SENATE
STATE OF MINNESOTA
NINETY-SECOND SESSION

S.F. No. 383

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DATE	D-PG	OFFICIAL STATUS
01/28/2021	181	Introduction and first reading
		Referred to Human Services Reform Finance and Policy
04/13/2021	2283a	Comm report: To pass as amended and re-refer to Finance
04/26/2021	3092a	Comm report: To pass as amended
	3235	Second reading
04/29/2021		Special Order: Amended
		Third reading Passed
		Laid on table

A bill for an act

relating to state government; modifying provisions governing children and family services, child protection, adoption, child support, behavioral health services, disability services, continuing care for older adults, community supports, health care, human services licensing, and background studies; prohibiting recovery of child care assistance overpayments due to department error; authorizing Tribal government access to food shelf programs; eliminating TEFRA fees; establishing grants to expand child care access for children with disabilities; implementing family first program requirements; authorizing court-appointed counsel in child protection proceedings; establishing children's mood disorder and emerging mood disorder grant program; establishing alternate licensing inspections for accredited substance use disorder providers; establishing the substance use disorder treatment pathfinder companion pilot project; establishing a moratorium on development of certain customized living settings; establishing the Minnesota inclusion initiative grant program; establishing a customized living rate floor for certain assisted living facilities; establishing a parent-to-parent peer support program for families of children with special needs; establishing the supportive parenting pilot program; establishing temporary retainer payments for certain providers of home and community-based service providers; modernizing public guardianship statutes; establishing the office of ombudsperson for child care providers; establishing nonresidential family child care licensing requirements; establishing family child care training advisory committee; establishing child care and early education quality and affordability working group; implementing mental health uniform services standards; establishing child care workforce development grants; establishing COVID-19 public health support funds for child care programs; establishing child care facility revitalization grant program; establishing the Jerry Relph family supports and improvement plan; establishing legislative task force on human services background studies disqualifications; making appointment; requiring reports; making technical and conforming changes; making forecast adjustments; transferring money; allocating federal block grant funds; appropriating money; amending Minnesota Statutes 2020, sections 62A.152, subdivision 3; 62A.3094, subdivision 1; 62Q.096; 62V.05, by adding a subdivision; 119B.09, subdivision 4; 119B.11, subdivision 2a; 119B.13, subdivisions 1, 6; 122A.18, subdivision 8; 144.0724, subdivision 4; 144.651, subdivision 2; 144A.073, subdivision 2, by adding a subdivision; 144D.01, subdivision 4; 144G.08, subdivision 7, as amended; 148B.5301, subdivision 2; 148E.120, subdivision 2; 148F.11, subdivision 1; 245.462, subdivisions 1, 6, 8, 9, 14, 16, 17, 18, 21, 23, by adding a subdivision; 245.4661, subdivision 5; 245.4662, subdivision 1; 245.467,

subdivisions 2, 3; 245.469, subdivisions 1, 2; 245.470, subdivision 1; 245.4712, subdivision 2; 245.472, subdivision 2; 245.4863; 245.4871, subdivisions 9a, 10, 11a, 17, 21, 26, 27, 29, 31, 32, 34, by adding a subdivision; 245.4874, subdivision 1; 245.4876, subdivisions 2, 3; 245.4879, subdivision 1; 245.488, subdivision 1; 245.4882, subdivision 1; 245.4885, subdivision 1; 245.4889, subdivision 1; 245.4901, subdivision 2; 245.62, subdivision 2; 245.697, subdivision 1; 245.735, subdivisions 3, 5, by adding a subdivision; 245A.02, by adding subdivisions; 245A.03, subdivision 7, by adding a subdivision; 245A.04, subdivision 5; 245A.041, by adding a subdivision; 245A.043, subdivision 3; 245A.05; 245A.07, subdivision 1; 245A.08, subdivisions 4, 5; 245A.10, subdivision 4; 245A.14, subdivisions 1, 4; 245A.16, subdivision 1, by adding a subdivision; 245A.50, subdivisions 1a, 7; 245A.65, subdivision 2; 245C.03, by adding subdivisions; 245C.05, subdivisions 2c, 2d, 4; 245C.08, subdivision 3; 245C.10, by adding subdivisions; 245C.14, subdivision 1; 245C.15, by adding a subdivision; 245C.24, subdivisions 2, 3, 4, by adding a subdivision; 245D.02, subdivision 20; 245E.07, subdivision 1; 245F.04, subdivision 2; 245G.03, subdivision 2; 246.54, subdivision 1b; 252.27, subdivision 2a; 252.43; 252A.01, subdivision 1; 252A.02, subdivisions 2, 9, 11, 12, by adding subdivisions; 252A.03, subdivisions 3, 4; 252A.04, subdivisions 1, 2, 4; 252A.05; 252A.06, subdivisions 1, 2; 252A.07, subdivisions 1, 2, 3; 252A.081, subdivisions 2, 3, 5; 252A.09, subdivisions 1, 2; 252A.101, subdivisions 2, 3, 5, 6, 7, 8; 252A.111, subdivisions 2, 4, 6; 252A.12; 252A.16; 252A.17; 252A.19, subdivisions 2, 4, 5, 7, 8; 252A.20; 252A.21, subdivisions 2, 4; 254B.03, subdivision 2; 254B.05, subdivision 5; 256.01, subdivision 14b; 256.0112, subdivision 6; 256.477; 256.741, by adding subdivisions; 256B.051, subdivisions 1, 3, 5, 6, 7, by adding a subdivision; 256B.0615, subdivisions 1, 5; 256B.0616, subdivisions 1, 3, 5; 256B.0622, subdivisions 1, 2, 3a, 4, 7, 7a, 7b, 7d; 256B.0623, subdivisions 1, 2, 3, 4, 5, 6, 9, 12; 256B.0624; 256B.0625, subdivisions 3b, 5, 5m, 19c, 28a, 42, 48, 49, 56a; 256B.0653, by adding a subdivision; 256B.0654, by adding a subdivision; 256B.0659, subdivisions 11, 17a; 256B.0757, subdivision 4c; 256B.0759, subdivisions 2, 4, by adding subdivisions; 256B.0911, subdivisions 3a, 6, by adding a subdivision; 256B.092, subdivision 1b; 256B.0941, subdivision 1; 256B.0943, subdivisions 1, 2, 3, 4, 5, 5a, 6, 7, 9, 11; 256B.0946, subdivisions 1, 1a, 2, 3, 4, 6; 256B.0947, subdivisions 1, 2, 3, 3a, 5, 6, 7; 256B.0949, subdivisions 2, 4, 5a, by adding a subdivision; 256B.097, by adding subdivisions; 256B.14, subdivision 2; 256B.19, subdivision 1; 256B.25, subdivision 3; 256B.49, subdivision 23, by adding a subdivision; 256B.4905, by adding subdivisions; 256B.4912, subdivision 13; 256B.4914, subdivisions 2, 5, 6, 7, 8, 9; 256B.5012, by adding a subdivision; 256B.5013, subdivisions 1, 6; 256B.5015, subdivision 2; 256B.69, subdivision 5a; 256B.761; 256B.763; 256B.85, subdivisions 1, 2, 3, 4, 5, 6, 7, 7a, 8, 9, 10, 11, 11b, 12, 12b, 13, 13a, 15, 16, 17a, 18a, 20b, 23, 23a, by adding subdivisions; 256D.051, by adding subdivisions; 256E.30, subdivision 2; 256E.34, subdivision 1; 256I.04, subdivision 3; 256I.05, subdivisions 1a, 1c, 1q, 11, by adding subdivisions; 256I.06, subdivision 8; 256J.08, subdivision 21; 256J.09, subdivision 3; 256J.30, subdivision 8; 256J.35; 256J.45, subdivision 1; 256J.626, subdivision 1; 256J.95, subdivision 5; 256L.03, subdivision 1; 256N.02, subdivisions 16, 17; 256N.22, subdivision 1; 256N.23, subdivisions 2, 6; 256N.24, subdivisions 1, 8, 11, 12, 14; 256N.25, subdivision 1, by adding a subdivision; 256P.01, subdivision 6a; 256P.02, subdivisions 1a, 2; 256P.04, subdivision 4; 256P.05; 256P.06, subdivision 3; 256S.203; 259.22, subdivision 4; 259.241; 259.35, subdivision 1; 259.53, subdivision 4; 259.73; 259.75, subdivisions 5, 6, 9; 259.83, subdivision 1a; 259A.75, subdivisions 1, 2, 3, 4; 260C.007, subdivisions 22a, 26c, 31; 260C.157, subdivision 3; 260C.163, subdivision 3; 260C.212, subdivisions 1, 1a, 2, 13, by adding a subdivision; 260C.215, subdivision 4; 260C.219, subdivision 5; 260C.4412; 260C.452; 260C.503, subdivision 2; 260C.515, subdivision 3; 260C.605, subdivision 1; 260C.607, subdivision 6; 260C.609; 260C.615; 260C.704; 260C.706; 260C.708; 260C.71; 260C.712; 260C.714; 260D.01; 260D.05; 260D.06, subdivision 2; 260D.07; 260D.08; 260D.14; 260E.20, subdivision 2; 260E.36, by

adding a subdivision; 295.50, subdivision 9b; 297E.02, subdivision 3; 325F.721, subdivision 1; 466.03, subdivision 6d; 518.157, subdivisions 1, 3; 518.68, subdivision 2; 518A.29; 518A.33; 518A.35, subdivisions 1, 2; 518A.39, subdivision 7; 518A.40, subdivision 4, by adding a subdivision; 518A.42; 518A.43, by adding a subdivision; 518A.685; 548.091, subdivisions 1a, 2a, 3b, 9, 10; 549.09, subdivision 1; Laws 2019, First Special Session chapter 9, article 5, section 86, subdivision 1, as amended; Laws 2020, First Special Session chapter 7, section 1, as amended; proposing coding for new law in Minnesota Statutes, chapters 119B; 245A; 245G; 254B; 256; 256B; 256S; 518A; proposing coding for new law as Minnesota Statutes, chapter 245I; repealing Minnesota Statutes 2020, sections 245.462, subdivision 4a; 245.4871, subdivision 32a; 245.4879, subdivision 2; 245.62, subdivisions 3, 4; 245.69, subdivision 2; 245.735, subdivisions 1, 2, 4; 252.28, subdivisions 1, 5; 252A.02, subdivisions 8, 10; 252A.21, subdivision 3; 256B.0615, subdivision 2; 256B.0616, subdivision 2; 256B.0622, subdivisions 3, 5a; 256B.0623, subdivisions 7, 8, 10, 11; 256B.0625, subdivisions 5l, 35a, 35b, 61, 62, 65; 256B.0943, subdivisions 8, 10; 256B.0944; 256B.0946, subdivision 5; 256B.097, subdivisions 1, 2, 3, 4, 5, 6; 256B.4905, subdivisions 1, 2, 3, 4, 5, 6; 256D.051, subdivisions 1, 1a, 2, 2a, 3, 3a, 3b, 6b, 6c, 7, 8, 9, 18; 256D.052, subdivision 3; 259A.70; Laws 2019, First Special Session chapter 9, article 5, section 90; Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020; 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090; 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160; 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; 9520.0230; 9520.0750; 9520.0760; 9520.0770; 9520.0780; 9520.0790; 9520.0800; 9520.0810; 9520.0820; 9520.0830; 9520.0840; 9520.0850; 9520.0860; 9520.0870; 9530.6800; 9530.6810.

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

ARTICLE 1

ECONOMIC SUPPORTS

Section 1. Minnesota Statutes 2020, section 119B.09, subdivision 4, is amended to read:

Subd. 4. **Eligibility; annual income; calculation.** (a) Annual income of the applicant family is the current monthly income of the family multiplied by 12 or the income for the 12-month period immediately preceding the date of application, or income calculated by the method which provides the most accurate assessment of income available to the family.

(b) Self-employment income must be calculated based on ~~gross receipts less operating expenses~~ section 256P.05, subdivision 2.

(c) Income changes are processed under section 119B.025, subdivision 4. Included lump sums counted as income under section 256P.06, subdivision 3, must be annualized over 12 months. Income must be verified with documentary evidence. If the applicant does not have sufficient evidence of income, verification must be obtained from the source of the income.

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

Sec. 2. Minnesota Statutes 2020, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) The maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be the greater of the 25th percentile of the ~~2018~~ 2021 child care provider rate survey or the rates in effect at the time of the update. For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid for child care assistance shall be equal to the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

(b) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(c) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

(d) If a child uses one provider, the maximum payment for one day of care must not exceed the daily rate. The maximum payment for one week of care must not exceed the weekly rate.

(e) If a child uses two providers under section 119B.097, the maximum payment must not exceed:

(1) the daily rate for one day of care;

(2) the weekly rate for one week of care by the child's primary provider; and

(3) two daily rates during two weeks of care by a child's secondary provider.

(f) Child care providers receiving reimbursement under this chapter must not be paid activity fees or an additional amount above the maximum rates for care provided during nonstandard hours for families receiving assistance.

(g) If the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

(h) All maximum provider rates changes shall be implemented on the Monday following the effective date of the maximum provider rate.

(i) ~~Beginning September 21, 2020,~~ The maximum registration fee paid for child care assistance in any county or county price cluster under the child care fund shall be the greater of the 25th percentile of the ~~2018~~ 2021 child care provider rate survey or the registration fee in effect at the time of the update. Maximum registration fees must be set for licensed family child care and for child care centers. For a child care provider located in the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum registration fee paid for child care assistance shall be equal to the maximum registration fee paid in the county with the highest maximum registration fee or the provider's charge, whichever is less.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 3. Minnesota Statutes 2020, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **Provider payments.** (a) A provider shall bill only for services documented according to section 119B.125, subdivision 6. The provider shall bill for services provided within ten days of the end of the service period. Payments under the child care fund shall be made within 21 days of receiving a complete bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(b) If a provider has received an authorization of care and been issued a billing form for an eligible family, the bill must be submitted within 60 days of the last date of service on the bill. A bill submitted more than 60 days after the last date of service must be paid if the county determines that the provider has shown good cause why the bill was not submitted within 60 days. Good cause must be defined in the county's child care fund plan under section 119B.08, subdivision 3, and the definition of good cause must include county error. Any bill submitted more than a year after the last date of service on the bill must not be paid.

(c) If a provider provided care for a time period without receiving an authorization of care and a billing form for an eligible family, payment of child care assistance may only be made retroactively for a maximum of ~~six~~ three months from the date the provider is issued an authorization of care and billing form. For a family at application, if a provider provided child care during a time period without receiving an authorization of care and a billing form, a county may only make child care assistance payments to the provider retroactively from the date that child care began, or from the date that the family's eligibility began under section 119B.09, subdivision 7, or from the date that the family meets authorization requirements, not to exceed six months from the date that the provider is issued an authorization of care and billing form, whichever is later.

(d) A county or the commissioner may refuse to issue a child care authorization to a licensed or legal nonlicensed provider, revoke an existing child care authorization to a licensed or legal nonlicensed provider, stop payment issued to a licensed or legal nonlicensed provider, or refuse to pay a bill submitted by a licensed or legal nonlicensed provider if:

(1) the provider admits to intentionally giving the county materially false information on the provider's billing forms;

(2) a county or the commissioner finds by a preponderance of the evidence that the provider intentionally gave the county materially false information on the provider's billing forms, or provided false attendance records to a county or the commissioner;

(3) the provider is in violation of child care assistance program rules, until the agency determines those violations have been corrected;

(4) the provider is operating after:

(i) an order of suspension of the provider's license issued by the commissioner;

(ii) an order of revocation of the provider's license; or

(iii) a final order of conditional license issued by the commissioner for as long as the conditional license is in effect;

(5) the provider submits false attendance reports or refuses to provide documentation of the child's attendance upon request;

(6) the provider gives false child care price information; or

(7) the provider fails to report decreases in a child's attendance as required under section 119B.125, subdivision 9.

(e) For purposes of paragraph (d), clauses (3), (5), (6), and (7), the county or the commissioner may withhold the provider's authorization or payment for a period of time not to exceed three months beyond the time the condition has been corrected.

(f) A county's payment policies must be included in the county's child care plan under section 119B.08, subdivision 3. If payments are made by the state, in addition to being in compliance with this subdivision, the payments must be made in compliance with section 16A.124.

(g) The commissioner shall not withhold a provider's authorization or payment under paragraph (d) where the provider's alleged misconduct is the result of the provider relying upon representations from the commissioner, local agency, or licensor that the provider had

been in compliance with the rules and regulations necessary to maintain the provider's authorization.

EFFECTIVE DATE. This section is effective July 1, 2021, except that the language in paragraph (g) is effective retroactively from July 1, 2020.

Sec. 4. Minnesota Statutes 2020, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, not including a child determined eligible for medical assistance without consideration of parental income under the TEFRA option or for the purposes of accessing home and community-based waiver services, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to chapter 259A or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 275 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 1.65 percent of adjusted gross income at 275 percent of federal poverty guidelines and increases to 4.5 percent of adjusted gross income for those with adjusted gross income up to 545 percent of federal poverty guidelines;

(2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 4.5 percent of adjusted gross income;

(3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 4.5 percent of adjusted gross income at 675 percent of federal

poverty guidelines and increases to 5.99 percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

(4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be 7.49 percent of adjusted gross income.

If the child lives with the parent, the annual adjusted gross income is reduced by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in

the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including~~,~~ but not limited to~~,~~ the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance.

The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

Sec. 5. Minnesota Statutes 2020, section 256B.14, subdivision 2, is amended to read:

Subd. 2. **Actions to obtain payment.** The state agency shall promulgate rules to determine the ability of responsible relatives to contribute partial or complete payment or repayment of medical assistance furnished to recipients for whom they are responsible. All medical assistance exclusions shall be allowed, and a resource limit of $10,000 for nonexcluded resources shall be implemented. Above these limits, a contribution of one-third of the excess resources shall be required. These rules shall not require payment or repayment when payment would cause undue hardship to the responsible relative or that relative's immediate family. These rules shall ~~be consistent with the requirements of section 252.27 for~~ not apply to parents of children whose eligibility for medical assistance was determined without deeming of the parents' resources and income under the TEFRA option or for the purposes of accessing home and community-based waiver services. The county agency shall give the responsible relative notice of the amount of the payment or repayment. If the state agency or county agency finds that notice of the payment obligation was given to the responsible relative, but that the relative failed or refused to pay, a cause of action exists against the responsible relative for that portion of medical assistance granted after notice was given to the responsible relative, which the relative was determined to be able to pay.

The action may be brought by the state agency or the county agency in the county where assistance was granted, for the assistance, together with the costs of disbursements incurred due to the action.

In addition to granting the county or state agency a money judgment, the court may, upon a motion or order to show cause, order continuing contributions by a responsible relative found able to repay the county or state agency. The order shall be effective only for the period of time during which the recipient receives medical assistance from the county or state agency.

Sec. 6. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 20. **SNAP employment and training.** The commissioner shall implement a Supplemental Nutrition Assistance Program (SNAP) employment and training program that meets the SNAP employment and training participation requirements of the United States Department of Agriculture governed by Code of Federal Regulations, title 7, section

273.7. The commissioner shall operate a SNAP employment and training program in which SNAP recipients elect to participate. In order to receive SNAP assistance beyond the time limit, unless residing in an area covered by a time-limit waiver governed by Code of Federal Regulations, title 7, section 273.24, nonexempt SNAP recipients who do not meet federal SNAP work requirements must participate in an employment and training program. In addition to county and Tribal agencies that administer SNAP, the commissioner may contract with third-party providers for SNAP employment and training services.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 7. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 21. **County and Tribal agency duties.** County or Tribal agencies that administer SNAP shall inform adult SNAP recipients about employment and training services and providers in the recipient's area. County or Tribal agencies that administer SNAP may elect to subcontract with a public or private entity approved by the commissioner to provide SNAP employment and training services.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 8. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 22. **Duties of commissioner.** In addition to any other duties imposed by law, the commissioner shall:

(1) supervise the administration of SNAP employment and training services to county, Tribal, and contracted agencies under this section and Code of Federal Regulations, title 7, section 273.7;

(2) disburse money allocated and reimbursed for SNAP employment and training services to county, Tribal, and contracted agencies;

(3) accept and supervise the disbursement of any funds that may be provided by the federal government or other sources for SNAP employment and training services;

(4) cooperate with other agencies, including any federal agency or agency of another state, in all matters concerning the powers and duties of the commissioner under this section;

(5) coordinate with the commissioner of employment and economic development to deliver employment and training services statewide;

(6) work in partnership with counties, tribes, and other agencies to enhance the reach and services of a statewide SNAP employment and training program; and

(7) identify eligible nonfederal funds to earn federal reimbursement for SNAP employment and training services.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 9. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 23. **Participant duties.** Unless residing in an area covered by a time-limit waiver, nonexempt SNAP recipients must meet federal SNAP work requirements to receive SNAP assistance beyond the time limit.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 10. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 24. **Program funding.** (a) The United States Department of Agriculture annually allocates SNAP employment and training funds to the commissioner of human services for the operation of the SNAP employment and training program.

(b) The United States Department of Agriculture authorizes the disbursement of SNAP employment and training reimbursement funds to the commissioner of human services for the operation of the SNAP employment and training program.

(c) Except for funds allocated for state program development and administrative purposes or designated by the United States Department of Agriculture for a specific project, the commissioner of human services shall disburse money allocated for federal SNAP employment and training to counties and tribes that administer SNAP based on a formula determined by the commissioner that includes but is not limited to the county's or tribe's proportion of adult SNAP recipients as compared to the statewide total.

(d) The commissioner of human services shall disburse federal funds that the commissioner receives as reimbursement for SNAP employment and training costs to the state agency, county, tribe, or contracted agency that incurred the costs being reimbursed.

(e) The commissioner of human services may reallocate unexpended money disbursed under this section to county, Tribal, or contracted agencies that demonstrate a need for additional funds.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 11. Minnesota Statutes 2020, section 256E.30, subdivision 2, is amended to read:

Subd. 2. **Allocation of money.** (a) State money appropriated and community service block grant money allotted to the state and all money transferred to the community service block grant from other block grants shall be allocated annually to community action agencies and Indian reservation governments under paragraphs (b) and (c), and to migrant and seasonal farmworker organizations under paragraph (d).

(b) The available annual money will provide base funding to all community action agencies and the Indian reservations. Base funding amounts per agency are as follows: for agencies with low income populations up to ~~1,999, $25,000; 2,000 to~~ 23,999, $50,000; and 24,000 or more, $100,000.

(c) All remaining money of the annual money available after the base funding has been determined must be allocated to each agency and reservation in proportion to the size of the poverty level population in the agency's service area compared to the size of the poverty level population in the state.

(d) Allocation of money to migrant and seasonal farmworker organizations must not exceed three percent of the total annual money available. Base funding allocations must be made for all community action agencies and Indian reservations that received money under this subdivision, in fiscal year 1984, and for community action agencies designated under this section with a service area population of 35,000 or greater.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 12. Minnesota Statutes 2020, section 256E.34, subdivision 1, is amended to read:

Subdivision 1. **Distribution of appropriation.** The commissioner must distribute funds appropriated to the commissioner by law for that purpose to Hunger Solutions, a statewide association of food shelves organized as a nonprofit corporation as defined under section 501(c)(3) of the Internal Revenue Code of 1986, to distribute to qualifying food shelves. A food shelf qualifies under this section if:

(1) it is a nonprofit corporation, or is affiliated with a nonprofit corporation, as defined in section 501(c)(3) of the Internal Revenue Code of 1986 or a federally recognized Tribal nation;

(2) it distributes standard food orders without charge to needy individuals. The standard food order must consist of at least a two-day supply or six pounds per person of nutritionally balanced food items;

(3) it does not limit food distributions to individuals of a particular religious affiliation, race, or other criteria unrelated to need or to requirements necessary to administration of a fair and orderly distribution system;

(4) it does not use the money received or the food distribution program to foster or advance religious or political views; and

(5) it has a stable address and directly serves individuals.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 13. Minnesota Statutes 2020, section 256J.08, subdivision 21, is amended to read:

Subd. 21. **Date of application.** "Date of application" means the date on which the county agency receives an applicant's ~~signed~~ application as a signed written application, an application submitted by telephone, or an application submitted through Internet telepresence.

Sec. 14. Minnesota Statutes 2020, section 256J.09, subdivision 3, is amended to read:

Subd. 3. **Submitting application form.** (a) A county agency must offer, in person or by mail, the application forms prescribed by the commissioner as soon as a person makes a written or oral inquiry. At that time, the county agency must:

(1) inform the person that assistance begins ~~with~~ on the date that the ~~signed~~ application is received by the county agency either as a signed written application; an application submitted by telephone; or an application submitted through Internet telepresence; or on the date that all eligibility criteria are met, whichever is later;

(2) inform a person that the person may submit the application by telephone or through Internet telepresence;

(3) inform a person that when the person submits the application by telephone or through Internet telepresence, the county agency must receive a signed written application within 30 days of the date that the person submitted the application by telephone or through Internet telepresence;

~~(2)~~ (4) inform the person that any delay in submitting the application will reduce the amount of assistance paid for the month of application;

~~(3)~~ (5) inform a person that the person may submit the application before an interview;

~~(4)~~ (6) explain the information that will be verified during the application process by the county agency as provided in section 256J.32;

~~(5)~~ (7) inform a person about the county agency's average application processing time and explain how the application will be processed under subdivision 5;

~~(6)~~ (8) explain how to contact the county agency if a person's application information changes and how to withdraw the application;

~~(7)~~ (9) inform a person that the next step in the application process is an interview and what a person must do if the application is approved including, but not limited to, attending orientation under section 256J.45 and complying with employment and training services requirements in sections 256J.515 to 256J.57;

~~(8)~~ (10) inform the person that ~~the~~ an interview must be conducted. The interview may be conducted face-to-face in the county office or at a location mutually agreed upon, through Internet telepresence, or ~~at a location mutually agreed upon~~ by telephone;

~~(9) inform a person who has received MFIP or DWP in the past 12 months of the option to have a face-to-face, Internet telepresence, or telephone interview;~~

~~(10)~~ (11) explain the child care and transportation services that are available under paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

~~(11)~~ (12) identify any language barriers and arrange for translation assistance during appointments, including, but not limited to, screening under subdivision 3a, orientation under section 256J.45, and assessment under section 256J.521.

(b) Upon receipt of a signed application, the county agency must stamp the date of receipt on the face of the application. The county agency must process the application within the time period required under subdivision 5. An applicant may withdraw the application at any time by giving written or oral notice to the county agency. The county agency must issue a written notice confirming the withdrawal. The notice must inform the applicant of the county agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a county agency, in writing, that the applicant does not wish to withdraw the application, the county agency must reinstate the application and finish processing the application.

(c) Upon a participant's request, the county agency must arrange for transportation and child care or reimburse the participant for transportation and child care expenses necessary

to enable participants to attend the screening under subdivision 3a and orientation under section 256J.45.

Sec. 15. Minnesota Statutes 2020, section 256J.30, subdivision 8, is amended to read:

Subd. 8. **Late MFIP household report forms.** (a) Paragraphs (b) to (e) apply to the reporting requirements in subdivision 7.

(b) When the county agency receives an incomplete MFIP household report form, the county agency must immediately ~~return the incomplete form and clearly state what the caregiver must do for the form to be complete~~ contact the caregiver by phone or in writing to acquire the necessary information to complete the form.

(c) The automated eligibility system must send a notice of proposed termination of assistance to the assistance unit if a complete MFIP household report form is not received by a county agency. The automated notice must be mailed to the caregiver by approximately the 16th of the month. When a caregiver submits an incomplete form on or after the date a notice of proposed termination has been sent, the termination is valid unless the caregiver submits a complete form before the end of the month.

(d) An assistance unit required to submit an MFIP household report form is considered to have continued its application for assistance if a complete MFIP household report form is received within a calendar month after the month in which the form was due and assistance shall be paid for the period beginning with the first day of that calendar month.

(e) A county agency must allow good cause exemptions from the reporting requirements under subdivision 5 when any of the following factors cause a caregiver to fail to provide the county agency with a completed MFIP household report form before the end of the month in which the form is due:

(1) an employer delays completion of employment verification;

(2) a county agency does not help a caregiver complete the MFIP household report form when the caregiver asks for help;

(3) a caregiver does not receive an MFIP household report form due to mistake on the part of the department or the county agency or due to a reported change in address;

(4) a caregiver is ill, or physically or mentally incapacitated; or

(5) some other circumstance occurs that a caregiver could not avoid with reasonable care which prevents the caregiver from providing a completed MFIP household report form before the end of the month in which the form is due.

EFFECTIVE DATE. This section is effective September 1, 2021.

Sec. 16. Minnesota Statutes 2020, section 256J.35, is amended to read:

256J.35 AMOUNT OF ASSISTANCE PAYMENT.

Except as provided in paragraphs (a) to (d), the amount of an assistance payment is equal to the difference between the MFIP standard of need or the Minnesota family wage level in section 256J.24 and countable income.

(a) Beginning July 1, 2015, MFIP assistance units are eligible for an MFIP housing assistance grant of ~~$110~~ $150 per month, unless:

(1) the housing assistance unit is currently receiving public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) and is subject to section 256J.37, subdivision 3a; or

(2) the assistance unit is a child-only case under section 256J.88.

(b) When MFIP eligibility exists for the month of application, the amount of the assistance payment for the month of application must be prorated from the date of application or the date all other eligibility factors are met for that applicant, whichever is later. This provision applies when an applicant loses at least one day of MFIP eligibility.

(c) MFIP overpayments to an assistance unit must be recouped according to section 256P.08, subdivision 6.

(d) An initial assistance payment must not be made to an applicant who is not eligible on the date payment is made.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 17. Minnesota Statutes 2020, section 256J.45, subdivision 1, is amended to read:

Subdivision 1. **County agency to provide orientation.** A county agency must provide ~~a face-to-face~~ an orientation to each MFIP caregiver unless the caregiver is:

(1) a single parent, or one parent in a two-parent family, employed at least 35 hours per week; or

(2) a second parent in a two-parent family who is employed for 20 or more hours per week provided the first parent is employed at least 35 hours per week.

The county agency must inform caregivers who are not exempt under clause (1) or (2) that failure to attend the orientation is considered an occurrence of noncompliance with program

requirements, and will result in the imposition of a sanction under section 256J.46. If the client complies with the orientation requirement prior to the first day of the month in which the grant reduction is proposed to occur, the orientation sanction shall be lifted.

Sec. 18. Minnesota Statutes 2020, section 256J.626, subdivision 1, is amended to read:

Subdivision 1. **Consolidated fund.** The consolidated fund is established to support counties and tribes in meeting their duties under this chapter. Counties and tribes must use funds from the consolidated fund to develop programs and services that are designed to improve participant outcomes as measured in section 256J.751, subdivision 2. Counties and tribes that administer MFIP eligibility may use the funds for any allowable expenditures under subdivision 2, including case management. Tribes that do not administer MFIP eligibility may use the funds for any allowable expenditures under subdivision 2, including case management, except those in subdivision 2, paragraph (a), clauses (1) and (6). All payments made through the MFIP consolidated fund to support a caregiver's pursuit of greater economic stability does not count when determining a family's available income.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 19. Minnesota Statutes 2020, section 256J.95, subdivision 5, is amended to read:

Subd. 5. **Submitting application form.** The eligibility date for the diversionary work program begins ~~with~~ on the date that the ~~signed~~ combined application form (CAF) is received by the county agency either as a signed written application; an application submitted by telephone; or an application submitted through Internet telepresence; or on the date that diversionary work program eligibility criteria are met, whichever is later. The county agency must inform an applicant that when the applicant submits the application by telephone or through Internet telepresence, the county agency must receive a signed written application within 30 days of the date that the applicant submitted the application by telephone or through Internet telepresence. The county agency must inform the applicant that any delay in submitting the application will reduce the benefits paid for the month of application. The county agency must inform a person that an application may be submitted before the person has an interview appointment. Upon receipt of a signed application, the county agency must stamp the date of receipt on the face of the application. The applicant may withdraw the application at any time prior to approval by giving written or oral notice to the county agency. The county agency must follow the notice requirements in section 256J.09, subdivision 3, when issuing a notice confirming the withdrawal.

