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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 2196

03/12/2025 Authored by Fischer, Curran and Pérez-Vega
The bill was read for the first time and referred to the Committee on Human Services Finance and Policy

A bill for an act

relating to mental health; updating mental health terminology; amending Minnesota Statutes 2024, sections 62Q.527, subdivisions 1, 2, 3; 121A.61, subdivision 3; 128C.02, subdivision 5; 142G.02, subdivision 56; 142G.27, subdivision 4; 142G.42, subdivision 3; 245.462, subdivision 4; 245.4682, subdivision 3; 245.4835, subdivision 2; 245.4863; 245.487, subdivision 2; 245.4871, subdivisions 3, 4, 6, 13, 15, 17, 19, 21, 22, 28, 29, 31, 32, 34; 245.4873, subdivision 2; 245.4874, subdivision 1; 245.4875, subdivision 5; 245.4876, subdivisions 4, 5; 245.4877; 245.488, subdivisions 1, 3; 245.4881, subdivisions 1, 4; 245.4882, subdivisions 1, 5; 245.4884; 245.4885, subdivision 1; 245.4889, subdivision 1; 245.4907, subdivision 2; 245.491, subdivision 2; 245.492, subdivision 3; 245.697, subdivision 2a; 245.814, subdivision 3; 245.826; 245.91, subdivisions 2, 4; 245.92; 245.94, subdivision 1; 245A.03, subdivision 2; 245A.26, subdivisions 1, 2; 245I.05, subdivisions 3, 5; 245I.11, subdivision 5; 246C.12, subdivision 4; 252.27, subdivision 1; 256B.02, subdivision 11; 256B.055, subdivision 12; 256B.0616, subdivision 1; 256B.0757, subdivision 2; 256B.0943, subdivisions 1, 3, 9, 12, 13; 256B.0945, subdivision 1; 256B.0946, subdivision 6; 256B.0947, subdivision 3a; 256B.69, subdivision 23; 256B.77, subdivision 7a; 260B.157, subdivision 3; 260C.007, subdivisions 16, 26d, 27b; 260C.157, subdivision 3; 260C.201, subdivisions 1, 2; 260C.301, subdivision 4; 260D.01; 260D.02, subdivisions 5, 9; 260D.03, subdivision 1; 260D.04; 260D.06, subdivision 2; 260D.07; 260E.11, subdivision 3; 295.50, subdivision 9b.

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

Section 1. Minnesota Statutes 2024, section 62Q.527, subdivision 1, is amended to read:

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

~~(b) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.~~

~~(c)~~ (b) "Mental illness" has the meaning given in ~~section~~ sections 245.462, subdivision 20, paragraph (a), and 245.4871, subdivision 15.

~~(d)~~ (c) "Health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, subdivision 3, clauses (7) and (10).

Sec. 2. Minnesota Statutes 2024, section 62Q.527, subdivision 2, is amended to read:

Subd. 2. **Required coverage for antipsychotic drugs.** (a) A health plan that provides prescription drug coverage must provide coverage for an antipsychotic drug prescribed to treat ~~emotional disturbance or~~ mental illness regardless of whether the drug is in the health plan's drug formulary, if the health care provider prescribing the drug:

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the health care provider has considered all equivalent drugs in the health plan's drug formulary and has determined that the drug prescribed will best treat the patient's condition.

(b) The health plan is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.

(c) For drugs covered under this section, no health plan company that has received a certification from the health care provider as described in paragraph (a) may:

(1) impose a special deductible, co-payment, coinsurance, or other special payment requirement that the health plan does not apply to drugs that are in the health plan's drug formulary; or

(2) require written certification from the prescribing provider each time a prescription is refilled or renewed that the drug prescribed will best treat the patient's condition.

Sec. 3. Minnesota Statutes 2024, section 62Q.527, subdivision 3, is amended to read:

Subd. 3. **Continuing care.** (a) Enrollees receiving a prescribed drug to treat a diagnosed mental illness ~~or emotional disturbance~~ may continue to receive the prescribed drug for up to one year without the imposition of a special deductible, co-payment, coinsurance, or other special payment requirements, when a health plan's drug formulary changes or an enrollee changes health plans and the medication has been shown to effectively treat the patient's condition. In order to be eligible for this continuing care benefit:

(1) the patient must have been treated with the drug for 90 days prior to a change in a health plan's drug formulary or a change in the enrollee's health plan;

(2) the health care provider prescribing the drug indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(3) the health care provider prescribing the drug certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

(b) The continuing care benefit shall be extended annually when the health care provider prescribing the drug:

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

(c) The health plan company is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.

Sec. 4. Minnesota Statutes 2024, section 121A.61, subdivision 3, is amended to read:

Subd. 3. **Policy components.** The policy must include at least the following components:

(a) rules governing student conduct and procedures for informing students of the rules;

(b) the grounds for removal of a student from a class;

(c) the authority of the classroom teacher to remove students from the classroom pursuant to procedures and rules established in the district's policy;

(d) the procedures for removal of a student from a class by a teacher, school administrator, or other school district employee;

(e) the period of time for which a student may be removed from a class, which may not exceed five class periods for a violation of a rule of conduct;

(f) provisions relating to the responsibility for and custody of a student removed from a class;

(g) the procedures for return of a student to the specified class from which the student has been removed;

(h) the procedures for notifying a student and the student's parents or guardian of violations of the rules of conduct and of resulting disciplinary actions;

(i) any procedures determined appropriate for encouraging early involvement of parents or guardians in attempts to improve a student's behavior;

(j) any procedures determined appropriate for encouraging early detection of behavioral problems;

(k) any procedures determined appropriate for referring a student in need of special education services to those services;

(l) any procedures determined appropriate for ensuring victims of bullying who respond with behavior not allowed under the school's behavior policies have access to a remedial response, consistent with section 121A.031;

(m) the procedures for consideration of whether there is a need for a further assessment or of whether there is a need for a review of the adequacy of a current individualized education program of a student with a disability who is removed from class;

(n) procedures for detecting and addressing chemical abuse problems of a student while on the school premises;

(o) the minimum consequences for violations of the code of conduct;

(p) procedures for immediate and appropriate interventions tied to violations of the code;

(q) a provision that states that a teacher, school employee, school bus driver, or other agent of a district may use reasonable force in compliance with section 121A.582 and other laws;

(r) an agreement regarding procedures to coordinate crisis services to the extent funds are available with the county board responsible for implementing sections 245.487 to 245.4889 for students with a serious ~~emotional disturbance~~ mental illness or other students who have an individualized education program whose behavior may be addressed by crisis intervention;

(s) a provision that states a student must be removed from class immediately if the student engages in assault or violent behavior. For purposes of this paragraph, "assault" has the meaning given it in section 609.02, subdivision 10. The removal shall be for a period of time deemed appropriate by the principal, in consultation with the teacher;

(t) a prohibition on the use of exclusionary practices for early learners as defined in section 121A.425; and

(u) a prohibition on the use of exclusionary practices to address attendance and truancy issues.

Sec. 5. Minnesota Statutes 2024, section 128C.02, subdivision 5, is amended to read:

Subd. 5. **Rules for open enrollees.** (a) The league shall adopt league rules and regulations governing the athletic participation of pupils attending school in a nonresident district under section 124D.03.

(b) Notwithstanding other law or league rule or regulation to the contrary, when a student enrolls in or is readmitted to a recovery-focused high school after successfully completing a licensed program for treatment of alcohol or substance abuse~~,~~ or mental illness, ~~or emotional disturbance,~~ the student is immediately eligible to participate on the same basis as other district students in the league-sponsored activities of the student's resident school district. Nothing in this paragraph prohibits the league or school district from enforcing a league or district penalty resulting from the student violating a league or district rule.

(c) The league shall adopt league rules making a student with an individualized education program who transfers from one public school to another public school as a reasonable accommodation to reduce barriers to educational access immediately eligible to participate in league-sponsored varsity competition on the same basis as other students in the school to which the student transfers. The league also must establish guidelines, consistent with this paragraph, for reviewing the 504 plan of a student who transfers between public schools to determine whether the student is immediately eligible to participate in league-sponsored varsity competition on the same basis as other students in the school to which the student transfers.

Sec. 6. Minnesota Statutes 2024, section 142G.02, subdivision 56, is amended to read:

Subd. 56. **Learning disabled.** "Learning disabled," for purposes of an extension to the 60-month time limit under section 142G.42, subdivision 4, clause (3), means the person has a disorder in one or more of the psychological processes involved in perceiving, understanding, or using concepts through verbal language or nonverbal means. Learning disabled does not include learning problems that are primarily the result of visual, hearing, or motor disabilities; developmental disability; ~~emotional disturbance;~~ or mental illness or due to environmental, cultural, or economic disadvantage.

Sec. 7. Minnesota Statutes 2024, section 142G.27, subdivision 4, is amended to read:

Subd. 4. **Good cause exemptions for not attending orientation.** (a) The county agency shall not impose the sanction under section 142G.70 if it determines that the participant has good cause for failing to attend orientation. Good cause exists when:

(1) appropriate child care is not available;

(2) the participant is ill or injured;

(3) a family member is ill and needs care by the participant that prevents the participant from attending orientation. For a caregiver with a child or adult in the household who meets the disability or medical criteria for home care services under section 256B.0659, or a home and community-based waiver services program under chapter 256B, or meets the criteria for ~~severe emotional disturbance~~ serious mental illness under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c), good cause also exists when an interruption in the provision of those services occurs which prevents the participant from attending orientation;

(4) the caregiver is unable to secure necessary transportation;

(5) the caregiver is in an emergency situation that prevents orientation attendance;

(6) the orientation conflicts with the caregiver's work, training, or school schedule; or

(7) the caregiver documents other verifiable impediments to orientation attendance beyond the caregiver's control.

(b) Counties must work with clients to provide child care and transportation necessary to ensure a caregiver has every opportunity to attend orientation.

Sec. 8. Minnesota Statutes 2024, section 142G.42, subdivision 3, is amended to read:

Subd. 3. **Ill or incapacitated.** (a) An assistance unit subject to the time limit in section 142G.40, subdivision 1, is eligible to receive months of assistance under a hardship extension if the participant who reached the time limit belongs to any of the following groups:

(1) participants who are suffering from an illness, injury, or incapacity which has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and severely limits the person's ability to obtain or maintain suitable employment. These participants must follow the treatment recommendations of the qualified professional certifying the illness, injury, or incapacity;

(2) participants whose presence in the home is required as a caregiver because of the illness, injury, or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness or incapacity and the need for a person to provide assistance in the home has been certified by a qualified professional and is expected to continue for more than 30 days; or

(3) caregivers with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0651, subdivision 1, paragraph (c), or a home and community-based waiver services program under chapter 256B, or meets the criteria for ~~severe emotional disturbance~~ serious mental illness under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c). Caregivers in this category are presumed to be prevented from obtaining or maintaining suitable employment.

(b) An assistance unit receiving assistance under a hardship extension under this subdivision may continue to receive assistance as long as the participant meets the criteria in paragraph (a), clause (1), (2), or (3).

Sec. 9. Minnesota Statutes 2024, 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. 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~~ a serious mental illness 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. 10. Minnesota Statutes 2024, section 245.4682, subdivision 3, is amended to read:

Subd. 3. **Projects for coordination of care.** (a) Consistent with section 256B.69 and chapter 256L, the commissioner is authorized to solicit, approve, and implement up to three projects to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with social services. The commissioner shall require that each project be based on locally defined partnerships that include at least one health maintenance organization, community integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T, or county-based purchasing entity under section 256B.692 that is eligible to contract with the commissioner as a prepaid health plan, and the county or counties within the service area. Counties shall retain responsibility and authority for social services in these locally defined partnerships.

(b) The commissioner, in consultation with consumers, families, and their representatives, shall:

(1) determine criteria for approving the projects and use those criteria to solicit proposals for preferred integrated networks. The commissioner must develop criteria to evaluate the partnership proposed by the county and prepaid health plan to coordinate access and delivery of services. The proposal must at a minimum address how the partnership will coordinate the provision of:

(i) client outreach and identification of health and social service needs paired with expedited access to appropriate resources;

(ii) activities to maintain continuity of health care coverage;

(iii) children's residential mental health treatment and treatment foster care;

(iv) court-ordered assessments and treatments;

(v) prepetition screening and commitments under chapter 253B;

(vi) assessment and treatment of children identified through mental health screening of child welfare and juvenile corrections cases;

(vii) home and community-based waiver services;

(viii) assistance with finding and maintaining employment;

(ix) housing; and

(x) transportation;

(2) determine specifications for contracts with prepaid health plans to improve the plan's ability to serve persons with mental health conditions, including specifications addressing:

(i) early identification and intervention of physical and behavioral health problems;

(ii) communication between the enrollee and the health plan;

(iii) facilitation of enrollment for persons who are also eligible for a Medicare special needs plan offered by the health plan;

(iv) risk screening procedures;

(v) health care coordination;

(vi) member services and access to applicable protections and appeal processes;

(vii) specialty provider networks;

(viii) transportation services;

(ix) treatment planning; and

(x) administrative simplification for providers;

(3) begin implementation of the projects no earlier than January 1, 2009, with not more than 40 percent of the statewide population included during calendar year 2009 and additional counties included in subsequent years;

(4) waive any administrative rule not consistent with the implementation of the projects;

(5) allow potential bidders at least 90 days to respond to the request for proposals; and

(6) conduct an independent evaluation to determine if mental health outcomes have improved in that county or counties according to measurable standards designed in consultation with the advisory body established under this subdivision and reviewed by the State Advisory Council on Mental Health.

(c) Notwithstanding any statute or administrative rule to the contrary, the commissioner may enroll all persons eligible for medical assistance with serious mental illness ~~or emotional disturbance~~ in the prepaid plan of their choice within the project service area unless:

(1) the individual is eligible for home and community-based services for persons with developmental disabilities and related conditions under section 256B.092; or

(2) the individual has a basis for exclusion from the prepaid plan under section 256B.69, subdivision 4, other than disability, or mental illness~~, or emotional disturbance~~.

(d) The commissioner shall involve organizations representing persons with mental illness and their families in the development and distribution of information used to educate potential enrollees regarding their options for health care and mental health service delivery under this subdivision.

