region within the state and between states within the Centers for Medicare and Medicaid Services region in which Minnesota is located;

(3) the number and outcomes of independent dispute resolutions;

(4) the number and outcomes of appeals;

(5) compliance with timelines for survey revisits and complaint investigations;

(6) techniques of surveyors in investigations, communication, and documentation to identify and support citations;

(7) compliance with timelines for providing facilities with completed statements of deficiencies; and

(8) other survey statistics relevant to improving the survey process.

(c) The report must also identify and explain inconsistencies and patterns across regions of the state; include analyses and recommendations for quality improvement areas identified by the commissioner, consumers, consumer advocates, and representatives of the nursing home industry and nursing home employees; and provide action plans to address problems that are identified.

Sec. 6. Minnesota Statutes 2020, section 144A.351, subdivision 1, is amended to read:

Subdivision 1. **Report requirements.** (a) The commissioners of health and human services, with the cooperation of counties and in consultation with stakeholders, including persons who need or are using long-term care services and supports, lead agencies, regional entities, senior, disability, and mental health organization representatives, service providers, and community members shall ~~prepare a report to the legislature by August 15, 2013, and biennially thereafter,~~ compile data regarding the status of the full range of long-term care services and supports for the elderly and children and adults with disabilities and mental illnesses in Minnesota. ~~Any amounts appropriated for this report are available in either year of the biennium.~~ The ~~report shall address~~ compiled data shall include:

(1) demographics and need for long-term care services and supports in Minnesota;

(2) summary of county and regional reports on long-term care gaps, surpluses, imbalances, and corrective action plans;

(3) status of long-term care services and related mental health services, housing options, and supports by county and region including:

(i) changes in availability of the range of long-term care services and housing options;

(ii) access problems, including access to the least restrictive and most integrated services and settings, regarding long-term care services; and

(iii) comparative measures of long-term care services availability, including serving people in their home areas near family, and changes over time; and

(4) recommendations regarding goals for the future of long-term care services and supports, policy and fiscal changes, and resource development and transition needs.

(b) The commissioners of health and human services shall make the compiled data available on at least one of the department's websites.

Sec. 7. Minnesota Statutes 2020, section 144A.483, subdivision 1, is amended to read:

Subdivision 1. **Annual legislative report on home care licensing.** The commissioner shall establish a quality improvement program for the home care survey and home care complaint investigation processes. The commissioner shall submit to the legislature an annual report, beginning October 1, 2015, and each October 1 thereafter, until October 1, 2027. Each report will review the previous state fiscal year of home care licensing and regulatory activities. The report must include, but is not limited to, an analysis of:

(1) the number of FTEs in the Division of Compliance Monitoring, including the Office of Health Facility Complaints units assigned to home care licensing, survey, investigation, and enforcement process;

(2) numbers of and descriptive information about licenses issued, complaints received and investigated, including allegations made and correction orders issued, surveys completed and timelines, and correction order reconsiderations and results;

(3) descriptions of emerging trends in home care provision and areas of concern identified by the department in its regulation of home care providers;

(4) information and data regarding performance improvement projects underway and planned by the commissioner in the area of home care surveys; and

(5) work of the Department of Health Home Care Advisory Council.

Sec. 8. Minnesota Statutes 2020, section 145.4134, is amended to read:

145.4134 COMMISSIONER'S PUBLIC REPORT.

(a) By July 1 of each year, except for 1998 and 1999 information, the commissioner shall issue a public report providing statistics for the previous calendar year compiled from the data submitted under sections 145.4131 to 145.4133 and sections 145.4241 to 145.4249. For 1998 and 1999 information, the report shall be issued October 1, 2000. Each report shall provide the statistics for all previous calendar years, adjusted to reflect any additional information from late or corrected reports. The commissioner shall ensure that none of the information included in the public reports can reasonably lead to identification of an individual having performed or having had an abortion. All data included on the forms under sections 145.4131 to 145.4133 and sections 145.4241 to 145.4249 must be included in the public report, except that the commissioner shall maintain as confidential, data which alone or in combination may constitute information from which an individual having performed or having had an abortion may be identified using epidemiologic principles. ~~The commissioner shall submit the report to the senate Health and Family Security Committee and the house of representatives Health and Human Services Committee.~~

(b) The commissioner may, by rules adopted under chapter 14, alter the submission dates established under sections 145.4131 to 145.4133 for administrative convenience, fiscal savings, or other valid reason, provided that physicians or facilities and the commissioner of human services submit the required information once each year and the commissioner issues a report once each year.

Sec. 9. Minnesota Statutes 2020, section 145.928, subdivision 13, is amended to read:

Subd. 13. **Reports.** (a) The commissioner shall submit a biennial report to the legislature on the local community projects, tribal government, and community health board prevention activities funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. These reports are due by January 15 of every other year, beginning in the year 2003.

(b) The commissioner shall release an annual report to the public ~~and submit the annual report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over public health~~ on grants made under subdivision 7 to decrease racial and ethnic disparities in infant mortality rates. The report must provide specific information on the amount of each grant awarded to each agency or organization, an itemized list submitted to the commissioner by each agency or organization awarded a

grant specifying all uses of grant funds and the amount expended for each use, the population served by each agency or organization, outcomes of the programs funded by each grant, and the amount of the appropriation retained by the commissioner for administrative and associated expenses. The commissioner shall issue a report each January 15 for the previous fiscal year beginning January 15, 2016.

Sec. 10. Minnesota Statutes 2020, section 245.4661, subdivision 10, is amended to read:

Subd. 10. **Commissioner duty to report on use of grant funds biennially.** (a) By November 1, 2016, and biennially thereafter, the commissioner of human services shall provide sufficient information to the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under this section of law. The commissioner shall provide, at a minimum, the following information:

(1) the amount of funding to mental health initiatives, what programs and services were funded in the previous two years, gaps in services that each initiative brought to the attention of the commissioner, and outcome data for the programs and services that were funded; and

(2) the amount of funding for other targeted services and the location of services.

(b) This subdivision expires January 1, 2032.

Sec. 11. Minnesota Statutes 2020, section 245.4889, subdivision 3, is amended to read:

Subd. 3. **Commissioner duty to report on use of grant funds biennially.** (a) By November 1, 2016, and biennially thereafter, the commissioner of human services shall provide sufficient information to the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under this section. The commissioner shall provide, at a minimum, the following information:

(1) the amount of funding for children's mental health grants, what programs and services were funded in the previous two years, and outcome data for the programs and services that were funded; and

(2) the amount of funding for other targeted services and the location of services.

(b) This subdivision expires January 1, 2032.

Sec. 12. Minnesota Statutes 2021 Supplement, 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 family child foster care home or family adult foster care home 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 where at least 80 percent of the residents are 55 years of age or older;

(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;

(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~~ data 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.

Sec. 13. Minnesota Statutes 2020, section 256.01, subdivision 29, is amended to read:

Subd. 29. **State medical review team.** (a) To ensure the timely processing of determinations of disability by the commissioner's state medical review team under sections

256B.055, subdivisions 7, paragraph (b), and 12, and 256B.057, subdivision 9, the commissioner shall review all medical evidence and seek information from providers, applicants, and enrollees to support the determination of disability where necessary. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

(b) Prior to a denial or withdrawal of a requested determination of disability due to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is necessary and appropriate to a determination of disability, and (2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

~~(c) The commissioner shall provide the chairs of the legislative committees with jurisdiction over health and human services finance and budget the following information on the activities of the state medical review team by February 1 of each year:~~

~~(1) the number of applications to the state medical review team that were denied, approved, or withdrawn;~~

~~(2) the average length of time from receipt of the application to a decision;~~

~~(3) the number of appeals, appeal results, and the length of time taken from the date the person involved requested an appeal for a written decision to be made on each appeal;~~

~~(4) for applicants, their age, health coverage at the time of application, hospitalization history within three months of application, and whether an application for Social Security or Supplemental Security Income benefits is pending; and~~

~~(5) specific information on the medical certification, licensure, or other credentials of the person or persons performing the medical review determinations and length of time in that position.~~

~~(d)~~ (c) Any appeal made under section 256.045, subdivision 3, of a disability determination made by the state medical review team must be decided according to the timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be immediately reviewed by the chief human services judge.

Sec. 14. Minnesota Statutes 2020, section 256.021, subdivision 3, is amended to read:

Subd. 3. **Report.** (a) By January 15 of each year, the panel shall submit a report to the committees of the legislature with jurisdiction over section 626.557 regarding the number

of requests for review it receives under this section, the number of cases where the panel requires the lead investigative agency to reconsider its final disposition, and the number of cases where the final disposition is changed, and any recommendations to improve the review or investigative process.

(b) This subdivision expires January 1, 2024.

Sec. 15. Minnesota Statutes 2021 Supplement, section 256.042, subdivision 4, as amended by Laws 2022, chapter 53, section 5, 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 calendar year to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by December 1 of each year, beginning ~~March 1, 2020~~ December 1, 2022. This paragraph expires upon the expiration of the advisory council.

(b) 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. The advisory council shall determine grant awards and funding amounts based on the funds appropriated to the commissioner under section 256.043, subdivision 3, paragraph (h), and subdivision 3a, paragraph (d). The commissioner shall award the grants from the opiate epidemic response fund and administer the grants in compliance with section 16B.97. No more than ten percent of the grant amount may be used by a grantee for administration.

Sec. 16. Minnesota Statutes 2020, section 256.042, subdivision 5, as amended by Laws 2022, chapter 53, section 6, is amended to read:

Subd. 5. **Reports.** (a) The advisory council shall report annually to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 31 of each year. The report shall include information about the individual projects that receive grants, the municipality projects funded by direct payments received as part of a statewide opioid settlement agreement, and the overall role of the project in addressing the opioid addiction and overdose epidemic in Minnesota. The report must describe the grantees and municipalities and the activities implemented, along with measurable outcomes as determined by the council in consultation with the commissioner of human services and the commissioner of management and budget. At a minimum, the report must include information about the number of individuals who received

information or treatment, the outcomes the individuals achieved, and demographic information about the individuals participating in the project; an assessment of the progress toward achieving statewide access to qualified providers and comprehensive treatment and recovery services; and an update on the evaluations implemented by the commissioner of management and budget for the promising practices and theory-based projects that receive funding.

(b) The commissioner of management and budget, in consultation with the Opiate Epidemic Response Advisory Council, shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance when an evaluation study described in subdivision 1, paragraph (c), is complete on the promising practices or theory-based projects that are selected for evaluation activities. The report shall include demographic information; outcome information for the individuals in the program; the results for the program in promoting recovery, employment, family reunification, and reducing involvement with the criminal justice system; and other relevant outcomes determined by the commissioner of management and budget that are specific to the projects that are evaluated. The report shall include information about the ability of grant programs to be scaled to achieve the statewide results that the grant project demonstrated.

(c) The advisory council, in its annual report to the legislature under paragraph (a) due by January 31, 2024, shall include recommendations on whether the appropriations to the specified entities under Laws 2019, chapter 63, should be continued, adjusted, or discontinued; whether funding should be appropriated for other purposes related to opioid abuse prevention, education, and treatment; and on the appropriate level of funding for existing and new uses.

(d) Municipalities receiving direct payments from a statewide opioid settlement agreement must report annually to the commissioner of human services on how the payments were used on opioid remediation. The report must be submitted in a format prescribed by the commissioner. The report must include data and measurable outcomes on expenditures funded with direct payments from a statewide opioid settlement agreement, including details on services listed in the categories of approved uses, as identified in agreements between the state of Minnesota, the Association of Minnesota Counties, and the League of Minnesota Cities. Reporting requirements must include, at a minimum:

(1) contact information;

(2) information on funded services and programs; and

(3) target populations for each funded service and program.

