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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. **1198**

02/01/2023 Authored by Hanson, J.; Olson, L.; Fischer; Frederick; Hicks and others
The bill was read for the first time and referred to the Committee on Human Services Policy
02/27/2023 Adoption of Report: Amended and re-referred to the Committee on Children and Families Finance and Policy
03/15/2023 Adoption of Report: Amended and re-referred to the Committee on Human Services Finance

1.1 A bill for an act

1.2 relating to human services; expanding child care assistance to certain families;

1.3 expanding and modifying grants and rules regarding children's mental health;

1.4 modifying the transition to community initiative; modifying training requirements

1.5 for mental health staff; modifying covered transportation services; modifying

1.6 coverage of mental health clinical care coordination; modifying rules regarding

1.7 children's long-term stays in the emergency room; establishing the rural family

1.8 response and stabilization services pilot program; requiring reports; appropriating

1.9 money; amending Minnesota Statutes 2022, sections 119B.05, subdivision 1;

1.10 245.4662; 245.4889, subdivision 1; 245I.04, subdivisions 5, 7; 254B.05, subdivision

1.11 1a; 256.478; 256B.0616, subdivisions 4, 5, by adding a subdivision; 256B.0622,

1.12 subdivision 2a; 256B.0624, subdivisions 5, 8; 256B.0625, subdivisions 17, 45a;

1.13 256B.0659, subdivisions 1, 17a; 256B.0671, subdivision 7; 256B.0943, by adding

1.14 a subdivision; 256B.0946, subdivision 7; 256B.0947, subdivision 7, by adding a

1.15 subdivision; 260C.007, subdivision 6; 260C.708; proposing coding for new law

1.16 in Minnesota Statutes, chapter 144.

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

1.18 Section 1. Minnesota Statutes 2022, section 119B.05, subdivision 1, is amended to read:

1.19 Subdivision 1. **Eligible participants.** Families eligible for child care assistance under

1.20 the MFIP child care program are:

1.21 (1) MFIP participants who are employed or in job search and meet the requirements of

1.22 section 119B.10;

1.23 (2) persons who are members of transition year families under section 119B.011,

1.24 subdivision 20, and meet the requirements of section 119B.10;

1.25 (3) families who are participating in employment orientation or job search, or other

1.26 employment or training activities that are included in an approved employability development

1.27 plan under section 256J.95;

2.1 (4) MFIP families who are participating in work job search, job support, employment,
2.2 or training activities as required in their employment plan, or in appeals, hearings,
2.3 assessments, or orientations according to chapter 256J;

2.4 (5) MFIP families who are participating in social services activities under chapter 256J
2.5 as required in their employment plan approved according to chapter 256J;

2.6 (6) families who are participating in services or activities that are included in an approved
2.7 family stabilization plan under section 256J.575;

2.8 (7) MFIP child-only families under section 256J.88, for up to 20 hours of child care per
2.9 week for children ages six and under, as recommended by the treating mental health
2.10 professional, when the child's primary caregiver has a diagnosis of a mental illness;

2.11 ~~(7)~~ (8) families who are participating in programs as required in tribal contracts under
2.12 section 119B.02, subdivision 2, or 256.01, subdivision 2;

2.13 ~~(8)~~ (9) families who are participating in the transition year extension under section
2.14 119B.011, subdivision 20a;

2.15 ~~(9)~~ (10) student parents as defined under section 119B.011, subdivision 19b; and

2.16 ~~(10)~~ (11) student parents who turn 21 years of age and who continue to meet the other
2.17 requirements under section 119B.011, subdivision 19b. A student parent continues to be
2.18 eligible until the student parent is approved for basic sliding fee child care assistance or
2.19 until the student parent's redetermination, whichever comes first. At the student parent's
2.20 redetermination, if the student parent was not approved for basic sliding fee child care
2.21 assistance, a student parent's eligibility ends following a 15-day adverse action notice.

2.22 **Sec. 2. [144.3435] NONRESIDENTIAL MENTAL HEALTH SERVICES.**

2.23 A minor who 16 years of age or older may give effective consent for nonresidential
2.24 mental health services, and the consent of no other person is required. For purposes of this
2.25 section, "nonresidential mental health services" means outpatient services as defined in
2.26 section 245.4871, subdivision 29, provided to a minor who is not residing in a hospital,
2.27 inpatient unit, or licensed residential treatment facility or program.

2.28 Sec. 3. Minnesota Statutes 2022, section 245.4662, is amended to read:

2.29 **245.4662 MENTAL HEALTH INNOVATION GRANT PROGRAM.**

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

3.1 (b) "Community partnership" means a project involving the collaboration of two or more
3.2 eligible applicants.

3.3 (c) "Eligible applicant" means an eligible county, Indian tribe, mental health service
3.4 provider, hospital, or community partnership. Eligible applicant does not include a
3.5 state-operated direct care and treatment facility or program under chapter 246.

3.6 (d) "Intensive residential treatment services" has the meaning given in section 256B.0622.

3.7 (e) "Psychiatric residential treatment facility" has the meaning given in section
3.8 256B.0941.

3.9 ~~(e)~~ (f) "Metropolitan area" means the seven-county metropolitan area, as defined in
3.10 section 473.121, subdivision 2.

3.11 Subd. 2. **Grants authorized.** (a) The commissioner of human services shall, in
3.12 consultation with stakeholders, award grants to eligible applicants to:

3.13 (1) plan, establish, or operate programs to improve accessibility and quality of
3.14 community-based, outpatient mental health services and reduce the number of clients
3.15 admitted to regional treatment centers and community behavioral health hospitals; or

3.16 (2) plan, establish, or operate programs to address the specific needs of children who
3.17 need specialized services and who have a mental illness, including:

3.18 (i) autism spectrum disorders with self-injury or aggression;

3.19 (ii) reactive attachment disorder or post-traumatic stress disorder with aggression;

3.20 (iii) a co-occurring intellectual disability or developmental disability;

3.21 (iv) a traumatic brain injury;

3.22 (v) a co-occurring complex medical issue; and

3.23 (vi) severe emotional dysregulation and schizophrenia.

3.24 (b) The commissioner shall award half of all grant funds to eligible applicants in the
3.25 metropolitan area and half of all grant funds to eligible applicants outside the metropolitan
3.26 area. An applicant may apply for and the commissioner may award grants for two-year
3.27 periods. The commissioner may reallocate underspending among grantees within the same
3.28 grant period. The mental health innovation account is established under section 246.18 for
3.29 ongoing funding.

3.30 Subd. 3. **Allocation of grants.** (a) An application must be on a form and contain
3.31 information as specified by the commissioner but at a minimum must contain:

- 4.1 (1) a description of the purpose or project for which grant funds will be used;
- 4.2 (2) a description of the specific problem the grant funds will address;
- 4.3 (3) a letter of support from the local mental health authority;
- 4.4 (4) a description of achievable objectives, a work plan, and a timeline for implementation
- 4.5 and completion of processes or projects enabled by the grant; and
- 4.6 (5) a process for documenting and evaluating results of the grant.

4.7 (b) The commissioner shall review each application to determine whether the application

4.8 is complete and whether the applicant and the project are eligible for a grant. In evaluating

4.9 applications according to paragraph (c), the commissioner shall establish criteria including,

4.10 but not limited to: the eligibility of the project; the applicant's thoroughness and clarity in

4.11 describing the problem grant funds are intended to address; a description of the applicant's

4.12 proposed project; a description of the population demographics and service area of the

4.13 proposed project; the manner in which the applicant will demonstrate the effectiveness of

4.14 any projects undertaken; the proposed project's longevity and demonstrated financial

4.15 sustainability after the initial grant period; and evidence of efficiencies and effectiveness

4.16 gained through collaborative efforts. The commissioner may also consider other relevant

4.17 factors. In evaluating applications, the commissioner may request additional information

4.18 regarding a proposed project, including information on project cost. An applicant's failure

4.19 to provide the information requested disqualifies an applicant. The commissioner shall

4.20 determine the number of grants awarded.