(e) If the person described in paragraph (c) does not elect to remain in fee-for-service medical assistance, or declines to choose a plan, the commissioner may preferentially assign that person to the prepaid plan participating in the preferred integrated network. The commissioner shall implement the enrollment changes within a project's service area on the timeline specified in that project's approved application.

(f) A person enrolled in a prepaid health plan under paragraphs (c) and (d) may disenroll from the plan at any time.

(g) The commissioner, in consultation with consumers, families, and their representatives, shall evaluate the projects begun in 2009, and shall refine the design of the service integration projects before expanding the projects. The commissioner shall report to the chairs of the legislative committees with jurisdiction over mental health services by March 1, 2008, on plans for evaluation of preferred integrated networks established under this subdivision.

(h) The commissioner shall apply for any federal waivers necessary to implement these changes.

(i) Payment for Medicaid service providers under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

Sec. 11. Minnesota Statutes 2024, section 245.4835, subdivision 2, is amended to read:

Subd. 2. **Failure to maintain expenditures.** (a) If a county does not comply with subdivision 1, the commissioner shall require the county to develop a corrective action plan according to a format and timeline established by the commissioner. If the commissioner determines that a county has not developed an acceptable corrective action plan within the required timeline, or that the county is not in compliance with an approved corrective action plan, the protections provided to that county under section 245.485 do not apply.

(b) The commissioner shall consider the following factors to determine whether to approve a county's corrective action plan:

(1) the degree to which a county is maximizing revenues for mental health services from noncounty sources;

(2) the degree to which a county is expanding use of alternative services that meet mental health needs, but do not count as mental health services within existing reporting systems. If approved by the commissioner, the alternative services must be included in the county's base as well as subsequent years. The commissioner's approval for alternative services must be based on the following criteria:

(i) the service must be provided to children ~~with emotional disturbance~~ or adults with mental illness;

(ii) the services must be based on an individual treatment plan or individual community support plan as defined in the Comprehensive Mental Health Act; and

(iii) the services must be supervised by a mental health professional and provided by staff who meet the staff qualifications defined in sections 256B.0943, subdivision 7, and 256B.0623, subdivision 5.

(c) Additional county expenditures to make up for the prior year's underspending may be spread out over a two-year period.

Sec. 12. Minnesota Statutes 2024, section 245.4863, is amended to read:

245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.

(a) The commissioner shall require individuals who perform substance use disorder assessments to screen clients for co-occurring mental health disorders, and staff who perform mental health diagnostic assessments to screen for co-occurring substance use disorders. Screening tools must be approved by the commissioner. If a client screens positive for a co-occurring mental health or substance use disorder, the individual performing the screening must document what actions will be taken in response to the results and whether further assessments must be performed.

(b) Notwithstanding paragraph (a), screening is not required when:

(1) the presence of co-occurring disorders was documented for the client in the past 12 months;

(2) the client is currently receiving co-occurring disorders treatment;

(3) the client is being referred for co-occurring disorders treatment; or

(4) a mental health professional who is competent to perform diagnostic assessments of co-occurring disorders is performing a diagnostic assessment to identify whether the client may have co-occurring mental health and substance use disorders. If an individual is identified to have co-occurring mental health and substance use disorders, the assessing mental health professional must document what actions will be taken to address the client's co-occurring disorders.

(c) The commissioner shall adopt rules as necessary to implement this section. The commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing a certification process for integrated dual disorder treatment providers and a system through which individuals receive integrated dual diagnosis treatment if assessed as having both a substance use disorder and ~~either~~ a serious mental illness ~~or emotional disturbance~~.

(d) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of integrated dual diagnosis treatment to persons with co-occurring disorders.

Sec. 13. Minnesota Statutes 2024, section 245.487, subdivision 2, is amended to read:

Subd. 2. **Findings.** The legislature finds there is a need for further development of existing clinical services for ~~emotionally disturbed~~ children with mental illness and their families and the creation of new services for this population. Although the services specified in sections 245.487 to 245.4889 are mental health services, sections 245.487 to 245.4889 emphasize the need for a child-oriented and family-oriented approach of therapeutic programming and the need for continuity of care with other community agencies. At the same time, sections 245.487 to 245.4889 emphasize the importance of developing special mental health expertise in children's mental health services because of the unique needs of this population.

Nothing in sections 245.487 to 245.4889 shall be construed to abridge the authority of the court to make dispositions under chapter 260, but the mental health services due any child with serious and persistent mental illness, as defined in section 245.462, subdivision 20, or with ~~severe emotional disturbance~~ a serious mental illness, as defined in section 245.4871, subdivision 6, shall be made a part of any disposition affecting that child.

Sec. 14. Minnesota Statutes 2024, section 245.4871, subdivision 3, is amended to read:

Subd. 3. **Case management services.** "Case management services" means activities that are coordinated with the family community support services and are designed to help the child with ~~severe emotional disturbance~~ serious mental illness and the child's family obtain needed mental health services, social services, educational services, health services, vocational services, recreational services, and related services in the areas of volunteer services, advocacy, transportation, and legal services. Case management services include assisting in obtaining a comprehensive diagnostic assessment, developing an individual family community support plan, and assisting the child and the child's family in obtaining needed services by coordination with other agencies and assuring continuity of care. Case managers must assess and reassess the delivery, appropriateness, and effectiveness of services over time.

Sec. 15. Minnesota Statutes 2024, section 245.4871, 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 subdivision 3 for the child with ~~severe emotional disturbance~~ serious mental illness and the child's family.

(b) A case manager must:

(1) have experience and training in working with children;

(2) have at least 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 or meet the requirements of paragraph (d);

(3) have experience and training in identifying and assessing a wide range of children's needs;

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families; and

(5) meet the supervision and continuing education requirements of paragraphs (e), (f), and (g), as applicable.

(c) A case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) A case manager 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;

(2) be a registered nurse without a bachelor's degree who has 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 Services waiver provision and meets the continuing education, supervision, and mentoring requirements in this section.

(e) A case manager with at least 2,000 hours of supervised experience in the delivery of mental health services to children 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 other 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.

(f) A case manager without 2,000 hours of supervised experience in the delivery of mental health services to children with ~~emotional disturbance~~ mental illness must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with ~~severe emotional disturbance~~ serious mental illness before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour each week until the requirement of 2,000 hours of experience is met.

(g) 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 ~~severe emotional disturbance~~ serious mental illness and mental health services every two years.

(h) Clinical supervision must be documented in the child's record. When the case manager is not a mental health professional, the county board must provide or contract for needed clinical supervision.

(i) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

(j) 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 registered nurse without a bachelor's degree;

(iii) have three years of life experience as a primary caregiver to a child with serious ~~emotional disturbance~~ mental illness as defined in subdivision 6 within the previous ten years;

(iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

(v) have 6,000 hours of supervised work experience in the delivery of mental health services to children with ~~emotional disturbances~~ mental illness; hours worked as a mental health behavioral aide I or II under section 256B.0943, subdivision 7, may count toward the 6,000 hours of supervised work experience.

Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (v) may qualify as a case manager after three years of supervised experience as a case manager associate.

(k) Case manager associates must meet the following supervision, mentoring, and continuing education requirements;

(1) have 40 hours of preservice training described under paragraph (f), clause (1);

(2) receive at least 40 hours of continuing education in ~~severe emotional disturbance~~ serious mental illness and mental health service 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.

(l) A case management supervisor must meet the criteria for a mental health professional as specified in subdivision 27.

(m) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to child immigrants with ~~severe emotional disturbance~~ serious mental illness of the same ethnic group as the immigrant 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 related fields at 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 obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Sec. 16. Minnesota Statutes 2024, section 245.4871, subdivision 6, is amended to read:

Subd. 6. **Child with ~~severe emotional disturbance~~ serious mental illness.** For purposes of eligibility for case management and family community support services, "child with ~~severe emotional disturbance~~ serious mental illness" means a child who has ~~an emotional disturbance~~ a mental illness and who meets one of the following criteria:

(1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for ~~an emotional disturbance~~ a mental illness; or

(2) the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for ~~an emotional disturbance~~ a mental illness through the interstate compact; or

(3) the child has one of the following as determined by a mental health professional:

(i) psychosis or a clinical depression; or

(ii) risk of harming self or others as a result of ~~an emotional disturbance~~ a mental illness; or

(iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or

(4) the child, as a result of ~~an emotional disturbance~~ a mental illness, has significantly impaired home, school, or community functioning that has lasted at least one year or that,

in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

Sec. 17. Minnesota Statutes 2024, section 245.4871, subdivision 13, is amended to read:

Subd. 13. **Education and prevention services.** (a) "Education and prevention services" means services designed to:

(1) educate the general public;

(2) increase the understanding and acceptance of problems associated with ~~emotional disturbances~~ children's mental illnesses;

(3) improve people's skills in dealing with high-risk situations known to affect children's mental health and functioning; and

(4) refer specific children or their families with mental health needs to mental health services.

(b) The services include distribution to individuals and agencies identified by the county board and the local children's mental health advisory council of information on predictors and symptoms of ~~emotional disturbances~~ mental illnesses, where mental health services are available in the county, and how to access the services.

Sec. 18. Minnesota Statutes 2024, section 245.4871, subdivision 15, is amended to read:

Subd. 15. ~~**Emotional disturbance**~~ **Mental illness.** ~~"Emotional disturbance"~~ "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

(1) is detailed in a diagnostic codes list published by the commissioner; and

(2) seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

~~"Emotional disturbance"~~ Mental illness is a generic term and is intended to reflect all categories of disorder described in the clinical code list published by the commissioner as "usually first evident in childhood or adolescence."

Sec. 19. Minnesota Statutes 2024, section 245.4871, subdivision 17, is amended to read:

Subd. 17. **Family community support services.** "Family community support services" means services provided under the treatment supervision of a mental health professional and designed to help each child with ~~severe emotional disturbance~~ serious mental illness to

function and remain with the child's family in the community. Family community support services do not include acute care hospital inpatient treatment, residential treatment services, or regional treatment center services. Family community support services include:

(1) client outreach to each child with ~~severe emotional disturbance~~ serious mental illness and the child's family;

(2) medication monitoring where necessary;

(3) assistance in developing independent living skills;

(4) assistance in developing parenting skills necessary to address the needs of the child with ~~severe emotional disturbance~~ serious mental illness;

(5) assistance with leisure and recreational activities;

(6) crisis planning, including crisis placement and respite care;

(7) professional home-based family treatment;

(8) foster care with therapeutic supports;

(9) day treatment;

(10) assistance in locating respite care and special needs day care; and

(11) assistance in obtaining potential financial resources, including those benefits listed in section 245.4884, subdivision 5.

Sec. 20. Minnesota Statutes 2024, section 245.4871, subdivision 19, is amended to read:

Subd. 19. **Individual family community support plan.** "Individual family community support plan" means a written plan developed by a case manager in conjunction with the family and the child with ~~severe emotional disturbance~~ serious mental illness on the basis of a diagnostic assessment and a functional assessment. The plan identifies specific services needed by a child and the child's family to:

(1) treat the symptoms and dysfunctions determined in the diagnostic assessment;

(2) relieve conditions leading to ~~emotional disturbance~~ mental illness and improve the personal well-being of the child;

(3) improve family functioning;

(4) enhance daily living skills;

(5) improve functioning in education and recreation settings;

(6) improve interpersonal and family relationships;

(7) enhance vocational development; and

(8) assist in obtaining transportation, housing, health services, and employment.

Sec. 21. Minnesota Statutes 2024, 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~~ a mental illness 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~~ a mental illness.

Sec. 22. Minnesota Statutes 2024, section 245.4871, subdivision 22, is amended to read:

Subd. 22. **Legal representative.** "Legal representative" means a guardian, conservator, or guardian ad litem of a child with ~~an emotional disturbance~~ a mental illness authorized by the court to make decisions about mental health services for the child.

Sec. 23. Minnesota Statutes 2024, section 245.4871, subdivision 28, is amended to read:

Subd. 28. **Mental health services.** "Mental health services" means at least all of the treatment services and case management activities that are provided to children with ~~emotional disturbances~~ mental illnesses and are described in sections 245.487 to 245.4889.

Sec. 24. Minnesota Statutes 2024, section 245.4871, subdivision 29, is amended to read:

Subd. 29. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under

the treatment supervision of a mental health professional to children with ~~emotional disturbances~~ mental illnesses who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 25. Minnesota Statutes 2024, section 245.4871, subdivision 31, is amended to read:

Subd. 31. **Professional home-based family treatment.** (a) "Professional home-based family treatment" means intensive mental health services provided to children because of ~~an emotional disturbance~~ a mental illness: (1) who are at risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care; (2) who are in ~~out-of-home placement~~ residential treatment or therapeutic foster care; or (3) who are returning from ~~out-of-home placement~~ residential treatment or therapeutic foster care.

(b) Services are provided to the child and the child's family primarily in the child's home environment. Services may also be provided in the child's school, child care setting, or other community setting appropriate to the child. Services must be provided on an individual family basis, must be child-oriented and family-oriented, and must be designed using information from diagnostic and functional assessments to meet the specific mental health needs of the child and the child's family. Services must be coordinated with other services provided to the child and family.

(c) Examples of services are: (1) individual therapy; (2) family therapy; (3) client outreach; (4) assistance in developing individual living skills; (5) assistance in developing parenting skills necessary to address the needs of the child; (6) assistance with leisure and recreational services; (7) crisis planning, including crisis respite care and arranging for crisis placement; and (8) assistance in locating respite and child care. Services must be coordinated with other services provided to the child and family.

Sec. 26. Minnesota Statutes 2024, section 245.4871, subdivision 32, is amended to read:

Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for children with ~~emotional disturbances~~ mental illnesses under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted by the commissioner.

Sec. 27. Minnesota Statutes 2024, section 245.4871, subdivision 34, is amended to read:

Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care" means the mental health training and mental health support services and treatment supervision provided by a mental health professional to foster families caring for children with ~~severe emotional disturbance~~ serious mental illnesses to provide a therapeutic family environment and support for the child's improved functioning. Therapeutic support of foster care includes services provided under section 256B.0946.