Sec. 20. Minnesota Statutes 2020, section 256N.02, subdivision 16, is amended to read:

Subd. 16. **Permanent legal and physical custody.** "Permanent legal and physical custody" means: (1) a full transfer of permanent legal and physical custody of a child ordered by a Minnesota juvenile court under section 260C.515, subdivision 4, to a relative ~~ordered by a Minnesota juvenile court under section 260C.515, subdivision 4,~~ who is not the child's parent as defined in section 260C.007, subdivision 25; or (2) for a child under jurisdiction of a tribal court, a judicial determination under a similar provision in tribal code which means that a relative will assume the duty and authority to provide care, control, and protection of a child who is residing in foster care, and to make decisions regarding the child's education, health care, and general welfare until adulthood. To establish eligibility for Northstar kinship assistance, permanent legal and physical custody does not include joint legal custody, joint physical custody, or joint legal and joint physical custody of a child shared by the child's parent and relative custodian.

Sec. 21. Minnesota Statutes 2020, section 256N.02, subdivision 17, is amended to read:

Subd. 17. **Reassessment.** "Reassessment" means an update of a previous assessment through the process under section 256N.24 for a child who has been continuously eligible for Northstar Care for Children, or when a child identified as an at-risk child (Level A) under ~~guardianship or~~ adoption assistance has manifested the disability upon which eligibility for the agreement was based according to section 256N.25, subdivision 3, paragraph (b). A reassessment may be used to update an initial assessment, a special assessment, or a previous reassessment.

Sec. 22. Minnesota Statutes 2020, section 256N.22, subdivision 1, is amended to read:

Subdivision 1. **General eligibility requirements.** (a) To be eligible for Northstar kinship assistance under this section, there must be a judicial determination under section 260C.515, subdivision 4, that a transfer of permanent legal and physical custody to a relative who is not the child's parent is in the child's best interest. For a child under jurisdiction of a tribal court, a judicial determination under a similar provision in tribal code indicating that a relative will assume the duty and authority to provide care, control, and protection of a child who is residing in foster care, and to make decisions regarding the child's education, health care, and general welfare until adulthood, and that this is in the child's best interest is considered equivalent. A child whose parent shares legal, physical, or legal and physical custody of the child with a relative custodian is not eligible for Northstar kinship assistance. Additionally, a child must:

(1) have been removed from the child's home pursuant to a voluntary placement agreement or court order;

(2)(i) have resided with the prospective relative custodian who has been a licensed child foster parent for at least six consecutive months; or

(ii) have received from the commissioner an exemption from the requirement in item (i) that the prospective relative custodian has been a licensed child foster parent for at least six consecutive months, based on a determination that:

(A) an expedited move to permanency is in the child's best interest;

(B) expedited permanency cannot be completed without provision of Northstar kinship assistance;

(C) the prospective relative custodian is uniquely qualified to meet the child's needs, as defined in section 260C.212, subdivision 2, on a permanent basis;

(D) the child and prospective relative custodian meet the eligibility requirements of this section; and

(E) efforts were made by the legally responsible agency to place the child with the prospective relative custodian as a licensed child foster parent for six consecutive months before permanency, or an explanation why these efforts were not in the child's best interests;

(3) meet the agency determinations regarding permanency requirements in subdivision 2;

(4) meet the applicable citizenship and immigration requirements in subdivision 3;

(5) have been consulted regarding the proposed transfer of permanent legal and physical custody to a relative, if the child is at least 14 years of age or is expected to attain 14 years of age prior to the transfer of permanent legal and physical custody; and

(6) have a written, binding agreement under section 256N.25 among the caregiver or caregivers, the financially responsible agency, and the commissioner established prior to transfer of permanent legal and physical custody.

(b) In addition to the requirements in paragraph (a), the child's prospective relative custodian or custodians must meet the applicable background study requirements in subdivision 4.

(c) To be eligible for title IV-E Northstar kinship assistance, a child must also meet any additional criteria in section 473(d) of the Social Security Act. The sibling of a child who meets the criteria for title IV-E Northstar kinship assistance in section 473(d) of the Social

Security Act is eligible for title IV-E Northstar kinship assistance if the child and sibling are placed with the same prospective relative custodian or custodians, and the legally responsible agency, relatives, and commissioner agree on the appropriateness of the arrangement for the sibling. A child who meets all eligibility criteria except those specific to title IV-E Northstar kinship assistance is entitled to Northstar kinship assistance paid through funds other than title IV-E.

Sec. 23. Minnesota Statutes 2020, section 256N.23, subdivision 2, is amended to read:

Subd. 2. **Special needs determination.** (a) A child is considered a child with special needs under this section if the requirements in paragraphs (b) to (g) are met.

(b) There must be a determination that the child must not or should not be returned to the home of the child's parents as evidenced by:

(1) a court-ordered termination of parental rights;

(2) a petition to terminate parental rights;

(3) consent of the child's parent to adoption accepted by the court under chapter 260C or, in the case of a child receiving Northstar kinship assistance payments under section 256N.22, consent of the child's parent to the child's adoption executed under chapter 259;

(4) in circumstances when tribal law permits the child to be adopted without a termination of parental rights, a judicial determination by a tribal court indicating the valid reason why the child cannot or should not return home;

(5) a voluntary relinquishment under section 259.25 ~~or 259.47~~ or, if relinquishment occurred in another state, the applicable laws in that state; or

(6) the death of the legal parent or parents if the child has two legal parents.

(c) There exists a specific factor or condition of which it is reasonable to conclude that the child cannot be placed with adoptive parents without providing adoption assistance as evidenced by:

(1) a determination by the Social Security Administration that the child meets all medical or disability requirements of title XVI of the Social Security Act with respect to eligibility for Supplemental Security Income benefits;

(2) a documented physical, mental, emotional, or behavioral disability not covered under clause (1);

(3) a member of a sibling group being adopted at the same time by the same parent;

(4) an adoptive placement in the home of a parent who previously adopted a sibling for whom they receive adoption assistance; or

(5) documentation that the child is an at-risk child.

(d) A reasonable but unsuccessful effort must have been made to place the child with adoptive parents without providing adoption assistance as evidenced by:

(1) a documented search for an appropriate adoptive placement; or

(2) a determination by the commissioner that a search under clause (1) is not in the best interests of the child.

(e) The requirement for a documented search for an appropriate adoptive placement under paragraph (d), including the registration of the child with the state adoption exchange and other recruitment methods under paragraph (f), must be waived if:

(1) the child is being adopted by a relative and it is determined by the child-placing agency that adoption by the relative is in the best interests of the child;

(2) the child is being adopted by a foster parent with whom the child has developed significant emotional ties while in the foster parent's care as a foster child and it is determined by the child-placing agency that adoption by the foster parent is in the best interests of the child; or

(3) the child is being adopted by a parent that previously adopted a sibling of the child, and it is determined by the child-placing agency that adoption by this parent is in the best interests of the child.

For an Indian child covered by the Indian Child Welfare Act, a waiver must not be granted unless the child-placing agency has complied with the placement preferences required by the Indian Child Welfare Act, United States Code, title 25, section 1915(a).

(f) To meet the requirement of a documented search for an appropriate adoptive placement under paragraph (d), clause (1), the child-placing agency minimally must:

(1) conduct a relative search as required by section 260C.221 and give consideration to placement with a relative, as required by section 260C.212, subdivision 2;

(2) comply with the placement preferences required by the Indian Child Welfare Act when the Indian Child Welfare Act, United States Code, title 25, section 1915(a), applies;

(3) locate prospective adoptive families by registering the child on the state adoption exchange, as required under section 259.75; and

(4) if registration with the state adoption exchange does not result in the identification of an appropriate adoptive placement, the agency must employ additional recruitment methods prescribed by the commissioner.

(g) Once the legally responsible agency has determined that placement with an identified parent is in the child's best interests and made full written disclosure about the child's social and medical history, the agency must ask the prospective adoptive parent if the prospective adoptive parent is willing to adopt the child without receiving adoption assistance under this section. If the identified parent is either unwilling or unable to adopt the child without adoption assistance, the legally responsible agency must provide documentation as prescribed by the commissioner to fulfill the requirement to make a reasonable effort to place the child without adoption assistance. If the identified parent is willing to adopt the child without adoption assistance, the parent must provide a written statement to this effect to the legally responsible agency and the statement must be maintained in the permanent adoption record of the legally responsible agency. For children under guardianship of the commissioner, the legally responsible agency shall submit a copy of this statement to the commissioner to be maintained in the permanent adoption record.

Sec. 24. Minnesota Statutes 2020, section 256N.23, subdivision 6, is amended to read:

Subd. 6. **Exclusions.** The commissioner must not enter into an adoption assistance agreement with the following individuals:

(1) a child's biological parent or stepparent;

(2) a child's relative under section 260C.007, subdivision 26b or 27, with whom the child resided immediately prior to child welfare involvement unless:

(i) the child was in the custody of a Minnesota county or tribal agency pursuant to an order under chapter 260C or equivalent provisions of tribal code and the agency had placement and care responsibility for permanency planning for the child; and

(ii) the child is under guardianship of the commissioner of human services according to the requirements of section 260C.325, subdivision 1 or 3, or is a ward of a Minnesota tribal court after termination of parental rights, suspension of parental rights, or a finding by the tribal court that the child cannot safely return to the care of the parent;

(3) an individual adopting a child who is the subject of a direct adoptive placement under section 259.47 or the equivalent in tribal code;

(4) a child's legal custodian or guardian who is now adopting the child, except for a relative custodian as defined in section 256N.02, subdivision 19, who is currently receiving Northstar kinship assistance benefits on behalf of the child; or

(5) an individual who is adopting a child who is not a citizen or resident of the United States and was either adopted in another country or brought to the United States for the purposes of adoption.

Sec. 25. Minnesota Statutes 2020, section 256N.24, subdivision 1, is amended to read:

Subdivision 1. **Assessment.** (a) Each child eligible under sections 256N.21, 256N.22, and 256N.23, must be assessed to determine the benefits the child may receive under section 256N.26, in accordance with the assessment tool, process, and requirements specified in subdivision 2.

(b) If an agency applies the emergency foster care rate for initial placement under section 256N.26, the agency may wait up to 30 days to complete the initial assessment.

(c) Unless otherwise specified in paragraph (d), a child must be assessed at the basic level, level B, or one of ten supplemental difficulty of care levels, levels C to L.

(d) An assessment must not be completed for:

(1) a child eligible for Northstar ~~kinship assistance under section 256N.22 or~~ adoption assistance under section 256N.23 who is determined to be an at-risk child. A child under this clause must be assigned level A under section 256N.26, subdivision 1; and

(2) a child transitioning into Northstar Care for Children under section 256N.28, subdivision 7, unless the commissioner determines an assessment is appropriate.

Sec. 26. Minnesota Statutes 2020, section 256N.24, subdivision 8, is amended to read:

Subd. 8. **Completing the special assessment.** (a) The special assessment must be completed in consultation with the child's caregiver. Face-to-face contact with the caregiver is not required to complete the special assessment.

(b) If a new special assessment is required prior to the effective date of the Northstar kinship assistance agreement, it must be completed by the financially responsible agency, in consultation with the legally responsible agency if different. If the prospective relative custodian is unable or unwilling to cooperate with the special assessment process, the child shall be assigned the basic level, level B under section 256N.26, subdivision 3~~, unless the~~

~~child is known to be an at-risk child, in which case, the child shall be assigned level A under section 256N.26, subdivision 1~~.

(c) If a special assessment is required prior to the effective date of the adoption assistance agreement, it must be completed by the financially responsible agency, in consultation with the legally responsible agency if different. If there is no financially responsible agency, the special assessment must be completed by the agency designated by the commissioner. If the prospective adoptive parent is unable or unwilling to cooperate with the special assessment process, the child must be assigned the basic level, level B under section 256N.26, subdivision 3, unless the child is known to be an at-risk child, in which case, the child shall be assigned level A under section 256N.26, subdivision 1.

(d) Notice to the prospective relative custodians or prospective adoptive parents must be provided as specified in subdivision 13.

Sec. 27. Minnesota Statutes 2020, section 256N.24, subdivision 11, is amended to read:

Subd. 11. **Completion of reassessment.** (a) The reassessment must be completed in consultation with the child's caregiver. Face-to-face contact with the caregiver is not required to complete the reassessment.

(b) For foster children eligible under section 256N.21, reassessments must be completed by the financially responsible agency, in consultation with the legally responsible agency if different.

(c) If reassessment is required after the effective date of the Northstar kinship assistance agreement, the reassessment must be completed by the financially responsible agency.

(d) If a reassessment is required after the effective date of the adoption assistance agreement, it must be completed by the financially responsible agency or, if there is no financially responsible agency, the agency designated by the commissioner.

(e) If the child's caregiver is unable or unwilling to cooperate with the reassessment, the child must be assessed at level B under section 256N.26, subdivision 3, unless the child has ~~an~~ a Northstar adoption assistance ~~or Northstar kinship assistance~~ agreement ~~in place~~ and is known to be an at-risk child, in which case the child must be assessed at level A under section 256N.26, subdivision 1.

Sec. 28. Minnesota Statutes 2020, section 256N.24, subdivision 12, is amended to read:

Subd. 12. **Approval of initial assessments, special assessments, and reassessments.** (a) Any agency completing initial assessments, special assessments, or reassessments must

designate one or more supervisors or other staff to examine and approve assessments completed by others in the agency under subdivision 2. The person approving an assessment must not be the case manager or staff member completing that assessment.

(b) In cases where a special assessment or reassessment for ~~guardian~~ Northstar kinship assistance and adoption assistance is required under subdivision 8 or 11, the commissioner shall review and approve the assessment as part of the eligibility determination process outlined in section 256N.22, subdivision 7, for Northstar kinship assistance, or section 256N.23, subdivision 7, for adoption assistance. The assessment determines the maximum ~~for~~ of the negotiated agreement amount under section 256N.25.

(c) The new rate is effective the calendar month that the assessment is approved, or the effective date of the agreement, whichever is later.

Sec. 29. Minnesota Statutes 2020, section 256N.24, subdivision 14, is amended to read:

Subd. 14. **Assessment tool determines rate of benefits.** The assessment tool established by the commissioner in subdivision 2 determines the monthly benefit level for children in foster care. The monthly payment for ~~guardian~~ Northstar kinship assistance or adoption assistance may be negotiated up to the monthly benefit level under foster care for those children eligible for a payment under section 256N.26, subdivision 1.

Sec. 30. Minnesota Statutes 2020, section 256N.25, subdivision 1, is amended to read:

Subdivision 1. **Agreement; Northstar kinship assistance; adoption assistance.** (a) In order to receive Northstar kinship assistance or adoption assistance benefits on behalf of an eligible child, a written, binding agreement between the caregiver or caregivers, the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, and the commissioner must be established prior to finalization of the adoption or a transfer of permanent legal and physical custody. The agreement must be negotiated with the caregiver or caregivers under subdivision 2 and renegotiated under subdivision 3, if applicable.

(b) The agreement must be on a form approved by the commissioner and must specify the following:

(1) duration of the agreement;

(2) the nature and amount of any payment, services, and assistance to be provided under such agreement;

(3) the child's eligibility for Medicaid services;

(4) the terms of the payment, including any child care portion as specified in section 256N.24, subdivision 3;

(5) eligibility for reimbursement of nonrecurring expenses associated with adopting or obtaining permanent legal and physical custody of the child, to the extent that the total cost does not exceed $2,000 per child pursuant to subdivision 1a;

(6) that the agreement must remain in effect regardless of the state of which the adoptive parents or relative custodians are residents at any given time;

(7) provisions for modification of the terms of the agreement, including renegotiation of the agreement;

(8) the effective date of the agreement; and

(9) the successor relative custodian or custodians for Northstar kinship assistance, when applicable. The successor relative custodian or custodians may be added or changed by mutual agreement under subdivision 3.

(c) The caregivers, the commissioner, and the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, must sign the agreement. A copy of the signed agreement must be given to each party. Once signed by all parties, the commissioner shall maintain the official record of the agreement.

(d) The effective date of the Northstar kinship assistance agreement must be the date of the court order that transfers permanent legal and physical custody to the relative. The effective date of the adoption assistance agreement is the date of the finalized adoption decree.

(e) Termination or disruption of the preadoptive placement or the foster care placement prior to assignment of custody makes the agreement with that caregiver void.

Sec. 31. Minnesota Statutes 2020, section 256N.25, is amended by adding a subdivision to read:

Subd. 1a. **Reimbursement of nonrecurring expenses.** (a) The commissioner of human services must reimburse a relative custodian with a fully executed Northstar kinship assistance benefit agreement for costs that the relative custodian incurs while seeking permanent legal and physical custody of a child who is the subject of a Northstar kinship assistance benefit agreement. The commissioner must reimburse a relative custodian for expenses that are reasonable and necessary that the relative incurs during the transfer of permanent legal and physical custody of a child to the relative custodian, subject to a maximum of $2,000. To

be eligible for reimbursement, the expenses must directly relate to the legal transfer of permanent legal and physical custody of the child to the relative custodian, must not have been incurred by the relative custodian in violation of state or federal law, and must not have been reimbursed from other sources or funds. The relative custodian must submit reimbursement requests to the commissioner within 21 months of the date of the child's finalized transfer of permanent legal and physical custody, and the relative custodian must follow all requirements and procedures that the commissioner prescribes.

(b) The commissioner of human services must reimburse an adoptive parent for costs that the adoptive parent incurs in an adoption of a child with special needs according to section 256N.23, subdivision 2. The commissioner must reimburse an adoptive parent for expenses that are reasonable and necessary for the adoption of the child to occur, subject to a maximum of $2,000. To be eligible for reimbursement, the expenses must directly relate to the legal adoption of the child, must not have been incurred by the adoptive parent in violation of state or federal law, and must not have been reimbursed from other sources or funds.

(1) Children who have special needs but who are not citizens or residents of the United States and were either adopted in another country or brought to this country for the purposes of adoption are categorically ineligible for the reimbursement program in this section, except when the child meets the eligibility criteria in this section after the dissolution of the child's international adoption.

(2) An adoptive parent, in consultation with the responsible child-placing agency, may request reimbursement of nonrecurring adoption expenses by submitting a complete application to the commissioner that follows the commissioner's requirements and procedures on forms that the commissioner prescribes.

(3) The commissioner must determine a child's eligibility for adoption expense reimbursement under title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 679c. If the commissioner determines that a child is eligible, the commissioner of human services must fully execute the agreement for nonrecurring adoption expense reimbursement by signing the agreement. For a child to be eligible, the commissioner must have fully executed the agreement for nonrecurring adoption expense reimbursement prior to finalizing a child's adoption.

(4) An adoptive parent who has a fully executed Northstar adoption assistance agreement is not required to submit a separate application for reimbursement of nonrecurring adoption expenses for the child who is the subject of the Northstar adoption assistance agreement.

(5) If the commissioner has determined the child to be eligible, the adoptive parent must submit reimbursement requests to the commissioner within 21 months of the date of the child's adoption decree, and the adoptive parent must follow requirements and procedures that the commissioner prescribes.

Sec. 32. Minnesota Statutes 2020, section 256P.02, subdivision 1a, is amended to read:

Subd. 1a. **Exemption.** Participants who qualify for child care assistance programs under chapter 119B are exempt from this section, except that the personal property identified in subdivision 2 is counted toward the asset limit of the child care assistance program under chapter 119B.

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

Sec. 33. Minnesota Statutes 2020, section 256P.02, subdivision 2, is amended to read:

Subd. 2. **Personal property limitations.** The equity value of an assistance unit's personal property listed in clauses (1) to ~~(4)~~ (5) must not exceed $10,000 for applicants and participants. For purposes of this subdivision, personal property is limited to:

(1) cash;

(2) bank accounts;

(3) liquid stocks and bonds that can be readily accessed without a financial penalty; ~~and~~

(4) vehicles not excluded under subdivision 3~~.~~; and

(5) the full value of business accounts used to pay expenses not related to the business.

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

Sec. 34. Minnesota Statutes 2020, section 256P.04, subdivision 4, is amended to read:

Subd. 4. **Factors to be verified.** (a) The agency shall verify the following at application:

(1) identity of adults;

(2) age, if necessary to determine eligibility;

(3) immigration status;

(4) income;

(5) spousal support and child support payments made to persons outside the household;

(6) vehicles;

(7) checking and savings accounts, including but not limited to any business accounts used to pay expenses not related to the business;

(8) inconsistent information, if related to eligibility;

(9) residence;

(10) Social Security number; and

(11) use of nonrecurring income under section 256P.06, subdivision 3, clause (2), item (ix), for the intended purpose for which it was given and received.

(b) Applicants who are qualified noncitizens and victims of domestic violence as defined under section 256J.08, subdivision 73, clause (7), are not required to verify the information in paragraph (a), clause (10). When a Social Security number is not provided to the agency for verification, this requirement is satisfied when each member of the assistance unit cooperates with the procedures for verification of Social Security numbers, issuance of duplicate cards, and issuance of new numbers which have been established jointly between the Social Security Administration and the commissioner.

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

Sec. 35. Minnesota Statutes 2020, section 256P.05, is amended to read:

256P.05 SELF-EMPLOYMENT EARNINGS.

Subdivision 1. **Exempted programs.** Participants who qualify for ~~child care assistance programs under chapter 119B,~~ Minnesota supplemental aid under chapter 256D~~,~~ and housing support under chapter 256I on the basis of eligibility for Supplemental Security Income are exempt from this section. Participants who qualify for child care assistance programs under chapter 119B are exempt from subdivision 3.

Subd. 2. **Self-employment income determinations.** Applicants and participants must choose one of the methods described in this subdivision for determining self-employment earned income. An agency must determine self-employment income, which is either:

(1) one-half of gross earnings from self-employment; or

(2) taxable income as determined from an Internal Revenue Service tax form that has been filed with the Internal Revenue Service ~~within the last~~ for the most recent year and according to guidance provided for the Supplemental Nutrition Assistance Program. A 12-month average using ~~net~~ taxable income shall be used to budget monthly income.

Subd. 3. **Self-employment budgeting.** (a) The self-employment budget period begins in the month of application or in the first month of self-employment. ~~Applicants and participants must choose one of the methods described in subdivision 2 for determining self-employment earned income.~~

(b) Applicants and participants who elect to use taxable income as described in subdivision 2, clause (2), to determine self-employment income must continue to use this method until recertification, unless there is an unforeseen significant change in gross income equaling a decline in gross income of the amount equal to or greater than the earned income disregard as defined in section 256P.03 from the income used to determine the benefit for the current month.

(c) For applicants and participants who elect to use one-half of gross earnings as described in subdivision 2, clause (1), to determine self-employment income, earnings must be counted as income in the month received.

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

Sec. 36. Minnesota Statutes 2020, section 256P.06, subdivision 3, is amended to read:

Subd. 3. **Income inclusions.** The following must be included in determining the income of an assistance unit:

(1) earned income; and

(2) unearned income, which includes:

(i) interest and dividends from investments and savings;

(ii) capital gains as defined by the Internal Revenue Service from any sale of real property;

(iii) proceeds from rent and contract for deed payments in excess of the principal and interest portion owed on property;

(iv) income from trusts, excluding special needs and supplemental needs trusts;

(v) interest income from loans made by the participant or household;

(vi) cash prizes and winnings;

(vii) unemployment insurance income that is received by an adult member of the assistance unit unless the individual receiving unemployment insurance income is:

(A) 18 years of age and enrolled in a secondary school; or

(B) 18 or 19 years of age, a caregiver, and is enrolled in school at least half-time;

(viii) retirement, survivors, and disability insurance payments;

(ix) nonrecurring income over $60 per quarter unless earmarked and used for the purpose for which it is intended. Income and use of this income is subject to verification requirements under section 256P.04;

(x) retirement benefits;

(xi) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I, and 256J;

(xii) tribal per capita payments unless excluded by federal and state law;

(xiii) income and payments from service and rehabilitation programs that meet or exceed the state's minimum wage rate;

(xiv) income from members of the United States armed forces unless excluded from income taxes according to federal or state law;

(xv) all child support payments for programs under chapters 119B, 256D, and 256I;

(xvi) the amount of child support received that exceeds $100 for assistance units with one child and $200 for assistance units with two or more children for programs under chapter 256J; and

(xvii) spousal support.

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

Sec. 37. Minnesota Statutes 2020, section 259.22, subdivision 4, is amended to read:

Subd. 4. **Time for filing petition.** A petition shall be filed not later than 12 months after a child is placed in a prospective adoptive home. If a petition is not filed by that time, the agency that placed the child, or, in a direct adoptive placement, the agency that is supervising the placement shall file with the district court in the county where the prospective adoptive parent resides a motion for an order and a report recommending one of the following:

(1) that the time for filing a petition be extended because of the child's special needs as defined under title IV-E of the Social Security Act, United States Code, title 42, section 673;

(2) that, based on a written plan for completing filing of the petition, including a specific timeline, to which the prospective adoptive parents have agreed, the time for filing a petition be extended long enough to complete the plan because such an extension is in the best

interests of the child and additional time is needed for the child to adjust to the adoptive home; or

(3) that the child be removed from the prospective adoptive home.

The prospective adoptive parent must reimburse an agency for the cost of preparing and filing the motion and report under this section, unless the costs are reimbursed by the commissioner under section 259.73 or ~~259A.70~~ 256N.25, subdivision 1a.

Sec. 38. Minnesota Statutes 2020, section 259.241, is amended to read:

259.241 ADULT ADOPTION.

(a) Any adult person may be adopted, regardless of the adult person's residence. A resident of Minnesota may petition the court of record having jurisdiction of adoption proceedings to adopt an individual who has reached the age of 18 years or older.

(b) The consent of the person to be adopted shall be the only consent necessary, according to section 259.24. The consent of an adult in the adult person's own adoption is invalid if the adult is considered to be a vulnerable adult under section 626.5572, subdivision 21, or if the person consenting to the adoption is determined not competent to give consent.

(c) Notwithstanding paragraph (b), a person in extended foster care under section 260C.451 may consent to the person's own adoption as long as the court with jurisdiction finds the person competent to give consent.

~~(c)~~ (d) The decree of adoption establishes a parent-child relationship between the adopting parent or parents and the person adopted, including the right to inherit, and also terminates the parental rights ~~and sibling relationship~~ between the adopted person and the adopted person's birth parents ~~and siblings~~ according to section 259.59.

~~(d)~~ (e) If the adopted person requests a change of name, the adoption decree shall order the name change.

Sec. 39. Minnesota Statutes 2020, section 259.35, subdivision 1, is amended to read:

Subdivision 1. **Parental responsibilities.** Prior to commencing an investigation of the suitability of proposed adoptive parents, a child-placing agency shall give the individuals the following written notice in all capital letters at least one-eighth inch high:

"Minnesota Statutes, section 259.59, provides that upon legally adopting a child, adoptive parents assume all the rights and responsibilities of birth parents. The responsibilities include providing for the child's financial support and caring for health, emotional, and behavioral

problems. Except for subsidized adoptions under Minnesota Statutes, chapter ~~259A~~ 256N, or any other provisions of law that expressly apply to adoptive parents and children, adoptive parents are not eligible for state or federal financial subsidies besides those that a birth parent would be eligible to receive for a child. Adoptive parents may not terminate their parental rights to a legally adopted child for a reason that would not apply to a birth parent seeking to terminate rights to a child. An individual who takes guardianship of a child for the purpose of adopting the child shall, upon taking guardianship from the child's country of origin, assume all the rights and responsibilities of birth and adoptive parents as stated in this paragraph."

Sec. 40. Minnesota Statutes 2020, section 259.53, subdivision 4, is amended to read:

Subd. 4. **Preadoption residence.** No petition shall be granted under this chapter until the child ~~shall have~~ has lived for three months in the proposed adoptive home, subject to a right of visitation by the commissioner or an agency or their authorized representatives.

Sec. 41. Minnesota Statutes 2020, section 259.73, is amended to read:

259.73 REIMBURSEMENT OF NONRECURRING ADOPTION EXPENSES.

An individual may apply for reimbursement for costs incurred in an adoption of a child with special needs under section ~~259A.70~~ 256N.25, subdivision 1a.

Sec. 42. Minnesota Statutes 2020, section 259.75, subdivision 5, is amended to read:

Subd. 5. **Withdrawal of registration.** A child's registration shall be withdrawn when the exchange service has been notified in writing by the local social service agency or the licensed child-placing agency that the child has been placed in an adoptive home ~~or~~, has died, or is no longer under the guardianship of the commissioner and is no longer seeking an adoptive home.

Sec. 43. Minnesota Statutes 2020, section 259.75, subdivision 6, is amended to read:

Subd. 6. **Periodic review of status.** (a) The ~~exchange service~~ commissioner shall ~~semiannually check~~ review the state adoption exchange status of ~~listed~~ children ~~for whom inquiries have been received~~ identified under subdivision 2, including a child whose registration was withdrawn pursuant to subdivision 5. The commissioner may determine that a child who is unregistered, or whose registration has been deferred, must be registered and require the authorized child-placing agency to register the child with the state adoption exchange within ten working days of the commissioner's determination.

(b) Periodic ~~checks~~ reviews shall be made by the ~~service~~ commissioner to determine the progress toward adoption of ~~those children and the status of~~ children registered ~~but never listed~~ in the ~~exchange book because of placement in an adoptive home prior to or at the time of registration~~ state adoption exchange.

Sec. 44. Minnesota Statutes 2020, section 259.75, subdivision 9, is amended to read:

Subd. 9. **Rules; staff.** The commissioner of human services shall make rules as necessary to administer this section and shall employ necessary staff to carry out the purposes of this section. The commissioner may contract for services to carry out the purposes of this section.

Sec. 45. Minnesota Statutes 2020, section 259.83, subdivision 1a, is amended to read:

Subd. 1a. **Social and medical history.** (a) If a person aged 19 years and over who was adopted on or after August 1, 1994, or the adoptive parent requests the detailed nonidentifying social and medical history of the adopted person's birth family that was provided at the time of the adoption, agencies must provide the information to the adopted person or adoptive parent on the applicable form required under ~~section~~ sections 259.43 and 260C.212, subdivision 15.

(b) If an adopted person aged 19 years and over or the adoptive parent requests the agency to contact the adopted person's birth parents to request current nonidentifying social and medical history of the adopted person's birth family, agencies must use the applicable form required under ~~section~~ sections 259.43 and 260C.212, subdivision 15, when obtaining the information for the adopted person or adoptive parent.

Sec. 46. Minnesota Statutes 2020, section 259A.75, subdivision 1, is amended to read:

Subdivision 1. **General information.** (a) Subject to the procedures required by the commissioner and the provisions of this section, a Minnesota county or Tribal agency shall receive a reimbursement from the commissioner equal to 100 percent of the reasonable and appropriate cost for contracted adoption placement services identified for a specific child that are not reimbursed under other federal or state funding sources.

(b) The commissioner may spend up to $16,000 for each purchase of service contract. Only one contract per child per adoptive placement is permitted. Funds encumbered and obligated under the contract for the child remain available until the terms of the contract are fulfilled or the contract is terminated.

(c) The commissioner shall set aside an amount not to exceed five percent of the total amount of the fiscal year appropriation from the state for the adoption assistance program

to reimburse a Minnesota county or tribal social services placing agency for child-specific adoption placement services. When adoption assistance payments for children's needs exceed 95 percent of the total amount of the fiscal year appropriation from the state for the adoption assistance program, the amount of reimbursement available to placing agencies for adoption services is reduced correspondingly.

Sec. 47. Minnesota Statutes 2020, section 259A.75, subdivision 2, is amended to read:

Subd. 2. **Purchase of service contract child eligibility criteria.** ~~(a)~~ A child who is the subject of a purchase of service contract must:

(1) have the goal of adoption, which may include an adoption in accordance with tribal law;

(2) be under the guardianship of the commissioner of human services or be a ward of tribal court pursuant to section 260.755, subdivision 20; and

(3) meet all of the special needs criteria according to section ~~259A.10, subdivision 2~~ 256N.23, subdivision 2.