4.21 (c) Eligible applicants may receive grants under this section for purposes including, but

4.22 not limited to, the following:

4.23 (1) intensive residential treatment services or psychiatric residential treatment services

4.24 providing time-limited mental health services in a residential setting;

4.25 (2) the creation of stand-alone urgent care centers for mental health and psychiatric

4.26 consultation services, crisis residential services, or collaboration between crisis teams and

4.27 critical access hospitals;

4.28 (3) establishing new community mental health services or expanding the capacity of

4.29 existing services, including supportive housing; and

4.30 (4) other innovative projects that improve options for mental health services in community

4.31 settings and reduce the number of:

5.1 (i) clients who remain in regional treatment centers and community behavioral health
5.2 hospitals beyond when discharge is determined to be clinically appropriate; or

5.3 (ii) children who have boarded in an emergency room or whose discharge from an
5.4 emergency room or residential setting is delayed because no other options for their care are
5.5 available.

5.6 Sec. 4. Minnesota Statutes 2022, section 245.4889, subdivision 1, is amended to read:

5.7 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to
5.8 make grants from available appropriations to assist:

5.9 (1) counties;

5.10 (2) Indian tribes;

5.11 (3) children's collaboratives under section 124D.23 or 245.493; or

5.12 (4) mental health service providers.

5.13 (b) The following services are eligible for grants under this section:

5.14 (1) services to children with emotional disturbances as defined in section 245.4871,
5.15 subdivision 15, and their families;

5.16 (2) transition services under section 245.4875, subdivision 8, for young adults under
5.17 age 21 and their families;

5.18 (3) respite care services for children with emotional disturbances or severe emotional
5.19 disturbances who are at risk of ~~out-of-home placement or residential treatment or~~
5.20 hospitalization, who are already in out-of-home placement in family foster settings as defined
5.21 in chapter 245A and at risk of change in out-of-home placement or placement in a residential
5.22 facility or other higher level of care, who have utilized crisis services or emergency room
5.23 services, or who have experienced a loss of in-home staffing support. Allowable activities
5.24 and expenses for respite care services are defined under subdivision 4. A child is not required
5.25 to have case management services to receive respite care services. Counties must work to
5.26 provide access to regularly scheduled respite care;

5.27 (4) children's mental health crisis services;

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

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

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

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

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

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

6.7 (11) mental health first aid training;

6.8 (12) training for parents, collaborative partners, and mental health providers on the
6.9 impact of adverse childhood experiences and trauma and development of an interactive
6.10 website to share information and strategies to promote resilience and prevent trauma;

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

6.13 (14) early childhood mental health consultation;

6.14 (15) evidence-based interventions for youth at risk of developing or experiencing a first
6.15 episode of psychosis, and a public awareness campaign on the signs and symptoms of
6.16 psychosis;

6.17 (16) psychiatric consultation for primary care practitioners; and

6.18 (17) providers to begin operations and meet program requirements when establishing a
6.19 new children's mental health program. These may be start-up grants.

6.20 (c) Services under paragraph (b) must be designed to help each child to function and
6.21 remain with the child's family in the community and delivered consistent with the child's
6.22 treatment plan. Transition services to eligible young adults under this paragraph must be
6.23 designed to foster independent living in the community.

6.24 (d) As a condition of receiving grant funds, a grantee shall obtain all available third-party
6.25 reimbursement sources, if applicable.

6.26 Sec. 5. Minnesota Statutes 2022, section 245I.04, subdivision 5, is amended to read:

6.27 Subd. 5. **Mental health practitioner scope of practice.** (a) A mental health practitioner
6.28 under the treatment supervision of a mental health professional or certified rehabilitation
6.29 specialist may provide an adult client with client education, rehabilitative mental health
6.30 services, functional assessments, level of care assessments, and treatment plans. A mental
6.31 health practitioner under the treatment supervision of a mental health professional may

7.1 provide skill-building services to a child client ~~and~~, complete treatment plans for a child
7.2 client, and provide clinical care consultation as defined in section 256B.0671, subdivision
7.3 7.

7.4 (b) A mental health practitioner must not provide treatment supervision to other staff
7.5 persons. A mental health practitioner may provide direction to mental health rehabilitation
7.6 workers and mental health behavioral aides.

7.7 (c) A mental health practitioner who provides services to clients according to section
7.8 256B.0624 or 256B.0944 may perform crisis assessments and interventions for a client.

7.9 Sec. 6. Minnesota Statutes 2022, section 245I.04, subdivision 7, is amended to read:

7.10 Subd. 7. **Clinical trainee scope of practice.** (a) A clinical trainee under the treatment
7.11 supervision of a mental health professional may provide a client with psychotherapy, client
7.12 education, rehabilitative mental health services, diagnostic assessments, functional
7.13 assessments, level of care assessments, and treatment plans. A mental health practitioner
7.14 clinical trainee under the treatment supervision of a mental health professional may provide
7.15 clinical care consultation as defined in section 256B.0671, subdivision 7.

7.16 (b) A clinical trainee must not provide treatment supervision to other staff persons. A
7.17 clinical trainee may provide direction to mental health behavioral aides and mental health
7.18 rehabilitation workers.

7.19 (c) A psychological clinical trainee under the treatment supervision of a psychologist
7.20 may perform psychological testing of clients.

7.21 (d) A clinical trainee must not provide services to clients that violate any practice act of
7.22 a health-related licensing board, including failure to obtain licensure if licensure is required.

7.23 Sec. 7. Minnesota Statutes 2022, section 254B.05, subdivision 1a, is amended to read:

7.24 Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000,
7.25 vendors of room and board are eligible for behavioral health fund payment if the vendor:

7.26 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals
7.27 while residing in the facility and provide consequences for infractions of those rules;

7.28 (2) is determined to meet applicable health and safety requirements;

7.29 (3) is not a jail or prison;

7.30 (4) is not concurrently receiving funds under chapter 256I for the recipient;

- 8.1 (5) admits individuals who are 18 years of age or older;
- 8.2 (6) is registered as a board and lodging or lodging establishment according to section
8.3 157.17;
- 8.4 (7) has awake staff on site 24 hours per day;
- 8.5 (8) has staff who are at least 18 years of age and meet the requirements of section
8.6 245G.11, subdivision 1, paragraph (b);
- 8.7 (9) has emergency behavioral procedures that meet the requirements of section 245G.16;
- 8.8 (10) meets the requirements of section 245G.08, subdivision 5, if administering
8.9 medications to clients;
- 8.10 (11) meets the abuse prevention requirements of section 245A.65, including a policy on
8.11 fraternization and the mandatory reporting requirements of section 626.557;
- 8.12 (12) documents coordination with the treatment provider to ensure compliance with
8.13 section 254B.03, subdivision 2;
- 8.14 (13) protects client funds and ensures freedom from exploitation by meeting the
8.15 provisions of section 245A.04, subdivision 13;
- 8.16 (14) has a grievance procedure that meets the requirements of section 245G.15,
8.17 subdivision 2; and
- 8.18 (15) has sleeping and bathroom facilities for men and women separated by a door that
8.19 is locked, has an alarm, or is supervised by awake staff.
- 8.20 (b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from
8.21 paragraph (a), clauses (5) to (15).
- 8.22 (c) Programs providing children's mental health crisis admissions and stabilization under
8.23 section 245.4882, subdivision 6, are eligible vendors of room and board.
- 8.24 (d) Programs providing children's residential services under section 245.4882, except
8.25 services for individuals who have a placement under chapter 260C or 260D, are eligible
8.26 vendors of room and board.
- 8.27 ~~(d)~~ (e) Licensed programs providing intensive residential treatment services or residential
8.28 crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors
8.29 of room and board and are exempt from paragraph (a), clauses (6) to (15).