(e) In reporting data and outcomes under paragraph (d), municipalities must include, to the extent feasible, information on the use of evidence-based and culturally relevant services.

(f) For municipal projects using $25,000 or more of statewide opioid settlement agreement payments in a calendar year, municipalities must also include in the report required under paragraph (d):

(1) a brief qualitative description of successes or challenges; and

(2) results using process and quality measures.

(g) This subdivision expires upon the expiration of the advisory council.

Sec. 17. Minnesota Statutes 2020, section 256.9657, subdivision 8, is amended to read:

Subd. 8. **Commissioner's duties.** (a) Beginning October 1, 2023, the commissioner of human services shall annually report to the ~~legislature quarterly on the first day of January, April, July, and October~~ chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance regarding the provider surcharge program. The report shall include information on total billings, total collections, and administrative expenditures for the previous fiscal year. ~~The report on January 1, 1993, shall include information on all surcharge billings, collections, federal matching payments received, efforts to collect unpaid amounts, and administrative costs pertaining to the surcharge program in effect from July 1, 1991, to September 30, 1992~~ This paragraph expires January 1, 2032.

(b) The surcharge shall be adjusted by inflationary and caseload changes in future bienniums to maintain reimbursement of health care providers in accordance with the requirements of the state and federal laws governing the medical assistance program, including the requirements of the Medicaid moratorium amendments of 1991 found in Public Law No. 102-234.

(c) The commissioner shall request the Minnesota congressional delegation to support a change in federal law that would prohibit federal disallowances for any state that makes a good faith effort to comply with Public Law 102-234 by enacting conforming legislation prior to the issuance of federal implementing regulations.

Sec. 18. Minnesota Statutes 2020, section 256.975, subdivision 11, is amended to read:

Subd. 11. **Regional and local dementia grants.** (a) The Minnesota Board on Aging shall award competitive grants to eligible applicants for regional and local projects and initiatives targeted to a designated community, which may consist of a specific geographic area or population, to increase awareness of Alzheimer's disease and other dementias, increase the rate of cognitive testing in the population at risk for dementias, promote the benefits of early diagnosis of dementias, or connect caregivers of persons with dementia to education and resources.

(b) The project areas for grants include:

(1) local or community-based initiatives to promote the benefits of physician or advanced practice registered nurse consultations for all individuals who suspect a memory or cognitive problem;

(2) local or community-based initiatives to promote the benefits of early diagnosis of Alzheimer's disease and other dementias; and

(3) local or community-based initiatives to provide informational materials and other resources to caregivers of persons with dementia.

(c) Eligible applicants for local and regional grants may include, but are not limited to, community health boards, school districts, colleges and universities, community clinics, tribal communities, nonprofit organizations, and other health care organizations.

(d) Applicants must:

(1) describe the proposed initiative, including the targeted community and how the initiative meets the requirements of this subdivision; and

(2) identify the proposed outcomes of the initiative and the evaluation process to be used to measure these outcomes.

(e) In awarding the regional and local dementia grants, the Minnesota Board on Aging must give priority to applicants who demonstrate that the proposed project:

(1) is supported by and appropriately targeted to the community the applicant serves;

(2) is designed to coordinate with other community activities related to other health initiatives, particularly those initiatives targeted at the elderly;

(3) is conducted by an applicant able to demonstrate expertise in the project areas;

(4) utilizes and enhances existing activities and resources or involves innovative approaches to achieve success in the project areas; and

(5) strengthens community relationships and partnerships in order to achieve the project areas.

(f) The board shall divide the state into specific geographic regions and allocate a percentage of the money available for the local and regional dementia grants to projects or initiatives aimed at each geographic region.

(g) The board shall award any available grants by January 1, 2016, and each July 1 thereafter.

(h) Each grant recipient shall report to the board on the progress of the initiative at least once during the grant period, and within two months of the end of the grant period shall submit a final report to the board that includes the outcome results.

(i) The Minnesota Board on Aging shall~~:~~

~~(1)~~ develop the criteria and procedures to allocate the grants under this subdivision, evaluate all applicants on a competitive basis and award the grants, and select qualified providers to offer technical assistance to grant applicants and grantees. The selected provider shall provide applicants and grantees assistance with project design, evaluation methods, materials, and training~~; and~~.

~~(2) submit by January 15, 2017, and on each January 15 thereafter, a progress report on the dementia grants programs under this subdivision to the chairs and ranking minority members of the senate and house of representatives committees and divisions with jurisdiction over health finance and policy. The report shall include:~~

~~(i) information on each grant recipient;~~

~~(ii) a summary of all projects or initiatives undertaken with each grant;~~

~~(iii) the measurable outcomes established by each grantee, an explanation of the evaluation process used to determine whether the outcomes were met, and the results of the evaluation; and~~

~~(iv) an accounting of how the grant funds were spent.~~

Sec. 19. Minnesota Statutes 2020, section 256.975, subdivision 12, is amended to read:

Subd. 12. **Self-directed caregiver grants.** The Minnesota Board on Aging shall, in consultation with area agencies on aging and other community caregiver stakeholders,

administer self-directed caregiver grants to support at-risk family caregivers of older adults or others eligible under the Older Americans Act of 1965, United States Code, title 42, chapter 35, sections 3001 to 3058ff, to sustain family caregivers in the caregivers' roles so older adults can remain at home longer. ~~The board shall submit by January 15, 2022, and each January 15 thereafter, a progress report on the self-directed caregiver grants program to the chairs and ranking minority members of the senate and house of representatives committees and divisions with jurisdiction over human services. The progress report must include metrics on the use of the grant program.~~

Sec. 20. Minnesota Statutes 2020, section 256B.0561, subdivision 4, is amended to read:

Subd. 4. **Report.** (a) By September 1, 2019, and each September 1 thereafter, the commissioner shall submit a report to the chairs and ranking minority members of the house and senate committees with jurisdiction over human services finance that includes the number of cases affected by periodic data matching under this section, the number of recipients identified as possibly ineligible as a result of a periodic data match, and the number of recipients whose eligibility was terminated as a result of a periodic data match. The report must also specify, for recipients whose eligibility was terminated, how many cases were closed due to failure to cooperate.

(b) This subdivision expires January 1, 2027.

Sec. 21. Minnesota Statutes 2020, section 256B.0911, subdivision 5, is amended to read:

Subd. 5. **Administrative activity.** (a) The commissioner shall streamline the processes, including timelines for when assessments need to be completed, required to provide the services in this section and shall implement integrated solutions to automate the business processes to the extent necessary for community support plan approval, reimbursement, program planning, evaluation, and policy development.

(b) The commissioner of human services shall work with lead agencies responsible for conducting long-term consultation services to modify the MnCHOICES application and assessment policies to create efficiencies while ensuring federal compliance with medical assistance and long-term services and supports eligibility criteria.

(c) The commissioner shall work with lead agencies responsible for conducting long-term consultation services to develop a set of measurable benchmarks sufficient to demonstrate quarterly improvement in the average time per assessment and other mutually agreed upon measures of increasing efficiency. The commissioner shall collect data on these benchmarks and provide to the lead agencies ~~and the chairs and ranking minority members of the~~

~~legislative committees with jurisdiction over human services~~ an annual trend analysis of the data in order to demonstrate the commissioner's compliance with the requirements of this subdivision.

Sec. 22. Minnesota Statutes 2020, section 256B.0949, subdivision 17, is amended to read:

Subd. 17. **Provider shortage; authority for exceptions.** (a) In consultation with the Early Intensive Developmental and Behavioral Intervention Advisory Council and stakeholders, including agencies, professionals, parents of people with ASD or a related condition, and advocacy organizations, the commissioner shall determine if a shortage of EIDBI providers exists. For the purposes of this subdivision, "shortage of EIDBI providers" means a lack of availability of providers who meet the EIDBI provider qualification requirements under subdivision 15 that results in the delay of access to timely services under this section, or that significantly impairs the ability of a provider agency to have sufficient providers to meet the requirements of this section. The commissioner shall consider geographic factors when determining the prevalence of a shortage. The commissioner may determine that a shortage exists only in a specific region of the state, multiple regions of the state, or statewide. The commissioner shall also consider the availability of various types of treatment modalities covered under this section.

(b) The commissioner, in consultation with the Early Intensive Developmental and Behavioral Intervention Advisory Council and stakeholders, must establish processes and criteria for granting an exception under this paragraph. The commissioner may grant an exception only if the exception would not compromise a person's safety and not diminish the effectiveness of the treatment. The commissioner may establish an expiration date for an exception granted under this paragraph. The commissioner may grant an exception for the following:

(1) EIDBI provider qualifications under this section;

(2) medical assistance provider enrollment requirements under section 256B.04, subdivision 21; or

(3) EIDBI provider or agency standards or requirements.

(c) If the commissioner, in consultation with the Early Intensive Developmental and Behavioral Intervention Advisory Council and stakeholders, determines that a shortage no longer exists, the commissioner must submit a notice that a shortage no longer exists to the chairs and ranking minority members of the senate and the house of representatives committees with jurisdiction over health and human services. The commissioner must post

the notice for public comment for 30 days. The commissioner shall consider public comments before submitting to the legislature a request to end the shortage declaration. ~~The commissioner shall annually provide an update on the status of the provider shortage and exceptions granted to the chairs and ranking minority members of the senate and house of representatives committees with jurisdiction over health and human services.~~ The commissioner shall not declare the shortage of EIDBI providers ended without direction from the legislature to declare it ended.

Sec. 23. Minnesota Statutes 2020, section 256B.493, subdivision 2, is amended to read:

Subd. 2. **Planned closure process needs determination.** A resource need determination process, managed at the state level, using available ~~reports~~ data required by section 144A.351 and other data and information shall be used by the commissioner to align capacity where needed.

Sec. 24. Minnesota Statutes 2020, section 256B.69, subdivision 9d, is amended to read:

Subd. 9d. **Financial and quality assurance audits.** (a) The commissioner shall require, in the request for bids and resulting contracts with managed care plans and county-based purchasing plans under this section and section 256B.692, that each managed care plan and county-based purchasing plan submit to and fully cooperate with the independent third-party financial audits by the legislative auditor under subdivision 9e of the information required under subdivision 9c, paragraph (b). Each contract with a managed care plan or county-based purchasing plan under this section or section 256B.692 must provide the commissioner, the legislative auditor, and vendors contracting with the legislative auditor, access to all data required to complete audits under subdivision 9e.

(b) Each managed care plan and county-based purchasing plan providing services under this section shall provide to the commissioner biweekly encounter data and claims data for state public health care programs and shall participate in a quality assurance program that verifies the timeliness, completeness, accuracy, and consistency of the data provided. The commissioner shall develop written protocols for the quality assurance program and shall make the protocols publicly available. The commissioner shall contract for an independent third-party audit to evaluate the quality assurance protocols as to the capacity of the protocols to ensure complete and accurate data and to evaluate the commissioner's implementation of the protocols.

(c) Upon completion of the evaluation under paragraph (b), the commissioner shall provide copies of the report to the legislative auditor ~~and the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and financing~~.

(d) Any actuary under contract with the commissioner to provide actuarial services must meet the independence requirements under the professional code for fellows in the Society of Actuaries and must not have provided actuarial services to a managed care plan or county-based purchasing plan that is under contract with the commissioner pursuant to this section and section 256B.692 during the period in which the actuarial services are being provided. An actuary or actuarial firm meeting the requirements of this paragraph must certify and attest to the rates paid to the managed care plans and county-based purchasing plans under this section and section 256B.692, and the certification and attestation must be auditable.