~~(b) A child under the guardianship of the commissioner must have an identified adoptive parent and a fully executed adoption placement agreement according to section 260C.613, subdivision 1, paragraph (a).~~

Sec. 48. Minnesota Statutes 2020, section 259A.75, subdivision 3, is amended to read:

Subd. 3. **Agency eligibility criteria.** (a) A Minnesota county or Tribal social services agency shall receive reimbursement for child-specific adoption placement services for an eligible child that it purchases from a private adoption agency licensed in Minnesota or any other state or tribal social services agency.

(b) Reimbursement for adoption services is available only for services provided prior to the date of the adoption decree.

Sec. 49. Minnesota Statutes 2020, section 259A.75, subdivision 4, is amended to read:

Subd. 4. **Application and eligibility determination.** (a) A Minnesota county or Tribal social services agency may request reimbursement of costs for adoption placement services by submitting a complete purchase of service application, according to the requirements and procedures and on forms prescribed by the commissioner.

(b) The commissioner shall determine eligibility for reimbursement of adoption placement services. If determined eligible, the commissioner of human services shall sign the purchase

of service agreement, making this a fully executed contract. No reimbursement under this section shall be made to an agency for services provided prior to the fully executed contract.

(c) Separate purchase of service agreements shall be made, and separate records maintained, on each child. Only one agreement per child per adoptive placement is permitted. For siblings who are placed together, services shall be planned and provided to best maximize efficiency of the contracted hours.

Sec. 50. Minnesota Statutes 2020, section 260C.007, subdivision 22a, is amended to read:

Subd. 22a. **Licensed residential family-based substance use disorder treatment program.** "Licensed residential family-based substance use disorder treatment program" means a residential treatment facility that provides the parent or guardian with parenting skills training, parent education, or individual and family counseling, under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma according to recognized principles of a trauma-informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing. The residential program must be licensed by the Department of Human Services under ~~chapter~~ chapters 245A and ~~sections 245G.01 to 245G.16, 245G.19, and 245G.21~~ 245G or Tribally licensed or approved as a residential substance use disorder treatment program specializing in the treatment of clients with children.

Sec. 51. Minnesota Statutes 2020, section 260C.212, subdivision 1, is amended to read:

Subdivision 1. **Out-of-home placement; plan.** (a) An out-of-home placement plan shall be prepared within 30 days after any child is placed in foster care by court order or a voluntary placement agreement between the responsible social services agency and the child's parent pursuant to section 260C.227 or chapter 260D.

(b) An out-of-home placement plan means a written document which is prepared by the responsible social services agency jointly with the parent or parents or guardian of the child and in consultation with the child's guardian ad litem, the child's tribe, if the child is an Indian child, the child's foster parent or representative of the foster care facility, and, where appropriate, the child. When a child is age 14 or older, the child may include two other individuals on the team preparing the child's out-of-home placement plan. The child may select one member of the case planning team to be designated as the child's advisor and to advocate with respect to the application of the reasonable and prudent parenting standards. The responsible social services agency may reject an individual selected by the child if the agency has good cause to believe that the individual would not act in the best interest of the

child. For a child in voluntary foster care for treatment under chapter 260D, preparation of the out-of-home placement plan shall additionally include the child's mental health treatment provider. For a child 18 years of age or older, the responsible social services agency shall involve the child and the child's parents as appropriate. As appropriate, the plan shall be:

(1) submitted to the court for approval under section 260C.178, subdivision 7;

(2) ordered by the court, either as presented or modified after hearing, under section 260C.178, subdivision 7, or 260C.201, subdivision 6; and

(3) signed by the parent or parents or guardian of the child, the child's guardian ad litem, a representative of the child's tribe, the responsible social services agency, and, if possible, the child.

(c) The out-of-home placement plan shall be explained to all persons involved in its implementation, including the child who has signed the plan, and shall set forth:

(1) a description of the foster care home or facility selected, including how the out-of-home placement plan is designed to achieve a safe placement for the child in the least restrictive, most family-like, setting available which is in close proximity to the home of the parent or parents or guardian of the child when the case plan goal is reunification, and how the placement is consistent with the best interests and special needs of the child according to the factors under subdivision 2, paragraph (b);

(2) the specific reasons for the placement of the child in foster care, and when reunification is the plan, a description of the problems or conditions in the home of the parent or parents which necessitated removal of the child from home and the changes the parent or parents must make for the child to safely return home;

(3) a description of the services offered and provided to prevent removal of the child from the home and to reunify the family including:

(i) the specific actions to be taken by the parent or parents of the child to eliminate or correct the problems or conditions identified in clause (2), and the time period during which the actions are to be taken; and

(ii) the reasonable efforts, or in the case of an Indian child, active efforts to be made to achieve a safe and stable home for the child including social and other supportive services to be provided or offered to the parent or parents or guardian of the child, the child, and the residential facility during the period the child is in the residential facility;

(4) a description of any services or resources that were requested by the child or the child's parent, guardian, foster parent, or custodian since the date of the child's placement

in the residential facility, and whether those services or resources were provided and if not, the basis for the denial of the services or resources;

(5) the visitation plan for the parent or parents or guardian, other relatives as defined in section 260C.007, subdivision 26b or 27, and siblings of the child if the siblings are not placed together in foster care, and whether visitation is consistent with the best interest of the child, during the period the child is in foster care;

(6) when a child cannot return to or be in the care of either parent, documentation of steps to finalize adoption as the permanency plan for the child through reasonable efforts to place the child for adoption. At a minimum, the documentation must include consideration of whether adoption is in the best interests of the child, child-specific recruitment efforts such as relative search and the use of state, regional, and national adoption exchanges to facilitate orderly and timely placements in and outside of the state. A copy of this documentation shall be provided to the court in the review required under section 260C.317, subdivision 3, paragraph (b);

(7) when a child cannot return to or be in the care of either parent, documentation of steps to finalize the transfer of permanent legal and physical custody to a relative as the permanency plan for the child. This documentation must support the requirements of the kinship placement agreement under section 256N.22 and must include the reasonable efforts used to determine that it is not appropriate for the child to return home or be adopted, and reasons why permanent placement with a relative through a Northstar kinship assistance arrangement is in the child's best interest; how the child meets the eligibility requirements for Northstar kinship assistance payments; agency efforts to discuss adoption with the child's relative foster parent and reasons why the relative foster parent chose not to pursue adoption, if applicable; and agency efforts to discuss with the child's parent or parents the permanent transfer of permanent legal and physical custody or the reasons why these efforts were not made;

(8) efforts to ensure the child's educational stability while in foster care for a child who attained the minimum age for compulsory school attendance under state law and is enrolled full time in elementary or secondary school, or instructed in elementary or secondary education at home, or instructed in an independent study elementary or secondary program, or incapable of attending school on a full-time basis due to a medical condition that is documented and supported by regularly updated information in the child's case plan. Educational stability efforts include:

(i) efforts to ensure that the child remains in the same school in which the child was enrolled prior to placement or upon the child's move from one placement to another, including efforts to work with the local education authorities to ensure the child's educational stability and attendance; or

(ii) if it is not in the child's best interest to remain in the same school that the child was enrolled in prior to placement or move from one placement to another, efforts to ensure immediate and appropriate enrollment for the child in a new school;

(9) the educational records of the child including the most recent information available regarding:

(i) the names and addresses of the child's educational providers;

(ii) the child's grade level performance;

(iii) the child's school record;

(iv) a statement about how the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement; and

(v) any other relevant educational information;

(10) the efforts by the responsible social services agency to ensure the oversight and continuity of health care services for the foster child, including:

(i) the plan to schedule the child's initial health screens;

(ii) how the child's known medical problems and identified needs from the screens, including any known communicable diseases, as defined in section 144.4172, subdivision 2, shall be monitored and treated while the child is in foster care;

(iii) how the child's medical information shall be updated and shared, including the child's immunizations;

(iv) who is responsible to coordinate and respond to the child's health care needs, including the role of the parent, the agency, and the foster parent;

(v) who is responsible for oversight of the child's prescription medications;

(vi) how physicians or other appropriate medical and nonmedical professionals shall be consulted and involved in assessing the health and well-being of the child and determine the appropriate medical treatment for the child; and

(vii) the responsibility to ensure that the child has access to medical care through either medical insurance or medical assistance;

(11) the health records of the child including information available regarding:

(i) the names and addresses of the child's health care and dental care providers;

(ii) a record of the child's immunizations;

(iii) the child's known medical problems, including any known communicable diseases as defined in section 144.4172, subdivision 2;

(iv) the child's medications; and

(v) any other relevant health care information such as the child's eligibility for medical insurance or medical assistance;

(12) an independent living plan for a child 14 years of age or older, developed in consultation with the child. The child may select one member of the case planning team to be designated as the child's advisor and to advocate with respect to the application of the reasonable and prudent parenting standards in subdivision 14. The plan should include, but not be limited to, the following objectives:

(i) educational, vocational, or employment planning;

(ii) health care planning and medical coverage;

(iii) transportation including, where appropriate, assisting the child in obtaining a driver's license;

(iv) money management, including the responsibility of the responsible social services agency to ensure that the child annually receives, at no cost to the child, a consumer report as defined under section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report;

(v) planning for housing;

(vi) social and recreational skills;

(vii) establishing and maintaining connections with the child's family and community; and

(viii) regular opportunities to engage in age-appropriate or developmentally appropriate activities typical for the child's age group, taking into consideration the capacities of the individual child;

(13) for a child in voluntary foster care for treatment under chapter 260D, diagnostic and assessment information, specific services relating to meeting the mental health care needs of the child, and treatment outcomes;

(14) for a child 14 years of age or older, a signed acknowledgment that describes the child's rights regarding education, health care, visitation, safety and protection from exploitation, and court participation; receipt of the documents identified in section 260C.452; and receipt of an annual credit report. The acknowledgment shall state that the rights were explained in an age-appropriate manner to the child; and

(15) for a child placed in a qualified residential treatment program, the plan must include the requirements in section 260C.708.

(d) The parent or parents or guardian and the child each shall have the right to legal counsel in the preparation of the case plan and shall be informed of the right at the time of placement of the child. The child shall also have the right to a guardian ad litem. If unable to employ counsel from their own resources, the court shall appoint counsel upon the request of the parent or parents or the child or the child's legal guardian. The parent or parents may also receive assistance from any person or social services agency in preparation of the case plan.

After the plan has been agreed upon by the parties involved or approved or ordered by the court, the foster parents shall be fully informed of the provisions of the case plan and shall be provided a copy of the plan.

Upon the child's discharge from foster care, the responsible social services agency must provide the child's parent, adoptive parent, or permanent legal and physical custodian, ~~as appropriate,~~ and the child, if ~~appropriate, must be provided~~ the child is 14 years of age or older, with a current copy of the child's health and education record. If a child meets the conditions in subdivision 15, paragraph (b), the agency must also provide the child with the child's social and medical history. The responsible social services agency may give a copy of the child's health and education record and social and medical history to a child who is younger than 14 years of age, if it is appropriate and if subdivision 15, paragraph (b), applies.

Sec. 52. Minnesota Statutes 2020, section 260C.212, subdivision 2, is amended to read:

Subd. 2. **Placement decisions based on best interests of the child.** (a) The policy of the state of Minnesota is to ensure that the child's best interests are met by requiring an individualized determination of the needs of the child and of how the selected placement will serve the needs of the child being placed. The authorized child-placing agency shall place a child, released by court order or by voluntary release by the parent or parents, in a family foster home selected by considering placement with relatives and important friends in the following order:

(1) with an individual who is related to the child by blood, marriage, or adoption, including the legal parent, guardian, or custodian of the child's siblings; or

(2) with an individual who is an important friend with whom the child has resided or had significant contact.

For an Indian child, the agency shall follow the order of placement preferences in the Indian Child Welfare Act of 1978, United States Code, title 25, section 1915.

(b) Among the factors the agency shall consider in determining the needs of the child are the following:

(1) the child's current functioning and behaviors;

(2) the medical needs of the child;

(3) the educational needs of the child;

(4) the developmental needs of the child;

(5) the child's history and past experience;

(6) the child's religious and cultural needs;

(7) the child's connection with a community, school, and faith community;

(8) the child's interests and talents;

(9) the child's relationship to current caretakers, parents, siblings, and relatives;

(10) the reasonable preference of the child, if the court, or the child-placing agency in the case of a voluntary placement, deems the child to be of sufficient age to express preferences; and

(11) for an Indian child, the best interests of an Indian child as defined in section 260.755, subdivision 2a.

(c) Placement of a child cannot be delayed or denied based on race, color, or national origin of the foster parent or the child.

(d) Siblings should be placed together for foster care and adoption at the earliest possible time unless it is documented that a joint placement would be contrary to the safety or well-being of any of the siblings or unless it is not possible after reasonable efforts by the responsible social services agency. In cases where siblings cannot be placed together, the agency is required to provide frequent visitation or other ongoing interaction between siblings unless the agency documents that the interaction would be contrary to the safety or well-being of any of the siblings.

(e) Except for emergency placement as provided for in section 245A.035, the following requirements must be satisfied before the approval of a foster or adoptive placement in a related or unrelated home: (1) a completed background study under section 245C.08; and (2) a completed review of the written home study required under section 260C.215, subdivision 4, clause (5), or 260C.611, to assess the capacity of the prospective foster or adoptive parent to ensure the placement will meet the needs of the individual child.

(f) The agency must determine whether colocation with a parent who is receiving services in a licensed residential family-based substance use disorder treatment program is in the child's best interests according to paragraph (b) and include that determination in the child's case plan under subdivision 1. The agency may consider additional factors not identified in paragraph (b). The agency's determination must be documented in the child's case plan before the child is colocated with a parent.

(g) The agency must establish a juvenile treatment screening team under section 260C.157 to determine whether it is necessary and appropriate to recommend placing a child in a qualified residential treatment program, as defined in section 260C.007, subdivision 26d.

Sec. 53. Minnesota Statutes 2020, section 260C.212, is amended by adding a subdivision to read:

Subd. 15. **Social and medical history.** (a) The responsible social services agency must complete each child's social and medical history using forms developed by the commissioner. The responsible social services agency must work with each child's birth family, foster family, medical and treatment providers, and school to ensure that there is a detailed and up-to-date social and medical history of the child on forms provided by the commissioner.

(b) If the child continues to be in placement out of the home of the parent or guardian from whom the child was removed, reasonable efforts by the responsible social services agency to complete the child's social and medical history must begin no later than the child's permanency progress review hearing required under section 260C.204 or six months after the child's placement in foster care, whichever occurs earlier.

(c) In a child's social and medical history, the responsible social services agency must include background information and health history specific to the child, the child's birth parents, and the child's other birth relatives. Applicable background and health information about the child includes the child's current health condition, behavior, and demeanor; placement history; education history; sibling information; and birth, medical, dental, and immunization information. Redacted copies of pertinent records, assessments, and evaluations must be attached to the child's social and medical history. Applicable background information

about the child's birth parents and other birth relatives includes general background information; education and employment history; physical health and mental health history; and reasons for the child's placement.

Sec. 54. Minnesota Statutes 2020, section 260C.219, subdivision 5, is amended to read:

Subd. 5. **Children reaching age of majority; copies of records.** Regardless of whether a child is under state guardianship ~~or not~~, if a child leaves foster care by reason of having attained the age of majority under state law, the child must be given at no cost a copy of the child's social and medical history, as ~~defined~~ described in section ~~259.43,~~ 260C.212, subdivision 15, including the child's health and education report.

Sec. 55. Minnesota Statutes 2020, section 260C.503, subdivision 2, is amended to read:

Subd. 2. **Termination of parental rights.** (a) The responsible social services agency must ask the county attorney to immediately file a termination of parental rights petition when:

(1) the child has been subjected to egregious harm as defined in section 260C.007, subdivision 14;

(2) the child is determined to be the sibling of a child who was subjected to egregious harm;

(3) the child is an abandoned infant as defined in section 260C.301, subdivision 2, paragraph (a), clause (2);

(4) the child's parent has lost parental rights to another child through an order involuntarily terminating the parent's rights;

(5) the parent has committed sexual abuse as defined in section 260E.03, against the child or another child of the parent;

(6) the parent has committed an offense that requires registration as a predatory offender under section 243.166, subdivision 1b, paragraph (a) or (b); or

(7) another child of the parent is the subject of an order involuntarily transferring permanent legal and physical custody of the child to a relative under this chapter or a similar law of another jurisdiction;

The county attorney shall file a termination of parental rights petition unless the conditions of paragraph (d) are met.

(b) When the termination of parental rights petition is filed under this subdivision, the responsible social services agency shall identify, recruit, and approve an adoptive family for the child. If a termination of parental rights petition has been filed by another party, the responsible social services agency shall be joined as a party to the petition.

(c) If criminal charges have been filed against a parent arising out of the conduct alleged to constitute egregious harm, the county attorney shall determine which matter should proceed to trial first, consistent with the best interests of the child and subject to the defendant's right to a speedy trial.

(d) The requirement of paragraph (a) does not apply if the responsible social services agency and the county attorney determine and file with the court:

(1) a petition for transfer of permanent legal and physical custody to a relative under sections 260C.505 and 260C.515, subdivision ~~3~~ 4, including a determination that adoption is not in the child's best interests and that transfer of permanent legal and physical custody is in the child's best interests; or

(2) a petition under section 260C.141 alleging the child, and where appropriate, the child's siblings, to be in need of protection or services accompanied by a case plan prepared by the responsible social services agency documenting a compelling reason why filing a termination of parental rights petition would not be in the best interests of the child.

Sec. 56. Minnesota Statutes 2020, section 260C.515, subdivision 3, is amended to read:

Subd. 3. **Guardianship; commissioner.** The court may issue an order that the child is under the guardianship ~~to~~ of the commissioner of human services under the following procedures and conditions:

(1) there is an identified prospective adoptive parent agreed to by the responsible social services agency ~~having~~ that has legal custody of the child pursuant to court order under this chapter and that prospective adoptive parent has agreed to adopt the child;

(2) the court accepts the parent's voluntary consent to adopt in writing on a form prescribed by the commissioner, executed before two competent witnesses and confirmed by the consenting parent before the court or executed before the court. The consent shall contain notice that consent given under this chapter:

(i) is irrevocable upon acceptance by the court unless fraud is established and an order is issued permitting revocation as stated in clause (9) unless the matter is governed by the Indian Child Welfare Act, United States Code, title 25, section 1913(c); and

(ii) will result in an order that the child is under the guardianship of the commissioner of human services;

(3) a consent executed and acknowledged outside of this state, either in accordance with the law of this state or in accordance with the law of the place where executed, is valid;

(4) the court must review the matter at least every 90 days under section 260C.317;

(5) a consent to adopt under this subdivision vests guardianship of the child with the commissioner of human services and makes the child a ward of the commissioner of human services under section 260C.325;

(6) the court must forward to the commissioner a copy of the consent to adopt, together with a certified copy of the order transferring guardianship to the commissioner;

(7) if an adoption is not finalized by the identified prospective adoptive parent within six months of the execution of the consent to adopt under this clause, the responsible social services agency shall pursue adoptive placement in another home unless the court finds in a hearing under section 260C.317 that the failure to finalize is not due to either an action or a failure to act by the prospective adoptive parent;

(8) notwithstanding clause (7), the responsible social services agency must pursue adoptive placement in another home as soon as the agency determines that finalization of the adoption with the identified prospective adoptive parent is not possible, that the identified prospective adoptive parent is not willing to adopt the child, or that the identified prospective adoptive parent is not cooperative in completing the steps necessary to finalize the adoption. The court may order a termination of parental rights under subdivision 2; and

(9) unless otherwise required by the Indian Child Welfare Act, United States Code, title 25, section 1913(c), a consent to adopt executed under this section shall be irrevocable upon acceptance by the court except upon order permitting revocation issued by the same court after written findings that consent was obtained by fraud.

Sec. 57. Minnesota Statutes 2020, section 260C.605, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** (a) Reasonable efforts to finalize the adoption of a child under the guardianship of the commissioner shall be made by the responsible social services agency responsible for permanency planning for the child.

(b) Reasonable efforts to make a placement in a home according to the placement considerations under section 260C.212, subdivision 2, with a relative or foster parent who will commit to being the permanent resource for the child in the event the child cannot be

reunified with a parent are required under section 260.012 and may be made concurrently with reasonable, or if the child is an Indian child, active efforts to reunify the child with the parent.

(c) Reasonable efforts under paragraph (b) must begin as soon as possible when the child is in foster care under this chapter, but not later than the hearing required under section 260C.204.

(d) Reasonable efforts to finalize the adoption of the child include:

(1) using age-appropriate engagement strategies to plan for adoption with the child;

(2) identifying an appropriate prospective adoptive parent for the child by updating the child's identified needs using the factors in section 260C.212, subdivision 2;

(3) making an adoptive placement that meets the child's needs by:

(i) completing or updating the relative search required under section 260C.221 and giving notice of the need for an adoptive home for the child to:

(A) relatives who have kept the agency or the court apprised of their whereabouts and who have indicated an interest in adopting the child; or

(B) relatives of the child who are located in an updated search;

(ii) an updated search is required whenever:

(A) there is no identified prospective adoptive placement for the child notwithstanding a finding by the court that the agency made diligent efforts under section 260C.221, in a hearing required under section 260C.202;

(B) the child is removed from the home of an adopting parent; or

(C) the court determines a relative search by the agency is in the best interests of the child;

(iii) engaging the child's foster parent and the child's relatives identified as an adoptive resource during the search conducted under section 260C.221, to commit to being the prospective adoptive parent of the child; or

(iv) when there is no identified prospective adoptive parent:

(A) registering the child on the state adoption exchange as required in section 259.75 unless the agency documents to the court an exception to placing the child on the state adoption exchange reported to the commissioner;

(B) reviewing all families with approved adoption home studies associated with the responsible social services agency;

(C) presenting the child to adoption agencies and adoption personnel who may assist with finding an adoptive home for the child;

(D) using newspapers and other media to promote the particular child;

(E) using a private agency under grant contract with the commissioner to provide adoption services for intensive child-specific recruitment efforts; and

(F) making any other efforts or using any other resources reasonably calculated to identify a prospective adoption parent for the child;

(4) updating and completing the social and medical history required under sections ~~259.43~~ 260C.212, subdivision 15, and 260C.609;

(5) making, and keeping updated, appropriate referrals required by section 260.851, the Interstate Compact on the Placement of Children;

(6) giving notice regarding the responsibilities of an adoptive parent to any prospective adoptive parent as required under section 259.35;

(7) offering the adopting parent the opportunity to apply for or decline adoption assistance under chapter ~~259A~~ 256N;

(8) certifying the child for adoption assistance, assessing the amount of adoption assistance, and ascertaining the status of the commissioner's decision on the level of payment if the adopting parent has applied for adoption assistance;

(9) placing the child with siblings. If the child is not placed with siblings, the agency must document reasonable efforts to place the siblings together, as well as the reason for separation. The agency may not cease reasonable efforts to place siblings together for final adoption until the court finds further reasonable efforts would be futile or that placement together for purposes of adoption is not in the best interests of one of the siblings; and

(10) working with the adopting parent to file a petition to adopt the child and with the court administrator to obtain a timely hearing to finalize the adoption.

Sec. 58. Minnesota Statutes 2020, section 260C.607, subdivision 6, is amended to read:

Subd. 6. **Motion and hearing to order adoptive placement.** (a) At any time after the district court orders the child under the guardianship of the commissioner of human services, but not later than 30 days after receiving notice required under section 260C.613, subdivision

1, paragraph (c), that the agency has made an adoptive placement, a relative or the child's foster parent may file a motion for an order for adoptive placement of a child who is under the guardianship of the commissioner if the relative or the child's foster parent:

(1) has an adoption home study under section 259.41 approving the relative or foster parent for adoption and has been a resident of Minnesota for at least six months before filing the motion; the court may waive the residency requirement for the moving party if there is a reasonable basis to do so; or

(2) is not a resident of Minnesota, but has an approved adoption home study by an agency licensed or approved to complete an adoption home study in the state of the individual's residence and the study is filed with the motion for adoptive placement.

(b) The motion shall be filed with the court conducting reviews of the child's progress toward adoption under this section. The motion and supporting documents must make a prima facie showing that the agency has been unreasonable in failing to make the requested adoptive placement. The motion must be served according to the requirements for motions under the Minnesota Rules of Juvenile Protection Procedure and shall be made on all individuals and entities listed in subdivision 2.

(c) If the motion and supporting documents do not make a prima facie showing for the court to determine whether the agency has been unreasonable in failing to make the requested adoptive placement, the court shall dismiss the motion. If the court determines a prima facie basis is made, the court shall set the matter for evidentiary hearing.

(d) At the evidentiary hearing, the responsible social services agency shall proceed first with evidence about the reason for not making the adoptive placement proposed by the moving party. The moving party then has the burden of proving by a preponderance of the evidence that the agency has been unreasonable in failing to make the adoptive placement.

(e) At the conclusion of the evidentiary hearing, if the court finds that the agency has been unreasonable in failing to make the adoptive placement and that the relative or the child's foster parent is the most suitable adoptive home to meet the child's needs using the factors in section 260C.212, subdivision 2, paragraph (b), the court may order the responsible social services agency to make an adoptive placement in the home of the relative or the child's foster parent.

(f) If, in order to ensure that a timely adoption may occur, the court orders the responsible social services agency to make an adoptive placement under this subdivision, the agency shall:

(1) make reasonable efforts to obtain a fully executed adoption placement agreement;

(2) work with the moving party regarding eligibility for adoption assistance as required under chapter ~~259A~~ 256N; and

(3) if the moving party is not a resident of Minnesota, timely refer the matter for approval of the adoptive placement through the Interstate Compact on the Placement of Children.

(g) Denial or granting of a motion for an order for adoptive placement after an evidentiary hearing is an order which may be appealed by the responsible social services agency, the moving party, the child, when age ten or over, the child's guardian ad litem, and any individual who had a fully executed adoption placement agreement regarding the child at the time the motion was filed if the court's order has the effect of terminating the adoption placement agreement. An appeal shall be conducted according to the requirements of the Rules of Juvenile Protection Procedure.

Sec. 59. Minnesota Statutes 2020, section 260C.609, is amended to read:

260C.609 SOCIAL AND MEDICAL HISTORY.

~~(a) The responsible social services agency shall work with the birth family of the child, foster family, medical and treatment providers, and the child's school to ensure there is a detailed, thorough, and currently up-to-date social and medical history of the child as required under section 259.43 on the forms required by the commissioner.~~

~~(b) When the child continues in foster care, the agency's reasonable efforts to complete the history shall begin no later than the permanency progress review hearing required under section 260C.204 or six months after the child's placement in foster care.~~

~~(c)~~ (a) The responsible social services agency shall thoroughly discuss the child's history with the ~~adopting~~ prospective adoptive parent of the child and shall give a redacted copy of ~~the report of~~ the child's social and medical history as described in section 260C.212, subdivision 15, including redacted attachments, to the ~~adopting~~ prospective adoptive parent. If the prospective adoptive parent does not pursue adoption of the child, the prospective adoptive parent must return the child's social and medical history and redacted attachments to the agency. The responsible social services agency may give a redacted copy of the child's social and medical history ~~may also be given~~ to the child~~, as appropriate~~ according to section 260C.212, subdivision 1.

~~(d)~~ (b) The report shall not include information that identifies birth relatives. Redacted copies of all of the child's relevant evaluations, assessments, and records must be attached to the social and medical history.

(c) The agency must submit the child's social and medical history to the Department of Human Services at the time that the agency submits the child's adoption placement agreement. Pursuant to section 260C.623, subdivision 4, the child's social and medical history must be submitted to the court at the time the adoption petition is filed with the court.

Sec. 60. Minnesota Statutes 2020, section 260C.615, is amended to read:

260C.615 DUTIES OF COMMISSIONER.

Subdivision 1. **Duties.** (a) For any child who is under the guardianship of the commissioner, the commissioner has the exclusive rights to consent to:

(1) the medical care plan for the treatment of a child who is at imminent risk of death or who has a chronic disease that, in a physician's judgment, will result in the child's death in the near future including a physician's order not to resuscitate or intubate the child; and

(2) the child donating a part of the child's body to another person while the child is living; the decision to donate a body part under this clause shall take into consideration the child's wishes and the child's culture.

(b) In addition to the exclusive rights under paragraph (a), the commissioner has a duty to:

(1) process any complete and accurate request for home study and placement through the Interstate Compact on the Placement of Children under section 260.851;

(2) process any complete and accurate application for adoption assistance forwarded by the responsible social services agency according to chapter ~~259A~~ 256N;

(3) ~~complete the execution of~~ review and process an adoption placement agreement forwarded to the commissioner by the responsible social services agency and return it to the agency in a timely fashion; and

(4) maintain records as required in chapter 259.

Subd. 2. **Duties not reserved.** All duties, obligations, and consents not specifically reserved to the commissioner in this section are delegated to the responsible social services agency, subject to supervision by the commissioner under section 393.07.

Sec. 61. **GRANTS TO EXPAND ACCESS TO CHILD CARE FOR CHILDREN WITH DISABILITIES.**

Subdivision 1. **Establishment.** The commissioner of human services must establish competitive grants to expand access to licensed family child care providers or licensed child

care centers for children with disabilities including medical complexities. Grants must be awarded to counties or tribes and must be used to assist family child care providers or child care centers to serve children with disabilities in inclusive settings alongside children without disabilities. Competitive grants must be awarded to at least two applicants beginning no later than December 1, 2021.

Subd. 2. **Commissioner's duties.** To implement these grants, the commissioner must:

(1) develop a request for proposals with stakeholder input;

(2) develop procedures for data collection, qualitative and quantitative measurement of programmatic outcomes, and reporting requirements for grantees;

(3) convene a working group of grantees, grantee partners, and participating families to assess progress on grant activities, share best practices, and collect and review data on grant activities; and

(4) based on information gathered throughout the grant period and at the conclusion of the grant period, provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services regarding grant activities, with legislative recommendations for implementing inclusive child care statewide. The report must be made available to the public.

Subd. 3. **Grant activities.** Grantees must use grant money to expand access to inclusive family child care providers or child care centers to children with disabilities, which may include:

(1) onetime needs to equip a child care setting to serve children with disabilities, such as:

(i) environmental modifications;

(ii) accessibility modifications;

(iii) sensory adaptation;

(iv) training and staff time for training; or

(v) equipment purchase;

(2) ongoing medical or disability-related services for children with disabilities in inclusive child care settings, such as:

(i) mental health supports;

(ii) inclusion specialist services;

(iii) home care nursing;

(iv) behavioral supports;

(v) coaching or training for staff;

(vi) substitute teaching time; or

(vii) enhanced rate for increased staff-to-child ratio; and

(3) other expenses determined by the grantee and family child care provider or child care center partners to be necessary to serve children with disabilities in inclusive child care settings.

Subd. 4. **Requirements for grantees.** Upon receipt of grant money and throughout the grant period, grant recipients must:

(1) partner with at least three family child care providers or child care centers, each of which must meet one of the following criteria:

(i) serve ten or fewer children, including at least one child with a disability who is not a family member of the family child care provider or of an employee of the child care center;

(ii) serve 11 to 30 children, including at least two children with disabilities; or

(iii) serve more than 30 children, including at least three children with disabilities;

(2) develop and use a process to ensure that grant funding be used to support children with disabilities who, without the additional supports made available through the grant, would have difficulty accessing inclusive child care settings;

(3) pursue funding for ongoing services needed for children with disabilities in inclusive child care settings, such as:

(i) Medicaid or private health insurance coverage;

(ii) additional grant funding; or

(iii) other sources of county, state, or federal funds; and

(4) explore and seek opportunities to use existing federal funds to provide ongoing support to family child care providers or child care centers serving children with disabilities. Grantees must seek to minimize family financial obligations for child care for a child with disabilities beyond what child care would cost for a child without disabilities.