9.1 Sec. 8. Minnesota Statutes 2022, section 256.478, is amended to read:

9.2 **256.478 CHILD AND ADULT TRANSITION TO COMMUNITY INITIATIVE.**

9.3 Subdivision 1. **Purpose.** (a) The commissioner shall establish the transition to community
9.4 initiative to award grants to serve individuals for whom supports and services not covered
9.5 by medical assistance would allow them to:

9.6 (1) live in the least restrictive setting and as independently as possible;

9.7 (2) access services that support short- and long-term needs for developmental growth
9.8 or individualized treatment needs;

9.9 ~~(2)~~ (3) build or maintain relationships with family and friends; and

9.10 ~~(3)~~ (4) participate in community life.

9.11 (b) Grantees must ensure that ~~individuals~~ the individual or the child and family are
9.12 engaged in a process that involves person-centered planning and informed choice
9.13 decision-making. The informed choice decision-making process must provide accessible
9.14 written information and be experiential whenever possible.

9.15 Subd. 2. **Eligibility.** ~~An individual~~ A child or adult is eligible for the transition to
9.16 community initiative if the ~~individual~~ child or adult does not meet eligibility criteria for the
9.17 medical assistance program under section 256B.056 or 256B.057, ~~but~~ or can demonstrate
9.18 that current services are not capable of meeting individual treatment and service needs that
9.19 can be met in the community with support, and who meets at least one of the following
9.20 criteria:

9.21 (1) the person otherwise meets the criteria under section 256B.092, subdivision 13, or
9.22 256B.49, subdivision 24;

9.23 (2) the person has met treatment objectives and no longer requires a hospital-level care
9.24 or a secure treatment setting, but the person's discharge from the Anoka Metro Regional
9.25 Treatment Center, the Minnesota Security Hospital, or a community behavioral health
9.26 hospital would be substantially delayed without additional resources available through the
9.27 transitions to community initiative;

9.28 (3) the person is in a community hospital, juvenile detention facility, or county supervised
9.29 building, but alternative community living options would be appropriate for the person, and
9.30 the person has received approval from the commissioner; ~~or~~

9.31 (4)(i) the person is receiving customized living services reimbursed under section
9.32 256B.4914, 24-hour customized living services reimbursed under section 256B.4914, or

10.1 community residential services reimbursed under section 256B.4914; (ii) the person expresses
10.2 a desire to move; and (iii) the person has received approval from the commissioner; or

10.3 (5) the person can demonstrate that individual needs are beyond the scope of current
10.4 service designs and grant funding can support the inclusion of additional supports for the
10.5 child or adult to access appropriate treatment and services in the least restrictive environment.

10.6 Sec. 9. Minnesota Statutes 2022, section 256B.0616, subdivision 4, is amended to read:

10.7 Subd. 4. **Peer support specialist program providers.** The commissioner shall develop
10.8 a process to certify family and youth peer support specialist programs and associated training
10.9 support, in accordance with the federal guidelines; in order for the program to bill for
10.10 reimbursable services. Family and youth peer support programs must operate within an
10.11 existing mental health community provider or center.

10.12 Sec. 10. Minnesota Statutes 2022, section 256B.0616, subdivision 5, is amended to read:

10.13 Subd. 5. **Certified family and youth peer specialist training and certification.** The
10.14 commissioner shall develop ~~a~~ or approve the use of an existing training and certification
10.15 process for certified family and youth peer specialists. ~~The~~ Family peer candidates must
10.16 have raised or be currently raising a child with a mental illness, have had experience
10.17 navigating the children's mental health system, and ~~must~~ demonstrate leadership and advocacy
10.18 skills and a strong dedication to family-driven and family-focused services. Youth peer
10.19 candidates must have demonstrated lived experience in children's mental health or related
10.20 adverse experiences in adolescence, a high school degree, and leadership and advocacy
10.21 skills with a focus on supporting client voices. The training curriculum must teach
10.22 participating family and youth peer specialists specific skills relevant to providing peer
10.23 support to other parents or youth in mental health treatment. In addition to initial training
10.24 and certification, the commissioner shall develop ongoing continuing educational workshops
10.25 on pertinent issues related to family and youth peer support counseling. Training for family
10.26 and youth peer support specialists can be delivered by the commissioner or by organizations
10.27 approved by the commissioner.

10.28 Sec. 11. Minnesota Statutes 2022, section 256B.0616, is amended by adding a subdivision
10.29 to read:

10.30 Subd. 6. **Payment rate increase.** Payment rates for services provided under this section
10.31 rendered on or after January 1, 2024, shall be increased by 50 percent over the rates in effect
10.32 on December 31, 2023.

11.1 Sec. 12. Minnesota Statutes 2022, section 256B.0622, subdivision 2a, is amended to read:

11.2 Subd. 2a. **Eligibility for assertive community treatment.** An eligible client for assertive
11.3 community treatment is an individual who meets the following criteria as assessed by an
11.4 ACT team:

11.5 (1) is age 18 or older. Individuals ages 16 and 17 may be eligible upon approval by the
11.6 commissioner;

11.7 (2) has a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive
11.8 disorder with psychotic features, other psychotic disorders, or bipolar disorder. Individuals
11.9 with other psychiatric illnesses may qualify for assertive community treatment if they have
11.10 a serious mental illness and meet the criteria outlined in clauses (3) and (4), but no more
11.11 than ten percent of an ACT team's clients may be eligible based on this criteria. Individuals
11.12 with a primary diagnosis of a substance use disorder, intellectual developmental disabilities,
11.13 borderline personality disorder, antisocial personality disorder, traumatic brain injury, or
11.14 an autism spectrum disorder are not eligible for assertive community treatment;

11.15 (3) has significant functional impairment as demonstrated by at least one of the following
11.16 conditions:

11.17 (i) significant difficulty consistently performing the range of routine tasks required for
11.18 basic adult functioning in the community or persistent difficulty performing daily living
11.19 tasks without significant support or assistance;

11.20 (ii) significant difficulty maintaining employment at a self-sustaining level or significant
11.21 difficulty consistently carrying out the head-of-household responsibilities; or

11.22 (iii) significant difficulty maintaining a safe living situation;

11.23 (4) has a need for continuous high-intensity services as evidenced by at least two of the
11.24 following:

11.25 (i) two or more psychiatric hospitalizations or residential crisis stabilization services in
11.26 the previous 12 months;

11.27 (ii) frequent utilization of mental health crisis services in the previous six months;

11.28 (iii) 30 or more consecutive days of psychiatric hospitalization in the previous 24 months;

11.29 (iv) intractable, persistent, or prolonged severe psychiatric symptoms;

11.30 (v) coexisting mental health and substance use disorders lasting at least six months;

12.1 (vi) recent history of involvement with the criminal justice system or demonstrated risk
12.2 of future involvement;

12.3 (vii) significant difficulty meeting basic survival needs;

12.4 (viii) residing in substandard housing, experiencing homelessness, or facing imminent
12.5 risk of homelessness;

12.6 (ix) significant impairment with social and interpersonal functioning such that basic
12.7 needs are in jeopardy;

12.8 (x) coexisting mental health and physical health disorders lasting at least six months;

12.9 (xi) residing in an inpatient or supervised community residence but clinically assessed
12.10 to be able to live in a more independent living situation if intensive services are provided;

12.11 (xii) requiring a residential placement if more intensive services are not available; ~~or~~

12.12 (xiii) difficulty effectively using traditional office-based outpatient services; or

12.13 (xiv) receiving services under section 256B.0947 and continuing to meet the criteria but
12.14 for turning age 21;

12.15 (5) there are no indications that other available community-based services would be
12.16 equally or more effective as evidenced by consistent and extensive efforts to treat the
12.17 individual; and

12.18 (6) in the written opinion of a licensed mental health professional, has the need for mental
12.19 health services that cannot be met with other available community-based services, or is
12.20 likely to experience a mental health crisis or require a more restrictive setting if assertive
12.21 community treatment is not provided.