Sec. 28. Minnesota Statutes 2024, section 245.4873, subdivision 2, is amended to read:

Subd. 2. **State level; coordination.** The Children's Cabinet, under section 4.045, in consultation with a representative of the Minnesota District Judges Association Juvenile Committee, shall:

(1) educate each agency about the policies, procedures, funding, and services for children with ~~emotional disturbances~~ mental illnesses of all agencies represented;

(2) develop mechanisms for interagency coordination on behalf of children with ~~emotional disturbances~~ mental illnesses;

(3) identify barriers including policies and procedures within all agencies represented that interfere with delivery of mental health services for children;

(4) recommend policy and procedural changes needed to improve development and delivery of mental health services for children in the agency or agencies they represent; and

(5) identify mechanisms for better use of federal and state funding in the delivery of mental health services for children.

Sec. 29. Minnesota Statutes 2024, section 245.4874, subdivision 1, is amended to read:

Subdivision 1. **Duties of county board.** (a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4889;

(2) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(3) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4889;

(4) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(5) assure that mental health services delivered according to sections 245.487 to 245.4889 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(6) provide for case management services to each child with ~~severe emotional disturbance~~ serious mental illness according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(7) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility~~, acute care hospital inpatient treatment, or informal admission to a regional treatment center~~;

(8) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4889;

(9) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

(10) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;

(11) assure that culturally competent mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and

(12) consistent with section 245.486, arrange for or provide a children's mental health screening for:

(i) a child receiving child protective services;

(ii) a child in ~~out-of-home placement~~ residential treatment or therapeutic foster care;

(iii) a child for whom parental rights have been terminated;

(iv) a child found to be delinquent; or

(v) a child found to have committed a juvenile petty offense for the third or subsequent time.

A children's mental health screening is not required when a screening or diagnostic assessment has been performed within the previous 180 days, or the child is currently under the care of a mental health professional.

(b) When a child is receiving protective services or is in ~~out-of-home placement~~ residential treatment or foster care, the court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing.

(c) When a child is found to be delinquent or a child is found to have committed a juvenile petty offense for the third or subsequent time, the court or county agency must obtain written informed consent from the parent or legal guardian before a screening is conducted unless the court, notwithstanding the parent's failure to consent, determines that the screening is in the child's best interest.

(d) The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations. Screenings shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include:

(1) training in the administration of the instrument;

(2) the interpretation of its validity given the child's current circumstances;

(3) the state and federal data practices laws and confidentiality standards;

(4) the parental consent requirement; and

(5) providing respect for families and cultural values.

If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results are classified as private data on individuals, as defined by section 13.02, subdivision 12. The county board or Tribal nation may provide

the commissioner with access to the screening results for the purposes of program evaluation and improvement.

(e) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Sec. 30. Minnesota Statutes 2024, section 245.4875, subdivision 5, is amended to read:

Subd. 5. **Local children's advisory council.** (a) By October 1, 1989, the county board, individually or in conjunction with other county boards, shall establish a local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council or shall include persons on its existing mental health advisory council who are representatives of children's mental health interests. The following individuals must serve on the local children's mental health advisory council, the children's mental health subcommittee of an existing local mental health advisory council, or be included on an existing mental health advisory council: (1) at least one person who was in a mental health program as a child or adolescent; (2) at least one parent of a child or adolescent with ~~severe emotional disturbance~~ serious mental illness; (3) one children's mental health professional; (4) representatives of minority populations of significant size residing in the county; (5) a representative of the children's mental health local coordinating council; and (6) one family community support services program representative.

(b) The local children's mental health advisory council or children's mental health subcommittee of an existing advisory council shall seek input from parents, former consumers, providers, and others about the needs of children with ~~emotional disturbance~~ mental illness in the local area and services needed by families of these children, and shall meet monthly, unless otherwise determined by the council or subcommittee, but not less than quarterly, to review, evaluate, and make recommendations regarding the local children's mental health system. Annually, the local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council shall:

(1) arrange for input from the local system of care providers regarding coordination of care between the services;

(2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.4877, clause (2); and

(3) provide to the county board a report of unmet mental health needs of children residing in the county.

(c) The county board shall consider the advice of its local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council in carrying out its authorities and responsibilities.

Sec. 31. Minnesota Statutes 2024, section 245.4876, subdivision 4, is amended to read:

Subd. 4. **Referral for case management.** Each provider of emergency services, outpatient treatment, community support services, family community support services, day treatment services, screening under section 245.4885, professional home-based family treatment services, residential treatment facilities, acute care hospital inpatient treatment facilities, or regional treatment center services must inform each child with ~~severe emotional disturbance~~ serious mental illness, and the child's parent or legal representative, of the availability and potential benefits to the child of case management. The information shall be provided as specified in subdivision 5. If consent is obtained according to subdivision 5, the provider must refer the child by notifying the county employee designated by the county board to coordinate case management activities of the child's name and address and by informing the child's family of whom to contact to request case management. The provider must document compliance with this subdivision in the child's record. The parent or child may directly request case management even if there has been no referral.

Sec. 32. Minnesota Statutes 2024, section 245.4876, subdivision 5, is amended to read:

Subd. 5. **Consent for services or for release of information.** (a) Although sections 245.487 to 245.4889 require each county board, within the limits of available resources, to make the mental health services listed in those sections available to each child residing in the county who needs them, the county board shall not provide any services, either directly or by contract, unless consent to the services is obtained under this subdivision. The case manager assigned to a child with a ~~severe emotional disturbance~~ serious mental illness shall not disclose to any person other than the case manager's immediate supervisor and the mental health professional providing clinical supervision of the case manager information on the child, the child's family, or services provided to the child or the child's family without informed written consent unless required to do so by statute or under the Minnesota Government Data Practices Act. Informed written consent must comply with section 13.05, subdivision 4, paragraph (d), and specify the purpose and use for which the case manager may disclose the information.

(b) The consent or authorization must be obtained from the child's parent unless: (1) the parental rights are terminated; or (2) consent is otherwise provided under sections 144.341 to 144.347; 253B.04, subdivision 1; 260C.148; 260C.151; and 260C.201, subdivision 1, the terms of appointment of a court-appointed guardian or conservator, or federal regulations governing substance use disorder services.

Sec. 33. Minnesota Statutes 2024, section 245.4877, is amended to read:

245.4877 EDUCATION AND PREVENTION SERVICES.

Education and prevention services must be available to all children residing in the county. Education and prevention services must be designed to:

(1) convey information regarding ~~emotional disturbances~~ mental illnesses, mental health needs, and treatment resources to the general public;

(2) at least annually, distribute to individuals and agencies identified by the county board and the local children's mental health advisory council information on predictors and symptoms of ~~emotional disturbances~~ mental illnesses, where mental health services are available in the county, and how to access the services;

(3) increase understanding and acceptance of problems associated with ~~emotional disturbances~~ mental illnesses;

(4) improve people's skills in dealing with high-risk situations known to affect children's mental health and functioning;

(5) prevent development or deepening of ~~emotional disturbances~~ mental illnesses; and

(6) refer each child with ~~emotional disturbance~~ mental illness or the child's family with additional mental health needs to appropriate mental health services.

Sec. 34. Minnesota Statutes 2024, section 245.488, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of each child with ~~emotional disturbance~~ mental illness residing in the county and the child's family. Services may be provided directly by the county through county-operated mental health clinics meeting the standards of chapter 245I; by contract with privately operated mental health clinics meeting the standards of chapter 245I; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a mental health professional. A child or a child's parent

may be required to pay a fee based in accordance with section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating the child's mental health needs through therapy; and

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the child requires necessary and appropriate services that are only available outside the county.

(c) Outpatient services offered by the county board to prevent placement must be at the level of treatment appropriate to the child's diagnostic assessment.

Sec. 35. Minnesota Statutes 2024, section 245.488, subdivision 3, is amended to read:

Subd. 3. **Mental health crisis services.** County boards must provide or contract for mental health crisis services within the county to meet the needs of children with ~~emotional disturbance~~ mental illness residing in the county who are determined, through an assessment by a mental health professional, to be experiencing a mental health crisis or mental health emergency. The mental health crisis services provided must be medically necessary, as defined in section 62Q.53, subdivision 2, and necessary for the safety of the child or others regardless of the setting.

Sec. 36. Minnesota Statutes 2024, section 245.4881, subdivision 1, is amended to read:

Subdivision 1. **Availability of case management services.** (a) The county board shall provide case management services for each child with ~~severe emotional disturbance~~ serious mental illness who is a resident of the county and the child's family who request or consent to the services. Case management services must be offered to a child with a serious ~~emotional disturbance~~ mental illness who is over the age of 18 consistent with section 245.4875, subdivision 8, or the child's legal representative, provided the child's service needs can be met within the children's service system. Before discontinuing case management services under this subdivision for children between the ages of 17 and 21, a transition plan must be

developed. The transition plan must be developed with the child and, with the consent of a child age 18 or over, the child's parent, guardian, or legal representative. The transition plan should include plans for health insurance, housing, education, employment, and treatment. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.4871, subdivision 4.

(b) Except as permitted by law and the commissioner under demonstration projects, case management services provided to children with ~~severe emotional disturbance~~ serious mental illness eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

(c) Case management services are eligible for reimbursement under the medical assistance program. Costs of mentoring, supervision, and continuing education may be included in the reimbursement rate methodology used for case management services under the medical assistance program.

Sec. 37. Minnesota Statutes 2024, section 245.4881, subdivision 4, is amended to read:

Subd. 4. **Individual family community support plan.** (a) For each child, the case manager must develop an individual family community support plan that incorporates the child's individual treatment plan. The individual treatment plan may not be a substitute for the development of an individual family community support plan. The case manager is responsible for developing the individual family community support plan within 30 days of intake based on a diagnostic assessment and for implementing and monitoring the delivery of services according to the individual family community support plan. The case manager must review the plan at least every 180 calendar days after it is developed, unless the case manager has received a written request from the child's family or an advocate for the child for a review of the plan every 90 days after it is developed. To the extent appropriate, the child with ~~severe emotional disturbance~~ serious mental illness, the child's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual family community support plan. Notwithstanding the lack of an individual family community support plan, the case manager shall assist the child and child's family in accessing the needed services listed in section 245.4884, subdivision 1.

(b) The child's individual family community support plan must state:

(1) the goals and expected outcomes of each service and criteria for evaluating the effectiveness and appropriateness of the service;

(2) the activities for accomplishing each goal;

(3) a schedule for each activity; and

(4) the frequency of face-to-face contacts by the case manager, as appropriate to client need and the implementation of the individual family community support plan.

Sec. 38. Minnesota Statutes 2024, section 245.4882, subdivision 1, is amended to read:

Subdivision 1. **Availability of residential treatment services.** County boards must provide or contract for enough residential treatment services to meet the needs of each child with ~~severe emotional disturbance~~ serious mental illness residing in the county and needing this level of care. Length of stay is based on the child's residential treatment need and shall be reviewed every 90 days. Services must be appropriate to the child's age and treatment needs and must be made available as close to the county as possible. Residential treatment must be designed to:

(1) help the child improve family living and social interaction skills;

(2) help the child gain the necessary skills to return to the community;

(3) stabilize crisis admissions; and

(4) work with families throughout the placement to improve the ability of the families to care for children with ~~severe emotional disturbance~~ serious mental illness in the home.

Sec. 39. Minnesota Statutes 2024, section 245.4882, subdivision 5, is amended to read:

Subd. 5. **Specialized residential treatment services.** The commissioner of human services shall continue efforts to further interagency collaboration to develop a comprehensive system of services, including family community support and specialized residential treatment services for children. The services shall be designed for children with ~~emotional disturbance~~ mental illness who exhibit violent or destructive behavior and for whom local treatment services are not feasible due to the small number of children statewide who need the services and the specialized nature of the services required. The services shall be located in community settings.

Sec. 40. Minnesota Statutes 2024, section 245.4884, is amended to read:

245.4884 FAMILY COMMUNITY SUPPORT SERVICES.

Subdivision 1. **Availability of family community support services.** By July 1, 1991, county boards must provide or contract for sufficient family community support services within the county to meet the needs of each child with ~~severe emotional disturbance~~ serious

mental illness who resides in the county and the child's family. Children or their parents may be required to pay a fee in accordance with section 245.481.

Family community support services must be designed to improve the ability of children with ~~severe emotional disturbance~~ serious mental illness to:

(1) manage basic activities of daily living;

(2) function appropriately in home, school, and community settings;

(3) participate in leisure time or community youth activities;

(4) set goals and plans;

(5) reside with the family in the community;

(6) participate in after-school and summer activities;

(7) make a smooth transition among mental health and education services provided to children; and

(8) make a smooth transition into the adult mental health system as appropriate.

In addition, family community support services must be designed to improve overall family functioning if clinically appropriate to the child's needs, and to reduce the need for and use of placements more intensive, costly, or restrictive both in the number of admissions and lengths of stay than indicated by the child's diagnostic assessment.

The commissioner of human services shall work with mental health professionals to develop standards for clinical supervision of family community support services. These standards shall be incorporated in rule and in guidelines for grants for family community support services.

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be part of the family community support services available to each child with ~~severe emotional disturbance~~ serious mental illness residing in the county. A child or the child's parent may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placements that are more intensive, costly, or restrictive than necessary to meet the child's need;

(4) coordinate with or be offered in conjunction with the child's education program;

(5) provide therapy and family intervention for children that are coordinated with education services provided and funded by schools; and

(6) operate during all 12 months of the year.

(b) County boards may request a waiver from including day treatment services if they can document that:

(1) alternative services exist through the county's family community support services for each child who would otherwise need day treatment services; and

(2) county demographics and geography make the provision of day treatment services cost ineffective and unfeasible.

Subd. 3. **Professional home-based family treatment provided.** (a) By January 1, 1991, county boards must provide or contract for sufficient professional home-based family treatment within the county to meet the needs of each child with ~~severe emotional disturbance~~ serious mental illness who is at risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care due to the child's ~~emotional disturbance~~ mental illness or who is returning to the home from ~~out-of-home placement~~ residential treatment or therapeutic foster care. The child or the child's parent may be required to pay a fee according to section 245.481. The county board shall require that all service providers of professional home-based family treatment set fee schedules approved by the county board that are based on the child's or family's ability to pay. The professional home-based family treatment must be designed to assist each child with ~~severe emotional disturbance~~ serious mental illness who is at risk of or who is returning from ~~out-of-home placement~~ residential treatment or therapeutic foster care and the child's family to:

(1) improve overall family functioning in all areas of life;

(2) treat the child's symptoms of ~~emotional disturbance~~ mental illness that contribute to a risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care;

(3) provide a positive change in the emotional, behavioral, and mental well-being of children and their families; and

(4) reduce risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care for the identified child with ~~severe emotional disturbance~~ serious mental illness and other siblings or successfully reunify and reintegrate into the family a child returning from ~~out-of-home placement~~ residential treatment or therapeutic foster care due to ~~emotional disturbance~~ mental illness.