Subd. 5. **Reporting.** Grantees must report semiannually to the commissioner according to the manner specified by the commissioner on the following:

(1) additional supports needed to serve children with disabilities in inclusive child care settings;

(2) costs for additional supports;

(3) billing best practices;

(4) available funding sources;

(5) processes for identifying families of children with disabilities who could benefit from grant activities and connecting them with family child care providers or child care centers interested in serving them; and

(6) processes used to determine whether a child is a child with a disability and means of prioritizing grant funding to serve children with significant support needs associated with their disability.

Sec. 62. **GRANT TO MINNESOTA ASSOCIATION FOR VOLUNTEER ADMINISTRATION.**

The commissioner of human services shall establish a onetime grant to the Minnesota Association for Volunteer Administration to administer needs-based volunteerism subgrants for underresourced nonprofit organizations in greater Minnesota to support selected organizations' efforts to address and minimize disparities in access to human services through increased volunteerism. Successful subgrant applicants must demonstrate that the populations served by the subgrantee are considered underserved or suffer from or are at risk of homelessness, hunger, poverty, lack of access to health care, or deficits in education. The Minnesota Association for Volunteer Administration shall give priority to organizations that are serving the needs of vulnerable populations. By December 15, 2023, the Minnesota Association for Volunteer Administration shall report data on outcomes of the subgrants and make recommendations for improving and sustaining volunteer efforts statewide to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services.

Sec. 63. **FEDERAL PANDEMIC EMERGENCY ASSISTANCE ALLOCATION; EMERGENCY ASSISTANCE GRANTS.**

(a) From the amount that Minnesota received under section 9201 of the federal American Rescue Plan Act, Public Law 117-2, for pandemic emergency assistance, the commissioner of human services shall allocate $10,000,000 in fiscal year 2022 for emergency assistance grants according to paragraph (b).

(b) The commissioner shall distribute funds to counties to provide emergency assistance grants to families with children under Minnesota Statutes, section 256J.626. The emergency assistance grants under this section must be available for:

(1) rent or mortgage, including arrears;

(2) utility bills, including arrears;

(3) food;

(4) clothing needed for work or school;

(5) public transportation and vehicle repairs; and

(6) school-related equipment needs.

(c) Notwithstanding any county policies to the contrary, applicants are eligible for grants, subject to applicable maximum payments, for a security deposit, or if they are in arrears for rent, mortgage, or contract for deed payments.

Sec. 64. **FEDERAL PANDEMIC EMERGENCY ASSISTANCE ALLOCATION; MFIP CONSOLIDATED FUND.**

From the amount that Minnesota received under section 9201 of the federal American Rescue Plan Act, Public Law 117-2, for pandemic emergency assistance, the commissioner of human services shall allocate $4,327,000 in fiscal year 2023 to counties according to Minnesota Statutes, section 256J.626.

Sec. 65. **APPROPRIATION; GRANT TO MINNESOTA ASSOCIATION FOR VOLUNTEER ADMINISTRATION.**

$250,000 in fiscal year 2022 is appropriated from the general fund to the commissioner of human services for a grant to the Minnesota Association for Volunteer Administration to administer needs-based volunteerism subgrants. This is a onetime appropriation and is available until June 30, 2023.

Sec. 66. **APPROPRIATION; MFIP HOUSING BENEFIT INCREASE.**

$8,137,000 in fiscal year 2022 and $10,043,000 in fiscal year 2023 are appropriated from the federal TANF fund to the commissioner of human services to increase the MFIP housing benefit under Minnesota Statutes, section 256J.35. The federal TANF fund base for this appropriation is $9,786,000 in fiscal year 2024 and $9,623,000 in fiscal year 2025.

Sec. 67. **REPEALER.**

Minnesota Statutes 2020, sections 256D.051, subdivisions 1, 1a, 2, 2a, 3, 3a, 3b, 6b, 6c, 7, 8, 9, and 18; 256D.052, subdivision 3; and 259A.70, are repealed.

EFFECTIVE DATE. This section is effective August 1, 2021, except that the repeal of Minnesota Statutes, section 259A.70, is effective July 1, 2021.

ARTICLE 2
CHILD PROTECTION

Section 1. Minnesota Statutes 2020, section 245.4876, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** All providers of outpatient services, day treatment services, professional home-based family treatment, residential treatment, and acute care hospital inpatient treatment, and all regional treatment centers that provide mental health services for children must develop an individual treatment plan for each child client. The individual treatment plan must be based on a diagnostic assessment. To the extent appropriate, the child and the child's family shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment, professional home-based family treatment, and acute care hospital inpatient treatment, and regional treatment centers must develop the individual treatment plan within ten working days of client intake or admission and must review the individual treatment plan every 90 days after intake~~, except that the administrative review of the treatment plan of a child placed in a residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9~~. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Providers of outpatient and day treatment services must review the individual treatment plan every 90 days after intake.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 2. Minnesota Statutes 2020, section 245.4882, subdivision 1, is amended to read:

Subdivision 1. **Availability of residential treatment services.** County boards must provide or contract for enough residential treatment services to meet the needs of each child

with severe emotional disturbance residing in the county and needing this level of care. Length of stay is based on the child's residential treatment need and shall be ~~subject to the six-month review process established in section 260C.203, and for children in voluntary placement for treatment, the court review process in section 260D.06~~ reviewed every 90 days. Services must be appropriate to the child's age and treatment needs and must be made available as close to the county as possible. Residential treatment must be designed to:

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

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

(3) stabilize crisis admissions; and

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

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 3. Minnesota Statutes 2020, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the case of an emergency, all children referred for treatment of severe emotional disturbance in a ~~treatment foster care setting,~~ residential treatment facility~~,~~ or informally admitted to a regional treatment center shall undergo an assessment to determine the appropriate level of care if ~~public~~ county funds are used to pay for the child's services.

(b) The ~~responsible social services agency~~ county board shall determine the appropriate level of care for a child when county-controlled funds are used to pay for the child's ~~services or placement~~ residential treatment under this chapter, including residential treatment provided in a qualified residential treatment ~~facility under chapter 260C and licensed by the commissioner under chapter 245A. In accordance with section 260C.157, a juvenile treatment screening team shall conduct a screening before the team may recommend whether to place a child in a qualified residential treatment~~ program as defined in section 260C.007, subdivision 26d. When a ~~social services agency~~ county board does not have responsibility for a child's placement and the child is enrolled in a prepaid health program under section 256B.69, the enrolled child's contracted health plan must determine the appropriate level of care for the child. When Indian Health Services funds or funds of a tribally owned facility funded under the Indian Self-Determination and Education Assistance Act, Public Law 93-638, are to be used for a child, the Indian Health Services or 638 tribal health facility must determine the appropriate level of care for the child. When more than one entity bears

responsibility for a child's coverage, the entities shall coordinate level of care determination activities for the child to the extent possible.

(c) The ~~responsible social services agency must make the level of care determination available to the juvenile treatment screening team, as permitted under chapter 13. The level of care determination shall inform the juvenile treatment screening team process and the assessment in section 260C.704 when considering whether to place the child in a qualified residential treatment program. When the responsible social services agency is not involved in determining a child's placement, the~~ child's level of care determination shall determine whether the proposed treatment:

(1) is necessary;

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

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

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

(d) When a level of care determination is conducted, the ~~responsible social services agency~~ county board or other entity may not determine that a screening ~~under section 260C.157 or~~, referral, or admission to a treatment foster care setting or residential treatment facility is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. The level of care determination must be based on a diagnostic assessment ~~that includes a functional assessment~~ of a child which evaluates the child's family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care to the child. The validated tool must be approved by the commissioner of human services. If a diagnostic assessment ~~including a functional assessment~~ has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether ~~or not~~ these services are available and accessible to the child and the child's family. The child and the child's family must be invited to any meeting at which the

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

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

(f) ~~When the responsible social services agency has authority, the agency must engage the child's parents in case planning under sections 260C.212 and 260C.708 unless a court terminates the parent's rights or court orders restrict the parent from participating in case planning, visitation, or parental responsibilities.~~

~~(g)~~ The level of care determination, and placement decision, and recommendations for mental health services must be documented in the child's record, as required in ~~chapter~~ chapters 260C and 260D.

(g) Discharge planning for the child to return to the community must include identification of and referrals to appropriate home and community supports to meet the needs of the child and family. Discharge planning must begin within 30 days after the child enters residential treatment and be updated every 60 days.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 4. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 3c. **At risk of becoming a victim of sex trafficking or commercial sexual exploitation.** For the purposes of section 245A.25, a youth who is "at risk of becoming a victim of sex trafficking or commercial sexual exploitation" means a youth who meets the criteria established by the commissioner of human services for this purpose.

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

Sec. 5. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 4a. **Children's residential facility.** "Children's residential facility" means a residential program licensed under this chapter or chapter 241 according to the applicable standards in Minnesota Rules, parts 2960.0010 to 2960.0710.

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

Sec. 6. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 6d. **Foster family setting.** "Foster family setting" has the meaning given in Minnesota Rules, part 2960.3010, subpart 23, and includes settings licensed by the commissioner of human services or the commissioner of corrections.

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

Sec. 7. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 6e. **Foster residence setting.** "Foster residence setting" has the meaning given in Minnesota Rules, part 2960.3010, subpart 26, and includes settings licensed by the commissioner of human services or the commissioner of corrections.

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

Sec. 8. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 18a. **Trauma.** For the purposes of section 245A.25, "trauma" means an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma includes the cumulative emotional or psychological harm of group traumatic experiences transmitted across generations within a community that are often associated with racial and ethnic population groups that have suffered major intergenerational losses.

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

Sec. 9. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 23. **Victim of sex trafficking or commercial sexual exploitation.** For the purposes of section 245A.25, "victim of sex trafficking or commercial sexual exploitation" means a person who meets the definitions in section 260C.007, subdivision 31, clauses (4) and (5).

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

Sec. 10. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 24. **Youth.** For the purposes of section 245A.25, "youth" means a child as defined in section 260C.007, subdivision 4, and includes individuals under 21 years of age who are in foster care pursuant to section 260C.451.

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

Sec. 11. Minnesota Statutes 2020, section 245A.041, is amended by adding a subdivision to read:

Subd. 5. **First date of working in a facility or setting; documentation requirements.** Children's residential facility and foster residence setting license holders must document the first date that a person who is a background study subject begins working in the license holder's facility or setting. If the license holder does not maintain documentation of each background study subject's first date of working in the facility or setting in the license holder's personnel files, the license holder must provide documentation to the commissioner that contains the first date that each background study subject began working in the license holder's program upon the commissioner's request.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 12. **[245A.25] RESIDENTIAL PROGRAM CERTIFICATIONS FOR COMPLIANCE WITH THE FAMILY FIRST PREVENTION SERVICES ACT.**

Subdivision 1. **Certification scope and applicability.** (a) This section establishes the requirements that a children's residential facility or child foster residence setting must meet to be certified for the purposes of Title IV-E funding requirements as:

(1) a qualified residential treatment program;

(2) a residential setting specializing in providing care and supportive services for youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation;

(3) a residential setting specializing in providing prenatal, postpartum, or parenting support for youth; or

(4) a supervised independent living setting for youth who are 18 years of age or older.

(b) This section does not apply to a foster family setting in which the license holder resides in the foster home.

(c) Children's residential facilities licensed as detention settings according to Minnesota Rules, parts 2960.0230 to 2960.0290, or secure programs according to Minnesota Rules, parts 2960.0300 to 2960.0420, may not be certified under this section.

(d) For purposes of this section, "license holder" means an individual, organization, or government entity that was issued a children's residential facility or foster residence setting license by the commissioner of human services under this chapter or by the commissioner of corrections under chapter 241.

(e) Certifications issued under this section for foster residence settings may only be issued by the commissioner of human services and are not delegated to county or private licensing agencies under section 245A.16.

Subd. 2. **Program certification types and requests for certification.** (a) By July 1, 2021, the commissioner of human services must offer certifications to license holders for the following types of programs:

(1) qualified residential treatment programs;

(2) residential settings specializing in providing care and supportive services for youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation;

(3) residential settings specializing in providing prenatal, postpartum, or parenting support for youth; and

(4) supervised independent living settings for youth who are 18 years of age or older.

(b) An applicant or license holder must submit a request for certification under this section on a form and in a manner prescribed by the commissioner of human services. The decision of the commissioner of human services to grant or deny a certification request is final and not subject to appeal under chapter 14.

Subd. 3. **Trauma-informed care.** (a) Programs certified under subdivision 4 or 5 must provide services to a person according to a trauma-informed model of care that meets the requirements of this subdivision, except that programs certified under subdivision 5 are not required to meet the requirements of paragraph (e).

(b) For the purposes of this section, "trauma-informed care" means care that:

(1) acknowledges the effects of trauma on a person receiving services and on the person's family;

(2) modifies services to respond to the effects of trauma on the person receiving services;

(3) emphasizes skill and strength-building rather than symptom management; and

(4) focuses on the physical and psychological safety of the person receiving services and the person's family.

(c) The license holder must have a process for identifying the signs and symptoms of trauma in a youth and must address the youth's needs related to trauma. This process must include:

(1) screening for trauma by completing a trauma-specific screening tool with each youth upon the youth's admission or obtaining the results of a trauma-specific screening tool that was completed with the youth within 30 days prior to the youth's admission to the program; and

(2) ensuring that trauma-based interventions targeting specific trauma-related symptoms are available to each youth when needed to assist the youth in obtaining services. For qualified residential treatment programs, this must include the provision of services in paragraph (e).

(d) The license holder must develop and provide services to each youth according to the principles of trauma-informed care including:

(1) recognizing the impact of trauma on a youth when determining the youth's service needs and providing services to the youth;

(2) allowing each youth to participate in reviewing and developing the youth's individualized treatment or service plan;

(3) providing services to each youth that are person-centered and culturally responsive; and

(4) adjusting services for each youth to address additional needs of the youth.

(e) In addition to the other requirements of this subdivision, qualified residential treatment programs must use a trauma-based treatment model that includes:

(1) assessing each youth to determine if the youth needs trauma-specific treatment interventions;

(2) identifying in each youth's treatment plan how the program will provide trauma-specific treatment interventions to the youth;

(3) providing trauma-specific treatment interventions to a youth that target the youth's specific trauma-related symptoms; and

(4) training all clinical staff of the program on trauma-specific treatment interventions.

(f) At the license holder's program, the license holder must provide a physical, social, and emotional environment that:

(1) promotes the physical and psychological safety of each youth;

(2) avoids aspects that may be retraumatizing;

(3) responds to trauma experienced by each youth and the youth's other needs; and

(4) includes designated spaces that are available to each youth for engaging in sensory and self-soothing activities.

(g) The license holder must base the program's policies and procedures on trauma-informed principles. In the program's policies and procedures, the license holder must:

(1) describe how the program provides services according to a trauma-informed model of care;

(2) describe how the program's environment fulfills the requirements of paragraph (f);

(3) prohibit the use of aversive consequences for a youth's violation of program rules or any other reason;

(4) describe the process for how the license holder incorporates trauma-informed principles and practices into the organizational culture of the license holder's program; and

(5) if the program is certified to use restrictive procedures under Minnesota Rules, part 2960.0710, describe how the program uses restrictive procedures only when necessary for a youth in a manner that addresses the youth's history of trauma and avoids causing the youth additional trauma.

(h) Prior to allowing a staff person to have direct contact, as defined in section 245C.02, subdivision 11, with a youth and annually thereafter, the license holder must train each staff person about:

(1) concepts of trauma-informed care and how to provide services to each youth according to these concepts; and

(2) impacts of each youth's culture, race, gender, and sexual orientation on the youth's behavioral health and traumatic experiences.

Subd. 4. **Qualified residential treatment programs; certification requirements.** (a) To be certified as a qualified residential treatment program, a license holder must meet:

(1) the definition of a qualified residential treatment program in section 260C.007, subdivision 26d;

(2) the requirements for providing trauma-informed care and using a trauma-based treatment model in subdivision 3; and

(3) the requirements of this subdivision.

(b) For each youth placed in the license holder's program, the license holder must collaborate with the responsible social services agency and other appropriate parties to implement the youth's out-of-home placement plan and the youth's short-term and long-term mental health and behavioral health goals in the assessment required by sections 260C.212, subdivision 1; 260C.704; and 260C.708.

(c) A qualified residential treatment program must use a trauma-based treatment model that meets all of the requirements of subdivision 3 that is designed to address the needs, including clinical needs, of youth with serious emotional or behavioral disorders or disturbances. The license holder must develop, document, and review a treatment plan for each youth according to the requirements of Minnesota Rules, parts 2960.0180, subpart 2, item B; and 2960.0190, subpart 2.

(d) The following types of staff must be on-site according to the program's treatment model and must be available 24 hours a day and seven days a week to provide care within the scope of their practice:

(1) a registered nurse or licensed practical nurse licensed by the Minnesota Board of Nursing to practice professional nursing or practical nursing as defined in section 148.171, subdivisions 14 and 15; and

(2) other licensed clinical staff to meet each youth's clinical needs.

(e) A qualified residential treatment program must be accredited by one of the following independent, not-for-profit organizations:

(1) the Commission on Accreditation of Rehabilitation Facilities (CARF);

(2) the Joint Commission;

(3) the Council on Accreditation (COA); or

(4) another independent, not-for-profit accrediting organization approved by the Secretary of the United States Department of Health and Human Services.

(f) The license holder must facilitate participation of a youth's family members in the youth's treatment program, consistent with the youth's best interests and according to the

youth's out-of-home placement plan required by sections 260C.212, subdivision 1; and 260C.708.

(g) The license holder must contact and facilitate outreach to each youth's family members, including the youth's siblings, and must document outreach to the youth's family members in the youth's file, including the contact method and each family member's contact information. In the youth's file, the license holder must record and maintain the contact information for all known biological family members and fictive kin of the youth.

(h) The license holder must document in the youth's file how the program integrates family members into the treatment process for the youth, including after the youth's discharge from the program, and how the program maintains the youth's connections to the youth's siblings.

(i) The program must provide discharge planning and family-based aftercare support to each youth for at least six months after the youth's discharge from the program. When providing aftercare to a youth, the program must have monthly contact with the youth and the youth's caregivers to promote the youth's engagement in aftercare services and to regularly evaluate the family's needs. The program's monthly contact with the youth may be face-to-face, by telephone, or virtual.

(j) The license holder must maintain a service delivery plan that describes how the program provides services according to the requirements in paragraphs (b) to (i).

Subd. 5. **Residential settings specializing in providing care and supportive services for youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation; certification requirements.** (a) To be certified as a residential setting specializing in providing care and supportive services for youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation, a license holder must meet the requirements of this subdivision.

(b) Settings certified according to this subdivision are exempt from the requirements of section 245A.04, subdivision 11, paragraph (b).

(c) The program must use a trauma-informed model of care that meets all of the applicable requirements of subdivision 3, and that is designed to address the needs, including emotional and mental health needs, of youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation.

(d) The program must provide high-quality care and supportive services for youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation and must:

(1) offer a safe setting to each youth designed to prevent ongoing and future trafficking of the youth;

(2) provide equitable, culturally responsive, and individualized services to each youth;

(3) assist each youth with accessing medical, mental health, legal, advocacy, and family services based on the youth's individual needs;

(4) provide each youth with relevant educational, life skills, and employment supports based on the youth's individual needs;

(5) offer a trafficking prevention education curriculum and provide support for each youth at risk of future sex trafficking or commercial sexual exploitation; and

(6) engage with the discharge planning process for each youth and the youth's family.

(e) The license holder must maintain a service delivery plan that describes how the program provides services according to the requirements in paragraphs (c) and (d).

(f) The license holder must ensure that each staff person who has direct contact, as defined in section 245C.02, subdivision 11, with a youth served by the license holder's program completes a human trafficking training approved by the Department of Human Services' Children and Family Services Administration before the staff person has direct contact with a youth served by the program and annually thereafter. For programs certified prior to January 1, 2022, the license holder must ensure that each staff person at the license holder's program completes the initial training by January 1, 2022.

Subd. 6. **Residential settings specializing in providing prenatal, postpartum, or parenting supports for youth; certification requirements.** (a) To be certified as a residential setting specializing in providing prenatal, postpartum, or parenting supports for youth, a license holder must meet the requirements of this subdivision.

(b) The license holder must collaborate with the responsible social services agency and other appropriate parties to implement each youth's out-of-home placement plan required by section 260C.212, subdivision 1.

(c) The license holder must specialize in providing prenatal, postpartum, or parenting supports for youth and must:

(1) provide equitable, culturally responsive, and individualized services to each youth;

(2) assist each youth with accessing postpartum services during the same period of time that a woman is considered pregnant for the purposes of medical assistance eligibility under section 256B.055, subdivision 6, including providing each youth with:

(i) sexual and reproductive health services and education; and

(ii) a postpartum mental health assessment and follow-up services; and

(3) discharge planning that includes the youth and the youth's family.

(d) On or before the date of a child's initial physical presence at the facility, the license holder must provide education to the child's parent related to safe bathing and reducing the risk of sudden unexpected infant death and abusive head trauma from shaking infants and young children. The license holder must use the educational material developed by the commissioner of human services to comply with this requirement. At a minimum, the education must address:

(1) instruction that: (i) a child or infant should never be left unattended around water; (ii) a tub should be filled with only two to four inches of water for infants; and (iii) an infant should never be put into a tub when the water is running; and

(2) the risk factors related to sudden unexpected infant death and abusive head trauma from shaking infants and young children and means of reducing the risks, including the safety precautions identified in section 245A.1435 and the risks of co-sleeping.

The license holder must document the parent's receipt of the education and keep the documentation in the parent's file. The documentation must indicate whether the parent agrees to comply with the safeguards described in this paragraph. If the parent refuses to comply, program staff must provide additional education to the parent as described in the parental supervision plan. The parental supervision plan must include the intervention, frequency, and staff responsible for the duration of the parent's participation in the program or until the parent agrees to comply with the safeguards described in this paragraph.

(e) On or before the date of a child's initial physical presence at the facility, the license holder must document the parent's capacity to meet the health and safety needs of the child while on the facility premises considering the following factors:

(1) the parent's physical and mental health;

(2) the parent being under the influence of drugs, alcohol, medications, or other chemicals;

(3) the child's physical and mental health; and

(4) any other information available to the license holder indicating that the parent may not be able to adequately care for the child.

(f) The license holder must have written procedures specifying the actions that staff shall take if a parent is or becomes unable to adequately care for the parent's child.

(g) If the parent refuses to comply with the safeguards described in paragraph (d) or is unable to adequately care for the child, the license holder must develop a parental supervision plan in conjunction with the parent. The plan must account for any factors in paragraph (e) that contribute to the parent's inability to adequately care for the child. The plan must be dated and signed by the staff person who completed the plan.

(h) The license holder must have written procedures addressing whether the program permits a parent to arrange for supervision of the parent's child by another youth in the program. If permitted, the facility must have a procedure that requires staff approval of the supervision arrangement before the supervision by the nonparental youth occurs. The procedure for approval must include an assessment of the nonparental youth's capacity to assume the supervisory responsibilities using the criteria in paragraph (e). The license holder must document the license holder's approval of the supervisory arrangement and the assessment of the nonparental youth's capacity to supervise the child and must keep this documentation in the file of the parent whose child is being supervised by the nonparental youth.

(i) The license holder must maintain a service delivery plan that describes how the program provides services according to paragraphs (b) to (h).

Subd. 7. **Supervised independent living settings for youth 18 years of age or older; certification requirements.** (a) To be certified as a supervised independent living setting for youth who are 18 years of age or older, a license holder must meet the requirements of this subdivision.

(b) A license holder must provide training, counseling, instruction, supervision, and assistance for independent living according to the youth's needs.

(c) A license holder may provide services to assist the youth with locating housing, money management, meal preparation, shopping, health care, transportation, and any other support services necessary to meet the youth's needs and improve the youth's ability to conduct such tasks independently.

(d) The service plan for the youth must contain an objective of independent living skills.

(e) The license holder must maintain a service delivery plan that describes how the program provides services according to paragraphs (b) to (d).

Subd. 8. **Monitoring and inspections.** (a) For a program licensed by the commissioner of human services, the commissioner of human services may review a program's compliance with certification requirements by conducting an inspection, a licensing review, or an investigation of the program. The commissioner may issue a correction order to the license holder for a program's noncompliance with the certification requirements of this section. For a program licensed by the commissioner of human services, a license holder must make a request for reconsideration of a correction order according to section 245A.06, subdivision 2.

(b) For a program licensed by the commissioner of corrections, the commissioner of human services may review the program's compliance with the requirements for a certification issued under this section biennially and may issue a correction order identifying the program's noncompliance with the requirements of this section. The correction order must state the following:

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

(2) the specific law or rule violated; and

(3) the time allowed for the program to correct each violation.

(c) For a program licensed by the commissioner of corrections, if a license holder believes that there are errors in the correction order of the commissioner of human services, the license holder may ask the Department of Human Services to reconsider the parts of the correction order that the license holder alleges are in error. To submit a request for reconsideration, the license holder must send a written request for reconsideration by United States mail to the commissioner of human services. The request for reconsideration must be postmarked within 20 calendar days of the date that the correction order was received by the license holder and must:

(1) specify the parts of the correction order that are alleged to be in error;

(2) explain why the parts of the correction order are in error; and

(3) include documentation to support the allegation of error.

A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner of human services' disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

(d) Nothing in this subdivision prohibits the commissioner of human services from decertifying a license holder according to subdivision 9 prior to issuing a correction order.

Subd. 9. **Decertification.** (a) The commissioner of human services may rescind a certification issued under this section if a license holder fails to comply with the certification requirements in this section.

(b) The license holder may request reconsideration of a decertification by notifying the commissioner of human services by certified mail or personal service. The license holder must request reconsideration of a decertification in writing. If the license holder sends the request for reconsideration of a decertification by certified mail, the license holder must send the request by United States mail to the commissioner of human services and the request must be postmarked within 20 calendar days after the license holder received the notice of decertification. If the license holder requests reconsideration of a decertification by personal service, the request for reconsideration must be received by the commissioner of human services within 20 calendar days after the license holder received the notice of decertification. When submitting a request for reconsideration of a decertification, the license holder must submit a written argument or evidence in support of the request for reconsideration.

(c) The commissioner of human services' disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

Subd. 10. **Variances.** The commissioner of human services may grant variances to the requirements in this section that do not affect a youth's health or safety or compliance with federal requirements for Title IV-E funding if the conditions in section 245A.04, subdivision 9, are met.

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

Sec. 13. Minnesota Statutes 2020, section 256.01, subdivision 14b, is amended to read:

Subd. 14b. **American Indian child welfare projects.** (a) The commissioner of human services may authorize projects to initiate tribal delivery of child welfare services to American Indian children and their parents and custodians living on the reservation. The commissioner has authority to solicit and determine which tribes may participate in a project. Grants may be issued to Minnesota Indian tribes to support the projects. The commissioner may waive existing state rules as needed to accomplish the projects. The commissioner may authorize projects to use alternative methods of (1) screening, investigating, and assessing reports of child maltreatment, and (2) administrative reconsideration, administrative appeal, and

judicial appeal of maltreatment determinations, provided the alternative methods used by the projects comply with the provisions of section 256.045 and chapter 260E that deal with the rights of individuals who are the subjects of reports or investigations, including notice and appeal rights and data practices requirements. The commissioner shall only authorize alternative methods that comply with the public policy under section 260E.01. The commissioner may seek any federal approval necessary to carry out the projects as well as seek and use any funds available to the commissioner, including use of federal funds, foundation funds, existing grant funds, and other funds. The commissioner is authorized to advance state funds as necessary to operate the projects. Federal reimbursement applicable to the projects is appropriated to the commissioner for the purposes of the projects. The projects must be required to address responsibility for safety, permanency, and well-being of children.

(b) For the purposes of this section, "American Indian child" means a person under 21 years old and who is a tribal member or eligible for membership in one of the tribes chosen for a project under this subdivision and who is residing on the reservation of that tribe.

(c) In order to qualify for an American Indian child welfare project, a tribe must:

(1) be one of the existing tribes with reservation land in Minnesota;

(2) have a tribal court with jurisdiction over child custody proceedings;

(3) have a substantial number of children for whom determinations of maltreatment have occurred;

(4)(i) have capacity to respond to reports of abuse and neglect under chapter 260E; or (ii) have codified the tribe's screening, investigation, and assessment of reports of child maltreatment procedures, if authorized to use an alternative method by the commissioner under paragraph (a);

(5) provide a wide range of services to families in need of child welfare services; ~~and~~

(6) have a tribal-state title IV-E agreement in effect; and

(7) enter into host Tribal contracts pursuant to section 256.0112, subdivision 6.

(d) Grants awarded under this section may be used for the nonfederal costs of providing child welfare services to American Indian children on the tribe's reservation, including costs associated with:

(1) assessment and prevention of child abuse and neglect;

(2) family preservation;

(3) facilitative, supportive, and reunification services;

(4) out-of-home placement for children removed from the home for child protective purposes; and

(5) other activities and services approved by the commissioner that further the goals of providing safety, permanency, and well-being of American Indian children.

(e) When a tribe has initiated a project and has been approved by the commissioner to assume child welfare responsibilities for American Indian children of that tribe under this section, the affected county social service agency is relieved of responsibility for responding to reports of abuse and neglect under chapter 260E for those children during the time within which the tribal project is in effect and funded. The commissioner shall work with tribes and affected counties to develop procedures for data collection, evaluation, and clarification of ongoing role and financial responsibilities of the county and tribe for child welfare services prior to initiation of the project. Children who have not been identified by the tribe as participating in the project shall remain the responsibility of the county. Nothing in this section shall alter responsibilities of the county for law enforcement or court services.

(f) Participating tribes may conduct children's mental health screenings under section 245.4874, subdivision 1, paragraph (a), clause (12), for children who are eligible for the initiative and living on the reservation and who meet one of the following criteria:

(1) the child must be receiving child protective services;

(2) the child must be in foster care; or

(3) the child's parents must have had parental rights suspended or terminated.

Tribes may access reimbursement from available state funds for conducting the screenings. Nothing in this section shall alter responsibilities of the county for providing services under section 245.487.

(g) Participating tribes may establish a local child mortality review panel. In establishing a local child mortality review panel, the tribe agrees to conduct local child mortality reviews for child deaths or near-fatalities occurring on the reservation under subdivision 12. Tribes with established child mortality review panels shall have access to nonpublic data and shall protect nonpublic data under subdivision 12, paragraphs (c) to (e). The tribe shall provide written notice to the commissioner and affected counties when a local child mortality review panel has been established and shall provide data upon request of the commissioner for purposes of sharing nonpublic data with members of the state child mortality review panel in connection to an individual case.

(h) The commissioner shall collect information on outcomes relating to child safety, permanency, and well-being of American Indian children who are served in the projects. Participating tribes must provide information to the state in a format and completeness deemed acceptable by the state to meet state and federal reporting requirements.

(i) In consultation with the White Earth Band, the commissioner shall develop and submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a plan to transfer legal responsibility for providing child protective services to White Earth Band member children residing in Hennepin County to the White Earth Band. The plan shall include a financing proposal, definitions of key terms, statutory amendments required, and other provisions required to implement the plan. The commissioner shall submit the plan by January 15, 2012.

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

Sec. 14. Minnesota Statutes 2020, section 256.0112, subdivision 6, is amended to read:

Subd. 6. **Contracting within and across county lines; lead county contracts; lead Tribal contracts.** Paragraphs (a) to (e) govern contracting within and across county lines and lead county contracts. Paragraphs (a) to (e) govern contracting within and across reservation boundaries and lead Tribal contracts for initiative tribes under section 256.01, subdivision 14b. For purposes of this subdivision, "local agency" includes a tribe or a county agency.

(a) Once a local agency and an approved vendor execute a contract that meets the requirements of this subdivision, the contract governs all other purchases of service from the vendor by all other local agencies for the term of the contract. The local agency that negotiated and entered into the contract becomes the lead tribe or county for the contract.

(b) When the local agency in the county or reservation where a vendor is located wants to purchase services from that vendor and the vendor has no contract with the local agency or any other tribe or county, the local agency must negotiate and execute a contract with the vendor.