12.22 Sec. 13. Minnesota Statutes 2022, section 256B.0624, subdivision 5, is amended to read:

12.23 Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Qualified
12.24 individual staff of a qualified provider entity must provide crisis assessment and intervention
12.25 services to a recipient. A staff member providing crisis assessment and intervention services
12.26 to a recipient must be qualified as a:

12.27 (1) mental health professional;

12.28 (2) clinical trainee;

12.29 (3) mental health practitioner;

12.30 (4) mental health certified family peer specialist; or

13.1 (5) mental health certified peer specialist.

13.2 (b) When crisis assessment and intervention services are provided to a recipient in the
13.3 community, a mental health professional, clinical trainee, or mental health practitioner must
13.4 lead the response.

13.5 (c) The 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph
13.6 (b), must be specific to providing crisis services to children and adults and include training
13.7 about evidence-based practices identified by the commissioner of health to reduce the
13.8 recipient's risk of suicide and self-injurious behavior.

13.9 (d) At least 6 hours of the ongoing training under paragraph (c) must be specific to
13.10 working with families and providing crisis stabilization services to children and include the
13.11 following topics:

13.12 (1) developmental tasks of childhood and adolescence;

13.13 (2) family relationships;

13.14 (3) child and youth engagement and motivation, including motivational interviewing;

13.15 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and
13.16 queer youth;

13.17 (5) positive behavior support;

13.18 (6) crisis intervention for youth with developmental disabilities;

13.19 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral
13.20 therapy; and

13.21 (8) youth substance use.

13.22 ~~(d)~~ (e) Team members must be experienced in crisis assessment, crisis intervention
13.23 techniques, treatment engagement strategies, working with families, and clinical
13.24 decision-making under emergency conditions and have knowledge of local services and
13.25 resources.

13.26 Sec. 14. Minnesota Statutes 2022, section 256B.0624, subdivision 8, is amended to read:

13.27 Subd. 8. **Crisis stabilization staff qualifications.** (a) Mental health crisis stabilization
13.28 services must be provided by qualified individual staff of a qualified provider entity. A staff
13.29 member providing crisis stabilization services to a recipient must be qualified as a:

13.30 (1) mental health professional;

14.1 (2) certified rehabilitation specialist;

14.2 (3) clinical trainee;

14.3 (4) mental health practitioner;

14.4 (5) mental health certified family peer specialist;

14.5 (6) mental health certified peer specialist; or

14.6 (7) mental health rehabilitation worker.

14.7 (b) The 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph

14.8 (b), must be specific to providing crisis services to children and adults and include training

14.9 about evidence-based practices identified by the commissioner of health to reduce a recipient's

14.10 risk of suicide and self-injurious behavior.

14.11 (c) At least 6 hours of the ongoing training under this subdivision must be specific to

14.12 working with families and providing crisis stabilization services to children and include the

14.13 following topics:

14.14 (1) developmental tasks of childhood and adolescence;

14.15 (2) family relationships;

14.16 (3) child and youth engagement and motivation, including motivational interviewing;

14.17 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and

14.18 queer youth;

14.19 (5) positive behavior support;

14.20 (6) crisis intervention for youth with developmental disabilities;

14.21 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral

14.22 therapy; and

14.23 (8) youth substance use.

14.24 Sec. 15. Minnesota Statutes 2022, section 256B.0625, subdivision 17, is amended to read:

14.25 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"

14.26 means motor vehicle transportation provided by a public or private person that serves

14.27 Minnesota health care program beneficiaries who do not require emergency ambulance

14.28 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

14.29 (b) Medical assistance covers medical transportation costs incurred solely for obtaining

14.30 emergency medical care or transportation costs incurred by eligible persons in obtaining

15.1 emergency or nonemergency medical care when paid directly to an ambulance company,
15.2 nonemergency medical transportation company, or other recognized providers of
15.3 transportation services. Medical transportation must be provided by:

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

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

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

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

15.9 (5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472,
15.10 subdivision 1, paragraph (h); or

15.11 (6) type III vehicles, as defined in section 169.011, subdivision 71, paragraph (h), that
15.12 meet the requirements of this subdivision.

15.13 (c) Medical assistance covers nonemergency medical transportation provided by
15.14 nonemergency medical transportation providers enrolled in the Minnesota health care
15.15 programs. All nonemergency medical transportation providers must comply with the
15.16 operating standards for special transportation service as defined in sections 174.29 to 174.30
15.17 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
15.18 commissioner and reported on the claim as the individual who provided the service. All
15.19 nonemergency medical transportation providers shall bill for nonemergency medical
15.20 transportation services in accordance with Minnesota health care programs criteria. Publicly
15.21 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
15.22 requirements outlined in this paragraph.

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

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

15.26 (2) the provider has initiated background studies on the individuals specified in section
15.27 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

- 16.1 (1) adhere to the policies defined by the commissioner;
- 16.2 (2) pay nonemergency medical transportation providers for services provided to
16.3 Minnesota health care programs beneficiaries to obtain covered medical services;
- 16.4 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
16.5 trips, and number of trips by mode; and
- 16.6 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
16.7 administrative structure assessment tool that meets the technical requirements established
16.8 by the commissioner, reconciles trip information with claims being submitted by providers,
16.9 and ensures prompt payment for nonemergency medical transportation services.
- 16.10 (f) Until the commissioner implements the single administrative structure and delivery
16.11 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
16.12 commissioner or an entity approved by the commissioner that does not dispatch rides for
16.13 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).
- 16.14 (g) The commissioner may use an order by the recipient's attending physician, advanced
16.15 practice registered nurse, physician assistant, or a medical or mental health professional to
16.16 certify that the recipient requires nonemergency medical transportation services.
- 16.17 Nonemergency medical transportation providers shall perform driver-assisted services for
16.18 eligible individuals, when appropriate. Driver-assisted service includes passenger pickup
16.19 at and return to the individual's residence or place of business, assistance with admittance
16.20 of the individual to the medical facility, and assistance in passenger securement or in securing
16.21 of wheelchairs, child seats, or stretchers in the vehicle.
- 16.22 Nonemergency medical transportation providers must take clients to the health care
16.23 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
16.24 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
16.25 authorization from the local agency.
- 16.26 Nonemergency medical transportation providers may not bill for separate base rates for
16.27 the continuation of a trip beyond the original destination. Nonemergency medical
16.28 transportation providers must maintain trip logs, which include pickup and drop-off times,
16.29 signed by the medical provider or client, whichever is deemed most appropriate, attesting
16.30 to mileage traveled to obtain covered medical services. Clients requesting client mileage
16.31 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
16.32 services.