(e) The commissioner, to the extent of available funding, shall conduct ad hoc audits of state public health care program administrative and medical expenses reported by managed care plans and county-based purchasing plans. This includes: financial and encounter data reported to the commissioner under subdivision 9c, including payments to providers and subcontractors; supporting documentation for expenditures; categorization of administrative and medical expenses; and allocation methods used to attribute administrative expenses to state public health care programs. These audits also must monitor compliance with data and financial report certification requirements established by the commissioner for the purposes of managed care capitation payment rate-setting. The managed care plans and county-based purchasing plans shall fully cooperate with the audits in this subdivision.

~~The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2016, and each February 1 thereafter, the number of ad hoc audits conducted in the past calendar year and the results of these audits.~~

(f) Nothing in this subdivision shall allow the release of information that is nonpublic data pursuant to section 13.02.

Sec. 25. Minnesota Statutes 2020, section 256E.28, subdivision 6, is amended to read:

Subd. 6. **Evaluation.** (a) Using the outcomes established according to subdivision 3, the commissioner shall conduct a biennial evaluation of the grant program funded under this section. Grant recipients shall cooperate with the commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation.

(b) The commissioner shall consult with the legislative task force on child protection during the evaluation process ~~and~~.

(c) The commissioner shall submit a biennial evaluation report to the task force and to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over child protection funding. This paragraph expires January 1, 2032.

Sec. 26. Minnesota Statutes 2020, section 256R.18, is amended to read:

256R.18 REPORT BY COMMISSIONER OF HUMAN SERVICES.

(a) Beginning January 1, 2019, the commissioner shall provide to the house of representatives and senate committees with jurisdiction over nursing facility payment rates a biennial report on the effectiveness of the reimbursement system in improving quality, restraining costs, and any other features of the system as determined by the commissioner.

(b) This section expires January 1, 2026.

Sec. 27. Minnesota Statutes 2020, section 257.0725, is amended to read:

257.0725 ANNUAL REPORT.

(a) The commissioner of human services shall publish an annual report on child maltreatment and on children in out-of-home placement. The commissioner shall confer with counties, child welfare organizations, child advocacy organizations, the courts, and other groups on how to improve the content and utility of the department's annual report. In regard to child maltreatment, the report shall include the number and kinds of maltreatment reports received and any other data that the commissioner determines is appropriate to include in a report on child maltreatment. In regard to children in out-of-home placement, the report shall include, by county and statewide, information on legal status, living arrangement, age, sex, race, accumulated length of time in placement, reason for most recent placement, race of family with whom placed, school enrollments within seven days of placement pursuant to section 120A.21, and other information deemed appropriate on all children in out-of-home placement. Out-of-home placement includes placement in any facility by an authorized child-placing agency.

(b) This section expires January 1, 2032.

Sec. 28. Minnesota Statutes 2020, section 260.775, is amended to read:

260.775 PLACEMENT RECORDS.

(a) The commissioner of human services shall publish annually an inventory of all Indian children in residential facilities. The inventory shall include, by county and statewide, information on legal status, living arrangement, age, sex, tribe in which the child is a member or eligible for membership, accumulated length of time in foster care, and other demographic information deemed appropriate concerning all Indian children in residential facilities. The report must also state the extent to which authorized child-placing agencies comply with the order of preference described in United States Code, title 25, section 1901, et seq. The commissioner shall include the information required under this paragraph in the annual report on child maltreatment and on children in out-of-home placement under section 257.0725.

(b) This section expires January 1, 2032.

Sec. 29. Minnesota Statutes 2020, section 260E.24, subdivision 6, is amended to read:

Subd. 6. **Required referral to early intervention services.** (a) A child under age three who is involved in a substantiated case of maltreatment shall be referred for screening under the Individuals with Disabilities Education Act, part C. Parents must be informed that the evaluation and acceptance of services are voluntary. The commissioner of human services shall monitor referral rates by county ~~and annually report the information to the legislature~~. Refusal to have a child screened is not a basis for a child in need of protection or services petition under chapter 260C.

(b) The commissioner of human services shall include the referral rates by county for screening under the Individuals with Disabilities Education Act, part C in the annual report on child maltreatment under section 257.0725. This paragraph expires January 1, 2032.

Sec. 30. Minnesota Statutes 2020, section 260E.38, subdivision 3, is amended to read:

Subd. 3. **Report required.** (a) The commissioner shall produce an annual report of the summary results of the reviews. The report must only contain aggregate data and may not include any data that could be used to personally identify any subject whose data is included in the report. The report is public information and must be provided to the chairs and ranking minority members of the legislative committees having jurisdiction over child protection issues. The commissioner shall include the information required under this paragraph in the

annual report on child maltreatment and on children in out-of-home placement under section 257.0725.

(b) This subdivision expires January 1, 2032.

Sec. 31. Minnesota Statutes 2020, section 518A.77, is amended to read:

518A.77 GUIDELINES REVIEW.

(a) No later than 2006 and every four years after that, the Department of Human Services must conduct a review of the child support guidelines.

(b) This section expires January 1, 2032.

Sec. 32. Minnesota Statutes 2020, section 626.557, subdivision 12b, is amended to read:

Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a lead investigative agency, the county social service agency shall maintain appropriate records. Data collected by the county social service agency under this section are welfare data under section 13.46. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph (c).

Data maintained by the common entry point are confidential data on individuals or protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the common entry point shall maintain data for three calendar years after date of receipt and then destroy the data unless otherwise directed by federal requirements.

(b) The commissioners of health and human services shall prepare an investigation memorandum for each report alleging maltreatment investigated under this section. County social service agencies must maintain private data on individuals but are not required to prepare an investigation memorandum. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02. Upon completion of the investigation, the data are classified as provided in clauses (1) to (3) and paragraph (c).

(1) The investigation memorandum must contain the following data, which are public:

(i) the name of the facility investigated;

(ii) a statement of the nature of the alleged maltreatment;

(iii) pertinent information obtained from medical or other records reviewed;

(iv) the identity of the investigator;

(v) a summary of the investigation's findings;

(vi) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;

(vii) a statement of any action taken by the facility;

(viii) a statement of any action taken by the lead investigative agency; and

(ix) when a lead investigative agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.

The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data listed in clause (2).

(2) Data on individuals collected and maintained in the investigation memorandum are private data, including:

(i) the name of the vulnerable adult;

(ii) the identity of the individual alleged to be the perpetrator;

(iii) the identity of the individual substantiated as the perpetrator; and

(iv) the identity of all individuals interviewed as part of the investigation.

(3) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.

(c) After the assessment or investigation is completed, the name of the reporter must be confidential. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.

(d) Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services must be maintained under the following schedule and then destroyed unless otherwise directed by federal requirements:

(1) data from reports determined to be false, maintained for three years after the finding was made;

(2) data from reports determined to be inconclusive, maintained for four years after the finding was made;

(3) data from reports determined to be substantiated, maintained for seven years after the finding was made; and

(4) data from reports which were not investigated by a lead investigative agency and for which there is no final disposition, maintained for three years from the date of the report.

(e) The commissioners of health and human services shall annually publish on their websites the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations.

~~On a biennial basis, the commissioners of health and human services shall jointly report the following information to the legislature and the governor:~~

~~(1) the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigations under this section, the resolution of those investigations, and which of the two lead agencies was responsible;~~

~~(2) trends about types of substantiated maltreatment found in the reporting period;~~

~~(3) if there are upward trends for types of maltreatment substantiated, recommendations for addressing and responding to them;~~

~~(4) efforts undertaken or recommended to improve the protection of vulnerable adults;~~

~~(5) whether and where backlogs of cases result in a failure to conform with statutory time frames and recommendations for reducing backlogs if applicable;~~

~~(6) recommended changes to statutes affecting the protection of vulnerable adults; and~~

~~(7) any other information that is relevant to the report trends and findings.~~

(f) Each lead investigative agency must have a record retention policy.

(g) Lead investigative agencies, prosecuting authorities, and law enforcement agencies may exchange not public data, as defined in section 13.02, if the agency or authority

requesting the data determines that the data are pertinent and necessary to the requesting agency in initiating, furthering, or completing an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, and licensing agencies investigating the alleged maltreatment under this section. The lead investigative agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section. Notwithstanding section 138.17, upon completion of the review, not public data received by the review panel must be destroyed.

(h) Each lead investigative agency shall keep records of the length of time it takes to complete its investigations.

(i) A lead investigative agency may notify other affected parties and their authorized representative if the lead investigative agency has reason to believe maltreatment has occurred and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

(j) Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead investigative agency may not provide any notice unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

Sec. 33. **REPEALER.**

(a) Minnesota Statutes 2020, sections 62U.10, subdivision 3; 144.1911, subdivision 10; 144.564, subdivision 3; 144A.483, subdivision 2; 245.981; 246.131; 246B.03, subdivision 2; 246B.035; 256.01, subdivision 31; and 256B.0638, subdivision 7, are repealed.

(b) Laws 1998, chapter 382, article 1, section 23, is repealed.

ARTICLE 15

FORECAST ADJUSTMENTS AND CARRY FORWARD AUTHORITY

Section 1. **HUMAN SERVICES APPROPRIATION.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2021, First Special Session chapter 7, article 16, from the general fund or any fund named to the Department of Human Services for the purposes specified in this article, to be available for the fiscal year 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 years 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**		**$**	**(585,901,000)**	**$ 182,791,000**
Appropriations by Fund				
General Fund	(406,629,000)	185,395,000		
Health Care Access Fund	(86,146,000)	(11,799,000)		
Federal TANF	(93,126,000)	9,195,000		
Subd. 2. **Forecasted Programs**				
(a) **MFIP/DWP**				
Appropriations by Fund				
General Fund	72,106,000	(14,397,000)		
Federal TANF	(93,126,000)	9,195,000		
(b) **MFIP Child Care Assistance**			(103,347,000)	(73,738,000)
(c) **General Assistance**			(4,175,000)	(1,488,000)
(d) **Minnesota Supplemental Aid**			318,000	1,613,000
(e) **Housing Support**			(1,994,000)	9,257,000
(f) **Northstar Care for Children**			(9,613,000)	(4,865,000)
(g) **MinnesotaCare**			(86,146,000)	(11,799,000)
These appropriations are from the health care access fund.				
(h) **Medical Assistance**				
Appropriations by Fund				
General Fund	(348,364,000)	292,880,000		
Health Care Access Fund	-0-	-0-		
(i) **Alternative Care Program**			-0-	-0-

(j) **Behavioral Health Fund** (11,560,000) (23,867,000)

Subd. 3. **Technical Activities** -0- -0-

These appropriations are from the federal TANF fund.

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

Sec. 3. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 23, is amended to read:

Subd. 23. **Grant Programs; Children and Community Service Grants**	61,251,000	~~61,856,000~~ 60,856,000

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

Sec. 4. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 24, is amended to read:

Subd. 24. **Grant Programs; Children and Economic Support Grants**	29,740,000	~~29,740,000~~ 30,740,000

Minnesota Food Assistance Program. Unexpended funds for the Minnesota food assistance program for fiscal year 2022 do not cancel but are available in fiscal year 2023.

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

Sec. 5. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 29, is amended to read:

Subd. 29. **Grant Programs; Disabilities Grants**	31,398,000	31,010,000

(a) **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~~ The 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.

(b) **Parent-to-Parent Peer Support.** $125,000 in fiscal year 2022 and $125,000 in fiscal year 2023 are from the general fund for a grant to an alliance member of Parent to Parent USA to support the alliance member's parent-to-parent peer support program for families of children with a disability or special health care need.