(c) When a local agency ~~in one county~~ wants to purchase services from a vendor located in another county or reservation, it must notify the local agency in the county or reservation where the vendor is located. Within 30 days of being notified, the local agency in the vendor's county or reservation must:

(1) if it has a contract with the vendor, send a copy to the inquiring local agency;

(2) if there is a contract with the vendor for which another local agency is the lead tribe or county, identify the lead tribe or county to the inquiring agency; or

(3) if no local agency has a contract with the vendor, inform the inquiring agency whether it will negotiate a contract and become the lead tribe or county. If the agency where the vendor is located will not negotiate a contract with the vendor because of concerns related to clients' health and safety, the agency must share those concerns with the inquiring local agency.

(d) If the local agency in the county where the vendor is located declines to negotiate a contract with the vendor or fails to respond within 30 days of receiving the notification under paragraph (c), the inquiring agency is authorized to negotiate a contract and must notify the local agency that declined or failed to respond.

(e) When the inquiring ~~county~~ local agency under paragraph (d) becomes the lead tribe or county for a contract and the contract expires and needs to be renegotiated, that tribe or county must again follow the requirements under paragraph (c) and notify the local agency where the vendor is located. The local agency where the vendor is located has the option of becoming the lead tribe or county for the new contract. If the local agency does not exercise the option, paragraph (d) applies.

(f) This subdivision does not affect the requirement to seek county concurrence under section 256B.092, subdivision 8a, when the services are to be purchased for a person with a developmental disability or under section 245.4711, subdivision 3, when the services to be purchased are for an adult with serious and persistent mental illness.

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

Sec. 15. Minnesota Statutes 2020, section 260C.007, subdivision 26c, is amended to read:

Subd. 26c. **Qualified individual.** (a) "Qualified individual" means a trained culturally competent professional or licensed clinician, including a mental health professional under section 245.4871, subdivision 27, who is ~~not~~ qualified to conduct the assessment approved by the commissioner. The qualified individual must not be an employee of the responsible social services agency ~~and~~ or an individual who is ~~not~~ connected to or affiliated with any placement setting in which a responsible social services agency has placed children.

(b) When the Indian Child Welfare Act of 1978, United States Code, title 25, sections 1901 to 1963, applies to a child, the county must contact the child's tribe without delay to give the tribe the option to designate a qualified individual who is a trained culturally competent professional or licensed clinician, including a mental health professional under

section 245.4871, subdivision 27, who is not employed by the responsible social services agency and who is not connected to or affiliated with any placement setting in which a responsible social services agency has placed children. Only a federal waiver that demonstrates maintained objectivity may allow a responsible social services agency employee or Tribal employee affiliated with any placement setting in which the responsible social services agency has placed children to be designated the qualified individual.

Sec. 16. Minnesota Statutes 2020, section 260C.007, subdivision 31, is amended to read:

Subd. 31. **Sexually exploited youth.** "Sexually exploited youth" means an individual who:

(1) is alleged to have engaged in conduct which would, if committed by an adult, violate any federal, state, or local law relating to being hired, offering to be hired, or agreeing to be hired by another individual to engage in sexual penetration or sexual conduct;

(2) is a victim of a crime described in section 609.342, 609.343, 609.344, 609.345, 609.3451, 609.3453, 609.352, 617.246, or 617.247;

(3) is a victim of a crime described in United States Code, title 18, section 2260; 2421; 2422; 2423; 2425; 2425A; or 2256; ~~or~~

(4) is a sex trafficking victim as defined in section 609.321, subdivision 7b~~.~~; or

(5) is a victim of commercial sexual exploitation as defined in United States Code, title 22, section 7102(11)(A) and (12).

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 17. Minnesota Statutes 2020, section 260C.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services agency shall establish a juvenile treatment screening team to conduct screenings under this chapter and chapter 260D, ~~and section 245.487, subdivision 3,~~ for a child to receive treatment for an emotional disturbance, a developmental disability, or related condition in a residential treatment facility licensed by the commissioner of human services under chapter 245A, or licensed or approved by a tribe. A screening team is not required for a child to be in: (1) a residential facility specializing in prenatal, postpartum, or parenting support; (2) a facility specializing in high-quality residential care and supportive services to children and youth who ~~are~~ have been or are at risk of becoming victims of ~~sex trafficking~~ sex trafficking ~~victims or are at risk of becoming sex trafficking victims~~ or commercial sexual exploitation; (3) supervised settings for youth who are 18 years ~~old~~ of age or older and living

independently; or (4) a licensed residential family-based treatment facility for substance abuse consistent with section 260C.190. Screenings are also not required when a child must be placed in a facility due to an emotional crisis or other mental health emergency.

(b) The responsible social services agency shall conduct screenings within 15 days of a request for a screening, unless the screening is for the purpose of residential treatment and the child is enrolled in a prepaid health program under section 256B.69, in which case the agency shall conduct the screening within ten working days of a request. The responsible social services agency shall convene the juvenile treatment screening team, which may be constituted under section 245.4885 or 256B.092 or Minnesota Rules, parts 9530.6600 to 9530.6655. The team shall consist of social workers; persons with expertise in the treatment of juveniles who are emotionally ~~disabled~~ disturbed, chemically dependent, or have a developmental disability; and the child's parent, guardian, or permanent legal custodian. The team may include the child's relatives as defined in section 260C.007, subdivisions 26b and 27, the child's foster care provider, and professionals who are a resource to the child's family such as teachers, medical or mental health providers, and clergy, as appropriate, consistent with the family and permanency team as defined in section 260C.007, subdivision 16a. Prior to forming the team, the responsible social services agency must consult with the child's parents, the child if the child is age 14 or older, ~~the child's parents,~~ and, if applicable, the child's tribe to obtain recommendations regarding which individuals to include on the team and to ensure that the team is family-centered and will act in the child's best ~~interest~~ interests. If the child, child's parents, or legal guardians raise concerns about specific relatives or professionals, the team should not include those individuals. This provision does not apply to paragraph (c).

(c) If the agency provides notice to tribes under section 260.761, and the child screened is an Indian child, the responsible social services agency must make a rigorous and concerted effort to include a designated representative of the Indian child's tribe on the juvenile treatment screening team, unless the child's tribal authority declines to appoint a representative. The Indian child's tribe may delegate its authority to represent the child to any other federally recognized Indian tribe, as defined in section 260.755, subdivision 12. The provisions of the Indian Child Welfare Act of 1978, United States Code, title 25, sections 1901 to 1963, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835, apply to this section.

(d) If the court, prior to, or as part of, a final disposition or other court order, proposes to place a child with an emotional disturbance or developmental disability or related condition in residential treatment, the responsible social services agency must conduct a screening.

If the team recommends treating the child in a qualified residential treatment program, the agency must follow the requirements of sections 260C.70 to 260C.714.

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 18. Minnesota Statutes 2020, section 260C.163, subdivision 3, is amended to read:

Subd. 3. **Appointment of counsel.** (a) The child, parent, guardian or custodian has the right to effective assistance of counsel in connection with a proceeding in juvenile court as provided in this subdivision.

(b) Except in proceedings where the sole basis for the petition is habitual truancy, if the child desires counsel but is unable to employ it, the court shall appoint counsel to represent the child who is ten years of age or older under section 611.14, clause (4), or other counsel at public expense.

(c) ~~Except in proceedings where the sole basis for the petition is habitual truancy, if the parent, guardian, or custodian desires counsel but is unable to employ it, the court shall appoint counsel to represent the parent, guardian, or custodian in any case in which it feels that such an appointment is appropriate if the person would be financially unable to obtain counsel under the guidelines set forth in section 611.17.~~ In all child protection proceedings where a child risks removal from the care of the child's parent, guardian, or custodian, including a child in need of protection or services petition, an action pursuing removal of a child from the child's home, a termination of parental rights petition, or a petition for permanent out-of-home placement, if the parent, guardian, or custodian desires counsel and is eligible for counsel under section 611.17, the court shall appoint counsel to represent each parent, guardian, or custodian prior to the first hearing on the petition and at all stages of the proceedings. Court appointed counsel shall be at county expense as outlined in paragraph (h).

(d) In any proceeding where the subject of a petition for a child in need of protection or services is ten years of age or older, the responsible social services agency shall, within 14 days after filing the petition or at the emergency removal hearing under section 260C.178, subdivision 1, if the child is present, fully and effectively inform the child of the child's right to be represented by appointed counsel upon request and shall notify the court as to whether the child desired counsel. Information provided to the child shall include, at a minimum, the fact that counsel will be provided without charge to the child, that the child's communications with counsel are confidential, and that the child has the right to participate in all proceedings on a petition, including the opportunity to personally attend all hearings. The responsible social services agency shall also, within 14 days of the child's tenth birthday,

fully and effectively inform the child of the child's right to be represented by counsel if the child reaches the age of ten years while the child is the subject of a petition for a child in need of protection or services or is a child under the guardianship of the commissioner.

(e) In any proceeding where the sole basis for the petition is habitual truancy, the child, parent, guardian, and custodian do not have the right to appointment of a public defender or other counsel at public expense. However, before any out-of-home placement, including foster care or inpatient treatment, can be ordered, the court must appoint a public defender or other counsel at public expense in accordance with this subdivision.

(f) Counsel for the child shall not also act as the child's guardian ad litem.

(g) In any proceeding where the subject of a petition for a child in need of protection or services is not represented by an attorney, the court shall determine the child's preferences regarding the proceedings, including informing the child of the right to appointed counsel and asking whether the child desires counsel, if the child is of suitable age to express a preference.

(h) Court-appointed counsel for the parent, guardian, or custodian under this subdivision is at county expense. If the county has contracted with counsel ~~meeting qualifications under paragraph (i)~~, the court shall appoint the counsel retained by the county, unless a conflict of interest exists. If a conflict exists, after consulting with the chief judge of the judicial district or the judge's designee, the county shall contract with competent counsel to provide the necessary representation. The court may appoint only one counsel at public expense for the first court hearing to represent the interests of the parents, guardians, and custodians, unless, at any time during the proceedings upon petition of a party, the court determines and makes written findings on the record that extraordinary circumstances exist that require counsel to be appointed to represent a separate interest of other parents, guardians, or custodians subject to the jurisdiction of the juvenile court.

~~(i) Counsel retained by the county under paragraph (h) must meet the qualifications established by the Judicial Council in at least one of the following: (1) has a minimum of two years' experience handling child protection cases; (2) has training in handling child protection cases from a course or courses approved by the Judicial Council; or (3) is supervised by an attorney who meets the minimum qualifications under clause (1) or (2).~~

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

Sec. 19. Minnesota Statutes 2020, section 260C.212, subdivision 1a, is amended to read:

Subd. 1a. **Out-of-home placement plan update.** (a) Within 30 days of placing the child in foster care, the agency must file the child's initial out-of-home placement plan with the court. After filing the child's initial out-of-home placement plan, the agency shall update and file the child's out-of-home placement plan with the court as follows:

(1) when the agency moves a child to a different foster care setting, the agency shall inform the court within 30 days of the child's placement change or court-ordered trial home visit. The agency must file the child's updated out-of-home placement plan with the court at the next required review hearing;

(2) when the agency places a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, or moves a child from one qualified residential treatment program to a different qualified residential treatment program, the agency must update the child's out-of-home placement plan within 60 days. To meet the requirements of section 260C.708, the agency must file the child's out-of-home placement plan ~~with the court as part of the 60-day hearing and~~ along with the agency's report seeking the court's approval of the child's placement at a qualified residential treatment program under section 260C.71. After the court issues an order, the agency must update the child's out-of-home placement plan ~~after the court hearing~~ to document the court's approval or disapproval of the child's placement in a qualified residential treatment program;

(3) when the agency places a child with the child's parent in a licensed residential family-based substance use disorder treatment program under section 260C.190, the agency must identify the treatment program where the child will be placed in the child's out-of-home placement plan prior to the child's placement. The agency must file the child's out-of-home placement plan with the court at the next required review hearing; and

(4) under sections 260C.227 and 260C.521, the agency must update the child's out-of-home placement plan and file the child's out-of-home placement plan with the court.

(b) When none of the items in paragraph (a) apply, the agency must update the child's out-of-home placement plan no later than 180 days after the child's initial placement and every six months thereafter, consistent with section 260C.203, paragraph (a).

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 20. Minnesota Statutes 2020, section 260C.212, subdivision 13, is amended to read:

Subd. 13. **Protecting missing and runaway children and youth at risk of sex trafficking or commercial sexual exploitation.** (a) The local social services agency shall expeditiously locate any child missing from foster care.

(b) The local social services agency shall report immediately, but no later than 24 hours, after receiving information on a missing or abducted child to the local law enforcement agency for entry into the National Crime Information Center (NCIC) database of the Federal Bureau of Investigation, and to the National Center for Missing and Exploited Children.

(c) The local social services agency shall not discharge a child from foster care or close the social services case until diligent efforts have been exhausted to locate the child and the court terminates the agency's jurisdiction.

(d) The local social services agency shall determine the primary factors that contributed to the child's running away or otherwise being absent from care and, to the extent possible and appropriate, respond to those factors in current and subsequent placements.

(e) The local social services agency shall determine what the child experienced while absent from care, including screening the child to determine if the child is a possible sex trafficking or commercial sexual exploitation victim as defined in section ~~609.321, subdivision 7b~~ 260C.007, subdivision 31.

(f) The local social services agency shall report immediately, but no later than 24 hours, to the local law enforcement agency any reasonable cause to believe a child is, or is at risk of being, a sex trafficking or commercial sexual exploitation victim.

(g) The local social services agency shall determine appropriate services as described in section 145.4717 with respect to any child for whom the local social services agency has responsibility for placement, care, or supervision when the local social services agency has reasonable cause to believe that the child is, or is at risk of being, a sex trafficking or commercial sexual exploitation victim.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 21. Minnesota Statutes 2020, section 260C.4412, is amended to read:

260C.4412 PAYMENT FOR RESIDENTIAL PLACEMENTS.

(a) When a child is placed in a foster care group residential setting under Minnesota Rules, parts 2960.0020 to 2960.0710, a foster residence licensed under chapter 245A that meets the standards of Minnesota Rules, parts 2960.3200 to 2960.3230, or a children's

residential facility licensed or approved by a tribe, foster care maintenance payments must be made on behalf of the child to cover the cost of providing food, clothing, shelter, daily supervision, school supplies, child's personal incidentals and supports, reasonable travel for visitation, or other transportation needs associated with the items listed. Daily supervision in the group residential setting includes routine day-to-day direction and arrangements to ensure the well-being and safety of the child. It may also include reasonable costs of administration and operation of the facility.

(b) The commissioner of human services shall specify the title IV-E administrative procedures under section 256.82 for each of the following residential program settings:

(1) residential programs licensed under chapter 245A or licensed by a tribe, including:

(i) qualified residential treatment programs as defined in section 260C.007, subdivision 26d;

(ii) program settings specializing in providing prenatal, postpartum, or parenting supports for youth; and

(iii) program settings providing high-quality residential care and supportive services to children and youth who are, or are at risk of becoming, sex trafficking victims;

(2) licensed residential family-based substance use disorder treatment programs as defined in section 260C.007, subdivision 22a; and

(3) supervised settings in which a foster child age 18 or older may live independently, consistent with section 260C.451.

(c) A lead contract under section 256.0112, subdivision 6, is not required to establish the foster care maintenance payment in paragraph (a) for foster residence settings licensed under chapter 245A that meet the standards of Minnesota Rules, parts 2960.3200 to 2960.3230. The foster care maintenance payment for these settings must be consistent with section 256N.26, subdivision 3, and subject to the annual revision as specified in section 256N.26, subdivision 9.

Sec. 22. Minnesota Statutes 2020, section 260C.452, is amended to read:

260C.452 SUCCESSFUL TRANSITION TO ADULTHOOD.

Subdivision 1. **Scope; purpose.** (a) For purposes of this section, "youth" means a person who is at least 14 years of age and under 23 years of age.

(b) This section pertains to a ~~child~~ youth who:

(1) is in foster care and is 14 years of age or older, including a youth who is under the guardianship of the commissioner of human services~~, or who~~;

(2) has a permanency disposition of permanent custody to the agency~~, or who~~;

(3) will leave foster care ~~at 18 to 21 years of age.~~ when the youth is 18 years of age or older and under 21 years of age;

(4) has left foster care and was placed at a permanent adoptive placement when the youth was 16 years of age or older;

(5) is 16 years of age or older, has left foster care, and was placed with a relative to whom permanent legal and physical custody of the youth has been transferred; or

(6) was reunified with the youth's primary caretaker when the youth was 14 years of age or older and under 18 years of age.

(c) The purpose of this section is to provide support to a youth who is transitioning to adulthood by providing services to the youth concerning:

(1) education;

(2) employment;

(3) daily living skills such as financial literacy training and driving instruction, preventive health activities including promoting abstinence from substance use and smoking, and nutrition education and pregnancy prevention;

(4) forming meaningful, permanent connections with caring adults;

(5) engaging in age-appropriate and developmentally appropriate activities under section 260C.212, subdivision 14, and positive youth development;

(6) financial, housing, counseling, and other services to assist a youth over 18 years of age in achieving self-sufficiency and accepting personal responsibility for the transition from adolescence to adulthood; and

(7) making vouchers available for education and training.

(d) The responsible social services agency may provide support and case management services to a youth as defined in paragraph (a) until the youth reaches 23 years of age. According to section 260C.451, a youth's placement in a foster care setting will end when the youth reaches 21 years of age.

Subd. 1a. **Case management services.** Case management services include the responsibility for planning, coordinating, authorizing, monitoring, and evaluating services

for a youth and shall be provided to a youth by the responsible social services agency or the contracted agency. Case management services include the out-of-home placement plan under section 260C.212, subdivision 1, when the youth is in out-of-home placement.

Subd. 2. **Independent living plan.** When the ~~child~~ youth is 14 years of age or older and is receiving support from the responsible social services agency under this section, the responsible social services agency, in consultation with the ~~child~~ youth, shall complete the youth's independent living plan according to section 260C.212, subdivision 1, paragraph (c), clause (12), regardless of the youth's current placement status.

~~Subd. 3. **Notification.** Six months before the child is expected to be discharged from foster care, the responsible social services agency shall provide written notice to the child regarding the right to continued access to services for certain children in foster care past 18 years of age and of the right to appeal a denial of social services under section 256.045.~~

Subd. 4. **Administrative or court review of placements.** (a) When the ~~child~~ youth is 14 years of age or older, the court, in consultation with the ~~child~~ youth, shall review the youth's independent living plan according to section 260C.203, paragraph (d).

(b) The responsible social services agency shall file a copy of the notification ~~required in subdivision 3~~ of foster care benefits for a youth who is 18 years of age or older according to section 260C.451, subdivision 1, with the court. If the responsible social services agency does not file the notice by the time the ~~child~~ youth is 17-1/2 years of age, the court shall require the responsible social services agency to file the notice.

(c) When a youth is 18 years of age or older, the court shall ensure that the responsible social services agency assists the ~~child~~ youth in obtaining the following documents before the ~~child~~ youth leaves foster care: a Social Security card; an official or certified copy of the ~~child's~~ youth's birth certificate; a state identification card or driver's license, tribal enrollment identification card, green card, or school visa; health insurance information; the ~~child's~~ youth's school, medical, and dental records; a contact list of the ~~child's~~ youth's medical, dental, and mental health providers; and contact information for the ~~child's~~ youth's siblings, if the siblings are in foster care.

(d) For a ~~child~~ youth who will be discharged from foster care at 18 years of age or older because the youth is not eligible for extended foster care benefits or chooses to leave foster care, the responsible social services agency must develop a personalized transition plan as directed by the ~~child~~ youth during the ~~90-day~~ 180-day period immediately prior to the expected date of discharge. The transition plan must be as detailed as the ~~child~~ youth elects and include specific options, including but not limited to:

(1) affordable housing with necessary supports that does not include a homeless shelter;

(2) health insurance, including eligibility for medical assistance as defined in section 256B.055, subdivision 17;

(3) education, including application to the Education and Training Voucher Program;

(4) local opportunities for mentors and continuing support services~~, including the Healthy Transitions and Homeless Prevention program, if available~~;

(5) workforce supports and employment services;

(6) a copy of the ~~child's~~ youth's consumer credit report as defined in section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report, at no cost to the ~~child~~ youth;

(7) information on executing a health care directive under chapter 145C and on the importance of designating another individual to make health care decisions on behalf of the ~~child~~ youth if the ~~child~~ youth becomes unable to participate in decisions;

(8) appropriate contact information through 21 years of age if the ~~child~~ youth needs information or help dealing with a crisis situation; and

(9) official documentation that the youth was previously in foster care.

Subd. 5. **Notice of termination of ~~foster care~~ social services.** (a) ~~When~~ Before a ~~child~~ youth who is 18 years of age or older leaves foster care ~~at 18 years of age or older~~, the responsible social services agency shall give the ~~child~~ youth written notice that foster care shall terminate 30 days from the date that the notice is sent by the agency according to section 260C.451, subdivision 8.

~~(b) The child or the child's guardian ad litem may file a motion asking the court to review the responsible social services agency's determination within 15 days of receiving the notice. The child shall not be discharged from foster care until the motion is heard. The responsible social services agency shall work with the child to transition out of foster care.~~

~~(c) The written notice of termination of benefits shall be on a form prescribed by the commissioner and shall give notice of the right to have the responsible social services agency's determination reviewed by the court under this section or sections 260C.203, 260C.317, and 260C.515, subdivision 5 or 6. A copy of the termination notice shall be sent to the child and the child's attorney, if any, the foster care provider, the child's guardian ad litem, and the court. The responsible social services agency is not responsible for paying foster care benefits for any period of time after the child leaves foster care.~~

(b) Before case management services will end for a youth who is at least 18 years of age and under 23 years of age, the responsible social services agency shall give the youth: (1) written notice that case management services for the youth shall terminate; and (2) written notice that the youth has the right to appeal the termination of case management services under section 256.045, subdivision 3, by responding in writing within ten days of the date that the agency mailed the notice. The termination notice must include information about services for which the youth is eligible and how to access the services.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 23. Minnesota Statutes 2020, section 260C.704, is amended to read:

260C.704 REQUIREMENTS FOR THE QUALIFIED INDIVIDUAL'S ASSESSMENT OF THE CHILD FOR PLACEMENT IN A QUALIFIED RESIDENTIAL TREATMENT PROGRAM.

(a) A qualified individual must complete an assessment of the child prior to ~~or within 30 days of~~ the child's placement in a qualified residential treatment program in a format approved by the commissioner of human services~~, and~~ unless, due to a crisis, the child must immediately be placed in a qualified residential treatment program. When a child must immediately be placed in a qualified residential treatment program without an assessment, the qualified individual must complete the child's assessment within 30 days of the child's placement. The qualified individual must:

(1) assess the child's needs and strengths, using an age-appropriate, evidence-based, validated, functional assessment approved by the commissioner of human services;

(2) determine whether the child's needs can be met by the child's family members or through placement in a family foster home; or, if not, determine which residential setting would provide the child with the most effective and appropriate level of care to the child in the least restrictive environment;

(3) develop a list of short- and long-term mental and behavioral health goals for the child; and

(4) work with the child's family and permanency team using culturally competent practices.

If a level of care determination was conducted under section 245.4885, that information must be shared with the qualified individual and the juvenile treatment screening team.

(b) The child and the child's parents, when appropriate, may request that a specific culturally competent qualified individual complete the child's assessment. The agency shall make efforts to refer the child to the identified qualified individual to complete the assessment. The assessment must not be delayed for a specific qualified individual to complete the assessment.

(c) The qualified individual must provide the assessment, when complete, to the responsible social services agency~~, the child's parents or legal guardians, the guardian ad litem, and the court~~. If the assessment recommends placement of the child in a qualified residential treatment facility, the agency must distribute the assessment to the child's parent or legal guardian and file the assessment with the court report as required in section 260C.71, subdivision 2. If the assessment does not recommend placement in a qualified residential treatment facility, the agency must provide a copy of the assessment to the parents or legal guardians and the guardian ad litem and file the assessment determination with the court at the next required hearing as required in section 260C.71, subdivision 5. If court rules and chapter 13 permit disclosure of the results of the child's assessment, the agency may share the results of the child's assessment with the child's foster care provider, other members of the child's family, and the family and permanency team. The agency must not share the child's private medical data with the family and permanency team unless: (1) chapter 13 permits the agency to disclose the child's private medical data to the family and permanency team; or (2) the child's parent has authorized the agency to disclose the child's private medical data to the family and permanency team.

(d) For an Indian child, the assessment of the child must follow the order of placement preferences in the Indian Child Welfare Act of 1978, United States Code, title 25, section 1915.

(e) In the assessment determination, the qualified individual must specify in writing:

(1) the reasons why the child's needs cannot be met by the child's family or in a family foster home. A shortage of family foster homes is not an acceptable reason for determining that a family foster home cannot meet a child's needs;

(2) why the recommended placement in a qualified residential treatment program will provide the child with the most effective and appropriate level of care to meet the child's needs in the least restrictive environment possible and how placing the child at the treatment program is consistent with the short-term and long-term goals of the child's permanency plan; and

(3) if the qualified individual's placement recommendation is not the placement setting that the parent, family and permanency team, child, or tribe prefer, the qualified individual must identify the reasons why the qualified individual does not recommend the parent's, family and permanency team's, child's, or tribe's placement preferences. The out-of-home placement plan under section 260C.708 must also include reasons why the qualified individual did not recommend the preferences of the parents, family and permanency team, child, or tribe.

(f) If the qualified individual determines that the child's family or a family foster home or other less restrictive placement may meet the child's needs, the agency must move the child out of the qualified residential treatment program and transition the child to a less restrictive setting within 30 days of the determination. If the responsible social services agency has placement authority of the child, the agency must make a plan for the child's placement according to section 260C.212, subdivision 2. The agency must file the child's assessment determination with the court at the next required hearing.

(g) If the qualified individual recommends placing the child in a qualified residential treatment program and if the responsible social services agency has placement authority of the child, the agency shall make referrals to appropriate qualified residential treatment programs and, upon acceptance by an appropriate program, place the child in an approved or certified qualified residential treatment program.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 24. Minnesota Statutes 2020, section 260C.706, is amended to read:

260C.706 FAMILY AND PERMANENCY TEAM REQUIREMENTS.

(a) When the responsible social services agency's juvenile treatment screening team, as defined in section 260C.157, recommends placing the child in a qualified residential treatment program, the agency must assemble a family and permanency team within ten days.

(1) The team must include all appropriate biological family members, the child's parents, legal guardians or custodians, foster care providers, and relatives as defined in section 260C.007, subdivisions ~~26e~~ 26b and 27, and professionals, as appropriate, who are a resource to the child's family, such as teachers, medical or mental health providers, or clergy.

(2) When a child is placed in foster care prior to the qualified residential treatment program, the agency shall include relatives responding to the relative search notice as required under section 260C.221 on this team, unless the juvenile court finds that contacting

a specific relative would ~~endanger~~ present a safety or health risk to the parent, guardian, child, sibling, or any other family member.

(3) When a qualified residential treatment program is the child's initial placement setting, the responsible social services agency must engage with the child and the child's parents to determine the appropriate family and permanency team members.

(4) When the permanency goal is to reunify the child with the child's parent or legal guardian, the purpose of the relative search and focus of the family and permanency team is to preserve family relationships and identify and develop supports for the child and parents.

(5) The responsible agency must make a good faith effort to identify and assemble all appropriate individuals to be part of the child's family and permanency team and request input from the parents regarding relative search efforts consistent with section 260C.221. The out-of-home placement plan in section 260C.708 must include all contact information for the team members, as well as contact information for family members or relatives who are not a part of the family and permanency team.

(6) If the child is age 14 or older, the team must include members of the family and permanency team that the child selects in accordance with section 260C.212, subdivision 1, paragraph (b).

(7) Consistent with section 260C.221, a responsible social services agency may disclose relevant and appropriate private data about the child to relatives in order for the relatives to participate in caring and planning for the child's placement.

(8) If the child is an Indian child under section 260.751, the responsible social services agency must make active efforts to include the child's tribal representative on the family and permanency team.

(b) The family and permanency team shall meet regarding the assessment required under section 260C.704 to determine whether it is necessary and appropriate to place the child in a qualified residential treatment program and to participate in case planning under section 260C.708.

(c) When reunification of the child with the child's parent or legal guardian is the permanency plan, the family and permanency team shall support the parent-child relationship by recognizing the parent's legal authority, consulting with the parent regarding ongoing planning for the child, and assisting the parent with visiting and contacting the child.

(d) When the agency's permanency plan is to transfer the child's permanent legal and physical custody to a relative or for the child's adoption, the team shall:

(1) coordinate with the proposed guardian to provide the child with educational services, medical care, and dental care;

(2) coordinate with the proposed guardian, the agency, and the foster care facility to meet the child's treatment needs after the child is placed in a permanent placement with the proposed guardian;

(3) plan to meet the child's need for safety, stability, and connection with the child's family and community after the child is placed in a permanent placement with the proposed guardian; and

(4) in the case of an Indian child, communicate with the child's tribe to identify necessary and appropriate services for the child, transition planning for the child, the child's treatment needs, and how to maintain the child's connections to the child's community, family, and tribe.

(e) The agency shall invite the family and permanency team to participate in case planning and the agency shall give the team notice of court reviews under sections 260C.152 and 260C.221 until: (1) the child is reunited with the child's parents; or (2) the child's foster care placement ends and the child is in a permanent placement.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 25. Minnesota Statutes 2020, section 260C.708, is amended to read:

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

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

(1) the case plan requirements in section ~~260.212, subdivision 1~~ 260C.212;

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

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

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

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

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

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

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

~~(5)~~ (7) when reunification of the child with the child's parent or legal guardian is the agency's goal, evidence demonstrating that the parent or legal guardian provided input about the members of the family and permanency team under section 260C.706;

~~(6)~~ (8) when the agency's permanency goal is to reunify the child with the child's parent or legal guardian, the out-of-home placement plan must identify services and supports that maintain the parent-child relationship and the parent's legal authority, decision-making, and responsibility for ongoing planning for the child. In addition, the agency must assist the parent with visiting and contacting the child;

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

~~(8)~~ (10) the qualified individual's recommendation regarding the child's placement in a qualified residential treatment program and the court approval or disapproval of the placement as required in section 260C.71.

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

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

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 26. Minnesota Statutes 2020, section 260C.71, is amended to read:

260C.71 COURT APPROVAL REQUIREMENTS.

Subdivision 1. **Judicial review.** When the responsible social services agency has legal authority to place a child at a qualified residential treatment facility under section 260C.007, subdivision 21a, and the child's assessment under section 260C.704 recommends placing the child in a qualified residential treatment facility, the agency shall place the child at a qualified residential facility. Within 60 days of placing the child at a qualified residential treatment facility, the agency must obtain a court order finding that the child's placement is appropriate and meets the child's individualized needs.

Subd. 2. **Qualified residential treatment program; agency report to court.** (a) The responsible social services agency shall file a written report with the court after receiving the qualified individual's assessment as specified in section 260C.704 prior to the child's placement or within 35 days of the date of the child's placement in a qualified residential treatment facility. The written report shall contain or have attached:

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

(2) the names, races, dates of birth, residence, and post office address of the child's parents or legal custodian, or guardian;

(3) the name and address of the qualified residential treatment program, including a chief administrator of the facility;

(4) a statement of the facts that necessitated the child's foster care placement;

(5) the child's out-of-home placement plan under section 260C.212, subdivision 1, including the requirements in section 260C.708;

(6) if the child is placed in an out-of-state qualified residential treatment program, the compelling reasons why the child's needs cannot be met by an in-state placement;

(7) the qualified individual's assessment of the child under section 260C.704, paragraph (c), in a format approved by the commissioner;

(8) if, at the time required for the report under this subdivision, the child's parent or legal guardian, a child who is ten years of age or older, the family and permanency team, or a

tribe disagrees with the recommended qualified residential treatment program placement, information regarding the disagreement and to the extent possible, the basis for the disagreement in the report; and

(9) any other information that the responsible social services agency, child's parent, legal custodian or guardian, child, or, in the case of an Indian child, tribe would like the court to consider.