(b) Professional home-based family treatment must be provided by a team consisting of a mental health professional and others who are skilled in the delivery of mental health services to children and families in conjunction with other human service providers. The professional home-based family treatment team must maintain flexible hours of service availability and must provide or arrange for crisis services for each family, 24 hours a day, seven days a week. Case loads for each professional home-based family treatment team must be small enough to permit the delivery of intensive services and to meet the needs of the family. Professional home-based family treatment providers shall coordinate services and service needs with case managers assigned to children and their families. The treatment team must develop an individual treatment plan that identifies the specific treatment objectives for both the child and the family.

Subd. 4. **Therapeutic support of foster care.** By January 1, 1992, county boards must provide or contract for foster care with therapeutic support as defined in section 245.4871, subdivision 34. Foster families caring for children with ~~severe emotional disturbance~~ serious mental illness must receive training and supportive services, as necessary, at no cost to the foster families within the limits of available resources.

Subd. 5. **Benefits assistance.** The county board must offer help to a child with ~~severe emotional disturbance~~ serious mental illness and the child's family in applying for federal benefits, including Supplemental Security Income, medical assistance, and Medicare.

Sec. 41. Minnesota Statutes 2024, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the case of an emergency, all children referred for treatment of ~~severe emotional disturbance~~ serious mental illness in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center shall undergo an assessment to determine the appropriate level of care if county funds are used to pay for the child's services. An emergency includes when a child is in need of and has been referred for crisis stabilization services under section 245.4882, subdivision 6. A child who has been referred to residential treatment for crisis stabilization services in a residential treatment center is not required to undergo an assessment under this section.

(b) The county board shall determine the appropriate level of care for a child when county-controlled funds are used to pay for the child's residential treatment under this chapter, including residential treatment provided in a qualified residential treatment program as defined in section 260C.007, subdivision 26d. When a county board does not have responsibility for a child's placement and the child is enrolled in a prepaid health program

under section 256B.69, the enrolled child's contracted health plan must determine the appropriate level of care for the child. When Indian Health Services funds or funds of a tribally owned facility funded under the Indian Self-Determination and Education Assistance Act, Public Law 93-638, are used for the child, the Indian Health Services or 638 tribal health facility must determine the appropriate level of care for the child. When more than one entity bears responsibility for a child's coverage, the entities shall coordinate level of care determination activities for the child to the extent possible.

(c) The child's level of care determination shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's needs.

(d) When a level of care determination is conducted, the county board or other entity may not determine that a screening of a child, referral, or admission to a residential treatment facility is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. The level of care determination must be based on a diagnostic assessment of a child that evaluates the child's family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care to the child. The validated tool must be approved by the commissioner of human services and may be the validated tool approved for the child's assessment under section 260C.704 if the juvenile treatment screening team recommended placement of the child in a qualified residential treatment program. If a diagnostic assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether these services are available and accessible to the child and the child's family. The child and the child's family must be invited to any meeting where the level of care determination is discussed

and decisions regarding residential treatment are made. The child and the child's family may invite other relatives, friends, or advocates to attend these meetings.

(e) During the level of care determination process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

(f) The level of care determination, placement decision, and recommendations for mental health services must be documented in the child's record and made available to the child's family, as appropriate.

Sec. 42. Minnesota Statutes 2024, 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 142D.15 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~~ mental illness 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~~ mental illness or ~~severe emotional disturbances~~ serious mental illness who are at risk of residential treatment or hospitalization~~,~~; who are already in ~~out-of-home placement~~ residential treatment, therapeutic foster care, or in family foster settings as defined in chapter 142B and at risk of change in ~~out-of-home placement~~ foster care or placement in a residential facility or other higher level of care~~,~~; who have utilized crisis services or emergency room services~~,~~; or who have experienced a loss of in-home staffing support. 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. Counties must work to provide access to regularly scheduled respite care;

(4) children's mental health crisis services;

(5) child-, youth-, and family-specific mobile response and stabilization services models;

(6) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(7) children's mental health screening and follow-up diagnostic assessment and treatment;

(8) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(9) school-linked mental health services under section 245.4901;

(10) building evidence-based mental health intervention capacity for children birth to age five;

(11) suicide prevention and counseling services that use text messaging statewide;

(12) mental health first aid training;

(13) 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;

(14) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(15) early childhood mental health consultation;

(16) 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;

(17) psychiatric consultation for primary care practitioners; and

(18) 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.

(e) The commissioner may establish and design a pilot program to expand the mobile response and stabilization services model for children, youth, and families. The commissioner may use grant funding to consult with a qualified expert entity to assist in the formulation of measurable outcomes and explore and position the state to submit a Medicaid state plan amendment to scale the model statewide.

Sec. 43. Minnesota Statutes 2024, section 245.4907, subdivision 2, is amended to read:

Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider that employs a mental health certified peer family specialist qualified under section 245I.04, subdivision 12, and that provides services to families who have a child:

(1) with ~~an emotional disturbance~~ a mental illness or ~~severe emotional disturbance~~ serious mental illness under chapter 245;

(2) receiving inpatient hospitalization under section 256B.0625, subdivision 1;

(3) admitted to a residential treatment facility under section 245.4882;

(4) receiving children's intensive behavioral health services under section 256B.0946;

(5) receiving day treatment or children's therapeutic services and supports under section 256B.0943; or

(6) receiving crisis response services under section 256B.0624.

Sec. 44. Minnesota Statutes 2024, section 245.491, subdivision 2, is amended to read:

Subd. 2. **Purpose.** The legislature finds that children with mental illnesses or emotional or behavioral disturbances or who are at risk of suffering such disturbances often require services from multiple service systems including mental health, social services, education, corrections, juvenile court, health, and employment and economic development. In order to better meet the needs of these children, it is the intent of the legislature to establish an integrated children's mental health service system that:

(1) allows local service decision makers to draw funding from a single local source so that funds follow clients and eliminates the need to match clients, funds, services, and provider eligibilities;

(2) creates a local pool of state, local, and private funds to procure a greater medical assistance federal financial participation;

(3) improves the efficiency of use of existing resources;

(4) minimizes or eliminates the incentives for cost and risk shifting; and

(5) increases the incentives for earlier identification and intervention.

The children's mental health integrated fund established under sections 245.491 to 245.495 must be used to develop and support this integrated mental health service system. In developing this integrated service system, it is not the intent of the legislature to limit any rights available to children and their families through existing federal and state laws.

Sec. 45. Minnesota Statutes 2024, section 245.492, subdivision 3, is amended to read:

Subd. 3. **Children with emotional or behavioral disturbances.** "Children with emotional or behavioral disturbances" includes children with ~~emotional disturbances~~ mental illnesses as defined in section 245.4871, subdivision 15, and children with emotional or behavioral disorders as defined in Minnesota Rules, part 3525.1329, subpart 1.

Sec. 46. Minnesota Statutes 2024, section 245.697, subdivision 2a, is amended to read:

Subd. 2a. **Subcommittee on Children's Mental Health.** The State Advisory Council on Mental Health (the "advisory council") must have a Subcommittee on Children's Mental Health. The subcommittee must make recommendations to the advisory council on policies, laws, regulations, and services relating to children's mental health. Members of the subcommittee must include:

(1) the commissioners or designees of the commissioners of the Departments of Human Services, Health, Education, State Planning, and Corrections;

(2) a designee of the Direct Care and Treatment executive board;

(3) the commissioner of commerce or a designee of the commissioner who is knowledgeable about medical insurance issues;

(4) at least one representative of an advocacy group for children with ~~emotional disturbances~~ mental illnesses;

(5) providers of children's mental health services, including at least one provider of services to preadolescent children, one provider of services to adolescents, and one hospital-based provider;

(6) parents of children who have ~~emotional disturbances~~ mental illnesses;

(7) a present or former consumer of adolescent mental health services;

(8) educators currently working with ~~emotionally disturbed~~ children with mental illnesses;

(9) people knowledgeable about the needs of ~~emotionally disturbed~~ children with mental illnesses of minority races and cultures;

(10) people experienced in working with ~~emotionally disturbed~~ children with mental illnesses who have committed status offenses;

(11) members of the advisory council;

(12) one person from the local corrections department and one representative of the Minnesota District Judges Association Juvenile Committee; and

(13) county commissioners and social services agency representatives.

The chair of the advisory council shall appoint subcommittee members described in clauses (4) to (12) through the process established in section 15.0597. The chair shall appoint members to ensure a geographical balance on the subcommittee. Terms, compensation, removal, and filling of vacancies are governed by subdivision 1, except that terms of subcommittee members who are also members of the advisory council are coterminous with their terms on the advisory council. The subcommittee shall meet at the call of the subcommittee chair who is elected by the subcommittee from among its members. The subcommittee expires with the expiration of the advisory council.

Sec. 47. Minnesota Statutes 2024, section 245.814, subdivision 3, is amended to read:

Subd. 3. **Compensation provisions.** (a) If the commissioner of human services is unable to obtain insurance through ordinary methods for coverage of foster home providers, the appropriation shall be returned to the general fund and the state shall pay claims subject to the following limitations.

~~(a)~~ (b) Compensation shall be provided only for injuries, damage, or actions set forth in subdivision 1.

~~(b)~~ (c) Compensation shall be subject to the conditions and exclusions set forth in subdivision 2.

~~(c)~~ (d) The state shall provide compensation for bodily injury, property damage, or personal injury resulting from the foster home providers activities as a foster home provider while the foster child or adult is in the care, custody, and control of the foster home provider in an amount not to exceed $250,000 for each occurrence.

~~(d)~~ (e) The state shall provide compensation for damage or destruction of property caused or sustained by a foster child or adult in an amount not to exceed $250 for each occurrence.

~~(c)~~ (f) The compensation in paragraphs ~~(c) and~~ (d) and (e) is the total obligation for all damages because of each occurrence regardless of the number of claims made in connection with the same occurrence, but compensation applies separately to each foster home. The state shall have no other responsibility to provide compensation for any injury or loss caused or sustained by any foster home provider or foster child or foster adult.

(g) This coverage is extended as a benefit to foster home providers to encourage care of persons who need ~~out-of-home~~ the providers' care. Nothing in this section shall be construed to mean that foster home providers are agents or employees of the state nor does the state accept any responsibility for the selection, monitoring, supervision, or control of foster home providers which is exclusively the responsibility of the counties which shall regulate foster home providers in the manner set forth in the rules of the commissioner of human services.

Sec. 48. Minnesota Statutes 2024, section 245.826, is amended to read:

245.826 USE OF RESTRICTIVE TECHNIQUES AND PROCEDURES IN FACILITIES SERVING ~~EMOTIONALLY DISTURBED~~ CHILDREN WITH MENTAL ILLNESSES.

When amending rules governing facilities serving ~~emotionally disturbed~~ children with mental illnesses that are licensed under section 245A.09 and Minnesota Rules, parts 2960.0510 to 2960.0530 and 2960.0580 to 2960.0700, the commissioner of human services shall include provisions governing the use of restrictive techniques and procedures. No provision of these rules may encourage or require the use of restrictive techniques and procedures. The rules must prohibit: (1) the application of certain restrictive techniques or procedures in facilities, except as authorized in the child's case plan and monitored by the county caseworker responsible for the child; (2) the use of restrictive techniques or procedures that restrict the clients' normal access to nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, and necessary clothing; and (3) the use of corporal punishment. The rule may specify other restrictive techniques and procedures and the specific conditions under which permitted techniques and procedures are to be carried out.

Sec. 49. Minnesota Statutes 2024, section 245.91, subdivision 2, is amended to read:

Subd. 2. **Agency.** "Agency" means the divisions, officials, or employees of the state Departments of Human Services, Direct Care and Treatment, Health, and Education, and of local school districts and designated county social service agencies as defined in section

256G.02, subdivision 7, that are engaged in monitoring, providing, or regulating services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~.

Sec. 50. Minnesota Statutes 2024, section 245.91, subdivision 4, is amended to read:

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, and any agency, facility, or program that provides services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~ that is required to be licensed, certified, or registered by the commissioner of human services, health, or education; a sober home as defined in section 254B.01, subdivision 11; peer recovery support services provided by a recovery community organization as defined in section 254B.01, subdivision 8; and an acute care inpatient facility that provides services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~.

Sec. 51. Minnesota Statutes 2024, section 245.92, is amended to read:

245.92 OFFICE OF OMBUDSMAN; CREATION; QUALIFICATIONS; FUNCTION.

The ombudsman for persons receiving services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~ shall promote the highest attainable standards of treatment, competence, efficiency, and justice. The ombudsman may gather information and data about decisions, acts, and other matters of an agency, facility, or program, and shall monitor the treatment of individuals participating in a University of Minnesota Department of Psychiatry clinical drug trial. The ombudsman is appointed by the governor, serves in the unclassified service, and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be a person who has knowledge and experience concerning the treatment, needs, and rights of clients, and who is highly competent and qualified. No person may serve as ombudsman while holding another public office.

Sec. 52. Minnesota Statutes 2024, section 245.94, subdivision 1, is amended to read:

Subdivision 1. **Powers.** (a) The ombudsman may prescribe the methods by which complaints to the office are to be made, reviewed, and acted upon. The ombudsman may not levy a complaint fee.

(b) The ombudsman is a health oversight agency as defined in Code of Federal Regulations, title 45, section 164.501. The ombudsman may access patient records according to Code of Federal Regulations, title 42, section 2.53. For purposes of this paragraph, "records" has the meaning given in Code of Federal Regulations, title 42, section 2.53(a)(1)(i).

(c) The ombudsman may mediate or advocate on behalf of a client.

(d) The ombudsman may investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients.

(e) At the request of a client, or upon receiving a complaint or other information affording reasonable grounds to believe that the rights of one or more clients who may not be capable of requesting assistance have been adversely affected, the ombudsman may gather information and data about and analyze, on behalf of the client, the actions of an agency, facility, or program.