17.1 (h) The administrative agency shall use the level of service process established by the
17.2 commissioner to determine the client's most appropriate mode of transportation. Clients 20
17.3 years of age or younger are eligible for assisted transport, unless they meet the requirements
17.4 for lift-equipped transport, ramp transport, or stretcher transport. If public transit or a certified
17.5 transportation provider is not available to provide the appropriate service mode for the client,
17.6 the client may receive a onetime service upgrade.

17.7 (i) The covered modes of transportation are:

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

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

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

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

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

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

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

17.29 (j) The local agency shall be the single administrative agency and shall administer and
17.30 reimburse for modes defined in paragraph (i) according to paragraphs (m) ~~and (n)~~ to (o)
17.31 when the commissioner has developed, made available, and funded the web-based single
17.32 administrative structure, assessment tool, and level of need assessment under subdivision

18.1 18e. The local agency's financial obligation is limited to funds provided by the state or
18.2 federal government.

18.3 (k) The commissioner shall:

18.4 (1) verify that the mode and use of nonemergency medical transportation is appropriate;

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

18.6 (3) investigate all complaints and appeals.

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

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

18.16 (1) \$0.22 per mile for client reimbursement;

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

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

18.22 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

18.23 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

18.24 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

18.25 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
18.26 an additional attendant if deemed medically necessary.

18.27 (n) The base rate and mileage rate for nonemergency medical transportation services is
18.28 equal to 125 percent of the respective base and mileage rate in paragraph (m), clauses (4)
18.29 and (5), when the client is 20 years old or younger and provided by a type III vehicle, as
18.30 defined in section 169.011, subdivision 71, paragraph (h).

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

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

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

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

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

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

19.19 Sec. 16. Minnesota Statutes 2022, section 256B.0625, subdivision 45a, is amended to
19.20 read:

19.21 Subd. 45a. **Psychiatric residential treatment facility services for persons younger**
19.22 **than 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility
19.23 services, according to section 256B.0941, for persons younger than 21 years of age.
19.24 Individuals who reach age 21 at the time they are receiving services are eligible to continue
19.25 receiving services until they no longer require services or until they reach age 22, whichever
19.26 occurs first.

19.27 (b) For purposes of this subdivision, "psychiatric residential treatment facility" means
19.28 a facility other than a hospital that provides psychiatric services, as described in Code of
19.29 Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in
19.30 an inpatient setting.

19.31 (c) The commissioner shall enroll up to ~~150~~250 certified psychiatric residential treatment
19.32 facility services beds at up to ten sites. The commissioner may enroll an additional 80
19.33 certified psychiatric residential treatment facility services beds beginning July 1, 2020, and

20.1 an additional 70 certified psychiatric residential treatment facility services beds beginning
20.2 July 1, 2023. The commissioner shall select psychiatric residential treatment facility services
20.3 providers through a request for proposals process. Providers of state-operated services may
20.4 respond to the request for proposals. Providers may specialize in the treatment of children
20.5 with specific diagnoses, disabilities, or other health care conditions. The commissioner shall
20.6 prioritize programs that demonstrate the capacity to serve children and youth with aggressive
20.7 and risky behaviors toward themselves or others, multiple diagnoses, neurodevelopmental
20.8 disorders, or complex trauma related issues.

20.9 Sec. 17. Minnesota Statutes 2022, section 256B.0659, subdivision 1, is amended to read:

20.10 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in
20.11 paragraphs (b) to (r) have the meanings given unless otherwise provided in text.

20.12 (b) "Activities of daily living" means grooming, dressing, bathing, transferring, mobility,
20.13 positioning, eating, and toileting.

20.14 (c) "Behavior," effective January 1, 2010, means a category to determine the home care
20.15 rating and is based on the criteria found in this section. "Level I behavior" means physical
20.16 aggression ~~towards~~ toward self, others, or destruction of property that requires the immediate
20.17 response of another person.

20.18 (d) "Complex health-related needs," effective January 1, 2010, means a category to
20.19 determine the home care rating and is based on the criteria found in this section.

20.20 (e) "Critical activities of daily living," effective January 1, 2010, means transferring,
20.21 mobility, eating, and toileting.

20.22 (f) "Dependency in activities of daily living" means a person requires assistance to begin
20.23 and complete one or more of the activities of daily living.

20.24 (g) "Extended personal care assistance service" means personal care assistance services
20.25 included in a service plan under one of the home and community-based services waivers
20.26 authorized under chapter 256S and sections 256B.092, subdivision 5, and 256B.49, which
20.27 exceed the amount, duration, and frequency of the state plan personal care assistance services
20.28 for participants who:

20.29 (1) need assistance provided periodically during a week, but less than daily will not be
20.30 able to remain in their homes without the assistance, and other replacement services are
20.31 more expensive or are not available when personal care assistance services are to be reduced;
20.32 ~~or~~

21.1 (2) need additional personal care assistance services beyond the amount authorized by
21.2 the state plan personal care assistance assessment in order to ensure that their safety, health,
21.3 and welfare are provided for in their homes; or

21.4 (3) due to their mental illness or co-occurring diagnosis, have experienced long stays in
21.5 the emergency room with a delayed discharge from the hospital and the family cannot hire
21.6 staff to provide in-home care.

21.7 (h) "Health-related procedures and tasks" means procedures and tasks that can be
21.8 delegated or assigned by a licensed health care professional under state law to be performed
21.9 by a personal care assistant.

21.10 (i) "Instrumental activities of daily living" means activities to include meal planning and
21.11 preparation; basic assistance with paying bills; shopping for food, clothing, and other
21.12 essential items; performing household tasks integral to the personal care assistance services;
21.13 communication by telephone and other media; and traveling, including to medical
21.14 appointments and to participate in the community.

21.15 (j) "Managing employee" has the same definition as Code of Federal Regulations, title
21.16 42, section 455.

21.17 (k) "Qualified professional" means a professional providing supervision of personal care
21.18 assistance services and staff as defined in section 256B.0625, subdivision 19c.

21.19 (l) "Personal care assistance provider agency" means a medical assistance enrolled
21.20 provider that provides or assists with providing personal care assistance services and includes
21.21 a personal care assistance provider organization, personal care assistance choice agency,
21.22 class A licensed nursing agency, and Medicare-certified home health agency.

21.23 (m) "Personal care assistant" or "PCA" means an individual employed by a personal
21.24 care assistance agency who provides personal care assistance services.

21.25 (n) "Personal care assistance care plan" means a written description of personal care
21.26 assistance services developed by the personal care assistance provider according to the
21.27 service plan.

21.28 (o) "Responsible party" means an individual who is capable of providing the support
21.29 necessary to assist the recipient to live in the community.

21.30 (p) "Self-administered medication" means medication taken orally, by injection, nebulizer,
21.31 or insertion, or applied topically without the need for assistance.

22.1 (q) "Service plan" means a written summary of the assessment and description of the
22.2 services needed by the recipient.

22.3 (r) "Wages and benefits" means wages and salaries, the employer's share of FICA taxes,
22.4 Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage
22.5 reimbursement, health and dental insurance, life insurance, disability insurance, long-term
22.6 care insurance, uniform allowance, and contributions to employee retirement accounts.

22.7 Sec. 18. Minnesota Statutes 2022, section 256B.0659, subdivision 17a, is amended to
22.8 read:

22.9 Subd. 17a. **Enhanced rate.** (a) An enhanced rate of 107.5 percent of the rate paid for
22.10 personal care assistance services shall be paid for services provided to persons who qualify
22.11 for ten or more hours of personal care assistance services per day when provided by a
22.12 personal care assistant who meets the requirements of subdivision 11, paragraph (d).