(c) **Self-Advocacy Grants.** (1) $143,000 in fiscal year 2022 and $143,000 in fiscal year 2023 are from the general fund for a grant under Minnesota Statutes, section 256.477, subdivision 1.

(2) $105,000 in fiscal year 2022 and $105,000 in fiscal year 2023 are from the general fund for subgrants under Minnesota Statutes, section 256.477, subdivision 2.

(d) **Minnesota Inclusion Initiative Grants.** $150,000 in fiscal year 2022 and $150,000 in fiscal year 2023 are from the general fund for grants under Minnesota Statutes, section 256.4772.

(e) **Grants to Expand Access to Child Care for Children with Disabilities.** $250,000 in fiscal year 2022 and $250,000 in fiscal year 2023 are from the general fund for grants to expand access to child care for children with disabilities. Any unexpended amount in fiscal year 2022 is available through June 30, 2023. This is a onetime appropriation.

(f) **Parenting with a Disability Pilot Project.** The general fund base includes $1,000,000 in fiscal year 2024 and $0 in fiscal year 2025 to implement the parenting with a disability pilot project.

(g) **Base Level Adjustment.** The general fund base is $29,260,000 in fiscal year 2024 and $22,260,000 in fiscal year 2025.

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

Sec. 6. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 31, is amended to read:

Subd. 31. **Grant Programs; Adult Mental Health Grants**

	Appropriations by Fund	
General	98,772,000	98,703,000
Opiate Epidemic Response	2,000,000	2,000,000

(a) **Culturally and Linguistically Appropriate Services Implementation Grants.** $2,275,000 in fiscal year 2022 and $2,206,000 in fiscal year 2023 are from the general fund for grants to disability services, mental health, and substance use disorder treatment providers to implement culturally and linguistically appropriate services standards, according to the implementation

and transition plan developed by the commissioner. Any unexpended amount in fiscal year 2022 is available through June 30, 2023. The general fund base for this appropriation is $1,655,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) **Base Level Adjustment.** The general fund base is $93,295,000 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.

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

Sec. 7. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 32, is amended to read:

Subd. 32. **Grant Programs; Child Mental Health Grants**	30,167,000	30,182,000

(a) **Children's Residential Facilities.** $1,964,000 in fiscal year 2022 and $1,979,000 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. The fiscal year 2022 appropriation is available until June 30, 2023.

(b) **Base Level Adjustment.** The general fund base is $29,580,000 in fiscal year 2024 and $27,705,000 in fiscal year 2025.

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

Sec. 8. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 33, is amended to read:

Subd. 33. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	4,273,000	4,274,000
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.** $2,000,000 in fiscal year 2022 and $2,000,000 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. Any unexpended amount in fiscal year 2022 is available through June 30, 2023. The general fund base for this appropriation is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025

(c) **Base Level Adjustment.** The general fund base is $4,636,000 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.

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

Sec. 9. Laws 2021, First Special Session chapter 7, article 17, section 3, is amended to read:

Sec. 3. **GRANTS FOR TECHNOLOGY FOR HCBS RECIPIENTS.**

(a) This act includes $500,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 for the commissioner of human services to issue competitive grants to home and community-based service providers. Grants must be used to provide technology assistance, including but not limited to Internet services, to older adults and people with disabilities who do not have access to technology resources necessary to use remote service delivery and telehealth. Any unexpended amount in fiscal year 2022 is available through June 30, 2023. The general fund base included in this act for this purpose is $1,500,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) All grant activities must be completed by March 31, 2024.

(c) This section expires June 30, 2024.

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

Sec. 10. Laws 2021, First Special Session chapter 7, article 17, section 6, is amended to read:

Sec. 6. **TRANSITION TO COMMUNITY INITIATIVE.**

(a) This act includes $5,500,000 in fiscal year 2022 and $5,500,000 in fiscal year 2023 for additional funding for grants awarded under the transition to community initiative described in Minnesota Statutes, section 256.478. Any unexpended amount in fiscal year 2022 is available through June 30, 2023. The general fund base in this act for this purpose is $4,125,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) All grant activities must be completed by March 31, 2024.

(c) This section expires June 30, 2024.

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

Sec. 11. Laws 2021, First Special Session chapter 7, article 17, section 10, is amended to read:

Sec. 10. **PROVIDER CAPACITY GRANTS FOR RURAL AND UNDERSERVED COMMUNITIES.**

(a) This act includes $6,000,000 in fiscal year 2022 and $8,000,000 in fiscal year 2023 for the commissioner to establish a grant program for small provider organizations that provide services to rural or underserved communities with limited home and community-based services provider capacity. The grants are available to build organizational capacity to provide home and community-based services in Minnesota and to build new or expanded infrastructure to access medical assistance reimbursement. Any unexpended amount in fiscal year 2022 is available through June 30, 2023. The general fund base in this act for this purpose is $8,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) The commissioner shall conduct community engagement, provide technical assistance, and establish a collaborative learning community related to the grants available under this section and work with the commissioner of management and budget and the commissioner of the Department of Administration to mitigate barriers in accessing grant funds. Funding awarded for the community engagement activities described in this paragraph is exempt from state solicitation requirements under Minnesota Statutes, section 16B.97, for activities that occur in fiscal year 2022.

(c) All grant activities must be completed by March 31, 2024.

(d) This section expires June 30, 2024.

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

Sec. 12. Laws 2021, First Special Session chapter 7, article 17, section 11, is amended to read:

Sec. 11. **EXPAND MOBILE CRISIS.**

(a) This act includes $8,000,000 in fiscal year 2022 and $8,000,000 in fiscal year 2023 for additional funding for grants for adult mobile crisis services under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (b), clause (15). Any unexpended amounts in fiscal year 2022 and fiscal year 2023 are available through June 30, 2024. The general fund base in this act for this purpose is $4,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) Beginning April 1, 2024, counties may fund and continue conducting activities funded under this section.

(c) All grant activities must be completed by March 31, 2024.

(d) This section expires June 30, 2024.

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

Sec. 13. Laws 2021, First Special Session chapter 7, article 17, section 12, is amended to read:

Sec. 12. **PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY AND CHILD AND ADOLESCENT MOBILE TRANSITION UNIT.**

(a) This act includes $2,500,000 in fiscal year 2022 and $2,500,000 in fiscal year 2023 for the commissioner of human services to create children's mental health transition and support teams to facilitate transition back to the community of children from psychiatric residential treatment facilities, and child and adolescent behavioral health hospitals. Any unexpended amount in fiscal year 2022 is available through June 30, 2023. The general fund base included in this act for this purpose is $1,875,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) Beginning April 1, 2024, counties may fund and continue conducting activities funded under this section.

(c) This section expires March 31, 2024.

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

Sec. 14. Laws 2021, First Special Session chapter 7, article 17, section 17, subdivision 3, is amended to read:

Subd. 3. **Respite services for older adults grants.** (a) This act includes $2,000,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 for the commissioner of human services to establish a grant program for respite services for older adults. The commissioner must award grants on a competitive basis to respite service providers. Any unexpended amount in fiscal year 2022 is available through June 30, 2023. The general fund base included in this act for this purpose is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) All grant activities must be completed by March 31, 2024.

(c) This subdivision expires June 30, 2024.

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

Sec. 15. Laws 2021, First Special Session chapter 7, article 17, section 19, is amended to read:

Sec. 19. **CENTERS FOR INDEPENDENT LIVING HCBS ACCESS GRANT.**

(a) This act includes $1,200,000 in fiscal year 2022 and $1,200,000 in fiscal year 2023 for grants to expand services to support people with disabilities from underserved communities who are ineligible for medical assistance to live in their own homes and communities by providing accessibility modifications, independent living services, and public health program facilitation. The commissioner of human services must award the grants in equal amounts to ~~the eight organizations~~ grantees. To be eligible, a grantee must be an organization defined in Minnesota Statutes, section 268A.01, subdivision 8. Any unexpended amount in fiscal year 2022 is available through June 30, 2023. The general fund base included in this act for this purpose is $0 in fiscal year 2024 and $0 in fiscal year 2025.

(b) All grant activities must be completed by March 31, 2024.

(c) This section expires June 30, 2024.

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

ARTICLE 16
LONG-TERM CARE CONSULTATION SERVICES RECODIFICATION

Section 1. Minnesota Statutes 2020, section 256B.0911, subdivision 1, is amended to read:

Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation services is to assist persons with long-term or chronic care needs in making care decisions and selecting support and service options that meet their needs and reflect their preferences. The availability of, and access to, information and other types of assistance, including long-term care consultation assessment and ~~community~~ support planning, is also intended to prevent or delay institutional placements and to provide access to transition assistance after placement. Further, the goal of long-term care consultation services is to contain costs associated with unnecessary institutional admissions. Long-term care consultation services must be available to any person regardless of public program eligibility.

(b) The commissioner of human services shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.

(c) Long-term care consultation services must be coordinated with long-term care options counseling ~~provided under subdivision 4d, section 256.975, subdivisions 7 to 7c, and section 256.01, subdivision 24~~, long-term care options counseling for assisted living, the Disability Hub, and preadmission screening.

(d) ~~The~~ A lead agency providing long-term care consultation services shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide community-based services.

Sec. 2. Minnesota Statutes 2020, section 256B.0911, subdivision 3c, is amended to read:

Subd. 3c. **~~Consultation~~ Long-term care options counseling for ~~housing with services~~ assisted living.** (a) The purpose of long-term care ~~consultation for registered housing with services~~ options counseling for assisted living is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings. Prospective residents maintain the right to choose ~~housing with services or~~ assisted living if that option is their preference.

(b) ~~Registered housing with services establishments~~ Licensed assisted living facilities shall inform each prospective resident or the prospective resident's designated or legal representative of the availability of long-term care ~~consultation~~ options counseling for assisted living and the need to receive and verify the ~~consultation~~ counseling prior to signing a ~~lease or~~ contract. Long-term care ~~consultation for registered housing with services~~ options counseling for assisted living is provided as determined by the commissioner of human services. The service is delivered under a partnership between lead agencies as defined in subdivision ~~1a~~ 10, paragraph ~~(d)~~ (g), and the Area Agencies on Aging, and is a point of entry to a combination of telephone-based long-term care options counseling provided by Senior LinkAge Line and in-person long-term care consultation provided by lead agencies. The point of entry service must be provided within five working days of the request of the prospective resident as follows:

(1) the ~~consultation~~ counseling shall be conducted with the prospective resident, or in the alternative, the resident's designated or legal representative, if:

(i) the resident verbally requests; or

(ii) the ~~registered housing with services provider~~ assisted living facility has documentation of the designated or legal representative's authority to enter into a lease or contract on behalf of the prospective resident and accepts the documentation in good faith;

(2) the ~~consultation~~ counseling shall be performed in a manner that provides objective and complete information;

(3) the ~~consultation~~ counseling must include a review of the prospective resident's reasons for considering ~~housing with services~~ assisted living services, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or ~~housing with services~~ settings that may meet the prospective resident's needs;

(4) the prospective resident ~~shall~~ must be informed of the availability of ~~a face-to-face~~ an in-person visit from a long-term care consultation team member at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs; and

(5) verification of counseling shall be generated and provided to the prospective resident by Senior LinkAge Line upon completion of the telephone-based counseling.

(c) ~~Housing with services establishments registered under chapter 144D~~ An assisted living facility licensed under chapter 144G shall:

(1) inform each prospective resident or the prospective resident's designated or legal representative of the availability of and contact information for ~~consultation~~ options counseling services under this subdivision;

(2) receive a copy of the verification of counseling prior to executing a ~~lease or service~~ contract with the prospective resident~~, and prior to executing a service contract with individuals who have previously entered into lease-only arrangements~~; and

(3) retain a copy of the verification of counseling as part of the resident's file.