(f) The ombudsman may gather, on behalf of one or more clients, records of an agency, facility, or program, or records related to clinical drug trials from the University of Minnesota Department of Psychiatry, if the records relate to a matter that is within the scope of the ombudsman's authority. If the records are private and the client is capable of providing consent, the ombudsman shall first obtain the client's consent. The ombudsman is not required to obtain consent for access to private data on clients with developmental disabilities and individuals served by the Minnesota Sex Offender Program. The ombudsman may also take photographic or videographic evidence while reviewing the actions of an agency, facility, or program, with the consent of the client. The ombudsman is not required to obtain consent for access to private data on decedents who were receiving services for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~. All data collected, created, received, or maintained by the ombudsman are governed by chapter 13 and other applicable law.

(g) Notwithstanding any law to the contrary, the ombudsman may subpoena a person to appear, give testimony, or produce documents or other evidence that the ombudsman considers relevant to a matter under inquiry. The ombudsman may petition the appropriate court in Ramsey County to enforce the subpoena. A witness who is at a hearing or is part of an investigation possesses the same privileges that a witness possesses in the courts or under the law of this state. Data obtained from a person under this paragraph are private data as defined in section 13.02, subdivision 12.

(h) The ombudsman may, at reasonable times in the course of conducting a review, enter and view premises within the control of an agency, facility, or program.

(i) The ombudsman may attend Direct Care and Treatment Review Board and Special Review Board proceedings; proceedings regarding the transfer of clients, as defined in section 246.50, subdivision 4, between institutions operated by the Direct Care and Treatment executive board; and, subject to the consent of the affected client, other proceedings affecting the rights of clients. The ombudsman is not required to obtain consent to attend meetings or proceedings and have access to private data on clients with developmental disabilities and individuals served by the Minnesota Sex Offender Program.

(j) The ombudsman shall gather data of agencies, facilities, or programs classified as private or confidential as defined in section 13.02, subdivisions 3 and 12, regarding services provided to clients with developmental disabilities and individuals served by the Minnesota Sex Offender Program.

(k) To avoid duplication and preserve evidence, the ombudsman shall inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program.

(l) The Office of Ombudsman shall provide the services of the Civil Commitment Training and Resource Center.

(m) The ombudsman shall monitor the treatment of individuals participating in a University of Minnesota Department of Psychiatry clinical drug trial and ensure that all protections for human subjects required by federal law and the Institutional Review Board are provided.

(n) Sections 245.91 to 245.97 are in addition to other provisions of law under which any other remedy or right is provided.

Sec. 53. Minnesota Statutes 2024, section 245A.03, subdivision 2, is amended to read:

Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

(1) residential or nonresidential programs that are provided to a person by an individual who is related;

(2) nonresidential programs that are provided by an unrelated individual to persons from a single related family;

(3) residential or nonresidential programs that are provided to adults who do not misuse substances or have a substance use disorder, a mental illness, a developmental disability, a functional impairment, or a physical disability;

(4) sheltered workshops or work activity programs that are certified by the commissioner of employment and economic development;

(5) programs operated by a public school for children 33 months or older;

(6) nonresidential programs primarily for children that provide care or supervision for periods of less than three hours a day while the child's parent or legal guardian is in the same building as the nonresidential program or present within another building that is directly contiguous to the building in which the nonresidential program is located;

(7) nursing homes or hospitals licensed by the commissioner of health except as specified under section 245A.02;

(8) board and lodge facilities licensed by the commissioner of health that do not provide children's residential services under Minnesota Rules, chapter 2960, mental health or substance use disorder treatment;

(9) programs licensed by the commissioner of corrections;

(10) recreation programs for children or adults that are operated or approved by a park and recreation board whose primary purpose is to provide social and recreational activities;

(11) noncertified boarding care homes unless they provide services for five or more persons whose primary diagnosis is mental illness or a developmental disability;

(12) programs for children such as scouting, boys clubs, girls clubs, and sports and art programs, and nonresidential programs for children provided for a cumulative total of less than 30 days in any 12-month period;

(13) residential programs for persons with mental illness, that are located in hospitals;

(14) camps licensed by the commissioner of health under Minnesota Rules, chapter 4630;

(15) mental health outpatient services for adults with mental illness or children with ~~emotional disturbance~~ mental illness;

(16) residential programs serving school-age children whose sole purpose is cultural or educational exchange, until the commissioner adopts appropriate rules;

(17) community support services programs as defined in section 245.462, subdivision 6, and family community support services as defined in section 245.4871, subdivision 17;

(18) assisted living facilities licensed by the commissioner of health under chapter 144G;

(19) substance use disorder treatment activities of licensed professionals in private practice as defined in section 245G.01, subdivision 17;

(20) consumer-directed community support service funded under the Medicaid waiver for persons with developmental disabilities when the individual who provided the service is:

(i) the same individual who is the direct payee of these specific waiver funds or paid by a fiscal agent, fiscal intermediary, or employer of record; and

(ii) not otherwise under the control of a residential or nonresidential program that is required to be licensed under this chapter when providing the service;

(21) a county that is an eligible vendor under section 254B.05 to provide care coordination and comprehensive assessment services;

(22) a recovery community organization that is an eligible vendor under section 254B.05 to provide peer recovery support services; or

(23) programs licensed by the commissioner of children, youth, and families in chapter 142B.

(b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a building in which a nonresidential program is located if it shares a common wall with the building in which the nonresidential program is located or is attached to that building by skyway, tunnel, atrium, or common roof.

(c) Except for the home and community-based services identified in section 245D.03, subdivision 1, nothing in this chapter shall be construed to require licensure for any services provided and funded according to an approved federal waiver plan where licensure is specifically identified as not being a condition for the services and funding.

Sec. 54. Minnesota Statutes 2024, section 245A.26, 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) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(c) "License holder" means an individual, organization, or government entity that was issued a license by the commissioner of human services under this chapter for residential mental health treatment for children with ~~emotional disturbance~~ mental illness according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to 2960.0700, or shelter care services according to Minnesota Rules, parts 2960.0010 to 2960.0120 and 2960.0510 to 2960.0530.

(d) "Mental health professional" means an individual who is qualified under section 245I.04, subdivision 2.

Sec. 55. Minnesota Statutes 2024, section 245A.26, subdivision 2, is amended to read:

Subd. 2. **Scope and applicability.** (a) This section establishes additional licensing requirements for a children's residential facility to provide children's residential crisis stabilization services to a client who is experiencing a mental health crisis and is in need of residential treatment services.

(b) A children's residential facility may provide residential crisis stabilization services only if the facility is licensed to provide:

(1) residential mental health treatment for children with ~~emotional disturbance~~ mental illness according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to 2960.0700; or

(2) shelter care services according to Minnesota Rules, parts 2960.0010 to 2960.0120 and 2960.0510 to 2960.0530.

(c) If a client receives residential crisis stabilization services for 35 days or fewer in a facility licensed according to paragraph (b), clause (1), the facility is not required to complete a diagnostic assessment or treatment plan under Minnesota Rules, part 2960.0180, subpart 2, and part 2960.0600.

(d) If a client receives residential crisis stabilization services for 35 days or fewer in a facility licensed according to paragraph (b), clause (2), the facility is not required to develop a plan for meeting the client's immediate needs under Minnesota Rules, part 2960.0520, subpart 3.

Sec. 56. Minnesota Statutes 2024, 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 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, including tardive dyskinesia.

(d) Within 90 days of first providing direct contact services to an adult client, 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, 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.

Sec. 57. Minnesota Statutes 2024, section 245I.05, subdivision 5, is amended to read:

Subd. 5. **Additional training for medication administration.** (a) Prior to administering medications to a client under delegated authority or observing a client self-administer medications, a staff person who is not a licensed prescriber, registered nurse, or licensed practical nurse qualified under section 148.171, subdivision 8, must receive training about psychotropic medications, side effects including tardive dyskinesia, and medication management.

(b) Prior to administering medications to a client under delegated authority, a staff person must successfully complete a:

(1) medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution with completion of the course documented in writing and placed in the staff person's personnel file; or

(2) formalized training program taught by a registered nurse or licensed prescriber that is offered by the license holder. A staff person's successful completion of the formalized training program must include direct observation of the staff person to determine the staff person's areas of competency.

Sec. 58. Minnesota Statutes 2024, section 245I.11, subdivision 5, is amended to read:

Subd. 5. **Medication administration in residential programs.** If a license holder is licensed as a residential program, the license holder must:

(1) assess and document each client's ability to self-administer medication. In the assessment, the license holder must evaluate the client's ability to: (i) comply with prescribed medication regimens; and (ii) store the client's medications safely and in a manner that protects other individuals in the facility. Through the assessment process, the license holder must assist the client in developing the skills necessary to safely self-administer medication;

(2) monitor the effectiveness of medications, side effects of medications, and adverse reactions to medications, including symptoms and signs of tardive dyskinesia, for each client. The license holder must address and document any concerns about a client's medications;

(3) ensure that no staff person or client gives a legend drug supply for one client to another client;

(4) have policies and procedures for: (i) keeping a record of each client's medication orders; (ii) keeping a record of any incident of deferring a client's medications; (iii) documenting any incident when a client's medication is omitted; and (iv) documenting when a client refuses to take medications as prescribed; and

(5) document and track medication errors, document whether the license holder notified anyone about the medication error, determine if the license holder must take any follow-up actions, and identify the staff persons who are responsible for taking follow-up actions.

Sec. 59. Minnesota Statutes 2024, section 246C.12, subdivision 4, is amended to read:

Subd. 4. **Staff safety training.** The executive board shall require all staff in mental health and support units at regional treatment centers who have contact with ~~persons~~ children or adults with mental illness ~~or severe emotional disturbance~~ to be appropriately trained in violence reduction and violence prevention and shall establish criteria for such training. Training programs shall be developed with input from consumer advocacy organizations and shall employ violence prevention techniques as preferable to physical interaction.

Sec. 60. Minnesota Statutes 2024, section 252.27, subdivision 1, is amended to read:

Subdivision 1. **County of financial responsibility.** Whenever any child who has a developmental disability, or a physical disability or ~~emotional disturbance~~ mental illness is in 24-hour care outside the home including respite care, in a facility licensed by the

commissioner of human services, the cost of services shall be paid by the county of financial responsibility determined pursuant to chapter 256G. If the child's parents or guardians do not reside in this state, the cost shall be paid by the responsible governmental agency in the state from which the child came, by the parents or guardians of the child if they are financially able, or, if no other payment source is available, by the commissioner of human services.

Sec. 61. Minnesota Statutes 2024, section 256B.02, subdivision 11, is amended to read:

Subd. 11. **Related condition.** "Related condition" means a condition:

(1) that is found to be closely related to a developmental disability, including but not limited to cerebral palsy, epilepsy, autism, fetal alcohol spectrum disorder, and Prader-Willi syndrome; and

(2) that meets all of the following criteria:

(i) is severe and chronic;

(ii) results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with developmental disabilities;

(iii) requires treatment or services similar to those required for persons with developmental disabilities;

(iv) is manifested before the person reaches 22 years of age;

(v) is likely to continue indefinitely;

(vi) results in substantial functional limitations in three or more of the following areas of major life activity:

(A) self-care;

(B) understanding and use of language;

(C) learning;

(D) mobility;

(E) self-direction; or

(F) capacity for independent living; and

(vii) is not attributable to mental illness as defined in section 245.462, subdivision 20, or ~~an emotional disturbance as defined in section~~ 245.4871, subdivision 15. For purposes of this item, notwithstanding section 245.462, subdivision 20, or 245.4871, subdivision 15, "mental illness" does not include autism or other pervasive developmental disorders.

Sec. 62. Minnesota Statutes 2024, section 256B.055, subdivision 12, is amended to read:

Subd. 12. **Children with disabilities.** (a) A person is eligible for medical assistance if the person is under age 19 and qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance under the state plan if residing in a medical institution, and the child requires a level of care provided in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, for whom home care is appropriate, provided that the cost to medical assistance under this section is not more than the amount that medical assistance would pay for if the child resides in an institution. After the child is determined to be eligible under this section, the commissioner shall review the child's disability under United States Code, title 42, section 1382c(a) and level of care defined under this section no more often than annually and may elect, based on the recommendation of health care professionals under contract with the state medical review team, to extend the review of disability and level of care up to a maximum of four years. The commissioner's decision on the frequency of continuing review of disability and level of care is not subject to administrative appeal under section 256.045. The county agency shall send a notice of disability review to the enrollee six months prior to the date the recertification of disability is due. Nothing in this subdivision shall be construed as affecting other redeterminations of medical assistance eligibility under this chapter and annual cost-effective reviews under this section.

(b) For purposes of this subdivision, "hospital" means an institution as defined in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child requires a level of care provided in a hospital if the child is determined by the commissioner to need an extensive array of health services, including mental health services, for an undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, who would reside in a hospital or require frequent hospitalization if these services were not provided, and the daily care needs are more complex than a nursing facility level of care.

A child with serious ~~emotional disturbance~~ mental illness requires a level of care provided in a hospital if the commissioner determines that the individual requires 24-hour supervision because the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that may become life threatening, recurrent or frequent severe socially unacceptable behavior associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic

developmental problems requiring continuous skilled observation, or severe disabling symptoms for which office-centered outpatient treatment is not adequate, and which overall severely impact the individual's ability to function.

(c) For purposes of this subdivision, "nursing facility" means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable episodes of active disease processes requiring immediate judgment by a licensed nurse. For purposes of this subdivision, a child requires the level of care provided in a nursing facility if the child is determined by the commissioner to meet the requirements of the preadmission screening assessment document under section 256B.0911, adjusted to address age-appropriate standards for children age 18 and under.

(d) For purposes of this subdivision, "intermediate care facility for persons with developmental disabilities" or "ICF/DD" means a program licensed to provide services to persons with developmental disabilities under section 252.28, and chapter 245A, and a physical plant licensed as a supervised living facility under chapter 144, which together are certified by the Minnesota Department of Health as meeting the standards in Code of Federal Regulations, title 42, part 483, for an intermediate care facility which provides services for persons with developmental disabilities who require 24-hour supervision and active treatment for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child requires a level of care provided in an ICF/DD if the commissioner finds that the child has a developmental disability in accordance with section 256B.092, is in need of a 24-hour plan of care and active treatment similar to persons with developmental disabilities, and there is a reasonable indication that the child will need ICF/DD services.