22.13 (b) An enhanced rate of 20 percent in addition to any enhancement in paragraph (a) must
22.14 be paid for services provided to children with a mental illness or developmental disability
22.15 who exhibit high aggression.

22.16 (c) Any change in the eligibility criteria for the enhanced rate for personal care assistance
22.17 services as described in this subdivision and referenced in subdivision 11, paragraph (d),
22.18 does not constitute a change in a term or condition for individual providers as defined in
22.19 section 256B.0711, and is not subject to the state's obligation to meet and negotiate under
22.20 chapter 179A.

22.21 Sec. 19. Minnesota Statutes 2022, section 256B.0671, subdivision 7, is amended to read:

22.22 Subd. 7. **Mental health clinical care consultation.** (a) Subject to federal approval,
22.23 medical assistance covers clinical care consultation for a person up to age 21 who is
22.24 diagnosed with a complex mental health condition or a mental health condition that co-occurs
22.25 with other complex and chronic conditions, when described in the person's individual
22.26 treatment plan and provided by a mental health professional as defined in section 245I.04,
22.27 subdivision 2, a mental health practitioner as defined in section 245I.04, subdivision 4, or
22.28 a clinical trainee, as defined in section 254I.04, subdivision 6. This medical assistance
22.29 benefit covers all mental health clinical care consultation services delivered by treating
22.30 providers, as needed based on the person's individual treatment plan.

22.31 (b) "Clinical care consultation" means communication from a treating mental health
22.32 professional to other providers or educators not under the treatment supervision of the

23.1 treating mental health professional who are working with the same client to inform, inquire,
23.2 and instruct regarding the client's symptoms; strategies for effective engagement, care, and
23.3 intervention needs; and treatment expectations across service settings and to direct and
23.4 coordinate clinical service components provided to the client and family.

23.5 Sec. 20. Minnesota Statutes 2022, section 256B.0943, is amended by adding a subdivision
23.6 to read:

23.7 Subd. 14. **At-home services rate enhancement.** The commissioner shall implement a
23.8 30 percent rate increase to providers of children's therapeutic services and supports for all
23.9 services provided directly to the child or family in their home.

23.10 Sec. 21. Minnesota Statutes 2022, section 256B.0946, subdivision 7, is amended to read:

23.11 **Subd. 7. Medical assistance payment and rate setting.** The commissioner shall establish
23.12 a single daily per-client encounter rate for children's intensive behavioral health services.
23.13 The rate must be constructed to cover only eligible services delivered to an eligible recipient
23.14 by an eligible provider, as prescribed in subdivision 1, paragraph (b). The rate must be
23.15 increased by 30 percent for all services provided directly to the child or family in their home.

23.16 Sec. 22. Minnesota Statutes 2022, section 256B.0947, subdivision 7, is amended to read:

23.17 **Subd. 7. Medical assistance payment and rate setting.** (a) Payment for services in this
23.18 section must be based on one daily encounter rate per provider inclusive of the following
23.19 services received by an eligible client in a given calendar day: all rehabilitative services,
23.20 supports, and ancillary activities under this section, staff travel time to provide rehabilitative
23.21 services under this section, and crisis response services under section 256B.0624.

23.22 (b) Payment must not be made to more than one entity for each client for services
23.23 provided under this section on a given day. If services under this section are provided by a
23.24 team that includes staff from more than one entity, the team shall determine how to distribute
23.25 the payment among the members.

23.26 (c) The commissioner shall establish regional cost-based rates for entities that will bill
23.27 medical assistance for nonresidential intensive rehabilitative mental health services. In
23.28 developing these rates, the commissioner shall consider:

23.29 (1) the cost for similar services in the health care trade area;

23.30 (2) actual costs incurred by entities providing the services;

23.31 (3) the intensity and frequency of services to be provided to each client;

24.1 (4) the degree to which clients will receive services other than services under this section;
24.2 and

24.3 (5) the costs of other services that will be separately reimbursed.

24.4 (d) The rate for a provider must not exceed the rate charged by that provider for the
24.5 same service to other payers.

24.6 (e) The commissioner must apply an enhanced rate of 130 percent for all services provided
24.7 directly to the client or family in their home.

24.8 Sec. 23. Minnesota Statutes 2022, section 256B.0947, is amended by adding a subdivision
24.9 to read:

24.10 Subd. 10. **Young adult continuity of care.** A client who received services under this
24.11 section or section 256B.0946 and aged out of eligibility may continue to receive services
24.12 from the same providers under this section until the client is 27 years old.

24.13 Sec. 24. Minnesota Statutes 2022, section 260C.007, subdivision 6, is amended to read:

24.14 Subd. 6. **Child in need of protection or services.** "Child in need of protection or
24.15 services" means a child who is in need of protection or services because the child:

24.16 (1) is abandoned or without parent, guardian, or custodian. A child must not be considered
24.17 abandoned if a child's parent cannot take their child home from an emergency room because
24.18 appropriate services are not in place or available to keep the child, other family members,
24.19 or other people in the home safe;

24.20 (2)(i) has been a victim of physical or sexual abuse as defined in section 260E.03,
24.21 subdivision 18 or 20, (ii) resides with or has resided with a victim of child abuse as defined
24.22 in subdivision 5 or domestic child abuse as defined in subdivision 13, (iii) resides with or
24.23 would reside with a perpetrator of domestic child abuse as defined in subdivision 13 or child
24.24 abuse as defined in subdivision 5 or 13, or (iv) is a victim of emotional maltreatment as
24.25 defined in subdivision 15;

24.26 (3) is without necessary food, clothing, shelter, education, or other required care for the
24.27 child's physical or mental health or morals because the child's parent, guardian, or custodian
24.28 is unable or unwilling to provide that care. This does not include when required and
24.29 appropriate care for the child is not available in the mental health system;

24.30 (4) is without the special care made necessary by a physical, mental, or emotional
24.31 condition because the child's parent, guardian, or custodian is unable or unwilling to provide

25.1 that care. This does not include when required and appropriate care for the child is not
25.2 available in the mental health system;

25.3 (5) is medically neglected, which includes, but is not limited to, the withholding of
25.4 medically indicated treatment from an infant with a disability with a life-threatening
25.5 condition. The term "withholding of medically indicated treatment" means the failure to
25.6 respond to the infant's life-threatening conditions by providing treatment, including
25.7 appropriate nutrition, hydration, and medication which, in the treating physician's, advanced
25.8 practice registered nurse's, or physician assistant's reasonable medical judgment, will be
25.9 most likely to be effective in ameliorating or correcting all conditions, except that the term
25.10 does not include the failure to provide treatment other than appropriate nutrition, hydration,
25.11 or medication to an infant when, in the treating physician's, advanced practice registered
25.12 nurse's, or physician assistant's reasonable medical judgment:

25.13 (i) the infant is chronically and irreversibly comatose;

25.14 (ii) the provision of the treatment would merely prolong dying, not be effective in
25.15 ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be
25.16 futile in terms of the survival of the infant; or

25.17 (iii) the provision of the treatment would be virtually futile in terms of the survival of
25.18 the infant and the treatment itself under the circumstances would be inhumane;

25.19 (6) is one whose parent, guardian, or other custodian for good cause desires to be relieved
25.20 of the child's care and custody, including a child who entered foster care under a voluntary
25.21 placement agreement between the parent and the responsible social services agency under
25.22 section 260C.227;

25.23 (7) has been placed for adoption or care in violation of law;