(b) The agency shall file the written report under paragraph (a) with the court and serve on the parties a request for a hearing or a court order without a hearing.

(c) The agency must inform the child's parent or legal guardian and a child who is ten years of age or older of the court review requirements of this section and the child and child's parent's or legal guardian's right to submit information to the court:

(1) the agency must inform the child's parent or legal guardian and a child who is ten years of age or older of the reporting date and the date by which the agency must receive information from the child and child's parent so that the agency is able to submit the report required by this subdivision to the court;

(2) the agency must inform the child's parent or legal guardian, and a child who is ten years of age or older that the court will hold a hearing upon the request of the child or the child's parent; and

(3) the agency must inform the child's parent or legal guardian, and a child who is ten years of age or older that they have the right to request a hearing and the right to present information to the court for the court's review under this subdivision.

Subd. 3. **Court hearing.** (a) The court shall hold a hearing when a party or a child who is ten years of age or older requests a hearing.

(b) In all other circumstances, the court has the discretion to hold a hearing or issue an order without a hearing.

Subd. 4. **Court findings and order.** (a) Within 60 days from the beginning of each placement in a qualified residential treatment program when the qualified individual's assessment of the child recommends placing the child in a qualified residential treatment program, the court must consider the qualified individual's assessment of the child under section 260C.704 and issue an order to:

~~(1) consider the qualified individual's assessment of whether it is necessary and appropriate to place the child in a qualified residential treatment program under section 260C.704;~~

~~(2)~~ (1) determine whether a family foster home can meet the child's needs, whether it is necessary and appropriate to place a child in a qualified residential treatment program that is the least restrictive environment possible, and whether the child's placement is consistent with the child's short and long term goals as specified in the permanency plan; and

~~(3)~~ (2) approve or disapprove of the child's placement.

(b) ~~In the out-of-home placement plan, the agency must document the court's approval or disapproval of the placement, as specified in section 260C.708.~~ If the court disapproves of the child's placement in a qualified residential treatment program, the responsible social services agency shall: (1) remove the child from the qualified residential treatment program within 30 days of the court's order; and (2) make a plan for the child's placement that is consistent with the child's best interests under section 260C.212, subdivision 2.

Subd. 5. **Court review and approval not required.** When the responsible social services agency has legal authority to place a child under section 260C.007, subdivision 21a, and the qualified individual's assessment of the child does not recommend placing the child in a qualified residential treatment program, the court is not required to hold a hearing and the court is not required to issue an order. Pursuant to section 260C.704, paragraph (f), the responsible social services agency shall make a plan for the child's placement consistent with the child's best interests under section 260C.212, subdivision 2. The agency must file the agency's assessment determination for the child with the court at the next required hearing.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 27. Minnesota Statutes 2020, section 260C.712, is amended to read:

260C.712 ONGOING REVIEWS AND PERMANENCY HEARING REQUIREMENTS.

As long as a child remains placed in a qualified residential treatment program, the responsible social services agency shall submit evidence at each administrative review under section 260C.203; each court review under sections 260C.202, 260C.203, ~~and~~ 260C.204, 260D.06, 260D.07, and 260D.08; and each permanency hearing under section 260C.515, 260C.519, ~~or~~ 260C.521, or 260D.07 that:

(1) demonstrates that an ongoing assessment of the strengths and needs of the child continues to support the determination that the child's needs cannot be met through placement in a family foster home;

(2) demonstrates that the placement of the child in a qualified residential treatment program provides the most effective and appropriate level of care for the child in the least restrictive environment;

(3) demonstrates how the placement is consistent with the short-term and long-term goals for the child, as specified in the child's permanency plan;

(4) documents how the child's specific treatment or service needs will be met in the placement;

(5) documents the length of time that the agency expects the child to need treatment or services; ~~and~~

(6) documents the responsible social services agency's efforts to prepare the child to return home or to be placed with a fit and willing relative, legal guardian, adoptive parent, or foster family~~.~~; and

(7) if the child is placed in a qualified residential treatment program out-of-state, documents the compelling reasons for placing the child out-of-state, and the reasons that the child's needs cannot be met by an in-state placement.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 28. Minnesota Statutes 2020, section 260C.714, is amended to read:

260C.714 REVIEW OF EXTENDED QUALIFIED RESIDENTIAL TREATMENT PROGRAM PLACEMENTS.

(a) When a responsible social services agency places a child in a qualified residential treatment program for more than 12 consecutive months or 18 nonconsecutive months or, in the case of a child who is under 13 years of age, for more than six consecutive or nonconsecutive months, the agency must submit: (1) the signed approval by the county social services director of the responsible social services agency; and (2) the evidence supporting the child's placement at the most recent court review or permanency hearing under section 260C.712~~, paragraph (b)~~.

(b) The commissioner shall specify the procedures and requirements for the agency's review and approval of a child's extended qualified residential treatment program placement. The commissioner may consult with counties, tribes, child-placing agencies, mental health providers, licensed facilities, the child, the child's parents, and the family and permanency team members to develop case plan requirements and engage in periodic reviews of the case plan.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 29. Minnesota Statutes 2020, section 260D.01, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) to ensure that the child's parent retains legal custody of the child and associated decision-making authority unless the child's parent willfully fails or is unable to make decisions that meet the child's safety, health, and best interests. The court may not find that the parent willfully fails or is unable to make decisions that meet the child's needs solely because the parent disagrees with the agency's choice of foster care facility, unless the agency files a petition under chapter 260C, and establishes by clear and convincing evidence that the child is in need of protection or services.

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

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

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

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

(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 parents and 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 or the child's parent or legal guardian raises concerns about specific relatives or professionals, the team should not include those individuals on the team unless the individual is a treating professional or an important connection to the youth as outlined in the case or crisis plan. For voluntary placements 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 tribe, to obtain recommendations regarding which adult relatives should be notified. If the child, parent, or legal guardian raises concerns about specific relatives, the county agency must not notify them.

(g) The provisions of section 260.012 to ensure placement prevention, family reunification, and all active and reasonable effort requirements of that section apply. This chapter shall be construed consistently with the requirements of the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901, et al., and the provisions of the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 30. Minnesota Statutes 2020, section 260D.05, is amended to read:

260D.05 ADMINISTRATIVE REVIEW OF CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.

The administrative reviews required under section 260C.203 must be conducted for a child in voluntary foster care for treatment, except that the initial administrative review

must take place prior to the submission of the report to the court required under section 260D.06, subdivision 2. When a child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, the responsible social services agency must submit evidence to the court as specified in section 260C.712.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 31. Minnesota Statutes 2020, section 260D.06, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) If the court finds continuing the voluntary foster care arrangement is not in the child's best interests or that the agency or the parent are not appropriately planning for the child, the court shall notify the agency, the parent, the foster parent or foster care facility, the child, age 12 or older, and the county attorney of the court's determinations and the basis for the court's determinations. In this case, the court shall set the matter for hearing and appoint a guardian ad litem for the child under section 260C.163, subdivision 5.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 32. Minnesota Statutes 2020, section 260D.07, is amended to read:

260D.07 REQUIRED PERMANENCY REVIEW HEARING.

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

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

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

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

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

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

(1) the date of the voluntary placement agreement;

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

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

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

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

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

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

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

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

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

(f) The court shall conduct the permanency review hearing on the petition no later than 14 months after the date of the voluntary placement agreement, within 30 days of the filing of the petition when the child has been in placement 15 of the last 22 months, or within 15

days of a motion to terminate jurisdiction and to dismiss an order for foster care under chapter 260C, as provided in section 260D.09, paragraph (b).

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

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

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

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

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

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

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

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

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

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

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

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

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

for the objection. Notwithstanding the child's objection, the court may approve the agency's compelling reasons and the voluntary arrangement.

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

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

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

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

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

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 33. Minnesota Statutes 2020, section 260D.08, is amended to read:

260D.08 ANNUAL REVIEW.

(a) After the court conducts a permanency review hearing under section 260D.07, the matter must be returned to the court for further review of the responsible social services reasonable efforts to finalize the permanent plan for the child and the child's foster care placement at least every 12 months while the child is in foster care. The court shall give notice to the parent and child, age 12 or older, and the foster parents of the continued review requirements under this section at the permanency review hearing.

(b) Every 12 months, the court shall determine whether the agency made reasonable efforts to finalize the permanency plan for the child, which means the exercise of due diligence by the agency to:

(1) ensure that the agreement for voluntary foster care is the most appropriate legal arrangement to meet the child's safety, health, and best interests and to conduct a genuine examination of whether there is another permanency disposition order under chapter 260C,

including returning the child home, that would better serve the child's need for a stable and permanent home;

(2) engage and support the parent in continued involvement in planning and decision making for the needs of the child;

(3) strengthen the child's ties to the parent, relatives, and community;

(4) implement the out-of-home placement plan required under section 260C.212, subdivision 1, and ensure that the plan requires the provision of appropriate services to address the physical health, mental health, and educational needs of the child; ~~and~~

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

~~(5)~~ (6) ensure appropriate planning for the child's safe, permanent, and independent living arrangement after the child's 18th birthday.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 34. Minnesota Statutes 2020, section 260D.14, is amended to read:

260D.14 SUCCESSFUL TRANSITION TO ADULTHOOD FOR ~~CHILDREN~~ YOUTH IN VOLUNTARY PLACEMENT.

Subdivision 1. **Case planning.** When ~~the child~~ a youth is 14 years of age or older, the responsible social services agency shall ensure that a ~~child~~ youth in foster care under this chapter is provided with the case plan requirements in section 260C.212, subdivisions 1 and 14.

Subd. 2. **Notification.** The responsible social services agency shall provide a youth with written notice of ~~the right to continued access to services for certain children in foster care past 18 years of age under section 260C.452, subdivision 3~~ foster care benefits that a youth who is 18 years of age or older may continue to receive according to section 260C.451, subdivision 1, and of the right to appeal a denial of social services under section 256.045. The notice must be provided to the ~~child~~ youth six months before the ~~child's~~ youth's 18th birthday.

Subd. 3. **Administrative or court reviews.** When ~~the child~~ a youth is ~~17~~ 14 years of age or older, the administrative review or court hearing must include a review of the responsible social services agency's support for the ~~child's~~ youth's successful transition to adulthood as required in section 260C.452, subdivision 4.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 35. Minnesota Statutes 2020, section 260E.36, is amended by adding a subdivision to read:

Subd. 1a. **Sex trafficking and sexual exploitation training requirement.** As required by the Child Abuse Prevention and Treatment Act amendments through Public Law 114-22 and to implement Public Law 115-123, all child protection social workers and social services staff who have responsibility for child protective duties under this chapter or chapter 260C shall complete training implemented by the commissioner of human services regarding sex trafficking and sexual exploitation of children and youth.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 36. **DIRECTION TO THE COMMISSIONER; INITIAL IMPLEMENTATION OF COURT-APPOINTED COUNSEL IN CHILD PROTECTION PROCEEDINGS.**

The commissioner of human services shall collect data from counties regarding court-appointed counsel under Minnesota Statutes, section 260C.163, subdivision 3, including but not limited to:

(1) data documenting the presence of court-appointed counsel for qualifying parents, guardians, or custodians at each emergency protective hearing;

(2) total annual court-appointed parent representation expenditures for each county; and

(3) additional demographic information that would assist counties in obtaining title IV-E reimbursement.

The commissioner must complete and submit a report on the data in this section and efforts to assist counties with implementation of required court-appointment of counsel under Minnesota Statutes, section 260C.163, subdivision 3, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and judiciary policy and finance on or before July 1, 2022.

Sec. 37. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; AFTERCARE SUPPORTS.**

The commissioner of human services shall consult with stakeholders to develop policies regarding aftercare supports for the transition of a child from a qualified residential treatment program as defined in Minnesota Statutes, section 260C.007, subdivision 26d, to reunification with the child's parent or legal guardian, including potential placement in a less restrictive

setting prior to reunification that aligns with the child's permanency plan and person-centered support plan, when applicable. The policies must be consistent with Minnesota Rules, part 2960.0190, and Minnesota Statutes, section 245A.25, subdivision 4, paragraph (i), and address the coordination of the qualified residential treatment program discharge planning and aftercare supports where needed, the county social services case plan, and services from community-based providers, to maintain the child's progress with behavioral health goals as defined in the child's treatment plan. The commissioner must complete development of the policy guidance by December 31, 2022.

Sec. 38. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; COSTS TO STATE, COUNTIES, AND PROVIDERS FOR IMPLEMENTATION OF THE FAMILY FIRST PRESERVATION SERVICES ACT.**

The commissioner of human services shall contract with an appropriate vendor to study the increased costs incurred by the state, counties, and providers to implement the requirements of the federal Family First Preservation Services Act in Minnesota. Identified costs should include, but are not limited to, reductions in Title IV-E payments to lead agencies; additional staff needs for the state, lead agencies, and providers; implementation of the federal Qualified Residential Treatment Program placement requirements and new prevention services by the state, lead agencies, and providers; costs incurred by residential facility providers to become certified as a qualified residential treatment program and to maintain certification standards; and other costs that are directly or indirectly related to implementation of the federal Family First Prevention Services Act. The study should also include known or estimates of increased federal funding that the state or lead agencies could receive through expanded Title IV-E reimbursements. The commissioner shall provide a report on these costs to the chairs and ranking minority members of the legislative committees with jurisdiction over human services by January 15, 2024.

Sec. 39. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; OMBUDSPERSON FOR FAMILIES REORGANIZATION STUDY.**

The commissioner of human services shall evaluate different options to reorganize the Office of Ombudsperson for Families under Minnesota Statutes, section 257.0755, into at least two separate offices, and develop and recommend a corresponding legislative proposal for introduction in the 2022 regular legislative session. The proposal shall also include any recommended reorganization of the community-specific boards under Minnesota Statutes, section 257.0768. The commissioner shall submit a copy of the legislative proposal and a letter describing the reasons for recommending the proposal, the analysis that led to the

recommended proposal, other reorganization options that were considered, and any fiscal impacts or considerations, to the chairs and ranking minority members of the legislative committees with jurisdiction over the Office of Ombudsperson for Families.

Sec. 40. **REPEALER.**

Minnesota Statutes 2020, section 245.4871, subdivision 32a, is repealed.

EFFECTIVE DATE. This section is effective September 30, 2021.

ARTICLE 3
CHILD PROTECTION POLICY

Section 1. Minnesota Statutes 2020, section 256.741, is amended by adding a subdivision to read:

Subd. 12a. **Appeals of good cause determinations.** According to section 256.045, an individual may appeal the determination or redetermination of good cause under this section. To initiate an appeal of a good cause determination or redetermination, the individual must make a request for a state agency hearing in writing within 30 calendar days after the date that a notice of denial for good cause is mailed or otherwise transmitted to the individual. Until a human services judge issues a decision under section 256.0451, subdivision 22, the child support agency shall cease all child support enforcement efforts and shall not report the individual's noncooperation to public assistance agencies.

Sec. 2. Minnesota Statutes 2020, section 256.741, is amended by adding a subdivision to read:

Subd. 12b. **Reporting noncooperation.** The public authority may issue a notice of the individual's noncooperation to each public assistance agency providing public assistance to the individual if:

(1) 30 calendar days have passed since the later of the initial county denial or the date of the denial following the state agency hearing; or

(2) the individual has not cooperated with the child support agency as required in subdivision 5.

Sec. 3. Minnesota Statutes 2020, section 260E.20, subdivision 2, is amended to read:

Subd. 2. **Face-to-face contact.** (a) Upon receipt of a screened in report, the local welfare agency shall ~~conduct a~~ have face-to-face contact with the child reported to be maltreated

and with the child's primary caregiver sufficient to complete a safety assessment and ensure the immediate safety of the child.

(b) The face-to-face contact with the child and primary caregiver shall occur immediately if sexual abuse or substantial child endangerment is alleged and within five calendar days for all other reports. If the alleged offender was not already interviewed as the primary caregiver, the local welfare agency shall also conduct a face-to-face interview with the alleged offender in the early stages of the assessment or investigation. Face-to-face contact with the child and primary caregiver in response to a report alleging sexual abuse or substantial child endangerment may be postponed for no more than five calendar days if the child is residing in a location that is confirmed to restrict contact with the alleged offender as established in guidelines issued by the commissioner, or if the local welfare agency is pursuing a court order for the child's caregiver to produce the child for questioning under section 260E.22, subdivision 5.

(c) At the initial contact with the alleged offender, the local welfare agency or the agency responsible for assessing or investigating the report must inform the alleged offender of the complaints or allegations made against the individual in a manner consistent with laws protecting the rights of the person who made the report. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation.

(d) The local welfare agency or the agency responsible for assessing or investigating the report must provide the alleged offender with an opportunity to make a statement. The alleged offender may submit supporting documentation relevant to the assessment or investigation.

Sec. 4. Minnesota Statutes 2020, section 518.157, subdivision 1, is amended to read:

Subdivision 1. **Implementation; administration.** (a) By January 1, 1998, the chief judge of each judicial district or a designee shall implement one or more parent education programs within the judicial district for the purpose of educating parents about the impact that divorce, the restructuring of families, and judicial proceedings have upon children and families; methods for preventing parenting time conflicts; and dispute resolution options. The chief judge of each judicial district or a designee may require that children attend a separate education program designed to deal with the impact of divorce upon children as part of the parent education program. Each parent education program must enable persons to have timely and reasonable access to education sessions.

(b) The chief judge of each judicial district shall ensure that the judicial district's website includes information on the parent education program or programs required under this section.

Sec. 5. Minnesota Statutes 2020, section 518.157, subdivision 3, is amended to read:

Subd. 3. **Attendance.** (a) In a proceeding under this chapter where the parties have not agreed to custody or a parenting time ~~is contested~~ schedule, the court shall order the parents of a minor child ~~shall attend~~ to attend or take online a minimum of eight hours in an orientation and education program that meets the minimum standards promulgated by the Minnesota Supreme Court.

(b) In all other proceedings involving custody, support, or parenting time the court may order the parents of a minor child to attend a parent education program.

(c) The program shall provide the court with names of persons who fail to attend the parent education program as ordered by the court. Persons who are separated or contemplating involvement in a dissolution, paternity, custody, or parenting time proceeding may attend a parent education program without a court order.

(d) Unless otherwise ordered by the court, participation in a parent education program must begin before an initial case management conference and within 30 days after the first filing with the court or as soon as practicable after that time based on the reasonable availability of classes for the program for the parent. Parent education programs must offer an opportunity to participate at all phases of a pending or postdecree proceeding.

(e) Upon request of a party and a showing of good cause, the court may excuse the party from attending the program. If past or present domestic abuse, as defined in chapter 518B, is alleged, the court shall not require the parties to attend the same parent education sessions and shall enter an order setting forth the manner in which the parties may safely participate in the program.

(f) Before an initial case management conference for a proceeding under this chapter where the parties have not agreed to custody or parenting time, the court shall notify the parties of their option to resolve disagreements, including the development of a parenting plan, through the use of private mediation.

Sec. 6. Minnesota Statutes 2020, section 518.68, subdivision 2, is amended to read:

Subd. 2. **Contents.** The required notices must be substantially as follows:

IMPORTANT NOTICE

1. PAYMENTS TO PUBLIC AGENCY

According to Minnesota Statutes, section 518A.50, payments ordered for maintenance and support must be paid to the public agency responsible for child support enforcement as long as the person entitled to receive the payments is receiving or has applied for public assistance or has applied for support and maintenance collection services. MAIL PAYMENTS TO:

2. DEPRIVING ANOTHER OF CUSTODIAL OR PARENTAL RIGHTS -- A FELONY

A person may be charged with a felony who conceals a minor child or takes, obtains, retains, or fails to return a minor child from or to the child's parent (or person with custodial or visitation rights), according to Minnesota Statutes, section 609.26. A copy of that section is available from any district court clerk.

3. NONSUPPORT OF A SPOUSE OR CHILD -- CRIMINAL PENALTIES

A person who fails to pay court-ordered child support or maintenance may be charged with a crime, which may include misdemeanor, gross misdemeanor, or felony charges, according to Minnesota Statutes, section 609.375. A copy of that section is available from any district court clerk.

4. RULES OF SUPPORT, MAINTENANCE, PARENTING TIME

(a) Payment of support or spousal maintenance is to be as ordered, and the giving of gifts or making purchases of food, clothing, and the like will not fulfill the obligation.

(b) Payment of support must be made as it becomes due, and failure to secure or denial of parenting time is NOT an excuse for nonpayment, but the aggrieved party must seek relief through a proper motion filed with the court.

(c) Nonpayment of support is not grounds to deny parenting time. The party entitled to receive support may apply for support and collection services, file a contempt motion, or obtain a judgment as provided in Minnesota Statutes, section 548.091.

(d) The payment of support or spousal maintenance takes priority over payment of debts and other obligations.

(e) A party who accepts additional obligations of support does so with the full knowledge of the party's prior obligation under this proceeding.

(f) Child support or maintenance is based on annual income, and it is the responsibility of a person with seasonal employment to budget income so that payments are made throughout the year as ordered.

(g) Reasonable parenting time guidelines are contained in Appendix B, which is available from the court administrator.

(h) The nonpayment of support may be enforced through the denial of student grants; interception of state and federal tax refunds; suspension of driver's, recreational, and occupational licenses; referral to the department of revenue or private collection agencies; seizure of assets, including bank accounts and other assets held by financial institutions; reporting to credit bureaus; ~~interest charging,~~ income withholding~~,~~ and contempt proceedings; and other enforcement methods allowed by law.

(i) The public authority may suspend or resume collection of the amount allocated for child care expenses if the conditions of Minnesota Statutes, section 518A.40, subdivision 4, are met.

(j) The public authority may remove or resume a medical support offset if the conditions of Minnesota Statutes, section 518A.41, subdivision 16, are met.

~~(k) The public authority may suspend or resume interest charging on child support judgments if the conditions of Minnesota Statutes, section 548.091, subdivision 1a, are met.~~

5. MODIFYING CHILD SUPPORT

If either the obligor or obligee is laid off from employment or receives a pay reduction, child support may be modified, increased, or decreased. Any modification will only take effect when it is ordered by the court, and will only relate back to the time that a motion is filed. Either the obligor or obligee may file a motion to modify child support, and may request the public agency for help. UNTIL A MOTION IS FILED, THE CHILD SUPPORT OBLIGATION WILL CONTINUE AT THE CURRENT LEVEL. THE COURT IS NOT PERMITTED TO REDUCE SUPPORT RETROACTIVELY.

6. PARENTAL RIGHTS FROM MINNESOTA STATUTES, SECTION 518.17, SUBDIVISION 3

Unless otherwise provided by the Court:

(a) Each party has the right of access to, and to receive copies of, school, medical, dental, religious training, and other important records and information about the minor children. Each party has the right of access to information regarding health or dental insurance available to the minor children. Presentation of a copy of this order to the custodian of a record or other information about the minor children constitutes sufficient authorization for the release of the record or information to the requesting party.

(b) Each party shall keep the other informed as to the name and address of the school of attendance of the minor children. Each party has the right to be informed by school officials about the children's welfare, educational progress and status, and to attend school and parent teacher conferences. The school is not required to hold a separate conference for each party.

(c) In case of an accident or serious illness of a minor child, each party shall notify the other party of the accident or illness, and the name of the health care provider and the place of treatment.

(d) Each party has the right of reasonable access and telephone contact with the minor children.

7. WAGE AND INCOME DEDUCTION OF SUPPORT AND MAINTENANCE

Child support and/or spousal maintenance may be withheld from income, with or without notice to the person obligated to pay, when the conditions of Minnesota Statutes, section 518A.53 have been met. A copy of those sections is available from any district court clerk.

8. CHANGE OF ADDRESS OR RESIDENCE

Unless otherwise ordered, each party shall notify the other party, the court, and the public authority responsible for collection, if applicable, of the following information within ten days of any change: the residential and mailing address, telephone number, driver's license number, Social Security number, and name, address, and telephone number of the employer.

9. COST OF LIVING INCREASE OF SUPPORT AND MAINTENANCE

Basic support and/or spousal maintenance may be adjusted every two years based upon a change in the cost of living (using Department of Labor Consumer Price Index ....., unless otherwise specified in this order) when the conditions of Minnesota Statutes, section 518A.75, are met. Cost of living increases are compounded. A copy of Minnesota Statutes, section 518A.75, and forms necessary to request or contest a cost of living increase are available from any district court clerk.

10. JUDGMENTS FOR UNPAID SUPPORT

If a person fails to make a child support payment, the payment owed becomes a judgment against the person responsible to make the payment by operation of law on or after the date the payment is due, and the person entitled to receive the payment or the public agency may obtain entry and docketing of the judgment WITHOUT NOTICE to the

person responsible to make the payment under Minnesota Statutes, section 548.091. ~~Interest begins to accrue on a payment or installment of child support whenever the unpaid amount due is greater than the current support due, according to Minnesota Statutes, section 548.091, subdivision 1a.~~

11. JUDGMENTS FOR UNPAID MAINTENANCE

(a) A judgment for unpaid spousal maintenance may be entered when the conditions of Minnesota Statutes, section 548.091, are met. A copy of that section is available from any district court clerk.

(b) The public authority is not responsible for calculating interest on any judgment for unpaid spousal maintenance. When providing services in IV-D cases, as defined in Minnesota Statutes, section 518A.26, subdivision 10, the public authority will only collect interest on spousal maintenance if spousal maintenance is reduced to a sum certain judgment.

12. ATTORNEY FEES AND COLLECTION COSTS FOR ENFORCEMENT OF CHILD SUPPORT

A judgment for attorney fees and other collection costs incurred in enforcing a child support order will be entered against the person responsible to pay support when the conditions of Minnesota Statutes, section 518A.735, are met. A copy of Minnesota Statutes, sections 518.14 and 518A.735 and forms necessary to request or contest these attorney fees and collection costs are available from any district court clerk.

13. PARENTING TIME EXPEDITOR PROCESS

On request of either party or on its own motion, the court may appoint a parenting time expeditor to resolve parenting time disputes under Minnesota Statutes, section 518.1751. A copy of that section and a description of the expeditor process is available from any district court clerk.

14. PARENTING TIME REMEDIES AND PENALTIES

Remedies and penalties for the wrongful denial of parenting time are available under Minnesota Statutes, section 518.175, subdivision 6. These include compensatory parenting time; civil penalties; bond requirements; contempt; and reversal of custody. A copy of that subdivision and forms for requesting relief are available from any district court clerk.

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

Sec. 7. Minnesota Statutes 2020, section 518A.29, is amended to read:

518A.29 CALCULATION OF GROSS INCOME.

(a) Subject to the exclusions and deductions in this section, gross income includes any form of periodic payment to an individual, including, but not limited to, salaries, wages, commissions, self-employment income under section 518A.30, workers' compensation, unemployment benefits, annuity payments, military and naval retirement, pension and disability payments, spousal maintenance received under a previous order or the current proceeding, Social Security or veterans benefits provided for a joint child under section 518A.31, and potential income under section 518A.32. Salaries, wages, commissions, or other compensation paid by third parties shall be based upon gross income before participation in an employer-sponsored benefit plan that allows an employee to pay for a benefit or expense using pretax dollars, such as flexible spending plans and health savings accounts. No deductions shall be allowed for contributions to pensions, 401-K, IRA, or other retirement benefits.

(b) Gross income does not include compensation received by a party for employment in excess of a 40-hour work week, provided that:

(1) child support is ordered in an amount at least equal to the guideline amount based on gross income not excluded under this clause; and

(2) the party demonstrates, and the court finds, that:

(i) the excess employment began after the filing of the petition for dissolution or legal separation or a petition related to custody, parenting time, or support;

(ii) the excess employment reflects an increase in the work schedule or hours worked over that of the two years immediately preceding the filing of the petition;

(iii) the excess employment is voluntary and not a condition of employment;

(iv) the excess employment is in the nature of additional, part-time or overtime employment compensable by the hour or fraction of an hour; and

(v) the party's compensation structure has not been changed for the purpose of affecting a support or maintenance obligation.

(c) Expense reimbursements or in-kind payments received by a parent in the course of employment, self-employment, or operation of a business shall be counted as income if they reduce personal living expenses.

(d) Gross income may be calculated on either an annual or monthly basis. Weekly income shall be translated to monthly income by multiplying the weekly income by 4.33.

(e) Gross income does not include a child support payment received by a party. It is a rebuttable presumption that adoption assistance payments, Northstar kinship assistance payments, and foster care subsidies are not gross income.

(f) Gross income does not include the income of the obligor's spouse and the obligee's spouse.

(g) ~~Child support or~~ Spousal maintenance payments ordered by a court for a ~~nonjoint child or~~ former spouse or ordered payable to the other party as part of the current proceeding are deducted from other periodic payments received by a party for purposes of determining gross income.

(h) Gross income does not include public assistance benefits received under section 256.741 or other forms of public assistance based on need.

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

Sec. 8. Minnesota Statutes 2020, section 518A.33, is amended to read:

518A.33 DEDUCTION FROM INCOME FOR NONJOINT CHILDREN.

(a) When either or both parents are legally responsible for a nonjoint child, a deduction for this obligation shall be calculated under this section ~~if:~~.

~~(1) the nonjoint child primarily resides in the parent's household; and~~

~~(2) the parent is not obligated to pay basic child support for the nonjoint child to the other parent or a legal custodian of the child under an existing child support order.~~

(b) ~~The court shall use the guidelines under section 518A.35 to determine the basic child support obligation for the nonjoint child or children by using the gross income of the parent for whom the deduction is being calculated and the number of nonjoint children primarily residing in the parent's household. If the number of nonjoint children to be used for the determination is greater than two, the determination must be made using the number two instead of the greater number.~~ Court-ordered child support for a nonjoint child shall be deducted from the payor's gross income.

(c) ~~The deduction for nonjoint children is 50 percent of the guideline amount determined under paragraph (b).~~ When a parent is legally responsible for a nonjoint child and the parent is not obligated to pay basic child support for the nonjoint child to the other parent or a legal custodian under an existing child support order, a deduction shall be calculated. The court

shall use the basic support guideline table under section 518A.35 to determine this deduction by using the gross income of the parent for whom the deduction is being calculated, minus any deduction under paragraph (b) and the number of eligible nonjoint children, up to six children. The deduction for nonjoint children is 75 percent of the guideline amount determined under this paragraph.

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

Sec. 9. Minnesota Statutes 2020, section 518A.35, subdivision 1, is amended to read:

Subdivision 1. **Determination of support obligation.** (a) The guideline in this section is a rebuttable presumption and shall be used in any judicial or administrative proceeding to establish or modify a support obligation under this chapter.

(b) The basic child support obligation shall be determined by referencing the guideline for the appropriate number of joint children and the combined parental income for determining child support of the parents.

(c) If a child is not in the custody of either parent and a support order is sought against one or both parents, the basic child support obligation shall be determined by referencing the guideline for the appropriate number of joint children, and the parent's individual parental income for determining child support, not the combined parental incomes for determining child support of the parents. Unless a parent has court-ordered parenting time, the parenting expense adjustment formula under section 518A.34 must not be applied.

(d) If a child is ~~in custody of either parent~~ not residing with the parent that has court-ordered or statutory custody and a support order is sought ~~by the public authority~~ under section 256.87 against one or both parents, ~~unless the parent against whom the support order is sought has court-ordered parenting time,~~ the basic support obligation must be determined by referencing the guideline for the appropriate number of joint children and the parent's individual income without application of the parenting expense adjustment formula under section 518A.34.

(e) For combined parental incomes for determining child support exceeding ~~$15,000~~ $20,000 per month, the presumed basic child support obligations shall be as for parents with combined parental income for determining child support of ~~$15,000~~ $20,000 per month. A basic child support obligation in excess of this level may be demonstrated for those reasons set forth in section 518A.43.