(e) For purposes of this subdivision, a person requires the level of care provided in a nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental health treatment because of specific symptoms or functional impairments associated with a serious mental illness or disorder diagnosis, which meet severity criteria for mental health established by the commissioner and published in March 1997 as the Minnesota Mental Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

(f) The determination of the level of care needed by the child shall be made by the commissioner based on information supplied to the commissioner by (1) the parent or guardian, (2) the child's physician or physicians, advanced practice registered nurse or advanced practice registered nurses, or physician assistant or physician assistants, and (3)

other professionals as requested by the commissioner. The commissioner shall establish a screening team to conduct the level of care determinations according to this subdivision.

(g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner must assess the case to determine whether:

(1) the child qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance if residing in a medical institution; and

(2) the cost of medical assistance services for the child, if eligible under this subdivision, would not be more than the cost to medical assistance if the child resides in a medical institution to be determined as follows:

(i) for a child who requires a level of care provided in an ICF/DD, the cost of care for the child in an institution shall be determined using the average payment rate established for the regional treatment centers that are certified as ICF's/DD;

(ii) for a child who requires a level of care provided in an inpatient hospital setting according to paragraph (b), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3520, items F and G; and

(iii) for a child who requires a level of care provided in a nursing facility according to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates which would be paid for children under age 16. The commissioner may authorize an amount up to the amount medical assistance would pay for a child referred to the commissioner by the preadmission screening team under section 256B.0911.

Sec. 63. Minnesota Statutes 2024, section 256B.0616, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services, as established in subdivision 2, subject to federal approval, if provided to recipients who have ~~an emotional disturbance~~ a mental illness or ~~severe emotional disturbance~~ serious mental illness under chapter 245, and are provided by a mental health certified family peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 12. A family peer specialist cannot provide services to the peer specialist's family.

Sec. 64. Minnesota Statutes 2024, section 256B.0757, subdivision 2, is amended to read:

Subd. 2. **Eligible individual.** (a) The commissioner may elect to develop health home models in accordance with United States Code, title 42, section 1396w-4.

(b) An individual is eligible for health home services under this section if the individual is eligible for medical assistance under this chapter and has a condition that meets the definition of mental illness as described in section 245.462, subdivision 20, paragraph (a), or ~~emotional disturbance as defined in section~~ 245.4871, subdivision 15, clause (2). The commissioner shall establish criteria for determining continued eligibility.

Sec. 65. Minnesota Statutes 2024, section 256B.0943, subdivision 1, is amended to read:

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

(b) "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, or 245.4871, subdivision 15. 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.

(c) "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

(d) "Crisis planning" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

(f) "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.

(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)~~ (i) "Individual treatment plan" means the plan described in section 245I.10, subdivisions 7 and 8.

~~(k)~~ (j) "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).

~~(l)~~ (k) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

~~(m)~~ (l) "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

~~(n)~~ (m) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

~~(o)~~ (n) "Mental health service plan development" includes:

(1) development and revision of a child's individual treatment plan; and

(2) administering and reporting standardized outcome measurements approved by the commissioner, as periodically needed to evaluate the effectiveness of treatment.

~~(p)~~ (o) "Mental illness~~,~~" ~~for persons at least age 18 but under age 21,~~ has the meaning given in section 245.462, subdivision 20, paragraph (a), for persons at least age 18 but under age 21, and has the meaning given in section 245.4871, subdivision 15, for children.

~~(q)~~ (p) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.

~~(r)~~ (q) "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.

~~(s)~~ (r) "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).

~~(t)~~ (s) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

~~(u)~~ (t) "Treatment supervision" means the supervision described in section 245I.06.

Sec. 66. Minnesota Statutes 2024, 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 and updated as required under section 245I.10, subdivision 2. The standard diagnostic assessment must:

(1) determine whether a child under age 18 has a diagnosis of ~~emotional disturbance~~ mental illness 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.

Sec. 67. Minnesota Statutes 2024, 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 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 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) 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;

(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

(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.

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 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.

Sec. 68. Minnesota Statutes 2024, section 256B.0943, subdivision 12, is amended to read:

Subd. 12. **Excluded services.** The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) treatment by multiple providers within the same agency at the same clock time, unless one service is delivered to the child and the other service is delivered to the child's family or treatment team without the child present;

(3) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(4) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(5) service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure; and

(6) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's ~~emotional disturbance~~ mental illness;

(iii) prevention or education programs provided to the community; and

(iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

Sec. 69. Minnesota Statutes 2024, section 256B.0943, subdivision 13, is amended to read:

Subd. 13. **Exception to excluded services.** Notwithstanding subdivision 12, up to 15 hours of children's therapeutic services and supports provided within a six-month period to a child with ~~severe emotional disturbance~~ serious mental illness who is residing in a hospital; a residential treatment facility licensed under Minnesota Rules, parts 2960.0580 to 2960.0690; a psychiatric residential treatment facility under section 256B.0625, subdivision 45a; a regional treatment center; or other institutional group setting or who is participating in a program of partial hospitalization are eligible for medical assistance payment if part of the discharge plan.

Sec. 70. Minnesota Statutes 2024, section 256B.0945, subdivision 1, is amended to read:

Subdivision 1. **Residential services; provider qualifications.** (a) Counties must arrange to provide residential services for children with ~~severe emotional disturbance~~ serious mental illness according to sections 245.4882, 245.4885, and this section.

(b) Services must be provided by a facility that is licensed according to section 245.4882 and administrative rules promulgated thereunder, and under contract with the county.

(c) Eligible service costs may be claimed for a facility that is located in a state that borders Minnesota if:

(1) the facility is the closest facility to the child's home, providing the appropriate level of care; and

(2) the commissioner of human services has completed an inspection of the out-of-state program according to the interagency agreement with the commissioner of corrections under section 260B.198, subdivision 11, paragraph (b), and the program has been certified by the commissioner of corrections under section 260B.198, subdivision 11, paragraph (a), to substantially meet the standards applicable to children's residential mental health treatment programs under Minnesota Rules, chapter 2960. Nothing in this section requires the commissioner of human services to enforce the background study requirements under chapter 245C or the requirements related to prevention and investigation of alleged maltreatment under section 626.557 or chapter 260E. Complaints received by the commissioner of human services must be referred to the out-of-state licensing authority for possible follow-up.

(d) Notwithstanding paragraph (b), eligible service costs may be claimed for an out-of-state inpatient treatment facility if:

(1) the facility specializes in providing mental health services to children who are deaf, deafblind, or hard-of-hearing and who use American Sign Language as their first language;

(2) the facility is licensed by the state in which it is located; and

(3) the state in which the facility is located is a member state of the Interstate Compact on Mental Health.

Sec. 71. Minnesota Statutes 2024, section 256B.0946, subdivision 6, is amended to read:

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of children's intensive behavioral health services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section 256B.0624;

(7) transportation; and

(8) mental health certified family peer specialist services under section 256B.0616.

(b) Children receiving intensive behavioral health services are not eligible for medical assistance reimbursement for the following services while receiving children's intensive behavioral health services:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section 256B.0943;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph ~~(l)~~ (j);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) medical assistance room and board rate, as defined in section 256B.056, subdivision 5d.

Sec. 72. Minnesota Statutes 2024, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** (a) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities that are covered by a single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

(2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph ~~(u)~~ (r);

(3) crisis planning as defined in section 245.4871, subdivision 9a;

(4) medication management provided by a physician, an advanced practice registered nurse with certification in psychiatric and mental health care, or a physician assistant;

(5) mental health case management as provided in section 256B.0625, subdivision 20;

(6) medication education services as defined in this section;

(7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;

(8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;

(9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

(10) coordination with, or performance of, crisis intervention and stabilization services as defined in section 256B.0624;

(11) transition services;

(12) co-occurring substance use disorder treatment as defined in section 245I.02, subdivision 11; and

(13) housing access support that assists clients to find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

(b) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity: client access to crisis

intervention services, as defined in section 256B.0624, and available 24 hours per day and seven days per week.

Sec. 73. Minnesota Statutes 2024, section 256B.69, subdivision 23, is amended to read:

Subd. 23. **Alternative services; elderly persons and persons with a disability.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans that are offered by a demonstration provider or by an entity that is directly or indirectly wholly owned or controlled by a demonstration provider to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. All enforcement and rulemaking powers available under chapters 62D, 62M, and 62Q are hereby granted to the commissioner of health with respect to Medicare-approved special needs plans with which the commissioner contracts to provide Medicaid services under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly persons with a disability, or persons with a disability only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious ~~emotional disturbance~~ mental illness in children, the commissioner

must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent mental illness, or serious ~~emotional disturbance,~~ mental illness in children without approval of the county board of the county in which the demonstration is being implemented.

(b) MS 2009 Supplement [Expired, 2003 c 47 s 4; 2007 c 147 art 7 s 60]

(c) Before implementation of a demonstration project for persons with a disability, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community access for disability inclusion or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the

state. Until July 1, 2009, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. Notwithstanding whether expansion occurs under this paragraph, in determining MnDHO payment rates and risk adjustment methods, the commissioner must consider the methods used to determine county allocations for home and community-based program participants. If necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs for home and community-based services, the commissioner shall achieve the reduction by maintaining the base rate for contract year 2010 for services provided under the community access for disability inclusion waiver at the same level as for contract year 2009. The commissioner may apply other reductions to MnDHO rates to implement decreases in provider payment rates required by state law. Effective January 1, 2011, enrollment and operation of the MnDHO program in effect during 2010 shall cease. The commissioner may reopen the program provided all applicable conditions of this section are met. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans to reopen MnDHO projects shall be presented to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance prior to implementation.

(g) Notwithstanding section 256B.0621, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

Sec. 74. Minnesota Statutes 2024, section 256B.77, subdivision 7a, is amended to read:

Subd. 7a. **Eligible individuals.** (a) Persons are eligible for the demonstration project as provided in this subdivision.

(b) "Eligible individuals" means those persons living in the demonstration site who are eligible for medical assistance and are disabled based on a disability determination under section 256B.055, subdivisions 7 and 12, or who are eligible for medical assistance and have been diagnosed as having:

(1) serious and persistent mental illness as defined in section 245.462, subdivision 20;

(2) ~~severe emotional disturbance~~ serious mental illness as defined in section 245.4871, subdivision 6; or

(3) developmental disability, or being a person with a developmental disability as defined in section 252A.02, or a related condition as defined in section 256B.02, subdivision 11.

Other individuals may be included at the option of the county authority based on agreement with the commissioner.

(c) Eligible individuals include individuals in excluded time status, as defined in chapter 256G. Enrollees in excluded time at the time of enrollment shall remain in excluded time status as long as they live in the demonstration site and shall be eligible for 90 days after placement outside the demonstration site if they move to excluded time status in a county within Minnesota other than their county of financial responsibility.

(d) A person who is a sexual psychopathic personality as defined in section 253D.02, subdivision 15, or a sexually dangerous person as defined in section 253D.02, subdivision 16, is excluded from enrollment in the demonstration project.

Sec. 75. Minnesota Statutes 2024, section 260B.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The local social services agency shall establish a juvenile treatment screening team to conduct screenings and prepare case plans under this subdivision. The team, which may be the team constituted under section 245.4885 or 256B.092 or chapter 254B, shall consist of social workers, juvenile justice professionals, and persons with expertise in the treatment of juveniles who are emotionally disabled, chemically dependent, or have a developmental disability. The team shall involve parents or guardians in the screening process as appropriate. The team may be the same team as defined in section 260C.157, subdivision 3.

(b) If the court, prior to~~,~~ or as part of~~,~~ a final disposition, proposes to place a child:

(1) for the primary purpose of treatment for ~~an emotional disturbance~~ mental illness, and residential placement is consistent with section 260.012, a developmental disability, or chemical dependency in a residential treatment facility out of state or in one which is within the state and licensed by the commissioner of human services under chapter 245A; or

(2) in any out-of-home setting potentially exceeding 30 days in duration, including a post-dispositional placement in a facility licensed by the commissioner of corrections or human services, the court shall notify the county welfare agency. The county's juvenile treatment screening team must either:

(i) screen and evaluate the child and file its recommendations with the court within 14 days of receipt of the notice; or

(ii) elect not to screen a given case, and notify the court of that decision within three working days.

(c) If the screening team has elected to screen and evaluate the child, the child may not be placed for the primary purpose of treatment for ~~an emotional disturbance~~ mental illness, a developmental disability, or chemical dependency, in a residential treatment facility out of state nor in a residential treatment facility within the state that is licensed under chapter 245A, unless one of the following conditions applies:

(1) a treatment professional certifies that an emergency requires the placement of the child in a facility within the state;

(2) the screening team has evaluated the child and recommended that a residential placement is necessary to meet the child's treatment needs and the safety needs of the community, that it is a cost-effective means of meeting the treatment needs, and that it will be of therapeutic value to the child; or

(3) the court, having reviewed a screening team recommendation against placement, determines to the contrary that a residential placement is necessary. The court shall state the reasons for its determination in writing, on the record, and shall respond specifically to the findings and recommendation of the screening team in explaining why the recommendation was rejected. The attorney representing the child and the prosecuting attorney shall be afforded an opportunity to be heard on the matter.

Sec. 76. Minnesota Statutes 2024, section 260C.007, subdivision 16, is amended to read:

Subd. 16. **~~Emotionally disturbed~~ Mental illness.** "~~Emotionally disturbed~~ Mental illness" means ~~emotional disturbance~~ a mental illness as described in section 245.4871, subdivision 15.