25.24 (8) is without proper parental care because of the emotional, mental, or physical disability,
25.25 or state of immaturity of the child's parent, guardian, or other custodian;

25.26 (9) is one whose behavior, condition, or environment is such as to be injurious or
25.27 dangerous to the child or others. An injurious or dangerous environment may include, but
25.28 is not limited to, the exposure of a child to criminal activity in the child's home;

25.29 (10) is experiencing growth delays, which may be referred to as failure to thrive, that
25.30 have been diagnosed by a physician and are due to parental neglect;

25.31 (11) is a sexually exploited youth;

26.1 (12) has committed a delinquent act or a juvenile petty offense before becoming ten
26.2 years old;

26.3 (13) is a runaway;

26.4 (14) is a habitual truant;

26.5 (15) has been found incompetent to proceed or has been found not guilty by reason of
26.6 mental illness or mental deficiency in connection with a delinquency proceeding, a
26.7 certification under section 260B.125, an extended jurisdiction juvenile prosecution, or a
26.8 proceeding involving a juvenile petty offense; or

26.9 (16) has a parent whose parental rights to one or more other children were involuntarily
26.10 terminated or whose custodial rights to another child have been involuntarily transferred to
26.11 a relative and there is a case plan prepared by the responsible social services agency
26.12 documenting a compelling reason why filing the termination of parental rights petition under
26.13 section 260C.503, subdivision 2, is not in the best interests of the child.

26.14 Sec. 25. Minnesota Statutes 2022, section 260C.708, is amended to read:

26.15 **260C.708 OUT-OF-HOME PLACEMENT PLAN FOR QUALIFIED**
26.16 **RESIDENTIAL TREATMENT PROGRAM PLACEMENTS.**

26.17 (a) When the responsible social services agency places a child in a qualified residential
26.18 treatment program as defined in section 260C.007, subdivision 26d, the out-of-home
26.19 placement plan must include:

26.20 (1) the case plan requirements in section 260C.212;

26.21 (2) the reasonable and good faith efforts of the responsible social services agency to
26.22 identify and include all of the individuals required to be on the child's family and permanency
26.23 team under section 260C.007;

26.24 (3) all contact information for members of the child's family and permanency team and
26.25 for other relatives who are not part of the family and permanency team;

26.26 (4) evidence that the agency scheduled meetings of the family and permanency team,
26.27 including meetings relating to the assessment required under section 260C.704, at a time
26.28 and place convenient for the family;

26.29 (5) evidence that the family and permanency team is involved in the assessment required
26.30 under section 260C.704 to determine the appropriateness of the child's placement in a
26.31 qualified residential treatment program;

27.1 (6) the family and permanency team's placement preferences for the child in the
27.2 assessment required under section 260C.704. When making a decision about the child's
27.3 placement preferences, the family and permanency team must recognize:

27.4 (i) that the agency should place a child with the child's siblings unless a court finds that
27.5 placing a child with the child's siblings is not possible due to a child's specialized placement
27.6 needs or is otherwise contrary to the child's best interests; and

27.7 (ii) that the agency should place an Indian child according to the requirements of the
27.8 Indian Child Welfare Act, the Minnesota Family Preservation Act under sections 260.751
27.9 to 260.835, and section 260C.193, subdivision 3, paragraph (g);

27.10 (7) when reunification of the child with the child's parent or legal guardian is the agency's
27.11 goal, evidence demonstrating that the parent or legal guardian provided input about the
27.12 members of the family and permanency team under section 260C.706;

27.13 (8) when the agency's permanency goal is to reunify the child with the child's parent or
27.14 legal guardian, the out-of-home placement plan must identify services and supports that
27.15 maintain the parent-child relationship and the parent's legal authority, decision-making, and
27.16 responsibility for ongoing planning for the child. In addition, the agency must assist the
27.17 parent with visiting and contacting the child;

27.18 (9) when the agency's permanency goal is to transfer permanent legal and physical
27.19 custody of the child to a proposed guardian or to finalize the child's adoption, the case plan
27.20 must document the agency's steps to transfer permanent legal and physical custody of the
27.21 child or finalize adoption, as required in section 260C.212, subdivision 1, paragraph (c),
27.22 clauses (6) and (7); and

27.23 (10) the qualified individual's recommendation regarding the child's placement in a
27.24 qualified residential treatment program and the court approval or disapproval of the placement
27.25 as required in section 260C.71.

27.26 (b) If the placement preferences of the family and permanency team, child, and tribe, if
27.27 applicable, are not consistent with the placement setting that the qualified individual
27.28 recommends, the case plan must include the reasons why the qualified individual did not
27.29 recommend following the preferences of the family and permanency team, child, and the
27.30 tribe.

27.31 (c) The agency must file the out-of-home placement plan with the court as part of the
27.32 60-day court order under section 260C.71.

28.1 (d) The agency must provide aftercare services as defined by the federal Family First
28.2 Prevention Services Act to the child for the six months following discharge from the qualified
28.3 residential treatment program. The services may include clinical care consultation, as defined
28.4 in section 256B.0671, subdivision 7, and family and youth peer specialists under section
28.5 256B.0616.

28.6 **Sec. 26. RURAL FAMILY RESPONSE AND STABILIZATION SERVICES PILOT**
28.7 **PROGRAM; APPROPRIATION.**

28.8 (a) The commissioner of human services must establish a pilot program to provide family
28.9 response and stabilization services in rural areas. Services must be provided at no cost to
28.10 families with children ages five to 18 who have a mental illness and must include:

28.11 (1) an immediate in-person response within one hour;

28.12 (2) support and engagement for up to 72 hours following the initial contact;

28.13 (3) connection to supports and resources in the community; and

28.14 (4) an optional stabilization service for up to eight weeks to help children and families
28.15 navigate systems, put natural and formal supports in place, and improve ability to manage
28.16 symptoms and unsafe behaviors.

28.17 (b) The commissioner must require reporting and establish program objectives including:

28.18 (1) increasing mental health support to families in rural areas;

28.19 (2) reducing emergency department utilization;

28.20 (3) reducing total days rural children with mental illness spend out of home; and

28.21 (4) reducing law enforcement and juvenile justice involvement.

28.22 (c) \$..... in fiscal year 2024 is appropriated from the general fund to the commissioner
28.23 of human services for the rural family response and stabilization services pilot program.

28.24 The department must develop a request for proposals for counties and adult mental health
28.25 initiatives in rural Minnesota to meet the requirements of the pilot program. A county or
28.26 adult mental health initiative may serve multiple counties provided the grantee can respond
28.27 in person within one hour in the established service area.

29.1 **Sec. 27. DIRECTION TO THE COMMISSIONER; BEHAVIORAL HEALTH FUND**
29.2 **ROOM AND BOARD RATES.**

29.3 The commissioner of human services must update the behavioral health fund room and
29.4 board rate schedule to include services provided under Minnesota Statutes, section 245.4882,
29.5 for individuals who do not have a placement under Minnesota Statutes, chapter 260C or
29.6 260D. The commissioner must establish room and board rates commensurate with current
29.7 room and board rates for adolescent programs licensed under Minnesota Statutes, section
29.8 245G.18.

29.9 **Sec. 28. DIRECTION TO THE COMMISSIONER; COLLABORATIVE INTENSIVE**
29.10 **BRIDGING SERVICES.**

29.11 No later than June 30, 2026, the commissioner of human services shall request approval
29.12 of a benefit and corresponding rate from the Centers for Medicare and Medicaid Services
29.13 to support collaborative intensive bridging services. The commissioner shall use all available
29.14 supporting data and consult with counties, service providers, and evaluators in making the
29.15 request.