(d) Emergency admissions to ~~registered housing with services establishments~~ licensed assisted living facilities prior to consultation under paragraph (b) are permitted according to policies established by the commissioner.

Sec. 3. Minnesota Statutes 2020, section 256B.0911, subdivision 3d, is amended to read:

Subd. 3d. **Exemptions from long-term care options counseling for assisted living.** Individuals shall be exempt from the requirements outlined in subdivision ~~3e~~ 7e in the following circumstances:

(1) the individual is seeking a lease-only arrangement in a subsidized housing setting;

(2) the individual has previously received a long-term care consultation assessment under ~~this~~ section 256B.0911. In this instance, the assessor who completes the long-term care consultation assessment will issue a verification code and provide it to the individual;

(3) the individual is receiving or is being evaluated for hospice services from a hospice provider licensed under sections 144A.75 to 144A.755; or

(4) the individual has used financial planning services and created a long-term care plan as defined by the commissioner in the 12 months prior to signing a lease or contract with a ~~registered housing with services establishment~~ licensed assisted living facility.

Sec. 4. Minnesota Statutes 2020, section 256B.0911, subdivision 3e, is amended to read:

Subd. 3e. ~~**Consultation**~~ **Long-term care options counseling at hospital discharge.** (a) Hospitals shall refer all individuals described in paragraph (b) prior to discharge from an inpatient hospital stay to the Senior LinkAge Line for long-term care options counseling. Hospitals shall make these referrals using referral protocols and processes developed under ~~section 256.975,~~ subdivision 7. The purpose of the counseling is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive setting.

(b) The individuals who shall be referred under paragraph (a) include older adults who are at risk of nursing home placement. Protocols for identifying at-risk individuals shall be developed under ~~section 256.975,~~ subdivision 7, paragraph (b), clause (12).

(c) Counseling provided under this subdivision shall meet the requirements for the consultation required under subdivision ~~3e~~ 7e.

Sec. 5. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 10. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "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.

(c) "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.

(d) "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.

(e) "Independent living" means living in a setting that is not controlled by a provider.

(f) "Informed choice" has the meaning given in section 256B.4905, subdivision 1a.

(g) "Lead agency" means a county administering or a Tribe or health plan under contract with the commissioner to administer long-term care consultation services.

(h) "Long-term care consultation services" means the activities described in subdivision 11.

(i) "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 after a long-term care consultation assessment has been completed.

(j) "Long-term care options counseling for assisted living" means the services provided under section 256.975, subdivisions 7e to 7g.

(k) "Minnesota health care programs" means the medical assistance program under this chapter and the alternative care program under section 256B.0913.

(l) "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.

(m) "Preadmission screening" means the services provided under section 256.975, subdivisions 7a to 7c.

Sec. 6. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 11. **Long-term care consultation services.** The following activities are included in long-term care consultation services:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) transfer or referral to long-term care options counseling services for telephone assistance and follow-up after a person requests assistance in identifying community supports without participating in a complete long-term care consultation assessment;

(3) long-term care consultation assessments conducted according to subdivisions 17 to 21, 23, or 24, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment center, or the person's current or planned residence;

(4) providing recommendations for and referrals to cost-effective community services that are available to the individual;

(5) providing recommendations for institutional placement when there are no cost-effective community services available;

(6) providing information regarding eligibility for Minnesota health care programs;

(7) determining service eligibility 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;

(8) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, gaining access to the following services, including obtaining necessary diagnostic information to determine eligibility:

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

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

(iii) case management services targeted to people with developmental disabilities under Minnesota Rules, part 9525.0016;

(9) determining eligibility for semi-independent living services under section 252.275, including obtaining necessary diagnostic information;

(10) determining home and community-based waiver and other service eligibility as required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including:

(i) level of care determination for individuals who need an institutional level of care as determined under subdivision 26;

(ii) appropriate referrals to obtain necessary diagnostic information; and

(iii) an eligibility determination for consumer-directed community supports;

(11) 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;

(12) providing information about independent living to ensure that an informed choice about independent living can be made;

(13) 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;

(14) developing an individual's person-centered assessment summary; and

(15) providing access to assistance to transition people back to community settings after institutional admission.

Sec. 7. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 12. **Exception to use of MnCHOICES assessment; contracted assessors.** (a) A lead agency that has not implemented MnCHOICES assessments and uses contracted assessors as of January 1, 2022, is not subject to the requirements of subdivisions 11, clauses (7) to (9); 13; 14, paragraphs (a) to (c); 16 to 21; 23; 24; and 29 to 31.

(b) This subdivision expires upon statewide implementation of MnCHOICES assessments. The commissioner shall notify the revisor of statutes when statewide implementation has occurred.

Sec. 8. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

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

(b) MnCHOICES certified assessors must:

(1) either have a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience or be a registered nurse with at least two years of home and community-based experience; and

(2) have received training and certification specific to assessment and consultation for long-term care services in the state.

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

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

Sec. 9. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 14. **Use of MnCHOICES certified assessors required.** (a) Each lead agency shall use MnCHOICES certified assessors who have completed MnCHOICES training and the certification process determined by the commissioner in subdivision 13.

(b) Each lead agency must ensure that the lead agency has sufficient numbers of certified assessors to provide long-term consultation assessment and support planning within the timelines and parameters of the service.

(c) A lead agency may choose, according to departmental policies, to contract with a qualified, certified assessor to conduct assessments and reassessments on behalf of the lead agency.

(d) Tribes and health plans under contract with the commissioner must provide long-term care consultation services as specified in the contract.

(e) A lead agency must provide the commissioner with an administrative contact for communication purposes.

Sec. 10. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 15. **Long-term care consultation team.** (a) Each county board of commissioners shall establish a long-term care consultation team. Two or more counties may collaborate to establish a joint local long-term care consultation team or teams.

(b) Each lead agency shall establish and maintain a team of certified assessors qualified under subdivision 13. Each team member is responsible for providing consultation with other team members upon request. The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs. The team of certified assessors must include, at a minimum:

(1) a social worker; and

(2) a public health nurse or registered nurse.

(c) The commissioner shall allow arrangements and make recommendations that encourage counties and Tribes to collaborate to establish joint local long-term care consultation teams to ensure that long-term care consultations are done within the timelines and parameters of the service. This includes coordinated service models as required in subdivision 1, paragraph (c).

Sec. 11. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 16. **MnCHOICES certified assessors; responsibilities.** (a) Certified assessors must use person-centered planning principles to conduct an interview that identifies what is important to the person; the person's needs for supports and health and safety concerns; and the person's abilities, interests, and goals.

(b) Certified assessors are responsible for:

(1) ensuring persons are offered objective, unbiased access to resources;

(2) ensuring persons have the needed information to support informed choice, including where and how they choose to live and the opportunity to pursue desired employment;

(3) determining level of care and eligibility for long-term services and supports;

(4) using the information gathered from the interview to develop a person-centered assessment summary that reflects identified needs and support options within the context of values, interests, and goals important to the person; and

(5) providing the person with an assessment summary of findings, support options, and agreed-upon next steps.

Sec. 12. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 17. **MnCHOICES assessments.** (a) A person requesting long-term care consultation services 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. Assessments must be conducted according to this subdivision and subdivisions 19 to 21, 23, 24, and 29 to 31.

(b) Lead agencies shall use certified assessors to conduct the assessment.

(c) For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(d) The lead agency must use the MnCHOICES assessment provided by the commissioner 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 assessment summary that meets the individual's needs and preferences.

(e) Except as provided in subdivision 24, an assessment must be conducted by a certified assessor in an in-person conversational interview with the person being assessed.

Sec. 13. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 18. **Exception to use of MnCHOICES assessments; long-term care consultation team visit; notice.** (a) Until statewide implementation of MnCHOICES assessments, the requirement under subdivision 17, paragraph (a), does not apply 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 statewide implementation.

(b) This subdivision expires upon statewide implementation of MnCHOICES assessments. The commissioner shall notify the revisor of statutes when statewide implementation has occurred.

Sec. 14. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 19. **MnCHOICES assessments; third-party participation.** (a) The person's legal representative, if any, must provide input during the assessment process and may do so remotely if requested.

(b) 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 complete the assessment and assessment summary. Except for legal representatives or family members invited by the person, a person participating in the assessment may not be a provider of service or have any financial interest in the provision of services.

(c) For a person 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 to submit this information. This information must be provided to the person conducting the assessment prior to the assessment.

(d) For a person 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 that the person completed in consultation with someone who is known to the person and who 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.

Sec. 15. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 20. **MnCHOICES assessments; duration of validity.** (a) An assessment that is 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 the assessment.

(b) The effective eligibility start date for programs in paragraph (a) 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 (a) cannot be prior to the completion date of the most recent updated assessment.

(c) If an eligibility update is completed within 90 days of the previous assessment and documented in the department's Medicaid Management Information System (MMIS), the effective date of eligibility for programs included in paragraph (a) is the date of the previous in-person assessment when all other eligibility requirements are met.

Sec. 16. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 21. **MnCHOICES assessments; exceptions following institutional stay.** (a) A person receiving home and community-based waiver services under section 256B.0913, 256B.092, or 256B.49 or chapter 256S may return to a community with home and community-based waiver services under the same waiver without being assessed or reassessed under this section if the person temporarily entered one of the following for 121 or fewer days:

(1) a hospital;

(2) an institution of mental disease;

(3) a nursing facility;

(4) an intensive residential treatment services program;

(5) a transitional care unit; or

(6) an inpatient substance use disorder treatment setting.

(b) Nothing in paragraph (a) changes annual long-term care consultation reassessment requirements, payment for institutional or treatment services, medical assistance financial eligibility, or any other law.

Sec. 17. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 22. **MnCHOICES reassessments.** (a) Prior to a reassessment, the certified assessor must review the person's most recent assessment.

(b) Reassessments must:

(1) be tailored using the professional judgment of the assessor to the person's known needs, strengths, preferences, and circumstances;

(2) 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;

(3) provide a review of the most recent assessment, the current support plan's effectiveness and monitoring of services, and the development of an updated person-centered assessment summary;

(4) verify continued eligibility, offer alternatives as warranted, and provide an opportunity for quality assurance of service delivery; and

(5) be conducted annually or as required by federal and state laws.

(c) The certified assessor and the individual responsible for developing the support plan must ensure the continuity of care for the person receiving services and complete the updated assessment summary and the updated support plan no more than 60 days after the reassessment visit.

(d) 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. 18. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 23. **MnCHOICES reassessments; option for alternative and self-directed waiver services.** (a) At the time of reassessment, the certified assessor shall assess a person receiving waiver residential supports and services and currently residing in a setting listed in clauses (1) to (5) to determine if the person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23, or 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. This paragraph applies to those currently residing in a:

(1) community residential setting;

(2) 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;

(3) family adult foster care residence;

(4) customized living setting; or

(5) supervised living facility.

(b) 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.

(c) 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.

Sec. 19. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 24. **Remote reassessments.** (a) Assessments performed according to subdivisions 17 to 20 and 23 must be in person unless the assessment is a reassessment meeting the requirements of this subdivision. Remote reassessments conducted by interactive video or telephone may substitute for in-person reassessments.

(b) For services provided by 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 an in-person reassessment.

(c) For services provided by alternative care under section 256B.0913, essential community supports under section 256B.0922, and the elderly waiver under chapter 256S, remote reassessments may be substituted for one reassessment if followed by an in-person reassessment.

(d) A remote reassessment is permitted only if the person being reassessed, or the person's legal representative, and the lead agency case manager both 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.

(e) The person being reassessed, or the person's legal representative, may refuse a remote reassessment at any time.