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

Sec. 10. Minnesota Statutes 2020, section 518A.35, subdivision 2, is amended to read:

Subd. 2. **Basic support; guideline.** Unless otherwise agreed to by the parents and approved by the court, when establishing basic support, the court must order that basic support be divided between the parents based on their proportionate share of the parents' combined monthly parental income for determining child support (PICS). Basic support must be computed using the following guideline:

Combined Parental Income for Determining Child Support	Number of Children					
	One	Two	Three	Four	Five	Six
$0- ~~$799~~		~~$50~~	~~$75~~	~~$75~~	~~$100~~	
$1,399	$50	$60	$70	$80	$90	$100
~~800- 899~~	~~80~~	~~129~~	~~149~~	~~173~~	~~201~~	~~233~~
~~900- 999~~	~~90~~	~~145~~	~~167~~	~~194~~	~~226~~	~~262~~
~~1,000- 1,099~~	~~116~~	~~161~~	~~186~~	~~216~~	~~251~~	~~291~~
~~1,100- 1,199~~	~~145~~	~~205~~	~~237~~	~~275~~	~~320~~	~~370~~
~~1,200- 1,299~~	~~177~~	~~254~~	~~294~~	~~341~~	~~396~~	~~459~~
~~1,300- 1,399~~	~~212~~	~~309~~	~~356~~	~~414~~	~~480~~	~~557~~
1,400- 1,499	~~251~~ 60	~~368~~ 75	~~425~~ 85	~~493~~ 100	~~573~~ 110	~~664~~ 120
1,500- 1,599	~~292~~ 75	~~433~~ 90	~~500~~ 105	~~580~~ 125	~~673~~ 135	~~780~~ 145
1,600- 1,699	~~337~~ 90	~~502~~ 110	~~580~~ 130	~~673~~ 150	~~781~~ 160	~~905~~ 170
1,700- 1,799	~~385~~ 110	~~577~~ 130	~~666~~ 155	~~773~~ 175	~~897~~ 185	~~1,040~~ 195
1,800- 1,899	~~436~~ 130	~~657~~ 150	~~758~~ 180	~~880~~ 200	~~1,021~~ 210	~~1,183~~ 220
1,900- 1,999	~~490~~ 150	~~742~~ 175	~~856~~ 205	~~994~~ 235	~~1,152~~ 245	~~1,336~~ 255
2,000- 2,099	~~516~~ 170	~~832~~ 200	~~960~~ 235	~~1,114~~ 270	~~1,292~~ 285	~~1,498~~ 295
2,100- 2,199	~~528~~ 190	~~851~~ 225	~~981~~ 265	~~1,139~~ 305	~~1,320~~ 325	~~1,531~~ 335
2,200- 2,299	~~538~~ 215	~~867~~ 255	~~1,000~~ 300	~~1,160~~ 345	~~1,346~~ 367	~~1,561~~ 379
2,300- 2,399	~~546~~ 240	~~881~~ 285	~~1,016~~ 335	~~1,179~~ 385	~~1,367~~ 409	~~1,586~~ 423
2,400- 2,499	~~554~~ 265	~~893~~ 315	~~1,029~~ 370	~~1,195~~ 425	~~1,385~~ 451	~~1,608~~ 467
2,500- 2,599	~~560~~ 290	~~903~~ 350	~~1,040~~ 408	~~1,208~~ 465	~~1,400~~ 493	~~1,625~~ 511

		~~570~~	~~920~~	~~1,060~~	~~1,230~~	~~1,426~~	~~1,655~~
2,600- 2,699		315	385	446	505	535	555
		~~580~~	~~936~~	~~1,078~~	~~1,251~~	~~1,450~~	~~1,683~~
2,700- 2,799		340	420	484	545	577	599
		~~589~~	~~950~~	~~1,094~~	~~1,270~~	~~1,472~~	~~1,707~~
2,800- 2,899		365	455	522	585	619	643
		~~596~~	~~963~~	~~1,109~~	~~1,287~~	~~1,492~~	~~1,730~~
2,900- 2,999		390	490	560	625	661	687
		~~603~~	~~975~~	~~1,122~~	~~1,302~~	~~1,509~~	~~1,749~~
3,000- 3,099		415	525	598	665	703	731
		~~613~~	~~991~~	~~1,141~~	~~1,324~~	~~1,535~~	~~1,779~~
3,100- 3,199		440	560	636	705	745	775
		~~623~~	~~1,007~~	~~1,158~~	~~1,344~~	~~1,558~~	~~1,807~~
3,200- 3,299		465	595	674	745	787	819
		~~636~~	~~1,021~~	~~1,175~~	~~1,363~~	~~1,581~~	~~1,833~~
3,300- 3,399		485	630	712	785	829	863
		~~650~~	~~1,034~~	~~1,190~~	~~1,380~~	~~1,601~~	~~1,857~~
3,400- 3,499		505	665	750	825	871	907
		~~664~~	~~1,047~~	~~1,204~~	~~1,397~~	~~1,621~~	~~1,880~~
3,500- 3,599		525	695	784	861	910	948
		~~677~~	~~1,062~~	~~1,223~~	~~1,418~~	~~1,646~~	~~1,909~~
3,600- 3,699		545	725	818	897	949	989
		~~691~~	~~1,077~~	~~1,240~~	~~1,439~~	~~1,670~~	~~1,937~~
3,700- 3,799		565	755	852	933	988	1,030
		~~705~~	~~1,081~~	~~1,257~~	~~1,459~~	~~1,693~~	~~1,963~~
3,800- 3,899		585	785	886	969	1,027	1,071
		~~719~~	~~1,104~~	~~1,273~~	~~1,478~~	~~1,715~~	~~1,988~~
3,900- 3,999		605	815	920	1,005	1,065	1,111
		~~732~~	~~1,116~~	~~1,288~~	~~1,496~~	~~1,736~~	~~2,012~~
4,000- 4,099		625	845	954	1,041	1,103	1,151
		~~746~~	~~1,132~~	~~1,305~~	~~1,516~~	~~1,759~~	~~2,039~~
4,100- 4,199		645	875	988	1,077	1,142	1,191
		~~760~~	~~1,147~~	~~1,322~~	~~1,536~~	~~1,781~~	~~2,064~~
4,200- 4,299		665	905	1,022	1,113	1,180	1,230
		~~774~~	~~1,161~~	~~1,338~~	~~1,554~~	~~1,802~~	~~2,088~~
4,300- 4,399		685	935	1,056	1,149	1,218	1,269
		~~787~~	~~1,175~~	~~1,353~~	~~1,572~~	~~1,822~~	~~2,111~~
4,400- 4,499		705	965	1,090	1,185	1,256	1,308
		~~801~~	~~1,184~~	~~1,368~~	~~1,589~~	~~1,841~~	~~2,133~~
4,500- 4,599		724	993	1,122	1,219	1,292	1,345
		~~808~~	~~1,200~~	~~1,386~~	~~1,608~~	~~1,864~~	~~2,160~~
4,600- 4,699		743	1,021	1,154	1,253	1,328	1,382
		~~814~~	~~1,215~~	~~1,402~~	~~1,627~~	~~1,887~~	~~2,186~~
4,700- 4,799		762	1,049	1,186	1,287	1,364	1,419
		~~820~~	~~1,231~~	~~1,419~~	~~1,645~~	~~1,908~~	~~2,212~~
4,800- 4,899		781	1,077	1,218	1,321	1,400	1,456

		~~825~~	~~1,246~~	~~1,435~~	~~1,663~~	~~1,930~~	~~2,236~~
4,900- 4,999		800	1,105	1,250	1,354	1,435	1,493
		~~831~~	~~1,260~~	~~1,450~~	~~1,680~~	~~1,950~~	~~2,260~~
5,000- 5,099		818	1,132	1,281	1,387	1,470	1,529
		~~837~~	~~1,275~~	~~1,468~~	~~1,701~~	~~1,975~~	~~2,289~~
5,100- 5,199		835	1,159	1,312	1,420	1,505	1,565
		~~843~~	~~1,290~~	~~1,485~~	~~1,722~~	~~1,999~~	~~2,317~~
5,200- 5,299		852	1,186	1,343	1,453	1,540	1,601
		~~849~~	~~1,304~~	~~1,502~~	~~1,743~~	~~2,022~~	~~2,345~~
5,300- 5,399		869	1,213	1,374	1,486	1,575	1,638
		~~854~~	~~1,318~~	~~1,518~~	~~1,763~~	~~2,046~~	~~2,372~~
5,400- 5,499		886	1,240	1,405	1,519	1,610	1,674
		~~860~~	~~1,331~~	~~1,535~~	~~1,782~~	~~2,068~~	~~2,398~~
5,500- 5,599		903	1,264	1,434	1,550	1,643	1,708
		~~866~~	~~1,346~~	~~1,551~~	~~1,801~~	~~2,090~~	~~2,424~~
5,600- 5,699		920	1,288	1,463	1,581	1,676	1,743
		~~873~~	~~1,357~~	~~1,568~~	~~1,819~~	~~2,111~~	~~2,449~~
5,700- 5,799		937	1,312	1,492	1,612	1,709	1,777
		~~881~~	~~1,376~~	~~1,583~~	~~1,837~~	~~2,132~~	~~2,473~~
5,800- 5,899		954	1,336	1,521	1,643	1,742	1,811
		~~888~~	~~1,390~~	~~1,599~~	~~1,855~~	~~2,152~~	~~2,497~~
5,900- 5,999		971	1,360	1,550	1,674	1,775	1,846
		~~895~~	~~1,404~~	~~1,604~~	~~1,872~~	~~2,172~~	~~2,520~~
6,000- 6,099		988	1,383	1,577	1,703	1,805	1,877
		~~902~~	~~1,419~~	~~1,631~~	~~1,892~~	~~2,195~~	~~2,546~~
6,100- 6,199		993	1,391	1,586	1,713	1,815	1,887
		~~909~~	~~1,433~~	~~1,645~~	~~1,912~~	~~2,217~~	~~2,572~~
6,200- 6,299		999	1,399	1,594	1,722	1,825	1,898
		~~916~~	~~1,448~~	~~1,664~~	~~1,932~~	~~2,239~~	~~2,597~~
6,300- 6,399		1,005	1,406	1,603	1,732	1,836	1,909
		~~923~~	~~1,462~~	~~1,682~~	~~1,951~~	~~2,260~~	~~2,621~~
6,400- 6,499		1,010	1,414	1,612	1,741	1,846	1,920
		~~930~~	~~1,476~~	~~1,697~~	~~1,970~~	~~2,282~~	~~2,646~~
6,500- 6,599		1,016	1,422	1,621	1,751	1,856	1,931
		~~936~~	~~1,490~~	~~1,713~~	~~1,989~~	~~2,305~~	~~2,673~~
6,600- 6,699		1,021	1,430	1,630	1,761	1,866	1,941
		~~943~~	~~1,505~~	~~1,730~~	~~2,009~~	~~2,328~~	~~2,700~~
6,700- 6,799		1,027	1,438	1,639	1,770	1,876	1,951
		~~950~~	~~1,519~~	~~1,746~~	~~2,028~~	~~2,350~~	~~2,727~~
6,800- 6,899		1,032	1,445	1,648	1,780	1,887	1,962
		~~957~~	~~1,533~~	~~1,762~~	~~2,047~~	~~2,379~~	~~2,747~~
6,900- 6,999		1,038	1,453	1,657	1,790	1,897	1,973
		~~963~~	~~1,547~~	~~1,778~~	~~2,065~~	~~2,394~~	~~2,753~~
7,000- 7,099		1,044	1,462	1,666	1,800	1,908	1,984
		~~970~~	~~1,561~~	~~1,795~~	~~2,085~~	~~2,417~~	~~2,758~~
7,100- 7,199		1,050	1,470	1,676	1,810	1,918	1,995

		~~974~~	~~1,574~~	~~1,812~~	~~2,104~~	~~2,439~~	~~2,764~~
	7,200- 7,299	1,056	1,479	1,686	1,821	1,930	2,007
		~~980~~	~~1,587~~	~~1,828~~	~~2,123~~	~~2,462~~	~~2,769~~
	7,300- 7,399	1,063	1,488	1,696	1,832	1,942	2,019
		~~989~~	~~1,600~~	~~1,844~~	~~2,142~~	~~2,483~~	~~2,775~~
	7,400- 7,499	1,069	1,496	1,706	1,843	1,953	2,032
		~~998~~	~~1,613~~	~~1,860~~	~~2,160~~	~~2,505~~	~~2,781~~
	7,500- 7,599	1,075	1,505	1,716	1,854	1,965	2,043
		~~1,006~~	~~1,628~~	~~1,877~~	~~2,180~~	~~2,528~~	~~2,803~~
	7,600- 7,699	1,081	1,514	1,725	1,863	1,975	2,054
		~~1,015~~	~~1,643~~	~~1,894~~	~~2,199~~	~~2,550~~	~~2,833~~
	7,700- 7,799	1,087	1,522	1,735	1,874	1,986	2,066
		~~1,023~~	~~1,658~~	~~1,911~~	~~2,218~~	~~2,572~~	~~2,864~~
	7,800- 7,899	1,093	1,531	1,745	1,885	1,998	2,078
		~~1,032~~	~~1,673~~	~~1,928~~	~~2,237~~	~~2,594~~	~~2,894~~
	7,900- 7,999	1,099	1,540	1,755	1,896	2,009	2,090
		~~1,040~~	~~1,688~~	~~1,944~~	~~2,256~~	~~2,616~~	~~2,925~~
	8,000- 8,099	1,106	1,548	1,765	1,907	2,021	2,102
		~~1,048~~	~~1,703~~	~~1,960~~	~~2,274~~	~~2,637~~	~~2,955~~
	8,100- 8,199	1,112	1,557	1,775	1,917	2,032	2,114
		~~1,056~~	~~1,717~~	~~1,976~~	~~2,293~~	~~2,658~~	~~2,985~~
	8,200- 8,299	1,118	1,566	1,785	1,928	2,044	2,126
		~~1,064~~	~~1,731~~	~~1,992~~	~~2,311~~	~~2,679~~	~~3,016~~
	8,300 -8,399	1,124	1,574	1,795	1,939	2,055	2,137
		~~1,072~~	~~1,746~~	~~2,008~~	~~2,328~~	~~2,700~~	~~3,046~~
	8,400- 8,499	1,131	1,583	1,804	1,949	2,066	2,149
		~~1,080~~	~~1,760~~	~~2,023~~	~~2,346~~	~~2,720~~	~~3,077~~
	8,500- 8,599	1,137	1,592	1,814	1,960	2,078	2,161
		~~1,092~~	~~1,780~~	~~2,047~~	~~2,374~~	~~2,752~~	~~3,107~~
	8,600- 8,699	1,143	1,600	1,824	1,970	2,089	2,173
		~~1,105~~	~~1,801~~	~~2,071~~	~~2,401~~	~~2,784~~	~~3,138~~
	8,700- 8,799	1,149	1,609	1,834	1,981	2,100	2,185
		~~1,118~~	~~1,822~~	~~2,094~~	~~2,429~~	~~2,816~~	~~3,168~~
	8,800- 8,899	1,155	1,618	1,844	1,992	2,112	2,197
		~~1,130~~	~~1,842~~	~~2,118~~	~~2,456~~	~~2,848~~	~~3,199~~
	8,900- 8,999	1,162	1,626	1,854	2,003	2,124	2,209
		~~1,143~~	~~1,863~~	~~2,142~~	~~2,484~~	~~2,880~~	~~3,223~~
	9,000- 9,099	1,168	1,635	1,864	2,014	2,135	2,221
		~~1,156~~	~~1,884~~	~~2,166~~	~~2,512~~	~~2,912~~	~~3,243~~
	9,100- 9,199	1,174	1,644	1,874	2,024	2,146	2,232
		~~1,168~~	~~1,904~~	~~2,190~~	~~2,539~~	~~2,944~~	~~3,263~~
	9,200- 9,299	1,180	1,652	1,884	2,035	2,158	2,244
		~~1,181~~	~~1,925~~	~~2,213~~	~~2,567~~	~~2,976~~	~~3,284~~
	9,300- 9,399	1,186	1,661	1,893	2,045	2,168	2,255
		~~1,194~~	~~1,946~~	~~2,237~~	~~2,594~~	~~3,008~~	~~3,304~~
	9,400- 9,499	1,193	1,670	1,903	2,056	2,179	2,267

		~~1,207~~	~~1,967~~	~~2,261~~	~~2,622~~	~~3,031~~	~~3,324~~
9,500- 9,599		1,199	1,678	1,913	2,066	2,190	2,278
		~~1,219~~	~~1,987~~	~~2,285~~	~~2,650~~	~~3,050~~	~~3,345~~
9,600- 9,699		1,205	1,687	1,923	2,077	2,202	2,290
		~~1,232~~	~~2,008~~	~~2,309~~	~~2,677~~	~~3,069~~	~~3,365~~
9,700- 9,799		1,211	1,696	1,933	2,088	2,214	2,302
		~~1,245~~	~~2,029~~	~~2,332~~	~~2,705~~	~~3,087~~	~~3,385~~
9,800- 9,899		1,217	1,704	1,943	2,099	2,225	2,314
		~~1,257~~	~~2,049~~	~~2,356~~	~~2,732~~	~~3,106~~	~~3,406~~
9,900- 9,999		1,224	1,713	1,953	2,110	2,237	2,326
		~~1,270~~	~~2,070~~	~~2,380~~	~~2,760~~	~~3,125~~	~~3,426~~
10,000-10,099		1,230	1,722	1,963	2,121	2,248	2,338
		~~1,283~~	~~2,091~~	~~2,404~~	~~2,788~~	~~3,144~~	~~3,446~~
10,100-10,199		1,236	1,730	1,973	2,131	2,259	2,350
		~~1,295~~	~~2,111~~	~~2,428~~	~~2,815~~	~~3,162~~	~~3,467~~
10,200-10,299		1,242	1,739	1,983	2,142	2,270	2,361
		~~1,308~~	~~2,132~~	~~2,451~~	~~2,843~~	~~3,181~~	~~3,487~~
10,300-10,399		1,248	1,748	1,992	2,152	2,281	2,373
		~~1,321~~	~~2,153~~	~~2,475~~	~~2,870~~	~~3,200~~	~~3,507~~
10,400-10,499		1,254	1,756	2,002	2,163	2,292	2,384
		~~1,334~~	~~2,174~~	~~2,499~~	~~2,898~~	~~3,218~~	~~3,528~~
10,500-10,599		1,261	1,765	2,012	2,173	2,304	2,396
		~~1,346~~	~~2,194~~	~~2,523~~	~~2,921~~	~~3,237~~	~~3,548~~
10,600-10,699		1,267	1,774	2,022	2,184	2,316	2,409
		~~1,359~~	~~2,215~~	~~2,547~~	~~2,938~~	~~3,256~~	~~3,568~~
10,700-10,799		1,273	1,782	2,032	2,195	2,327	2,420
		~~1,372~~	~~2,236~~	~~2,570~~	~~2,955~~	~~3,274~~	~~3,589~~
10,800-10,899		1,279	1,791	2,042	2,206	2,338	2,432
		~~1,384~~	~~2,256~~	~~2,594~~	~~2,972~~	~~3,293~~	~~3,609~~
10,900-10,999		1,285	1,800	2,052	2,217	2,349	2,444
		~~1,397~~	~~2,277~~	~~2,618~~	~~2,989~~	~~3,312~~	~~3,629~~
11,000-11,099		1,292	1,808	2,061	2,226	2,360	2,455
		~~1,410~~	~~2,294~~	~~2,642~~	~~3,006~~	~~3,331~~	~~3,649~~
11,100-11,199		1,298	1,817	2,071	2,237	2,372	2,467
		~~1,422~~	~~2,306~~	~~2,666~~	~~3,023~~	~~3,349~~	~~3,667~~
11,200-11,299		1,304	1,826	2,081	2,248	2,384	2,479
		~~1,435~~	~~2,319~~	~~2,689~~	~~3,040~~	~~3,366~~	~~3,686~~
11,300-11,399		1,310	1,834	2,091	2,259	2,395	2,491
		~~1,448~~	~~2,331~~	~~2,713~~	~~3,055~~	~~3,383~~	~~3,705~~
11,400-11,499		1,316	1,843	2,101	2,270	2,406	2,503
		~~1,461~~	~~2,344~~	~~2,735~~	~~3,071~~	~~3,400~~	~~3,723~~
11,500-11,599		1,323	1,852	2,111	2,280	2,417	2,514
		~~1,473~~	~~2,356~~	~~2,748~~	~~3,087~~	~~3,417~~	~~3,742~~
11,600-11,699		1,329	1,860	2,121	2,291	2,428	2,526
		~~1,486~~	~~2,367~~	~~2,762~~	~~3,102~~	~~3,435~~	~~3,761~~
11,700-11,799		1,335	1,869	2,131	2,302	2,439	2,537

		~~1,499~~	~~2,378~~	~~2,775~~	~~3,116~~	~~3,452~~	~~3,780~~
	11,800-11,899	1,341	1,878	2,141	2,313	2,451	2,549
		~~1,511~~	~~2,389~~	~~2,788~~	~~3,131~~	~~3,469~~	~~3,798~~
	11,900-11,999	1,347	1,886	2,150	2,323	2,463	2,561
		~~1,524~~	~~2,401~~	~~2,801~~	~~3,146~~	~~3,485~~	~~3,817~~
	12,000-12,099	1,354	1,895	2,160	2,333	2,474	2,573
		~~1,537~~	~~2,412~~	~~2,814~~	~~3,160~~	~~3,501~~	~~3,836~~
	12,100-12,199	1,360	1,904	2,170	2,344	2,485	2,585
		~~1,549~~	~~2,423~~	~~2,828~~	~~3,175~~	~~3,517~~	~~3,854~~
	12,200-12,299	1,366	1,912	2,180	2,355	2,497	2,597
		~~1,562~~	~~2,434~~	~~2,841~~	~~3,190~~	~~3,534~~	~~3,871~~
	12,300-12,399	1,372	1,921	2,190	2,366	2,509	2,609
		~~1,575~~	~~2,445~~	~~2,854~~	~~3,205~~	~~3,550~~	~~3,889~~
	12,400-12,499	1,378	1,930	2,200	2,377	2,520	2,621
		~~1,588~~	~~2,456~~	~~2,867~~	~~3,219~~	~~3,566~~	~~3,907~~
	12,500-12,599	1,385	1,938	2,210	2,387	2,531	2,633
		~~1,600~~	~~2,467~~	~~2,880~~	~~3,234~~	~~3,582~~	~~3,924~~
	12,600-12,699	1,391	1,947	2,220	2,397	2,542	2,644
		~~1,613~~	~~2,478~~	~~2,894~~	~~3,249~~	~~3,598~~	~~3,942~~
	12,700-12,799	1,397	1,956	2,230	2,408	2,553	2,656
		~~1,626~~	~~2,489~~	~~2,907~~	~~3,264~~	~~3,615~~	~~3,960~~
	12,800-12,899	1,403	1,964	2,240	2,419	2,565	2,668
		~~1,638~~	~~2,500~~	~~2,920~~	~~3,278~~	~~3,631~~	~~3,977~~
	12,900-12,999	1,409	1,973	2,250	2,430	2,576	2,680
		~~1,651~~	~~2,512~~	~~2,933~~	~~3,293~~	~~3,647~~	~~3,995~~
	13,000-13,099	1,416	1,982	2,259	2,440	2,587	2,691
		~~1,664~~	~~2,523~~	~~2,946~~	~~3,308~~	~~3,663~~	~~4,012~~
	13,100-13,199	1,422	1,990	2,269	2,451	2,599	2,703
		~~1,676~~	~~2,534~~	~~2,960~~	~~3,322~~	~~3,679~~	~~4,030~~
	13,200-13,299	1,428	1,999	2,279	2,462	2,610	2,715
		~~1,689~~	~~2,545~~	~~2,973~~	~~3,337~~	~~3,696~~	~~4,048~~
	13,300-13,399	1,434	2,008	2,289	2,473	2,622	2,727
		~~1,702~~	~~2,556~~	~~2,986~~	~~3,352~~	~~3,712~~	~~4,065~~
	13,400-13,499	1,440	2,016	2,299	2,484	2,633	2,739
		~~1,715~~	~~2,567~~	~~2,999~~	~~3,367~~	~~3,728~~	~~4,083~~
	13,500-13,599	1,446	2,025	2,309	2,494	2,644	2,751
		~~1,727~~	~~2,578~~	~~3,012~~	~~3,381~~	~~3,744~~	~~4,100~~
	13,600-13,699	1,453	2,034	2,318	2,504	2,655	2,762
		~~1,740~~	~~2,589~~	~~3,026~~	~~3,396~~	~~3,760~~	~~4,118~~
	13,700-13,799	1,459	2,042	2,328	2,515	2,666	2,773
		~~1,753~~	~~2,600~~	~~3,039~~	~~3,411~~	~~3,777~~	~~4,136~~
	13,800-13,899	1,465	2,051	2,338	2,526	2,677	2,784
		~~1,765~~	~~2,611~~	~~3,052~~	~~3,425~~	~~3,793~~	~~4,153~~
	13,900-13,999	1,471	2,060	2,348	2,537	2,688	2,795
		~~1,778~~	~~2,623~~	~~3,065~~	~~3,440~~	~~3,809~~	~~4,171~~
	14,000-14,099	1,477	2,068	2,358	2,547	2,699	2,807

		~~1,791~~	~~2,634~~	~~3,078~~	~~3,455~~	~~3,825~~	~~4,189~~
14,100-14,199		1,484	2,077	2,368	2,558	2,711	2,819
		~~1,803~~	~~2,645~~	~~3,092~~	~~3,470~~	~~3,841~~	~~4,206~~
14,200-14,299		1,490	2,086	2,378	2,569	2,722	2,831
		~~1,816~~	~~2,656~~	~~3,105~~	~~3,484~~	~~3,858~~	~~4,224~~
14,300-14,399		1,496	2,094	2,388	2,580	2,734	2,843
		~~1,829~~	~~2,667~~	~~3,118~~	~~3,499~~	~~3,874~~	~~4,239~~
14,400-14,499		1,502	2,103	2,398	2,590	2,746	2,855
		~~1,842~~	~~2,678~~	~~3,131~~	~~3,514~~	~~3,889~~	~~4,253~~
14,500-14,599		1,508	2,111	2,407	2,600	2,757	2,867
		~~1,854~~	~~2,689~~	~~3,144~~	~~3,529~~	~~3,902~~	~~4,268~~
14,600-14,699		1,515	2,120	2,417	2,611	2,768	2,879
		~~1,864~~	~~2,700~~	~~3,158~~	~~3,541~~	~~3,916~~	~~4,282~~
14,700-14,799		1,521	2,129	2,427	2,622	2,780	2,891
		~~1,872~~	~~2,711~~	~~3,170~~	~~3,553~~	~~3,929~~	~~4,297~~
14,800-14,899		1,527	2,138	2,437	2,633	2,792	2,903
		~~1,879~~	~~2,722~~	~~3,181~~	~~3,565~~	~~3,942~~	~~4,311~~
14,900-14,999		1,533	2,146	2,447	2,643	2,802	2,914
15,000~~, or the amount in effect under subd. 4~~ -15,099		~~1,883~~ 1,539	~~2,727~~ 2,155	~~3,186~~ 2,457	~~3,571~~ 2,654	~~3,949~~ 2,813	~~4,319~~ 2,926
15,100-15,199		1,545	2,163	2,466	2,664	2,825	2,937
15,200-15,299		1,551	2,171	2,476	2,675	2,836	2,949
15,300-15,399		1,557	2,180	2,486	2,685	2,847	2,961
15,400-15,499		1,563	2,188	2,495	2,695	2,858	2,973
15,500-15,599		1,569	2,197	2,505	2,706	2,869	2,985
15,600-15,699		1,575	2,205	2,514	2,716	2,880	2,996
15,700-15,799		1,581	2,214	2,524	2,727	2,891	3,008
15,800-15,899		1,587	2,222	2,534	2,737	2,902	3,019
15,900-15,999		1,593	2,230	2,543	2,747	2,913	3,030
16,000-16,099		1,599	2,239	2,553	2,758	2,924	3,042
16,100-16,199		1,605	2,247	2,562	2,768	2,935	3,053
16,200-16,299		1,611	2,256	2,572	2,779	2,946	3,065
16,300-16,399		1,617	2,264	2,582	2,789	2,957	3,076
16,400-16,499		1,623	2,272	2,591	2,799	2,968	3,088
16,500-16,599		1,629	2,281	2,601	2,810	2,979	3,099
16,600-16,699		1,635	2,289	2,610	2,820	2,990	3,110
16,700-16,799		1,641	2,298	2,620	2,830	3,001	3,121
16,800-16,899		1,647	2,306	2,629	2,840	3,011	3,132
16,900-16,999		1,653	2,315	2,639	2,851	3,022	3,143
17,000-17,099		1,659	2,323	2,649	2,861	3,033	3,155

17,100-17,199	1,665	2,331	2,658	2,871	3,044	3,167
17,200-17,299	1,671	2,340	2,668	2,882	3,055	3,178
17,300-17,399	1,677	2,348	2,677	2,892	3,066	3,189
17,400-17,499	1,683	2,357	2,687	2,902	3,077	3,201
17,500-17,599	1,689	2,365	2,696	2,912	3,088	3,212
17,600-17,699	1,695	2,373	2,705	2,922	3,098	3,223
17,700-17,799	1,701	2,382	2,715	2,932	3,109	3,234
17,800-17,899	1,707	2,390	2,724	2,942	3,119	3,245
17,900-17,999	1,713	2,399	2,734	2,953	3,130	3,256
18,000-18,099	1,719	2,407	2,744	2,963	3,141	3,268
18,100-18,199	1,725	2,415	2,753	2,973	3,152	3,279
18,200-18,299	1,731	2,424	2,763	2,984	3,163	3,290
18,300-18,399	1,737	2,432	2,772	2,994	3,174	3,301
18,400-18,499	1,743	2,441	2,782	3,004	3,185	3,313
18,500-18,599	1,749	2,449	2,791	3,014	3,196	3,324
18,600-18,699	1,755	2,457	2,801	3,024	3,206	3,335
18,700-18,799	1,761	2,466	2,811	3,035	3,217	3,346
18,800-18,899	1,767	2,474	2,820	3,045	3,227	3,357
18,900-18,999	1,773	2,483	2,830	3,056	3,238	3,368
19,000-19,099	1,779	2,491	2,840	3,066	3,249	3,380
19,100-19,199	1,785	2,499	2,849	3,076	3,260	3,392
19,200-19,299	1,791	2,508	2,859	3,087	3,271	3,403
19,300-19,399	1,797	2,516	2,868	3,097	3,282	3,414
19,400-19,499	1,803	2,525	2,878	3,107	3,293	3,426
19,500-19,599	1,809	2,533	2,887	3,117	3,304	3,437
19,600-19,699	1,815	2,541	2,896	3,127	3,315	3,448
19,700-19,799	1,821	2,550	2,906	3,138	3,326	3,459
19,800-19,899	1,827	2,558	2,915	3,148	3,337	3,470
19,900-19,999	1,833	2,567	2,925	3,159	3,348	3,481
20,000 and over or the amount in effect under subdivision 4	1,839	2,575	2,935	3,170	3,359	3,492

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

Sec. 11. Minnesota Statutes 2020, section 518A.39, subdivision 7, is amended to read:

Subd. 7. **Child care exception.** Child care support must be based on the actual child care expenses. The court may provide that a decrease in the amount of the child care based

on a decrease in the actual child care expenses is effective as of the date the expense is decreased. Under section 518A.40, subdivision 4, paragraph (d), a decrease in the amount of child care support shall be effective as of the date the expenses terminated unless otherwise found by the court.

Sec. 12. Minnesota Statutes 2020, section 518A.40, is amended by adding a subdivision to read:

Subd. 3a. **Child care cost information.** (a) Upon the request of the obligor when child care support is ordered to be paid, unless there is a protective or restraining order issued by the court regarding one of the parties or on behalf of a joint child, or the obligee is a participant in the Safe at Home program:

(1) the obligee must give the child care provider the name and address of the obligor and must give the obligor the name, address, and telephone number of the child care provider;

(2) by February 1 of each year, the obligee must provide the obligor with verification from the child care provider that indicates the total child care expenses paid for the previous year; and

(3) when there is a change in the child care provider, the type of child care provider, or the age group of the child, the obligee must provide updated information to the obligor within 30 calendar days. If the obligee fails to provide the annual verification from the provider or updated information, the obligor may request the verification from the provider.