29.16 **Sec. 29. APPROPRIATION; CHILD AND ADULT TRANSITION TO COMMUNITY**
29.17 **INITIATIVE.**

29.18 \$480,000 in fiscal year 2024 and \$1,087,000 in fiscal year 2025 are appropriated from
29.19 the general fund to the commissioner of human services for additional funding for grants
29.20 awarded under the child and adult transition to community initiative in Minnesota Statutes,
29.21 section 256.478.

29.22 **Sec. 30. APPROPRIATION; RESPITE CARE SERVICES.**

29.23 \$350,000 in fiscal year 2024 and \$350,000 in fiscal year 2025 are appropriated from the
29.24 general fund to the commissioner of human services for children's mental health grants
29.25 under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (3), to
29.26 provide respite care services to families of children with serious mental illness.

29.27 **Sec. 31. APPROPRIATION; CHILDREN'S SCHOOL-LINKED BEHAVIORAL**
29.28 **HEALTH GRANTS.**

29.29 \$2,000,000 in fiscal year 2024 and \$4,000,000 in fiscal year 2025 are appropriated from
29.30 the general fund to the commissioner of human services for children's school-linked
29.31 behavioral health services. At least 25 percent of the new funding must be targeted to

30.1 providers that can serve schools that have the highest percentage of special education students
30.2 categorized as having an emotional or behavioral disorder or being high poverty. The
30.3 commissioner shall ensure that grants are distributed to rural and urban counties. The
30.4 commissioner shall require grantees to use all available third-party reimbursement sources
30.5 as a condition of receipt of grant funds. The commissioner shall consult with school districts
30.6 that have not received school-linked behavioral health grants but want to collaborate with
30.7 a community mental health provider. The commissioner shall also work with culturally
30.8 specific providers so that the providers can serve students from their community in multiple
30.9 schools. When administering grants under this program, the commissioner shall take into
30.10 account the need to have consistency of providers over time among schools and students.

30.11 **Sec. 32. APPROPRIATION; INTERMEDIATE SCHOOL-LINKED BEHAVIORAL**
30.12 **HEALTH GRANTS.**

30.13 \$4,400,000 in fiscal year 2024 and \$4,400,000 in fiscal year 2025 are appropriated from
30.14 the general fund to the commissioner of human services for intermediate school-linked
30.15 behavioral health grants.

30.16 **Sec. 33. APPROPRIATION; SHELTER-LINKED MENTAL HEALTH GRANTS.**

30.17 \$1,500,000 in fiscal year 2024 and \$1,500,000 in fiscal year 2025 are appropriated from
30.18 the general fund to the commissioner of human services for shelter-linked youth mental
30.19 health grants under Minnesota Statutes, section 256K.46.

30.20 **Sec. 34. APPROPRIATION; STATE MEDICAL REVIEW TEAM STAFFING.**

30.21 \$..... in fiscal year 2024 is appropriated from the general fund to the commissioner of
30.22 human services to increase the staffing of the state medical review team to ensure timely
30.23 processing of disability determinations, including case specialists, disability analysts, appeals
30.24 staff, and supervisors.

30.25 **Sec. 35. APPROPRIATION; EARLY CHILDHOOD MENTAL HEALTH SERVICES**
30.26 **AND CONSULTATION.**

30.27 \$1,000,000 in fiscal year 2024 and \$1,000,000 in fiscal year 2025 are appropriated from
30.28 the general fund to the commissioner of human services to expand early childhood mental
30.29 health services under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b),
30.30 clause (9), and early childhood mental health consultation grants under Minnesota Statutes,
30.31 section 245.4889, subdivision 1, paragraph (b), clause (14). The commissioner, in

31.1 consultation with early childhood mental health providers and advocates, shall develop an
31.2 abbreviated assessment to support access to early childhood mental health services. Mental
31.3 health consultation grants must be to early learning programs in schools, family home
31.4 visiting programs, public health programs, and health care settings. Mental health consultation
31.5 includes a mental health professional with early childhood competency providing training,
31.6 regular on-site consultation to staff serving high-risk and low-income families, and referrals
31.7 to clinical services for parents and children struggling with mental health conditions. The
31.8 commissioner may award money to new grantees and proportionately among current grantees
31.9 based on the number of regions a grantee serves.

31.10 **Sec. 36. APPROPRIATION; MFIP CHILD CARE ASSISTANCE EXPANSION.**

31.11 \$..... in fiscal year 2024 and \$..... in fiscal year 2025 are appropriated from the general
31.12 fund to the commissioner of human services to cover administrative costs of expanding
31.13 MFIP child care assistance to child-only cases under Minnesota Statutes, section 119B.05,
31.14 subdivision 1, clause (7).

31.15 **Sec. 37. APPROPRIATION; MOBILE CRISIS TEAM ONGOING TRAINING.**

31.16 \$..... in fiscal year 2024 is appropriated from the general fund to the commissioner of
31.17 human services to provide ongoing training to mobile crisis teams on providing crisis
31.18 assessment, intervention, and stabilization services to children and working with families
31.19 in crisis situations.

31.20 **Sec. 38. APPROPRIATION; PSYCHIATRIC RESIDENTIAL TREATMENT**
31.21 **FACILITIES.**

31.22 \$2,000,000 in fiscal year 2024 and \$1,500,000 in fiscal year 2025 are appropriated from
31.23 the general fund to the commissioner of human services for start-up and capacity development
31.24 grants to psychiatric residential treatment facilities as described in Minnesota Statutes,
31.25 section 256B.0941. Grantees may use grant money to increase capacity in existing facilities,
31.26 support additional training and equipment to serve specialized child needs, and address the
31.27 emergency workforce shortage.

31.28 **Sec. 39. APPROPRIATION; TRAINING GRANTS FOR INTENSIVE IN-HOME**
31.29 **SERVICES.**

31.30 \$1,250,000 in fiscal year 2024 is appropriated from the general fund to the commissioner
31.31 of human services for grants for training of staff providing intensive in-home children's

32.1 mental health care under Minnesota Statutes, sections 256B.0943, 256B.0946, and
32.2 256B.0947. Grant money shall be to reimburse certified providers for training on
32.3 evidence-based practices, trauma-informed approaches, and de-escalation and train-the-trainer
32.4 models to equip staff and families accessing intensive mental health care models to effectively
32.5 care for children while they access treatment and maintain safety.

32.6 Sec. 40. **APPROPRIATION; COLLABORATIVE INTENSIVE BRIDGING**
32.7 **SERVICES.**

32.8 \$2,010,000 in fiscal year 2024 and \$2,010,000 in fiscal year 2025 are appropriated from
32.9 the general fund to the commissioner of human services for grants to sustain existing mental
32.10 health infrastructure. The grant must include money for:

- 32.11 (1) maintaining current levels of collaborative intensive bridging services and evaluation;
32.12 (2) limited expansions of collaborative intensive bridging services and evaluation; and
32.13 (3) training and technical assistance by an expert contractor with experience in
32.14 collaborative intensive bridging services to counties and service providers on maintaining
32.15 fidelity to the collaborative intensive bridging services model.

32.16 Sec. 41. **APPROPRIATION; CHILDREN'S MENTAL HEALTH DISCHARGE**
32.17 **OPTIONS.**

32.18 \$..... in fiscal year 2024 and \$..... in fiscal year 2025 are appropriated from the general
32.19 fund to the commissioner of human services for developing placement options for children
32.20 with mental illness whose discharge from the emergency room is delayed because no other
32.21 options for their care are available.