(f) During a remote reassessment, if the certified assessor determines an in-person reassessment is necessary in order to complete the assessment, the lead agency shall schedule an in-person reassessment.

(g) All other requirements of an in-person reassessment apply to a remote reassessment, including updates to a person's support plan.

Sec. 20. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 25. **Reassessments for Rule 185 case management.** Unless otherwise required by federal law, the county agency is not required to conduct or arrange for an annual needs reassessment by a certified assessor for people receiving Rule 185 case management under Minnesota Rules, part 9525.0016. The case manager who works on behalf of the person to identify the person's needs and to minimize the impact of the disability on the person's life must instead develop a person-centered service plan based on the person's assessed needs and preferences. The person-centered service plan must be reviewed annually for persons with developmental disabilities who are receiving only case management services under Minnesota Rules, part 9525.0016, and who make an informed choice to decline an assessment under this section.

Sec. 21. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 26. **Determination of institutional level of care.** (a) The determination of need for hospital and intermediate care facility levels of care must be made according to criteria developed by the commissioner, and in section 256B.092, using forms developed by the commissioner.

(b) The determination of need for nursing facility level of care must be made based on criteria in section 144.0724, subdivision 11.

Sec. 22. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 27. **Transition assistance.** (a) Lead agency certified assessors shall provide transition assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with developmental disabilities who request or are referred for assistance.

(b) Transition assistance must include:

(1) assessment;

(2) referrals to long-term care options counseling under section 256.975, subdivision 7, for support plan implementation and to Minnesota health care programs, including home and community-based waiver services and consumer-directed options through the waivers; and

(3) referrals to programs that provide assistance with housing.

(c) Transition assistance must also include information about the Centers for Independent Living, Disability Hub, and other organizations that can provide assistance with relocation efforts and information about contacting these organizations to obtain their assistance and support.

(d) The lead agency shall ensure that:

(1) referrals for in-person assessments are taken from long-term care options counselors as provided for in section 256.975, subdivision 7, paragraph (b), clause (11);

(2) persons assessed in institutions receive information about available transition assistance;

(3) the assessment is completed for persons within 20 calendar days of the date of request or recommendation for assessment;

(4) there is a plan for transition and follow-up for the individual's return to the community, including notification of other local agencies when a person may require assistance from agencies located in another county; and

(5) relocation targeted case management as defined in section 256B.0621, subdivision 2, clause (4), is authorized for an eligible medical assistance recipient.

Sec. 23. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 28. **Transition assistance; nursing home residents under 65 years of age.** (a) Upon referral from the Senior LinkAge Line, individuals under 65 years of age who are admitted to nursing facilities on an emergency basis with only a telephone screening must receive an in-person assessment from the long-term care consultation team member of the county in which the facility is located within the timeline established by the commissioner based on review of data.

(b) At the in-person assessment, the long-term care consultation team member or county case manager must:

(1) perform the activities required under subdivision 27; and

(2) present information about home and community-based options, including consumer-directed options, so the individual can make informed choices.

(c) 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 must describe the services needed to move the individual out of the facility and a timeline for the move that is designed to ensure a smooth transition to the individual's home and community.

(d) For individuals under 21 years of age, a screening interview that recommends nursing facility admission must be in person and approved by the commissioner before the individual is admitted to the nursing facility.

(e) An individual under 65 years of age residing in a nursing facility must receive an in-person assessment 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 an in-person assessment at least once every 36 months for the same purposes.

(f) Notwithstanding subdivision 33, the commissioner may pay county agencies directly for in-person assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

Sec. 24. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 29. **Support planning.** (a) The certified assessor and the individual responsible for developing the support plan must complete the assessment summary and the support plan no more than 60 calendar days after the assessment visit.

(b) The person or the person's legal representative must be provided with a written assessment summary within the timelines established by the commissioner, regardless of whether the person is eligible for Minnesota health care programs.

(c) For a person being assessed for elderly waiver services under chapter 256S, a provider who submitted information under subdivision 19, paragraph (c), must receive the final written support plan when available.

(d) The written support plan must include:

(1) a summary of assessed needs as defined in subdivision 17, paragraphs (d) and (e);

(2) the individual's options and choices to meet identified needs, including all available options for:

(i) case management services and providers;

(ii) employment services, settings, and providers;

(iii) living arrangements;

(iv) 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.

(e) For a person determined eligible for state plan home care under subdivision 11, clause (7), the person or person's legal representative must also receive a copy of the home care service plan developed by the certified assessor.

Sec. 25. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 30. **Assessment and support planning; supplemental information.** 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 person;

(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 person 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 11, clauses (7) to (10);

(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 26 and regarding eligibility for all services and programs as defined in subdivision 11, clauses (7) to (10);

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 11, clauses (5), (7) to (10), and (15), and 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 person.

Sec. 26. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 31. **Assessment and support planning; right to final decision.** The person has the right to make the final decision:

(1) between institutional placement and community placement after the recommendations have been provided under subdivision 30, clause (1), 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.

Sec. 27. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

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

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

(2) provide the services in this section; and

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

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

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

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

(c) The commissioner shall collect data on the benchmarks developed under paragraph (b) and provide to the lead agencies and the chairs and ranking minority members of the legislative committees with jurisdiction over human services an annual trend analysis of the data in order to demonstrate the commissioner's compliance with the requirements of this subdivision.

Sec. 28. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 33. **Payment for long-term care consultation services.** (a) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 11. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in subdivision 1.

(b) The county is accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan.

The county must document its compliance with the local objectives on a form provided by the commissioner.

(c) The state shall pay 81.9 percent of the nonfederal share as reimbursement to the counties.

Sec. 29. **DIRECTION TO COMMISSIONER; TRANSITION PROCESS.**

(a) The commissioner of human services shall update references to statutes recodified in this act when printed material is replaced and new printed material is obtained in the normal course of business. The commissioner is not required to replace existing printed material to comply with this act.

(b) The commissioner of human services shall update references to statutes recodified in this act when online documents and websites are edited in the normal course of business. The commissioner is not required to edit online documents and websites merely to comply with this act.

(c) The commissioner of human services shall update references to statutes recodified in this act when the home and community-based service waiver plans are updated in the normal course of business. The commissioner is not required to update the home and community-based service waiver plans merely to comply with this act.

Sec. 30. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall renumber each section of Minnesota Statutes listed in column A with the number listed in column B. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

Column A	Column B
256B.0911, subdivision 3c	256.975, subdivision 7e
256B.0911, subdivision 3d	256.975, subdivision 7f
256B.0911, subdivision 3e	256.975, subdivision 7g

(b) The revisor of statutes, in consultation with the House of Representatives Research Department; the Office of Senate Counsel, Research and Fiscal Analysis; and the Department of Human Services, shall make necessary cross-reference changes and remove statutory cross-references in Minnesota Statutes to conform with the recodification in this act. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text. The revisor may alter the coding in this act to incorporate statutory changes made by other law in a regular or special session of the 2022 legislature. If a

provision stricken in this act is also amended in a regular or special session of the 2022 legislature by other law, the revisor shall restore the stricken language and give effect to the amendment, notwithstanding Minnesota Statutes, section 645.30.

(c) If a provision repealed in this article is also amended by a section in this act or any other act in a regular or special session of the 2022 legislature, the revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research and Fiscal Analysis, and the Department of Human Services, shall give effect to the amendment and incorporate the amendment consistent with the recodification of Minnesota Statutes, section 256B.0911, by this article, notwithstanding any law to the contrary. When incorporating any such amendment, the revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research and Fiscal Analysis, and the Department of Human Services, may make technical and other necessary changes to sentence structure to preserve the meaning of the text of the recodification.

Sec. 31. **REPEALER.**

Minnesota Statutes 2020, section 256B.0911, subdivisions 2b, 2c, 3, 3b, 3g, 4d, 4e, 5, and 6, are repealed.

Minnesota Statutes 2021 Supplement, section 256B.0911, subdivisions 1a, 3a, and 3f, are repealed.

Sec. 32. **EFFECTIVE DATE.**

Sections 1 to 31 are effective July 1, 2022.

ARTICLE 17

LONG-TERM CARE CONSULTATION SERVICES RECODIFICATION; CONFORMING CHANGES

Section 1. Minnesota Statutes 2021 Supplement, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the federal database MDS assessments that conform with the assessment schedule defined by 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. 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 ARD within 92 days of a previous quarterly review assessment or a previous comprehensive assessment, which must occur at least once every 366 days;

(3) a significant change in status comprehensive assessment, which must have an ARD within 14 days 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 comprehensive assessment or quarterly review assessment;

(4) a quarterly review assessment must have an 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;

(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~~ 26, 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 144.0724, subdivision 11, is amended to read:

Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment of long-term care services, a recipient must be determined, using assessments defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

(1) the person requires formal clinical monitoring at least once per day;

(2) the person needs the assistance of another person or constant supervision to begin and complete at least four of the following activities of living: bathing, bed mobility, dressing, eating, grooming, toileting, transferring, and walking;

(3) the person needs the assistance of another person or constant supervision to begin and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

(4) the person has significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention;

(5) the person has had a qualifying nursing facility stay of at least 90 days;

(6) the person meets the nursing facility level of care criteria determined 90 days after admission or on the first quarterly assessment after admission, whichever is later; or

(7) the person is determined to be at risk for nursing facility admission or readmission through a face-to-face long-term care consultation assessment as specified in section 256B.0911, ~~subdivision 3a, 3b, or 4d~~ subdivision 17 to 21, 23, 24, 27, or 28, by a county, tribe, or managed care organization under contract with the Department of Human Services. The person is considered at risk under this clause if the person currently lives alone or will live alone or be homeless without the person's current housing and also meets one of the following criteria:

(i) the person has experienced a fall resulting in a fracture;

(ii) the person has been determined to be at risk of maltreatment or neglect, including self-neglect; or

(iii) the person has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.

(b) The assessment used to establish medical assistance payment for nursing facility services must be the most recent assessment performed under subdivision 4, paragraph (b), that occurred no more than 90 calendar days before the effective date of medical assistance eligibility for payment of long-term care services. In no case shall medical assistance payment for long-term care services occur prior to the date of the determination of nursing facility level of care.

(c) The assessment used to establish medical assistance payment for long-term care services provided under chapter 256S and section 256B.49 and alternative care payment for services provided under section 256B.0913 must be the most recent face-to-face assessment performed under section 256B.0911, ~~subdivision 3a, 3b, or 4d~~ subdivisions 17 to 21, 23, 24, 27, or 28, that occurred no more than 60 calendar days before the effective date of medical assistance eligibility for payment of long-term care services.

Sec. 3. Minnesota Statutes 2021 Supplement, section 144.0724, subdivision 12, as amended by Laws 2022, chapter 55, article 1, section 36, 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 (j)~~ 30, 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.

Sec. 4. Minnesota Statutes 2020, section 256.975, subdivision 7a, is amended to read:

Subd. 7a. **Preadmission screening activities related to nursing facility admissions.** (a) All individuals seeking admission to Medicaid-certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 7b, paragraphs (a) and (b). The purpose of the screening is to determine the need for nursing facility level

of care as described in section 256B.0911, subdivision ~~4e~~ 26, and to complete activities required under federal law related to mental illness and developmental disability as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 7b, paragraphs (a) and (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

(c) The following criteria apply to the preadmission screening:

(1) requests for preadmission screenings must be submitted via an online form developed by the commissioner;

(2) the Senior LinkAge Line must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(3) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified developmental disability professional, for persons with a primary or secondary diagnosis of developmental disability. For purposes of this requirement, a qualified developmental disability professional must meet the standards for a qualified developmental disability professional under Code of Federal Regulations, title 42, section 483.430.