Sec. 77. Minnesota Statutes 2024, section 260C.007, subdivision 26d, is amended to read:

Subd. 26d. **Qualified residential treatment program.** "Qualified residential treatment program" means a children's residential treatment program licensed under chapter 245A or licensed or approved by a tribe that is approved to receive foster care maintenance payments under section 142A.418 that:

(1) has a trauma-informed treatment model designed to address the needs of children with serious emotional or behavioral disorders or disturbances or mental illnesses;

(2) has registered or licensed nursing staff and other licensed clinical staff who:

(i) provide care within the scope of their practice; and

(ii) are available 24 hours per day and seven days per week;

(3) is accredited by any of the following independent, nonprofit organizations: the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Council on Accreditation (COA), or any other nonprofit accrediting organization approved by the United States Department of Health and Human Services;

(4) if it is in the child's best interests, facilitates participation of the child's family members in the child's treatment programming consistent with the child's out-of-home placement plan under sections 260C.212, subdivision 1, and 260C.708;

(5) facilitates outreach to family members of the child, including siblings;

(6) documents how the facility facilitates outreach to the child's parents and relatives, as well as documents the child's parents' and other relatives' contact information;

(7) documents how the facility includes family members in the child's treatment process, including after the child's discharge, and how the facility maintains the child's sibling connections; and

(8) provides the child and child's family with discharge planning and family-based aftercare support for at least six months after the child's discharge. Aftercare support may include clinical care consultation under section 256B.0671, subdivision 7, and mental health certified family peer specialist services under section 256B.0616.

Sec. 78. Minnesota Statutes 2024, section 260C.007, subdivision 27b, is amended to read:

Subd. 27b. **Residential treatment facility.** "Residential treatment facility" means a 24-hour-a-day program that provides treatment for children with ~~emotional disturbance~~ mental illness, consistent with section 245.4871, subdivision 32, and includes a licensed residential program specializing in caring 24 hours a day for children with a developmental delay or related condition. A residential treatment facility does not include a psychiatric residential treatment facility under section 256B.0941 or a family foster home as defined in section 260C.007, subdivision 16b.

Sec. 79. Minnesota Statutes 2024, section 260C.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services agency shall establish a juvenile treatment screening team to conduct screenings under this chapter and chapter 260D, for a child to receive treatment for ~~an emotional disturbance~~ a mental illness, ~~a~~ developmental disability, or related condition in a residential treatment facility licensed by the commissioner of human services under chapter 245A, or licensed or approved by a tribe. A screening team is not required for a child to be in: (1) a residential facility specializing in prenatal, postpartum, or parenting support; (2) a facility specializing in high-quality residential care and supportive services to children and youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation; (3) supervised settings for youth who are 18 years of age or older and living independently; or (4) a licensed residential family-based treatment facility for substance abuse consistent with section 260C.190. Screenings are also not required when a child must be placed in a facility due to an emotional crisis or other mental health emergency.

(b) The responsible social services agency shall conduct screenings within 15 days of a request for a screening, unless the screening is for the purpose of residential treatment and the child is enrolled in a prepaid health program under section 256B.69, in which case the agency shall conduct the screening within ten working days of a request. The responsible social services agency shall convene the juvenile treatment screening team, which may be constituted under section 245.4885, 254B.05, or 256B.092. The team shall consist of social workers; persons with expertise in the treatment of juveniles who are emotionally disturbed, chemically dependent, or have a developmental disability; and the child's parent, guardian, or permanent legal custodian. The team may include the child's relatives as defined in section 260C.007, subdivisions 26b and 27, the child's foster care provider, and professionals who are a resource to the child's family such as teachers, medical or mental health providers, and clergy, as appropriate, consistent with the family and permanency team as defined in section 260C.007, subdivision 16a. Prior to forming the team, the responsible social services agency must consult with the child's parents, the child if the child is age 14 or older, and, if applicable, the child's tribe to obtain recommendations regarding which individuals to include on the team and to ensure that the team is family-centered and will act in the child's best interests. If the child, child's parents, or legal guardians raise concerns about specific relatives or professionals, the team should not include those individuals. This provision does not apply to paragraph (c).

(c) If the agency provides notice to tribes under section 260.761, and the child screened is an Indian child, the responsible social services agency must make a rigorous and concerted

effort to include a designated representative of the Indian child's tribe on the juvenile treatment screening team, unless the child's tribal authority declines to appoint a representative. The Indian child's tribe may delegate its authority to represent the child to any other federally recognized Indian tribe, as defined in section 260.755, subdivision 12. The provisions of the Indian Child Welfare Act of 1978, United States Code, title 25, sections 1901 to 1963, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835, apply to this section.

(d) If the court, prior to, or as part of, a final disposition or other court order, proposes to place a child with ~~an emotional disturbance or~~ a mental illness, developmental disability, or related condition in residential treatment, the responsible social services agency must conduct a screening. If the team recommends treating the child in a qualified residential treatment program, the agency must follow the requirements of sections 260C.70 to 260C.714.

The court shall ascertain whether the child is an Indian child and shall notify the responsible social services agency and, if the child is an Indian child, shall notify the Indian child's tribe as paragraph (c) requires.

(e) When the responsible social services agency is responsible for placing and caring for the child and the screening team recommends placing a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, the agency must: (1) begin the assessment and processes required in section 260C.704 without delay; and (2) conduct a relative search according to section 260C.221 to assemble the child's family and permanency team under section 260C.706. Prior to notifying relatives regarding the family and permanency team, the responsible social services agency must consult with the child's parent or legal guardian, the child if the child is age 14 or older, and, if applicable, the child's tribe to ensure that the agency is providing notice to individuals who will act in the child's best interests. The child and the child's parents may identify a culturally competent qualified individual to complete the child's assessment. The agency shall make efforts to refer the assessment to the identified qualified individual. The assessment may not be delayed for the purpose of having the assessment completed by a specific qualified individual.

(f) When a screening team determines that a child does not need treatment in a qualified residential treatment program, the screening team must:

(1) document the services and supports that will prevent the child's foster care placement and will support the child remaining at home;

(2) document the services and supports that the agency will arrange to place the child in a family foster home; or

(3) document the services and supports that the agency has provided in any other setting.

(g) When the Indian child's tribe or tribal health care services provider or Indian Health Services provider proposes to place a child for the primary purpose of treatment for ~~an emotional disturbance~~ a mental illness, a developmental disability, or co-occurring ~~emotional disturbance~~ mental illness and chemical dependency, the Indian child's tribe or the tribe delegated by the child's tribe shall submit necessary documentation to the county juvenile treatment screening team, which must invite the Indian child's tribe to designate a representative to the screening team.

(h) The responsible social services agency must conduct and document the screening in a format approved by the commissioner of human services.

Sec. 80. Minnesota Statutes 2024, 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, 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 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, 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 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~~ a mental illness 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 paragraph (f).

(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.

(f) For the purposes of this subdivision, "alternative safe living arrangement" means a living arrangement for a child proposed by a petitioning parent or guardian if a court excludes the minor from the parent's or guardian's home that is separate from the victim of domestic abuse and safe for the child respondent. A living arrangement proposed by a petitioning parent or guardian is presumed to be an alternative safe living arrangement absent information to the contrary presented to the court. In evaluating any proposed living arrangement, the court shall consider whether the arrangement provides the child with necessary food, clothing, shelter, and education in a safe environment. Any proposed living arrangement that would place the child in the care of an adult who has been physically or sexually violent is presumed unsafe.

Sec. 81. Minnesota Statutes 2024, 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, 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 142B.06, 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~~ a mental illness 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 that is for reunification with the child's parent or guardian and a secondary plan that is for an alternative, legally permanent home for the child in the event reunification cannot be achieved in a timely manner.

Sec. 82. Minnesota Statutes 2024, section 260C.301, subdivision 4, is amended to read:

Subd. 4. **Current foster care children.** Except for cases where the child is in placement due solely to the child's developmental disability or ~~emotional disturbance~~ a mental illness, where custody has not been transferred to the responsible social services agency, and where the court finds compelling reasons to continue placement, the county attorney shall file a

termination of parental rights petition or a petition to transfer permanent legal and physical custody to a relative under section 260C.515, subdivision 4, for all children who have been in out-of-home care for 15 of the most recent 22 months. This requirement does not apply if there is a compelling reason approved by the court for determining that filing a termination of parental rights petition or other permanency petition would not be in the best interests of the child or if the responsible social services agency has not provided reasonable efforts necessary for the safe return of the child, if reasonable efforts are required.

Sec. 83. Minnesota Statutes 2024, section 260D.01, is amended to read:

260D.01 CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.

(a) Sections 260D.01 to 260D.10, may be cited as the "child in voluntary foster care for treatment" provisions of the Juvenile Court Act.

(b) The juvenile court has original and exclusive jurisdiction over a child in voluntary foster care for treatment upon the filing of a report or petition required under this chapter. All obligations of the responsible social services agency to a child and family in foster care contained in chapter 260C not inconsistent with this chapter are also obligations of the agency with regard to a child in foster care for treatment under this chapter.

(c) This chapter shall be construed consistently with the mission of the children's mental health service system as set out in section 245.487, subdivision 3, and the duties of an agency under sections 256B.092 and 260C.157 and Minnesota Rules, parts 9525.0004 to 9525.0016, to meet the needs of a child with a developmental disability or related condition. This chapter:

(1) establishes voluntary foster care through a voluntary foster care agreement as the means for an agency and a parent to provide needed treatment when the child must be in foster care to receive necessary treatment for ~~an emotional disturbance or~~ a mental illness, developmental disability, or related condition;

(2) establishes court review requirements for a child in voluntary foster care for treatment due to ~~emotional disturbance or~~ a mental illness, developmental disability, or ~~a~~ related condition;

(3) establishes the ongoing responsibility of the parent as legal custodian to visit the child, to plan together with the agency for the child's treatment needs, to be available and accessible to the agency to make treatment decisions, and to obtain necessary medical, dental, and other care for the child;

(4) applies to voluntary foster care when the child's parent and the agency agree that the child's treatment needs require foster care either:

(i) due to a level of care determination by the agency's screening team informed by the child's diagnostic and functional assessment under section 245.4885; or

(ii) due to a determination regarding the level of services needed by the child by the responsible social services agency's screening team under section 256B.092, and Minnesota Rules, parts 9525.0004 to 9525.0016; and

(5) includes the requirements for a child's placement in sections 260C.70 to 260C.714, when the juvenile treatment screening team recommends placing a child in a qualified residential treatment program, except as modified by this chapter.

(d) This chapter does not apply when there is a current determination under chapter 260E that the child requires child protective services or when the child is in foster care for any reason other than treatment for the child's ~~emotional disturbance or~~ mental illness, developmental disability, or related condition. When there is a determination under chapter 260E that the child requires child protective services based on an assessment that there are safety and risk issues for the child that have not been mitigated through the parent's engagement in services or otherwise, or when the child is in foster care for any reason other than the child's ~~emotional disturbance or~~ mental illness, developmental disability, or related condition, the provisions of chapter 260C apply.

(e) The paramount consideration in all proceedings concerning a child in voluntary foster care for treatment is the safety, health, and the best interests of the child. The purpose of this chapter is:

(1) to ensure that a child with a disability is provided the services necessary to treat or ameliorate the symptoms of the child's disability;

(2) to preserve and strengthen the child's family ties whenever possible and in the child's best interests, approving the child's placement away from the child's parents only when the child's need for care or treatment requires out-of-home placement and the child cannot be maintained in the home of the parent; and

(3) to ensure that the child's parent retains legal custody of the child and associated decision-making authority unless the child's parent willfully fails or is unable to make decisions that meet the child's safety, health, and best interests. The court may not find that the parent willfully fails or is unable to make decisions that meet the child's needs solely because the parent disagrees with the agency's choice of foster care facility, unless the

agency files a petition under chapter 260C, and establishes by clear and convincing evidence that the child is in need of protection or services.

(f) The legal parent-child relationship shall be supported under this chapter by maintaining the parent's legal authority and responsibility for ongoing planning for the child and by the agency's assisting the parent, when necessary, to exercise the parent's ongoing right and obligation to visit or to have reasonable contact with the child. Ongoing planning means:

(1) actively participating in the planning and provision of educational services, medical, and dental care for the child;

(2) actively planning and participating with the agency and the foster care facility for the child's treatment needs;

(3) planning to meet the child's need for safety, stability, and permanency, and the child's need to stay connected to the child's family and community;

(4) engaging with the responsible social services agency to ensure that the family and permanency team under section 260C.706 consists of appropriate family members. For purposes of voluntary placement of a child in foster care for treatment under chapter 260D, prior to forming the child's family and permanency team, the responsible social services agency must consult with the child's parent or legal guardian, the child if the child is 14 years of age or older, and, if applicable, the child's Tribe to obtain recommendations regarding which individuals to include on the team and to ensure that the team is family-centered and will act in the child's best interests. If the child, child's parents, or legal guardians raise concerns about specific relatives or professionals, the team should not include those individuals unless the individual is a treating professional or an important connection to the youth as outlined in the case or crisis plan; and

(5) for a voluntary placement under this chapter in a qualified residential treatment program, as defined in section 260C.007, subdivision 26d, for purposes of engaging in a relative search as provided in section 260C.221, the county agency must consult with the child's parent or legal guardian, the child if the child is 14 years of age or older, and, if applicable, the child's Tribe to obtain recommendations regarding which adult relatives the county agency should notify. If the child, child's parents, or legal guardians raise concerns about specific relatives, the county agency should not notify those relatives.

(g) The provisions of section 260.012 to ensure placement prevention, family reunification, and all active and reasonable effort requirements of that section apply.

Sec. 84. Minnesota Statutes 2024, section 260D.02, subdivision 5, is amended to read:

Subd. 5. **Child in voluntary foster care for treatment.** "Child in voluntary foster care for treatment" means a child with ~~emotional disturbance~~ a mental illness or developmental disability~~,~~ or who has a related condition and is in foster care under a voluntary foster care agreement between the child's parent and the agency due to concurrence between the agency and the parent when it is determined that foster care is medically necessary:

(1) due to a determination by the agency's screening team based on its review of the diagnostic and functional assessment under section 245.4885; or

(2) due to a determination by the agency's screening team under section 256B.092 and Minnesota Rules, parts 9525.0004 to 9525.0016.

A child is not in voluntary foster care for treatment under this chapter when there is a current determination under chapter 260E that the child requires child protective services or when the child is in foster care for any reason other than the child's ~~emotional or~~ mental illness, developmental disability, or related condition.

Sec. 85. Minnesota Statutes 2024, section 260D.02, subdivision 9, is amended to read:

Subd. 9. **~~Emotional disturbance~~ Mental illness.** "~~Emotional disturbance~~ Mental illness" means ~~emotional disturbance~~ a mental illness as described in section 245.4871, subdivision 15.

Sec. 86. Minnesota Statutes 2024, section 260D.03, subdivision 1, is amended to read:

Subdivision 1. **Voluntary foster care.** When the agency's screening team, based upon the diagnostic and functional assessment under section 245.4885 or medical necessity screenings under section 256B.092, subdivision 7, determines the child's need for treatment due to ~~emotional disturbance or~~ a mental illness, developmental disability, or related condition requires foster care placement of the child, a voluntary foster care agreement between the child's parent and the agency gives the agency legal authority to place the child in foster care.

Sec. 87. Minnesota Statutes 2024, section 260D.04, is amended to read:

260D.04 REQUIRED INFORMATION FOR A CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.

An agency with authority to place a child in voluntary foster care for treatment due to ~~emotional disturbance or~~ a mental illness, developmental disability, or related condition~~,~~ shall inform the child, age 12 or older, of the following:

(1) the child has the right to be consulted in the preparation of the out-of-home placement plan required under section 260C.212, subdivision 1, and the administrative review required under section 260C.203;

(2) the child has the right to visit the parent and the right to visit the child's siblings as determined safe and appropriate by the parent and the agency;

(3) if the child disagrees with the foster care facility or services provided under the out-of-home placement plan required under section 260C.212, subdivision 1, the agency shall include information about the nature of the child's disagreement and, to the extent possible, the agency's understanding of the basis of the child's disagreement in the information provided to the court in the report required under section 260D.06; and

(4) the child has the rights established under Minnesota Rules, part 2960.0050, as a resident of a facility licensed by the state.

Sec. 88. Minnesota Statutes 2024, section 260D.06, subdivision 2, is amended to read:

Subd. 2. **Agency report to court; court review.** The agency shall obtain judicial review by reporting to the court according to the following procedures:

(a) A written report shall be forwarded to the court within 165 days of the date of the voluntary placement agreement. The written report shall contain or have attached:

(1) a statement of facts that necessitate the child's foster care placement;

(2) the child's name, date of birth, race, gender, and current address;

(3) the names, race, date of birth, residence, and post office addresses of the child's parents or legal custodian;

(4) a statement regarding the child's eligibility for membership or enrollment in an Indian tribe and the agency's compliance with applicable provisions of sections 260.751 to 260.835;

(5) the names and addresses of the foster parents or chief administrator of the facility in which the child is placed, if the child is not in a family foster home or group home;

(6) a copy of the out-of-home placement plan required under section 260C.212, subdivision 1;

(7) a written summary of the proceedings of any administrative review required under section 260C.203;

(8) evidence as specified in section 260C.712 when a child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d; and

(9) any other information the agency, parent or legal custodian, the child or the foster parent, or other residential facility wants the court to consider.

(b) In the case of a child in placement due to ~~emotional disturbance~~ a mental illness, the written report shall include as an attachment, the child's individual treatment plan developed by the child's treatment professional, as provided in section 245.4871, subdivision 21, or the child's standard written plan, as provided in section 125A.023, subdivision 3, paragraph (e).

(c) In the case of a child in placement due to developmental disability or a related condition, the written report shall include as an attachment, the child's individual service plan, as provided in section 256B.092, subdivision 1b; the child's individual program plan, as provided in Minnesota Rules, part 9525.0004, subpart 11; the child's waiver care plan; or the child's standard written plan, as provided in section 125A.023, subdivision 3, paragraph (e).

(d) The agency must inform the child, age 12 or older, the child's parent, and the foster parent or foster care facility of the reporting and court review requirements of this section and of their right to submit information to the court:

(1) if the child or the child's parent or the foster care provider wants to send information to the court, the agency shall advise those persons of the reporting date and the date by which the agency must receive the information they want forwarded to the court so the agency is timely able submit it with the agency's report required under this subdivision;

(2) the agency must also inform the child, age 12 or older, the child's parent, and the foster care facility that they have the right to be heard in person by the court and how to exercise that right;

(3) the agency must also inform the child, age 12 or older, the child's parent, and the foster care provider that an in-court hearing will be held if requested by the child, the parent, or the foster care provider; and

(4) if, at the time required for the report under this section, a child, age 12 or older, disagrees about the foster care facility or services provided under the out-of-home placement plan required under section 260C.212, subdivision 1, the agency shall include information regarding the child's disagreement, and to the extent possible, the basis for the child's disagreement in the report required under this section.

(e) After receiving the required report, the court has jurisdiction to make the following determinations and must do so within ten days of receiving the forwarded report, whether a hearing is requested:

(1) whether the voluntary foster care arrangement is in the child's best interests;

(2) whether the parent and agency are appropriately planning for the child; and

(3) in the case of a child age 12 or older, who disagrees with the foster care facility or services provided under the out-of-home placement plan, whether it is appropriate to appoint counsel and a guardian ad litem for the child using standards and procedures under section 260C.163.

(f) Unless requested by a parent, representative of the foster care facility, or the child, no in-court hearing is required in order for the court to make findings and issue an order as required in paragraph (e).

(g) If the court finds the voluntary foster care arrangement is in the child's best interests and that the agency and parent are appropriately planning for the child, the court shall issue an order containing explicit, individualized findings to support its determination. The individualized findings shall be based on the agency's written report and other materials submitted to the court. The court may make this determination notwithstanding the child's disagreement, if any, reported under paragraph (d).

(h) The court shall send a copy of the order to the county attorney, the agency, parent, child, age 12 or older, and the foster parent or foster care facility.

(i) The court shall also send the parent, the child, age 12 or older, the foster parent, or representative of the foster care facility notice of the permanency review hearing required under section 260D.07, paragraph (e).

(j) If the court finds continuing the voluntary foster care arrangement is not in the child's best interests or that the agency or the parent are not appropriately planning for the child, the court shall notify the agency, the parent, the foster parent or foster care facility, the child, age 12 or older, and the county attorney of the court's determinations and the basis for the

court's determinations. In this case, the court shall set the matter for hearing and appoint a guardian ad litem for the child under section 260C.163, subdivision 5.

Sec. 89. Minnesota Statutes 2024, section 260D.07, is amended to read:

260D.07 REQUIRED PERMANENCY REVIEW HEARING.

(a) When the court has found that the voluntary arrangement is in the child's best interests and that the agency and parent are appropriately planning for the child pursuant to the report submitted under section 260D.06, and the child continues in voluntary foster care as defined in section 260D.02, subdivision 10, for 13 months from the date of the voluntary foster care agreement, or has been in placement for 15 of the last 22 months, the agency must:

(1) terminate the voluntary foster care agreement and return the child home; or

(2) determine whether there are compelling reasons to continue the voluntary foster care arrangement and, if the agency determines there are compelling reasons, seek judicial approval of its determination; or

(3) file a petition for the termination of parental rights.

(b) When the agency is asking for the court's approval of its determination that there are compelling reasons to continue the child in the voluntary foster care arrangement, the agency shall file a "Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment" and ask the court to proceed under this section.

(c) The "Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment" shall be drafted or approved by the county attorney and be under oath. The petition shall include:

(1) the date of the voluntary placement agreement;

(2) whether the petition is due to the child's developmental disability or ~~emotional disturbance~~ mental illness;

(3) the plan for the ongoing care of the child and the parent's participation in the plan;

(4) a description of the parent's visitation and contact with the child;

(5) the date of the court finding that the foster care placement was in the best interests of the child, if required under section 260D.06, or the date the agency filed the motion under section 260D.09, paragraph (b);

(6) the agency's reasonable efforts to finalize the permanent plan for the child, including returning the child to the care of the child's family;

(7) a citation to this chapter as the basis for the petition; and

(8) evidence as specified in section 260C.712 when a child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d.

(d) An updated copy of the out-of-home placement plan required under section 260C.212, subdivision 1, shall be filed with the petition.

(e) The court shall set the date for the permanency review hearing no later than 14 months after the child has been in placement or within 30 days of the petition filing date when the child has been in placement 15 of the last 22 months. The court shall serve the petition together with a notice of hearing by United States mail on the parent, the child age 12 or older, the child's guardian ad litem, if one has been appointed, the agency, the county attorney, and counsel for any party.

(f) The court shall conduct the permanency review hearing on the petition no later than 14 months after the date of the voluntary placement agreement, within 30 days of the filing of the petition when the child has been in placement 15 of the last 22 months, or within 15 days of a motion to terminate jurisdiction and to dismiss an order for foster care under chapter 260C, as provided in section 260D.09, paragraph (b).

(g) At the permanency review hearing, the court shall:

(1) inquire of the parent if the parent has reviewed the "Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment," whether the petition is accurate, and whether the parent agrees to the continued voluntary foster care arrangement as being in the child's best interests;

(2) inquire of the parent if the parent is satisfied with the agency's reasonable efforts to finalize the permanent plan for the child, including whether there are services available and accessible to the parent that might allow the child to safely be with the child's family;

(3) inquire of the parent if the parent consents to the court entering an order that:

(i) approves the responsible agency's reasonable efforts to finalize the permanent plan for the child, which includes ongoing future planning for the safety, health, and best interests of the child; and

(ii) approves the responsible agency's determination that there are compelling reasons why the continued voluntary foster care arrangement is in the child's best interests; and

(4) inquire of the child's guardian ad litem and any other party whether the guardian or the party agrees that:

(i) the court should approve the responsible agency's reasonable efforts to finalize the permanent plan for the child, which includes ongoing and future planning for the safety, health, and best interests of the child; and

(ii) the court should approve of the responsible agency's determination that there are compelling reasons why the continued voluntary foster care arrangement is in the child's best interests.

(h) At a permanency review hearing under this section, the court may take the following actions based on the contents of the sworn petition and the consent of the parent:

(1) approve the agency's compelling reasons that the voluntary foster care arrangement is in the best interests of the child; and

(2) find that the agency has made reasonable efforts to finalize the permanent plan for the child.

(i) A child, age 12 or older, may object to the agency's request that the court approve its compelling reasons for the continued voluntary arrangement and may be heard on the reasons for the objection. Notwithstanding the child's objection, the court may approve the agency's compelling reasons and the voluntary arrangement.

(j) If the court does not approve the voluntary arrangement after hearing from the child or the child's guardian ad litem, the court shall dismiss the petition. In this case, either:

(1) the child must be returned to the care of the parent; or

(2) the agency must file a petition under section 260C.141, asking for appropriate relief under sections 260C.301 or 260C.503 to 260C.521.

(k) When the court approves the agency's compelling reasons for the child to continue in voluntary foster care for treatment, and finds that the agency has made reasonable efforts to finalize a permanent plan for the child, the court shall approve the continued voluntary foster care arrangement, and continue the matter under the court's jurisdiction for the purposes of reviewing the child's placement every 12 months while the child is in foster care.

(l) A finding that the court approves the continued voluntary placement means the agency has continued legal authority to place the child while a voluntary placement agreement remains in effect. The parent or the agency may terminate a voluntary agreement as provided in section 260D.10. Termination of a voluntary foster care placement of an Indian child is governed by section 260.765, subdivision 4.

Sec. 90. Minnesota Statutes 2024, section 260E.11, subdivision 3, is amended to read:

Subd. 3. **Report to medical examiner or coroner; notification to local agency and law enforcement; report ombudsman.** (a) A person mandated to report maltreatment who knows or has reason to believe a child has died as a result of maltreatment shall report that information to the appropriate medical examiner or coroner instead of the local welfare agency, police department, or county sheriff.

(b) The medical examiner or coroner shall notify the local welfare agency, police department, or county sheriff in instances in which the medical examiner or coroner believes that the child has died as a result of maltreatment. The medical examiner or coroner shall complete an investigation as soon as feasible and report the findings to the police department or county sheriff and the local welfare agency.

(c) If the child was receiving services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~ from an agency, facility, or program as defined in section 245.91, the medical examiner or coroner shall also notify and report findings to the ombudsman established under sections 245.91 to 245.97.

Sec. 91. Minnesota Statutes 2024, section 295.50, subdivision 9b, is amended to read:

Subd. 9b. **Patient services.** (a) "Patient services" means inpatient and outpatient services and other goods and services provided by hospitals, surgical centers, or health care providers. They include the following health care goods and services provided to a patient or consumer:

(1) bed and board;

(2) nursing services and other related services;

(3) use of hospitals, surgical centers, or health care provider facilities;

(4) medical social services;

(5) drugs, biologicals, supplies, appliances, and equipment;

(6) other diagnostic or therapeutic items or services;

(7) medical or surgical services;

(8) items and services furnished to ambulatory patients not requiring emergency care; and

(9) emergency services.

(b) "Patient services" does not include:

(1) services provided to nursing homes licensed under chapter 144A;

(2) examinations for purposes of utilization reviews, insurance claims or eligibility, litigation, and employment, including reviews of medical records for those purposes;

(3) services provided to and by community residential mental health facilities licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, and to and by residential treatment programs for children with ~~severe emotional disturbance~~ a serious mental illness licensed or certified under chapter 245A;

(4) services provided under the following programs: day treatment services as defined in section 245.462, subdivision 8; assertive community treatment as described in section 256B.0622; adult rehabilitative mental health services as described in section 256B.0623; crisis response services as described in section 256B.0624; and children's therapeutic services and supports as described in section 256B.0943;

(5) services provided to and by community mental health centers as defined in section 245.62, subdivision 2;

(6) services provided to and by assisted living programs and congregate housing programs;

(7) hospice care services;

(8) home and community-based waivered services under chapter 256S and sections 256B.49 and 256B.501;

(9) targeted case management services under sections 256B.0621; 256B.0625, subdivisions 20, 20a, 33, and 44; and 256B.094; and

(10) services provided to the following: supervised living facilities for persons with developmental disabilities licensed under Minnesota Rules, parts 4665.0100 to 4665.9900; housing with services establishments required to be registered under chapter 144D; board and lodging establishments providing only custodial services that are licensed under chapter 157 and registered under section 157.17 to provide supportive services or health supervision services; adult foster homes as defined in Minnesota Rules, part 9555.5105; day training and habilitation services for adults with developmental disabilities as defined in section 252.41, subdivision 3; boarding care homes as defined in Minnesota Rules, part 4655.0100; adult day care services as defined in section 245A.02, subdivision 2a; and home health agencies as defined in Minnesota Rules, part 9505.0175, subpart 15, or licensed under chapter 144A.