(d) The local county mental health authority or the state developmental disability authority under Public Laws 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Laws 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(e) In assessing a person's needs, the screener shall:

(1) use an automated system designated by the commissioner;

(2) consult with care transitions coordinators, physician, or advanced practice registered nurse; and

(3) consider the assessment of the individual's physician or advanced practice registered nurse.

(f) Other personnel may be included in the level of care determination as deemed necessary by the screener.

Sec. 5. Minnesota Statutes 2020, section 256.975, subdivision 7b, is amended to read:

Subd. 7b. **Exemptions and emergency admissions.** (a) Exemptions from the federal screening requirements outlined in subdivision 7a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility; or

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the Veterans Administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility; and

(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act.

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during Senior LinkAge Line nonworking hours;

(2) a physician or advanced practice registered nurse has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician or advanced practice registered nurse has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the Senior LinkAge Line is contacted on the first working day following the emergency admission.

(e) Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care and from whom admission is being sought on a nonworking day.

~~(e)~~ (f) A nursing facility must provide written information to all persons admitted regarding the person's right to request and receive long-term care consultation services as defined in section 256B.0911, subdivision ~~1a~~ 11. The information must be provided prior to the person's discharge from the facility and in a format specified by the commissioner.

Sec. 6. Minnesota Statutes 2020, section 256.975, subdivision 7c, is amended to read:

Subd. 7c. **Screening requirements.** (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. The Senior LinkAge Line shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face long-term care consultation assessment completed under section 256B.0911, ~~subdivision 3a, 3b, or 4d~~ subdivisions 17 to 21, 24, 27 or 28, by a county, tribe, or managed care organization under contract with the Department of Human Services to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face long-term care consultation assessment completed under section 256B.0911, ~~subdivision 3a, 3b, or 4d~~ subdivisions 17 to 21, 24, 27, or 28, by a county, tribe, or managed care organization under contract with the

Department of Human Services to determine the need for nursing facility level of care and complete activities required under subdivision 7a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 7b, but will need ~~transitional~~ transition assistance after admission or in-person follow-along after a return home.

(b) The Senior LinkAge Line shall refer individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening ~~must receive a face-to-face~~ for an in-person 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 40 calendar days of admission~~ as described in section 256B.0911, subdivision ~~4d~~ 28, paragraph ~~(c)~~ (a).

(c) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

(d) Screenings provided by the Senior LinkAge Line must include processes to identify persons who may require transition assistance described in subdivision 7, paragraph (b), clause (12), and section 256B.0911, subdivision ~~3b~~ 27.

Sec. 7. Minnesota Statutes 2020, section 256.975, subdivision 7d, is amended to read:

Subd. 7d. **Payment for preadmission screening.** ~~Funding~~ (a) The Department of Human Services shall provide funding for preadmission screening ~~shall be provided~~ to the Minnesota Board on Aging ~~by the Department of Human Services~~ to cover screener salaries and expenses to provide the services described in subdivisions 7a to 7c. The Minnesota Board on Aging shall:

(1) employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening and level of care determination services; and ~~shall~~

(2) seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (aa).

(b) The Department of Human Services shall provide funding for preadmission screening follow-up to the Disability Hub for the under-60 population to cover options counseling salaries and expenses to provide the services described in subdivisions 7a to 7c. The Disability Hub shall:

(1) employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening follow-up services; and

(2) seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (aa).

Sec. 8. Minnesota Statutes 2020, section 256B.051, subdivision 4, is amended to read:

Subd. 4. **Assessment requirements.** (a) An individual's assessment of functional need must be conducted by one of the following methods:

(1) an assessor according to the criteria established in section 256B.0911, ~~subdivision 3a~~ subdivisions 17 to 21, 23, 24, and 29 to 31, using a format established by the commissioner;

(2) documented need for services as verified by a professional statement of need as defined in section 256I.03, subdivision 12; or

(3) according to the continuum of care coordinated assessment system established in Code of Federal Regulations, title 24, section 578.3, using a format established by the commissioner.

(b) An individual must be reassessed within one year of initial assessment, and annually thereafter.

Sec. 9. Minnesota Statutes 2020, section 256B.0646, is amended to read:

256B.0646 MINNESOTA RESTRICTED RECIPIENT PROGRAM; PERSONAL CARE ASSISTANCE SERVICES.

(a) When a recipient's use of personal care assistance services or community first services and supports under section 256B.85 results in abusive or fraudulent billing, the commissioner may place a recipient in the Minnesota restricted recipient program under Minnesota Rules, part 9505.2165. A recipient placed in the Minnesota restricted recipient program under this section must: (1) use a designated traditional personal care assistance provider agency; and (2) obtain a new assessment under section 256B.0911, including consultation with a registered or public health nurse on the long-term care consultation team pursuant to section 256B.0911, subdivision ~~3~~ 15, paragraph (b), clause (2).

(b) A recipient must comply with additional conditions for the use of personal care assistance services or community first services and supports if the commissioner determines it is necessary to prevent future misuse of personal care assistance services or abusive or fraudulent billing. Additional conditions may include but are not limited to restricting service authorizations for a duration of no more than one month and requiring a qualified professional to monitor and report services on a monthly basis.

(c) A recipient placed in the Minnesota restricted recipient program under this section may appeal the placement according to section 256.045.

Sec. 10. Minnesota Statutes 2020, section 256B.0659, subdivision 3a, is amended to read:

Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a recipient's need for personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care consultation assessment is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services including personal care assistance services according to section 256B.0911. During the transition to MnCHOICES, a certified assessor may complete the assessment defined in this subdivision. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and ~~on going~~ ongoing consumer education. Assessments or reassessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

(b) This subdivision expires when notification is given by the commissioner as described in section 256B.0911, subdivision ~~3a~~ 18.

Sec. 11. Minnesota Statutes 2020, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person is a citizen of the United States or a United States national;

(2) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, as determined under section 256B.0911, subdivision ~~4e~~ 26, but for the provision of services under the alternative care program;

(3) the person is age 65 or older;

(4) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(5) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(6) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

(7) except for individuals described in clause (8), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256S.04, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph;

(8) for individuals assigned a case mix classification A as described under section 256S.18, with (i) no dependencies in activities of daily living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911, the monthly cost of alternative care services funded by the program cannot exceed $593 per month for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in section 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased exceed the difference between the client's monthly service limit defined in this clause and the limit described in clause (7) for case mix classification A; and

(9) the person is making timely payments of the assessed monthly fee. A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the lead agency to ensure prompt fee payments.

(b) The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

~~(b)~~ (c) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a

medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

~~(c)~~ (d) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

~~(d)~~ (e) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256S.05, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

Sec. 12. Minnesota Statutes 2020, section 256B.092, subdivision 1a, is amended to read:

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

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

(1) development of the person-centered coordinated service and support plan under subdivision 1b;

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

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

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

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

(ii) employment service providers;

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

(iv) providers of financial management services;

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

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

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

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

(c) Case management service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision ~~1a, paragraph (e)~~ 10.

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

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

(1) phasing out the use of prohibited procedures;

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

(3) accomplishment of identified outcomes.

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

(f) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year. The education and training must include person-centered planning. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision ~~1a, paragraph (f)~~ 10.

Sec. 13. Minnesota Statutes 2020, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written person-centered coordinated service and support plan that:

(1) is developed with and signed by the recipient within the timelines established by the commissioner and section 256B.0911, subdivision ~~3a, paragraph (c)~~ 29;

(2) includes the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and welfare of the recipient;

(4) identifies the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor, including the person's choices made on self-directed options, services and supports to achieve employment goals, and living arrangements;

(5) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (o), of service and support providers, and identifies all available options for case management services and providers;

(6) identifies long-range and short-range goals for the person;

(7) identifies specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The person-centered coordinated service and support plan shall also specify other services the person needs that are not available;

(8) identifies the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

(9) identifies provider responsibilities to implement and make recommendations for modification to the coordinated service and support plan;

(10) includes notice of the right to request a conciliation conference or a hearing under section 256.045;

(11) is agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative;

(12) is reviewed by a health professional if the person has overriding medical needs that impact the delivery of services; and

(13) includes the authorized annual and monthly amounts for the services.

(b) In developing the person-centered coordinated service and support plan, the case manager is encouraged to include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

(c) Approved, written, and signed changes to a consumer's services that meet the criteria in this subdivision shall be an addendum to that consumer's individual service plan.

Sec. 14. Minnesota Statutes 2020, section 256B.0922, subdivision 1, is amended to read:

Subdivision 1. **Essential community supports.** (a) The purpose of the essential community supports program is to provide targeted services to persons age 65 and older who need essential community support, but whose needs do not meet the level of care required for nursing facility placement under section 144.0724, subdivision 11.

(b) Essential community supports are available not to exceed $400 per person per month. Essential community supports may be used as authorized within an authorization period not to exceed 12 months. Services must be available to a person who:

(1) is age 65 or older;

(2) is not eligible for medical assistance;

(3) has received a community assessment under section 256B.0911, ~~subdivision 3a or 3b~~ subdivisions 17 to 21, 23, 24, or 27, and does not require the level of care provided in a nursing facility;

(4) meets the financial eligibility criteria for the alternative care program under section 256B.0913, subdivision 4;

(5) has a community support plan; and

(6) has been determined by a community assessment under section 256B.0911, ~~subdivision 3a or 3b~~ subdivisions 17 to 21, 23, 24 or 27, to be a person who would require provision of at least one of the following services, as defined in the approved elderly waiver plan, in order to maintain their community residence:

(i) adult day services;

(ii) caregiver support;

(iii) homemaker support;

(iv) chores;

(v) a personal emergency response device or system;

(vi) home-delivered meals; or

(vii) community living assistance as defined by the commissioner.

(c) The person receiving any of the essential community supports in this subdivision must also receive service coordination, not to exceed $600 in a 12-month authorization period, as part of their community support plan.

(d) A person who has been determined to be eligible for essential community supports must be reassessed at least annually and continue to meet the criteria in paragraph (b) to remain eligible for essential community supports.

(e) The commissioner is authorized to use federal matching funds for essential community supports as necessary and to meet demand for essential community supports as outlined in subdivision 2, and that amount of federal funds is appropriated to the commissioner for this purpose.

Sec. 15. Minnesota Statutes 2020, section 256B.49, subdivision 12, is amended to read:

Subd. 12. **Informed choice.** Persons who are determined likely to require the level of care provided in a nursing facility as determined under section 256B.0911, subdivision ~~4e~~ 26, or a hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Sec. 16. Minnesota Statutes 2020, section 256B.49, subdivision 13, is amended to read:

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

(1) finalizing the person-centered written coordinated service and support plan within the timelines established by the commissioner and section 256B.0911, subdivision ~~3a, paragraph (e)~~ 29;

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

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

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

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

(iii) employment service providers;

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

(v) providers of financial management services;

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

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

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

(1) finalizing the person-centered coordinated service and support plan;

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

(3) adjustments to the person-centered coordinated service and support plan.

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not

be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision ~~1a, paragraph (e)~~ 10.

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

(1) phasing out the use of prohibited procedures;

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

(3) accomplishment of identified outcomes.

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

(e) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year. The education and training must include person-centered planning. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision ~~1a, paragraph (f)~~ 10.

Sec. 17. Minnesota Statutes 2021 Supplement, 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~~ subdivisions 13 and 14.

(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~~ 26, 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 assessments conducted according to section 256B.0911, subdivisions ~~3a, 3b, and 4d~~ 17 to 21, 23, 24, and 27 to 31, 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. 18. Minnesota Statutes 2021 Supplement, 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:

(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 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 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, including traveling to medical appointments. For purposes of this paragraph, traveling includes driving and accompanying the recipient in the recipient's chosen mode of transportation and according to the individual CFSS service delivery plan.

(p) "Lead agency" has the meaning given in section 256B.0911, subdivision ~~1a, paragraph (e)~~ 10.

(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 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 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. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one.

(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 a written agreement to receive services at the same time, in the same setting, and through the same 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. 19. Minnesota Statutes 2021 Supplement, 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~~ subdivisions 17 to 21, 23, 24, and 29 to 31;

(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 assessor as defined in section 256B.0911 to the participant or the participant's representative and chosen CFSS

providers within 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. 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. 20. Minnesota Statutes 2020, section 256S.02, subdivision 15, is amended to read:

Subd. 15. **Lead agency.** "Lead agency" means a county administering long-term care consultation services as defined in section 256B.0911, subdivision ~~1a~~ 10, or a tribe or managed care organization under contract with the commissioner to administer long-term care consultation services as defined in section 256B.0911, subdivision ~~1a~~ 10.

Sec. 21. Minnesota Statutes 2020, section 256S.02, subdivision 20, is amended to read:

Subd. 20. **Nursing facility level of care determination.** "Nursing facility level of care determination" refers to determination of institutional level of care described in section 256B.0911, subdivision ~~4e~~ 26.

Sec. 22. Minnesota Statutes 2021 Supplement, 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 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. 23. Minnesota Statutes 2020, section 256S.06, subdivision 1, is amended to read:

Subdivision 1. **Initial assessments.** A lead agency shall provide each participant with an initial long-term care consultation assessment of strengths, informal supports, and need for services according to section 256B.0911~~, subdivisions 3, 3a, and 3b~~.

Sec. 24. Minnesota Statutes 2020, section 256S.06, subdivision 2, is amended to read:

Subd. 2. **Annual reassessments.** At least every 12 months, a lead agency shall provide each participant with an annual long-term care consultation reassessment according to section 256B.0911, subdivisions ~~3, 3a, and 3b~~ 22 to 25.

Sec. 25. Minnesota Statutes 2020, section 256S.10, subdivision 2, is amended to read:

Subd. 2. **Plan development timeline.** Within the timelines established by the commissioner and section 256B.0911, subdivision ~~3a, paragraph (c)~~ 29, the case manager must develop with the participant and the participant must sign the participant's individualized written coordinated service and support plan.

Sec. 26. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall change the term "coordinated service and support plan" and similar terms to "support plan" and similar terms wherever these terms appear in Minnesota Statutes, sections 144G.911, 245A.11, 245D.02, 245D.04, 245D.05, 245D.051, 245D.06, 245D.061, 245D.07, 245D.071, 245D.081, 245D.09, 245D.091, 245D.095, 245D.11, 245D.22, 245D.31, 252.41, 252.42, 252.44, 252.45, 252A.02, 256B.0913, 256B.092, 256B.49, 256B.4911, 256B.4914, 256B.85, 256S.01, 256S.08, 256S.09, 256S.10, 256S.11, and 325F.722. The revisor shall also make necessary grammatical changes related to the change in terms in order to preserve the meaning of the text.

(b) The revisor of statutes shall change the term "community support plan" and similar terms to "assessment summary" and similar terms wherever these terms appear in Minnesota Statutes, sections 245.462, 245.4711, 245.477, 245.4835, 245.4871, 245.4873, 245.4881, 245.4885, 245.4887, 245D.091, 256.975, 256B.0623, 256B.0659, 256B.092, 256B.0922, 256B.4911, 256B.4914, and 256B.85. The revisor shall also make necessary grammatical changes related to the change in terms in order to preserve the meaning of the text.

Sec. 27. **EFFECTIVE DATE.**

Sections 1 to 26 are effective July 1, 2022.

62U.10 HEALTH CARE TRANSFER, SAVINGS, AND REPAYMENT.

No active language found for: 62U.10.3

144.1911 INTERNATIONAL MEDICAL GRADUATES ASSISTANCE PROGRAM.

No active language found for: 144.1911.10

144.564 MONITORING OF SUBACUTE OR TRANSITIONAL CARE SERVICES.

No active language found for: 144.564.3

144A.483 AGENCY QUALITY IMPROVEMENT PROGRAM.

No active language found for: 144A.483.2

No active language found for: 144G.07.6

150A.091 FEES.

No active language found for: 150A.091.3

No active language found for: 150A.091.15

No active language found for: 150A.091.17

No active language found for: 245.981

245A.03 WHO MUST BE LICENSED.

No active language found for: 245A.03.5

245F.15 STAFF QUALIFICATIONS.

No active language found for: 245F.15.2

245G.11 STAFF QUALIFICATIONS.

No active language found for: 245G.11.2

No active language found for: 246.0136

No active language found for: 246.131

246B.03 LICENSURE, EVALUATION, AND GRIEVANCE RESOLUTION.

No active language found for: 246B.03.2

No active language found for: 246B.035

No active language found for: 252.025.7

No active language found for: 252.035

No active language found for: 254A.04

254A.21 FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION GRANTS.

(a) The commissioner of human services shall award a grant to a statewide organization that focuses solely on prevention of and intervention with fetal alcohol spectrum disorders. The grant recipient must make subgrants to eligible regional collaboratives in rural and urban areas of the state for the purposes specified in paragraph (c).

(b) "Eligible regional collaboratives" means a partnership between at least one local government or tribal government and at least one community-based organization and, where available, a family home visiting program. For purposes of this paragraph, a local government includes a county or a multicounty organization, a county-based purchasing entity, or a community health board.

(c) Eligible regional collaboratives must use subgrant funds to reduce the incidence of fetal alcohol spectrum disorders and other prenatal drug-related effects in children in Minnesota by identifying and serving pregnant women suspected of or known to use or abuse alcohol or other drugs. Eligible regional collaboratives must provide intensive services to women with substance use disorder to increase positive birth outcomes.

(d) An eligible regional collaborative that receives a subgrant under this section must report to the grant recipient by January 15 of each year on the services and programs funded by the subgrant.

The report must include measurable outcomes for the previous year, including the number of pregnant women served and the number of toxic-free babies born. The grant recipient must compile the information in the subgrant reports and submit a summary report to the commissioner of human services by February 15 of each year.

No active language found for: 254B.14.1

No active language found for: 254B.14.2

No active language found for: 254B.14.3

No active language found for: 254B.14.4

No active language found for: 254B.14.5

No active language found for: 254B.14.6

256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

No active language found for: 256.01.31

256B.057 ELIGIBILITY REQUIREMENTS FOR SPECIAL CATEGORIES.

No active language found for: 256B.057.7

256B.0638 OPIOID PRESCRIBING IMPROVEMENT PROGRAM.

No active language found for: 256B.0638.7

256B.0911 LONG-TERM CARE CONSULTATION SERVICES.

No active language found for: 256B.0911.1a

No active language found for: 256B.0911.2b

No active language found for: 256B.0911.2c

No active language found for: 256B.0911.3

No active language found for: 256B.0911.3a

No active language found for: 256B.0911.3b

No active language found for: 256B.0911.3f

No active language found for: 256B.0911.3g

No active language found for: 256B.0911.4d

No active language found for: 256B.0911.4e

No active language found for: 256B.0911.5

No active language found for: 256B.0911.6

256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.

Subd. 8a. **Level II mental health behavioral aide.** The commissioner of human services, in collaboration with children's mental health providers and the Board of Trustees of the Minnesota State Colleges and Universities, shall develop a certificate program for level II mental health behavioral aides.

256B.69 PREPAID HEALTH PLANS.

No active language found for: 256B.69.20

No active language found for: 256D.055

256R.08 REPORTING OF FINANCIAL STATEMENTS.

No active language found for: 256R.08.2

501C.0408 TRUST FOR CARE OF ANIMAL.

No active language found for: 501C.0408.4

No active language found for: 501C.1206

Laws 1998, chapter 382, article 1, section 23 by Laws 2022, chapter 98, article 14, section 33

Sec. 23. Laws 1995, chapter 257, article 1, section 34, is amended to read:

Sec. 34. **REPORT.**

(a) The commissioner of human services shall evaluate all child support programs and enforcement mechanisms

to determine the following:

(1) Minnesota's performance on the child support and incentive measures submitted by the federal Office of Child Support to the United States Congress;

(2) Minnesota's performance relative to other states;

(3) individual county performance; and

(4) recommendations for further improvement.

(b) The commissioner shall evaluate in separate categories the federal, state, and local government costs of child support enforcement in this state. The evaluation must also include a representative sample of private business costs relating to child support enforcement based on a survey of at least 50 Minnesota businesses and nonprofit organizations.

(c) The commissioner shall also report on the amount of child support arrearages in this state with separate categories for the amount of child support in arrears for 90 days, six months, one year, and two or more years. The report must establish a process for determining when an arrearage is considered uncollectible based on the age of the arrearage and likelihood of collection of the amount owed. The amounts determined to be uncollectible must be deducted from the total amount of outstanding arrearages for purposes of determining arrearages that are considered collectible.

(d) The first report on these topics shall be submitted to the legislature by January 1, 1999, and subsequent reports shall be submitted biennially before January 15 of each odd-numbered year.

2960.0460 STAFF QUALIFICATIONS.

Subp. 2. **Qualifications applying to employees with direct resident contact.** An employee working directly with residents must be at least 21 years of age and must, at the time of hiring, document meeting the qualifications in item A or B.

A. A program director, supervisor, counselor, or any other person who has direct resident contact must be free of chemical use problems for at least the two years immediately preceding hiring and freedom from chemical use problems must be maintained during employment.

B. Overnight staff must be free of chemical use problems for at least one year preceding their hiring and maintain freedom from chemical use problems during their employment.

9530.6565 STAFF QUALIFICATIONS.

Subp. 2. **Continuing employment requirement.** License holders must require freedom from chemical use problems as a condition of continuing employment. Staff must remain free of chemical use problems although they are not required to sign statements after the initial statement required by subpart 1, item A. Staff with chemical use problems must be immediately removed from any responsibilities that include direct client contact.

9555.6255 RESIDENT'S RIGHTS.

Subpart 1. **Information about rights.** The operator shall ensure that a resident and a resident's legal representative are given, at admission:

A. an explanation and copy of the resident's rights specified in subparts 2 to 7;

B. a written summary of the Vulnerable Adults Act prepared by the department; and

C. the name, address, and telephone number of the local agency to which a resident or a resident's legal representative may submit an oral or written complaint.

Subp. 2. **Right to use telephone.** A resident has the right to daily, private access to and use of a non-coin operated telephone for local calls and long distance calls made collect or paid for by the resident.

Subp. 3. **Right to receive and send mail.** A resident has the right to receive and send uncensored, unopened mail.

Subp. 4. **Right to privacy.** A resident has the right to personal privacy and privacy for visits from others, and the respect of individuality and cultural identity. Privacy must be respected by operators, caregivers, household members, and volunteers by knocking on the door of a resident's bedroom and seeking consent before entering, except in an emergency, and during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance as noted in the resident's individual record.

Subp. 5. **Right to use personal property.** A resident has the right to keep and use personal clothing and possessions as space permits, unless to do so would infringe on the health, safety, or rights of other residents or household members.

Subp. 6. **Right to associate.** A resident has the right to meet with or refuse to meet with visitors and participate in activities of commercial, religious, political, and community groups without interference if the activities do not infringe on the rights of other residents or household members.

Subp. 7. **Married residents.** Married residents have the right to privacy for visits by their spouses, and, if both spouses are residents of the adult foster home, they have the right to share a bedroom and bed.