(b) When the obligee is no longer incurring child care expenses, the obligee must notify the obligor, and the public authority if it provides child support services, that the child care expenses ended and on which date. If the public authority is providing services, the public authority must follow the procedure outlined in subdivision 4.

Sec. 13. Minnesota Statutes 2020, section 518A.40, subdivision 4, is amended to read:

Subd. 4. **Change in child care.** (a) When a court order provides for child care expenses, and child care support is not assigned under section 256.741, the public authority, if the public authority provides child support enforcement services, may suspend collecting the amount allocated for child care expenses when either party informs the public authority that no child care ~~costs~~ expenses are being incurred and:

(1) the public authority verifies the accuracy of the information with the obligee; or

(2) the obligee fails to respond within 30 days of the date of a written request from the public authority for information regarding child care costs. A written or oral response from

the obligee that child care costs are being incurred is sufficient for the public authority to continue collecting child care expenses.

The suspension is effective as of the first day of the month following the date that the public authority either verified the information with the obligee or the obligee failed to respond.

The public authority will resume collecting child care expenses when either party provides information that child care costs are incurred, or when a child care support assignment takes effect under section 256.741, subdivision 4. The resumption is effective as of the first day of the month after the date that the public authority received the information.

(b) If the parties provide conflicting information to the public authority regarding whether child care expenses are being incurred, the public authority will continue or resume collecting child care expenses. Either party, by motion to the court, may challenge the suspension, continuation, or resumption of the collection of child care expenses under this subdivision. If the public authority suspends collection activities for the amount allocated for child care expenses, all other provisions of the court order remain in effect.

(c) In cases where there is a substantial increase or decrease in child care expenses, the parties may modify the order under section 518A.39.

(d) In cases where child care expenses have terminated, the parties may modify the order under section 518A.39.

(e) When the public authority is providing child support services, the parties may contact the public authority about the option of a stipulation to modify or terminate the child care support amount.

Sec. 14. Minnesota Statutes 2020, section 518A.42, is amended to read:

518A.42 ABILITY TO PAY; SELF-SUPPORT ADJUSTMENT.

Subdivision 1. **Ability to pay.** (a) It is a rebuttable presumption that a child support order should not exceed the obligor's ability to pay. To determine the amount of child support the obligor has the ability to pay, the court shall follow the procedure set out in this section.

(b) The court shall calculate the obligor's income available for support by subtracting a monthly self-support reserve equal to 120 percent of the federal poverty guidelines for one person from the obligor's ~~gross income~~ parental income for determining child support (PICS). If the obligor's income available for support calculated under this paragraph is equal to or greater than the obligor's support obligation calculated under section 518A.34, the court shall order child support under section 518A.34.

(c) If the obligor's income available for support calculated under paragraph (b) is more than the minimum support amount under subdivision 2, but less than the guideline amount under section 518A.34, then the court shall apply a reduction to the child support obligation in the following order, until the support order is equal to the obligor's income available for support:

(1) medical support obligation;

(2) child care support obligation; and

(3) basic support obligation.

(d) If the obligor's income available for support calculated under paragraph (b) is equal to or less than the minimum support amount under subdivision 2 or if the obligor's gross income is less than 120 percent of the federal poverty guidelines for one person, the minimum support amount under subdivision 2 applies.

Subd. 2. **Minimum basic support amount.** (a) If the basic support amount applies, the court must order the following amount as the minimum basic support obligation:

(1) for one ~~or two children~~ child, the obligor's basic support obligation is $50 per month;

(2) for two children, the obligor's basic support obligation is $60 per month;

(3) for three ~~or four~~ children, the obligor's basic support obligation is ~~$75~~ $70 per month; ~~and~~

(4) for four children, the obligor's basic support obligation is $80 per month;

~~(3)~~ (5) for five ~~or more~~ children, the obligor's basic support obligation is ~~$100~~ $90 per month~~.~~; and

(6) for six or more children, the obligor's basic support obligation is $100 per month.

(b) If the court orders the obligor to pay the minimum basic support amount under this subdivision, the obligor is presumed unable to pay child care support and medical support.

~~If the court finds the obligor receives no income and completely lacks the ability to earn income, the minimum basic support amount under this subdivision does not apply.~~

Subd. 3. **Exception.** (a) This section does not apply to an obligor who is incarcerated.

(b) If the court finds the obligor receives no income and completely lacks the ability to earn income, the minimum basic support amount under this subdivision does not apply.

(c) If the obligor's basic support amount is reduced below the minimum basic support amount due to the application of the parenting expense adjustment, the minimum basic

support amount under this subdivision does not apply and the lesser amount is the guideline basic support.

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

Sec. 15. Minnesota Statutes 2020, section 518A.43, is amended by adding a subdivision to read:

Subd. 1b. **Increase in income of custodial parent.** In a modification of support under section 518A.39, the court may deviate from the presumptive child support obligation under section 518A.34 when the only change in circumstances is an increase to the custodial parent's income and:

(1) the basic support increases;

(2) the parties' combined gross income is $6,000 or less; or

(3) the obligor's income is $2,000 or less.

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

Sec. 16. Minnesota Statutes 2020, section 518A.685, is amended to read:

518A.685 CONSUMER REPORTING AGENCY; REPORTING ARREARS.

(a) If a public authority determines that an obligor has not paid the current monthly support obligation plus any required arrearage payment for three months, the public authority ~~must~~ may report this information to a consumer reporting agency.

(b) Before reporting that an obligor is in arrears for court-ordered child support, the public authority must:

(1) provide written notice to the obligor that the public authority intends to report the arrears to a consumer reporting agency; and

(2) mail the written notice to the obligor's last known mailing address at least 30 days before the public authority reports the arrears to a consumer reporting agency.

(c) The obligor may, within 21 days of receipt of the notice, do the following to prevent the public authority from reporting the arrears to a consumer reporting agency:

(1) pay the arrears in full; ~~or~~

(2) request an administrative review. An administrative review is limited to issues of mistaken identity, a pending legal action involving the arrears, or an incorrect arrears balance~~.~~; or

(3) enter into a written payment agreement pursuant to section 518A.69 that is approved by a court, a child support magistrate, or the public authority responsible for child support enforcement.

(d) A public authority that reports arrearage information under this section must make monthly reports to a consumer reporting agency. The monthly report must be consistent with credit reporting industry standards for child support.

(e) For purposes of this section, "consumer reporting agency" has the meaning given in section 13C.001, subdivision 4, and United States Code, title 15, section 1681a(f).

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

Sec. 17. **[518A.80] MOTION TO TRANSFER TO TRIBAL COURT.**

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

(b) "Case participant" means a person who is a party to the case.

(c) "District court" means a district court of the state of Minnesota.

(d) "Party" means a person or entity named or admitted as a party or seeking to be admitted as a party in the district court action, including the county IV-D agency, regardless of whether the person or entity is named in the caption.

(e) "Tribal court" means a tribal court of a federally recognized Indian tribe located in Minnesota that is receiving funding from the federal government to operate a child support program under United States Code, title 42, chapter 7, subchapter IV, part D, sections 654 to 669b.

(f) "Tribal IV-D agency" has the meaning given in Code of Federal Regulations, title 45, part 309.05.

(g) "Title IV-D child support case" has the meaning given in section 518A.26, subdivision 10.

Subd. 2. **Actions eligible for transfer.** Under this section, a postjudgment child support, custody, or parenting time action is eligible for transfer to a Tribal court. This section does not apply to a child protection action or a dissolution action involving a child.

Subd. 3. **Motion to transfer.** (a) A party's or Tribal IV-D agency's motion to transfer a child support, custody, or parenting time action to a Tribal court shall include:

(1) the address of each case participant;

(2) the Tribal affiliation of each case participant, if applicable;

(3) the name, Tribal affiliation if applicable, and date of birth of each living minor or dependent child of a case participant who is subject to the action; and

(4) the legal and factual basis for the court to find that the district court and a Tribal court have concurrent jurisdiction in the case.

(b) A party or Tribal IV-D agency bringing a motion to transfer a child support, custody, or parenting time action to a Tribal court must file the motion with the district court and serve the required documents on each party and the Tribal IV-D agency, regardless of whether the Tribal IV-D agency is a party to the action.

(c) A party's or Tribal IV-D agency's motion to transfer a child support, custody, or parenting time action to a Tribal court must be accompanied by an affidavit setting forth facts in support of the motion.

(d) When a party other than the Tribal IV-D agency has filed a motion to transfer a child support, custody, or parenting time action to a Tribal court, an affidavit of the Tribal IV-D agency stating whether the Tribal IV-D agency provides services to a party must be filed and served on each party within 15 days from the date of service of the motion to transfer the action.

Subd. 4. **Order to transfer to Tribal court.** (a) Unless a district court holds a hearing under subdivision 6, upon motion of a party or a Tribal IV-D agency, a district court must transfer a postjudgment child support, custody, or parenting time action to a Tribal court when the district court finds that:

(1) the district court and Tribal court have concurrent jurisdiction of the action;

(2) a case participant in the action is receiving services from the Tribal IV-D agency; and

(3) no party or Tribal IV-D agency files and serves a timely objection to transferring the action to a Tribal court.

(b) When the district court finds that each requirement of this subdivision is satisfied, the district court is not required to hold a hearing on the motion to transfer the action to a Tribal court. The district court's order transferring the action to a Tribal court must include written findings that describe how each requirement of this subdivision is met.

Subd. 5. **Objection to motion to transfer.** (a) To object to a motion to transfer a child support, custody, or parenting time action to a Tribal court, a party or Tribal IV-D agency

must file with the court and serve on each party and the Tribal IV-D agency a responsive motion objecting to the motion to transfer within 30 days of the motion to transfer's date of service.

(b) If a party or Tribal IV-D agency files with the district court and properly serves a timely objection to the motion to transfer a child support, custody, or parenting time action to a Tribal court, the district court must hold a hearing on the motion.

Subd. 6. **Hearing.** If a district court holds a hearing under this section, the district court must evaluate and make written findings about all relevant factors, including:

(1) whether an issue requires interpretation of Tribal law, including the Tribal constitution, statutes, bylaws, ordinances, resolutions, treaties, or case law;

(2) whether the action involves Tribal traditional or cultural matters;

(3) whether the tribe is a party to the action;

(4) whether Tribal sovereignty, jurisdiction, or territory is an issue in the action;

(5) the Tribal membership status of each case participant in the action;

(6) where the claim arises that forms the basis of the action;

(7) the location of the residence of each case participant in the action and each child who is a subject of the action;

(8) whether the parties have by contract chosen a forum or the law to be applied in the event of a dispute;

(9) the timing of any motion to transfer the action to a Tribal court, each party's expenditure of time and resources, the court's expenditure of time and resources, and the district court's scheduling order;

(10) which court will hear and decide the action more expeditiously;

(11) the burden on each party if the court transfers the action to a Tribal court, including costs, access to and admissibility of evidence, and matters of procedure; and

(12) any other factor that the court determines to be relevant.

Subd. 7. **Future exercise of jurisdiction.** Nothing in this section shall be construed to limit the district court's exercise of jurisdiction when the Tribal court waives jurisdiction, transfers the action back to district court, or otherwise declines to exercise jurisdiction over the action.

Subd. 8. **Transfer to Red Lake Nation Tribal Court.** When a party or Tribal IV-D agency brings a motion to transfer a child support, custody, or parenting time action to the Red Lake Nation Tribal Court, the court must transfer the action to the Red Lake Nation Tribal Court if the case participants and child resided within the boundaries of the Red Lake Reservation for six months preceding the motion to transfer the action to the Red Lake Nation Tribal Court.

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

Sec. 18. Minnesota Statutes 2020, section 548.091, subdivision 1a, is amended to read:

Subd. 1a. **Child support judgment by operation of law.** ~~(a)~~ Any payment or installment of support required by a judgment or decree of dissolution or legal separation, determination of parentage, an order under chapter 518C, an order under section 256.87, or an order under section 260B.331 or 260C.331, that is not paid or withheld from the obligor's income as required under section 518A.53, or which is ordered as child support by judgment, decree, or order by a court in any other state, is a judgment by operation of law on and after the date it is due, is entitled to full faith and credit in this state and any other state, and shall be entered and docketed by the court administrator on the filing of affidavits as provided in subdivision 2a. ~~Except as otherwise provided by paragraphs (b) and (c), interest accrues from the date the unpaid amount due is greater than the current support due at the annual rate provided in section 549.09, subdivision 1, not to exceed an annual rate of 18 percent.~~ A payment or installment of support that becomes a judgment by operation of law between the date on which a party served notice of a motion for modification under section 518A.39, subdivision 2, and the date of the court's order on modification may be modified under that subdivision. Interest does not accrue on a judgment for child support, confinement and pregnancy expenses, or genetic testing fees.

~~(b) Notwithstanding the provisions of section 549.09, upon motion to the court and upon proof by the obligor of 12 consecutive months of complete and timely payments of both current support and court-ordered paybacks of a child support debt or arrearage, the court may order interest on the remaining debt or arrearage to stop accruing. Timely payments are those made in the month in which they are due. If, after that time, the obligor fails to make complete and timely payments of both current support and court-ordered paybacks of child support debt or arrearage, the public authority or the obligee may move the court for the reinstatement of interest as of the month in which the obligor ceased making complete and timely payments.~~

~~The court shall provide copies of all orders issued under this section to the public authority. The state court administrator shall prepare and make available to the court and the parties forms to be submitted by the parties in support of a motion under this paragraph.~~

~~(c) Notwithstanding the provisions of section 549.09, upon motion to the court, the court may order interest on a child support debt or arrearage to stop accruing where the court finds that the obligor is:~~

~~(1) unable to pay support because of a significant physical or mental disability;~~

~~(2) a recipient of Supplemental Security Income (SSI), Title II Older Americans Survivor's Disability Insurance (OASDI), other disability benefits, or public assistance based upon need; or~~

~~(3) institutionalized or incarcerated for at least 30 days for an offense other than nonsupport of the child or children involved, and is otherwise financially unable to pay support.~~

~~(d) If the conditions in paragraph (c) no longer exist, upon motion to the court, the court may order interest accrual to resume retroactively from the date of service of the motion to resume the accrual of interest.~~

~~(e) Notwithstanding section 549.09, the public authority must suspend the charging of interest when:~~

~~(1) the obligor makes a request to the public authority that the public authority suspend the charging of interest;~~

~~(2) the public authority provides full IV-D child support services; and~~

~~(3) the obligor has made, through the public authority, 12 consecutive months of complete and timely payments of both current support and court-ordered paybacks of a child support debt or arrearage.~~

~~Timely payments are those made in the month in which they are due.~~

~~Interest charging must be suspended on the first of the month following the date of the written notice of the public authority's action to suspend the charging of interest. If, after interest charging has been suspended, the obligor fails to make complete and timely payments of both current support and court-ordered paybacks of child support debt or arrearage, the public authority may resume the charging of interest as of the first day of the month in which the obligor ceased making complete and timely payments.~~

~~The public authority must provide written notice to the parties of the public authority's action to suspend or resume the charging of interest. The notice must inform the parties of the right to request a hearing to contest the public authority's action. The notice must be sent by first class mail to the parties' last known addresses.~~

~~A party may contest the public authority's action to suspend or resume the charging of interest if the party makes a written request for a hearing within 30 days of the date of written notice. If a party makes a timely request for a hearing, the public authority must schedule a hearing and send written notice of the hearing to the parties by mail to the parties' last known addresses at least 14 days before the hearing. The hearing must be conducted in district court or in the expedited child support process if section 484.702 applies. The district court or child support magistrate must determine whether suspending or resuming the interest charging is appropriate and, if appropriate, the effective date.~~

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

Sec. 19. Minnesota Statutes 2020, section 548.091, subdivision 2a, is amended to read:

Subd. 2a. **Entry and docketing of child support judgment.** (a) On or after the date an unpaid amount becomes a judgment by operation of law under subdivision 1a, the obligee or the public authority may file with the court administrator:

(1) a statement identifying, or a copy of, the judgment or decree of dissolution or legal separation, determination of parentage, order under chapter 518B or 518C, an order under section 256.87, an order under section 260B.331 or 260C.331, or judgment, decree, or order for child support by a court in any other state, which provides for periodic installments of child support, or a judgment or notice of attorney fees and collection costs under section 518A.735;

(2) an affidavit of default. The affidavit of default must state the full name, occupation, place of residence, and last known post office address of the obligor, the name of the obligee, the date or dates payment was due and not received and judgment was obtained by operation of law, the total amount of the judgments to be entered and docketed; and

(3) an affidavit of service of a notice of intent to enter and docket judgment and to recover attorney fees and collection costs on the obligor, in person or by first class mail at the obligor's last known post office address. Service is completed upon mailing in the manner designated. Where applicable, a notice of interstate lien in the form promulgated under United States Code, title 42, section 652(a), is sufficient to satisfy the requirements of clauses (1) and (2).

(b) A judgment entered and docketed under this subdivision has the same effect and is subject to the same procedures, defenses, and proceedings as any other judgment in district court, and may be enforced or satisfied in the same manner as judgments under section 548.09, except as otherwise provided.

(c) A judgment entered and docketed under this subdivision is not subject to interest charging or accrual.

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

Sec. 20. Minnesota Statutes 2020, section 548.091, subdivision 3b, is amended to read:

Subd. 3b. **Child support judgment administrative renewals.** Child support judgments may be renewed by service of notice upon the debtor. Service must be by first class mail at the last known address of the debtor, with service deemed complete upon mailing in the manner designated, or in the manner provided for the service of civil process. Upon the filing of the notice and proof of service, the court administrator shall administratively renew the judgment for child support without any additional filing fee in the same court file as the original child support judgment. The judgment must be renewed in an amount equal to the unpaid principal plus the ~~accrued~~ unpaid interest accrued prior to August 1, 2022. Child support judgments may be renewed multiple times until paid.

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

Sec. 21. Minnesota Statutes 2020, section 548.091, subdivision 9, is amended to read:

Subd. 9. **Payoff statement.** The public authority shall issue to the obligor, attorneys, lenders, and closers, or their agents, a payoff statement setting forth conclusively the amount necessary to satisfy the lien. Payoff statements must be issued within three business days after receipt of a request by mail, personal delivery, telefacsimile, or electronic mail transmission, and must be delivered to the requester by telefacsimile or electronic mail transmission if requested and if appropriate technology is available to the public authority. If the payoff statement includes amounts for unpaid maintenance, the statement shall specify that the public authority does not calculate accrued interest and that an interest balance in addition to the payoff statement may be owed.

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

Sec. 22. Minnesota Statutes 2020, section 548.091, subdivision 10, is amended to read:

Subd. 10. **Release of lien.** Upon payment of the child support amount due, the public authority shall execute and deliver a satisfaction of the judgment lien within five business days. The public authority is not responsible for satisfaction of judgments for unpaid maintenance.

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

Sec. 23. Minnesota Statutes 2020, section 549.09, subdivision 1, is amended to read:

Subdivision 1. **When owed; rate.** (a) When a judgment or award is for the recovery of money, including a judgment for the recovery of taxes, interest from the time of the verdict, award, or report until judgment is finally entered shall be computed by the court administrator or arbitrator as provided in paragraph (c) and added to the judgment or award.

(b) Except as otherwise provided by contract or allowed by law, preverdict, preaward, or prereport interest on pecuniary damages shall be computed as provided in paragraph (c) from the time of the commencement of the action or a demand for arbitration, or the time of a written notice of claim, whichever occurs first, except as provided herein. The action must be commenced within two years of a written notice of claim for interest to begin to accrue from the time of the notice of claim. If either party serves a written offer of settlement, the other party may serve a written acceptance or a written counteroffer within 30 days. After that time, interest on the judgment or award shall be calculated by the judge or arbitrator in the following manner. The prevailing party shall receive interest on any judgment or award from the time of commencement of the action or a demand for arbitration, or the time of a written notice of claim, or as to special damages from the time when special damages were incurred, if later, until the time of verdict, award, or report only if the amount of its offer is closer to the judgment or award than the amount of the opposing party's offer. If the amount of the losing party's offer was closer to the judgment or award than the prevailing party's offer, the prevailing party shall receive interest only on the amount of the settlement offer or the judgment or award, whichever is less, and only from the time of commencement of the action or a demand for arbitration, or the time of a written notice of claim, or as to special damages from when the special damages were incurred, if later, until the time the settlement offer was made. Subsequent offers and counteroffers supersede the legal effect of earlier offers and counteroffers. For the purposes of clause (2), the amount of settlement offer must be allocated between past and future damages in the same proportion as determined by the trier of fact. Except as otherwise provided by contract or allowed by law, preverdict, preaward, or prereport interest shall not be awarded on the following:

(1) judgments, awards, or benefits in workers' compensation cases, but not including third-party actions;

(2) judgments or awards for future damages;

(3) punitive damages, fines, or other damages that are noncompensatory in nature;

(4) judgments or awards not in excess of the amount specified in section 491A.01; and

(5) that portion of any verdict, award, or report which is founded upon interest, or costs, disbursements, attorney fees, or other similar items added by the court or arbitrator.

(c)(1)(i) For a judgment or award of $50,000 or less or a judgment or award for or against the state or a political subdivision of the state, regardless of the amount, or a judgment or award in a family court action, except for a child support judgment, regardless of the amount, the interest shall be computed as simple interest per annum. The rate of interest shall be based on the secondary market yield of one year United States Treasury bills, calculated on a bank discount basis as provided in this section.

On or before the 20th day of December of each year the state court administrator shall determine the rate from the one-year constant maturity treasury yield for the most recent calendar month, reported on a monthly basis in the latest statistical release of the board of governors of the Federal Reserve System. This yield, rounded to the nearest one percent, or four percent, whichever is greater, shall be the annual interest rate during the succeeding calendar year. The state court administrator shall communicate the interest rates to the court administrators and sheriffs for use in computing the interest on verdicts and shall make the interest rates available to arbitrators.

This item applies to any section that references section 549.09 by citation for the purposes of computing an interest rate on any amount owed to or by the state or a political subdivision of the state, regardless of the amount.

(ii) The court, in a family court action, may order a lower interest rate or no interest rate if the parties agree or if the court makes findings explaining why application of a lower interest rate or no interest rate is necessary to avoid causing an unfair hardship to the debtor. This item does not apply to child support or spousal maintenance judgments subject to section 548.091.

(2) For a judgment or award over $50,000, other than a judgment or award for or against the state or a political subdivision of the state or a judgment or award in a family court action, the interest rate shall be ten percent per year until paid.

(3) When a judgment creditor, or the judgment creditor's attorney or agent, has received a payment after entry of judgment, whether the payment is made voluntarily by or on behalf of the judgment debtor, or is collected by legal process other than execution levy where a proper return has been filed with the court administrator, the judgment creditor, or the judgment creditor's attorney, before applying to the court administrator for an execution shall file with the court administrator an affidavit of partial satisfaction. The affidavit must state the dates and amounts of payments made upon the judgment after the most recent affidavit of partial satisfaction filed, if any; the part of each payment that is applied to taxable disbursements and to accrued interest and to the unpaid principal balance of the judgment; and the accrued, but the unpaid interest owing, if any, after application of each payment.

(4) Interest shall not accrue on child support judgments.

(d) This section does not apply to arbitrations between employers and employees under chapter 179 or 179A. An arbitrator is neither required to nor prohibited from awarding interest under chapter 179 or under section 179A.16 for essential employees.

(e) For purposes of this subdivision:

(1) "state" includes a department, board, agency, commission, court, or other entity in the executive, legislative, or judicial branch of the state; and

(2) "political subdivision" includes a town, statutory or home rule charter city, county, school district, or any other political subdivision of the state.

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

ARTICLE 4
BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2020, section 245.4889, subdivision 1, is amended to read:

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

(1) counties;

(2) Indian tribes;

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

(4) mental health service providers.

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

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

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

(3) respite care services for children with emotional disturbances or severe emotional disturbances who are at risk of out-of-home placement. A child is not required to have case management services to receive respite care services;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

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

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

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

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

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

(11) mental health first aid training;

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

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

(14) early childhood mental health consultation;

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

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

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

(18) evidence-informed interventions for youth and young adults who are at risk of developing a mood disorder or are experiencing an emerging mood disorder, including major depression and bipolar disorders, and a public awareness campaign on the signs and symptoms of mood disorders in youth and young adults.

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

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

Sec. 2. Minnesota Statutes 2020, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification process for certified community behavioral health clinics (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this section to be eligible for reimbursement under medical assistance, without service area limits based on geographic area or region. The commissioner shall consult with CCBHC stakeholders before establishing and implementing changes in the certification process and requirements. Entities that choose to be CCBHCs must:

~~(1) comply with the CCBHC criteria published by the United States Department of Health and Human Services;~~

(1) comply with state licensing requirements and other requirements issued by the commissioner;

(2) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors, and staff who are culturally and linguistically trained to meet the needs of the population the clinic serves;

(3) ensure that clinic services are available and accessible to individuals and families of all ages and genders and that crisis management services are available 24 hours per day;

(4) establish fees for clinic services for individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to an individual's inability to pay for services;

(5) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

(6) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services, through existing mobile crisis services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans~~;~~. CCBHCs must directly provide the majority of these services to enrollees, but may coordinate some services with another entity through a collaboration or agreement, pursuant to paragraph (b);

(7) provide coordination of care across settings and providers to ensure seamless transitions for individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be certified as mental health clinics under section 245.69, subdivision 2;

(9) comply with standards established by the commissioner relating to ~~mental health services in Minnesota Rules, parts 9505.0370 to 9505.0372~~ CCBHC screenings, assessments, and evaluations;

(10) be licensed to provide substance use disorder treatment under chapter 245G;

(11) be certified to provide children's therapeutic services and supports under section 256B.0943;

(12) be certified to provide adult rehabilitative mental health services under section 256B.0623;

(13) be enrolled to provide mental health crisis response services under ~~sections~~ section 256B.0624 ~~and 256B.0944~~;

(14) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

(15) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926;

(16) provide services that comply with the evidence-based practices described in paragraph (e); and

(17) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer services are provided.

(b) If ~~an entity~~ a certified CCBHC is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the ~~commissioner may certify the entity as a~~ CCBHC~~, if the entity has a current~~ may contract with another entity that has the required authority to provide that service and that meets ~~federal CCBHC~~ the following criteria as a designated collaborating organization~~, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.~~:

(1) the entity has a formal agreement with the CCBHC to furnish one or more of the services under paragraph (a), clause (6);

(2) the entity provides assurances that it will provide services according to CCBHC service standards and provider requirements;

(3) the entity agrees that the CCBHC is responsible for coordinating care and has clinical and financial responsibility for the services that the entity provides under the agreement; and

(4) the entity meets any additional requirements issued by the commissioner.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under section 256B.0625, subdivision 5m, for those services without a county contract or county approval. As part of

the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

(f) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

Sec. 3. Minnesota Statutes 2020, section 245.735, subdivision 5, is amended to read:

Subd. 5. **Information systems support.** The commissioner and the state chief information officer shall provide information systems support to the projects as necessary to comply with state and federal requirements.

Sec. 4. Minnesota Statutes 2020, section 245.735, is amended by adding a subdivision to read:

Subd. 6. **Demonstration entities.** The commissioner may operate the demonstration program established by section 223 of the Protecting Access to Medicare Act if federal funding for the demonstration program remains available from the United States Department of Health and Human Services. To the extent practicable, the commissioner shall align the requirements of the demonstration program with the requirements under this section for CCBHCs receiving medical assistance reimbursement. A CCBHC may not apply to participate as a billing provider in both the CCBHC federal demonstration and the benefit for CCBHCs under the medical assistance program.

Sec. 5. Minnesota Statutes 2020, section 245A.043, subdivision 3, is amended to read:

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

(b) The party must submit a license application under this chapter on the form and in the manner prescribed by the commissioner at least 30 days before the change in ownership is complete, and must include documentation to support the upcoming change. The party must comply with background study requirements under chapter 245C and shall pay the application fee required under section 245A.10. ~~A party that intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service is exempt from the requirements of Minnesota Rules, part 9530.6800.~~

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

(d) Except when a temporary change in ownership license is issued pursuant to subdivision 4, the existing license holder is solely responsible for operating the program

according to applicable laws and rules until a license under this chapter is issued to the party.

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

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

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

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

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

Sec. 6. Minnesota Statutes 2020, section 245F.04, subdivision 2, is amended to read:

Subd. 2. **Contents of application.** Prior to the issuance of a license, an applicant must submit, on forms provided by the commissioner, documentation demonstrating the following:

(1) compliance with this section;

(2) compliance with applicable building, fire, and safety codes; health rules; zoning ordinances; and other applicable rules and regulations or documentation that a waiver has been granted. The granting of a waiver does not constitute modification of any requirement of this section; and

(3) ~~completion of an assessment of need for a new or expanded program as required by Minnesota Rules, part 9530.6800; and~~

~~(4)~~ insurance coverage, including bonding, sufficient to cover all patient funds, property, and interests.

Sec. 7. Minnesota Statutes 2020, section 245G.03, subdivision 2, is amended to read:

Subd. 2. **Application.** (a) Before the commissioner issues a license, an applicant must submit, on forms provided by the commissioner, any documents the commissioner requires.

(b) At least 60 days prior to submitting an application for licensure under this chapter, the applicant must notify the county human services director in writing of the applicant's intent to open a new treatment program. The written notification must include, at a minimum:

(1) a description of the proposed treatment program;

(2) a description of the target population served by the treatment program; and

(3) a copy of the program's abuse prevention plan, required by section 245A.65, subdivision 2.

(c) The county human services director may submit a written statement to the commissioner regarding the county's support of or opposition to opening the new treatment program. The written statement must include documentation of the rationale for the county's determination. The commissioner shall consider the county's written statement when determining whether to issue a license for the treatment program. If the county does not submit a written statement, the commissioner shall confirm with the county that the county received the notification required by paragraph (b).

Sec. 8. **[245G.031] ALTERNATIVE LICENSING INSPECTIONS.**

Subdivision 1. **Eligibility for an alternative licensing inspection.** (a) A license holder providing services licensed under this chapter, with a qualifying accreditation and meeting the eligibility criteria in paragraphs (b) and (c), may request approval for an alternative licensing inspection when all services provided under the license holder's license are accredited. A license holder with a qualifying accreditation and meeting the eligibility criteria in paragraphs (b) and (c) may request approval for an alternative licensing inspection for individual community residential settings or day services facilities licensed under this chapter.

(b) In order to be eligible for an alternative licensing inspection, the program must have had at least one inspection by the commissioner following issuance of the initial license.

(c) In order to be eligible for an alternative licensing inspection, the program must have been in substantial and consistent compliance at the time of the last licensing inspection and during the current licensing period. For purposes of this section, "substantial and consistent compliance" means:

(1) the license holder's license was not made conditional, suspended, or revoked;

(2) there have been no substantiated allegations of maltreatment against the license holder within the past ten years; and

(3) the license holder maintained substantial compliance with the other requirements of chapters 245A and 245C and other applicable laws and rules.

(d) For the purposes of this section, the license holder's license includes services licensed under this chapter that were previously licensed under chapter 245A or Minnesota Rules, chapter 9530, until January 1, 2018.

Subd. 2. **Qualifying accreditation.** The commissioner must accept an accreditation from the joint commission as a qualifying accreditation.

Subd. 3. **Request for approval of an alternative inspection status.** (a) A request for an alternative inspection must be made on the forms and in the manner prescribed by the commissioner. When submitting the request, the license holder must submit all documentation issued by the accrediting body verifying that the license holder has obtained and maintained the qualifying accreditation and has complied with recommendations or requirements from the accrediting body during the period of accreditation. Based on the request and the additional required materials, the commissioner may approve an alternative inspection status.

(b) The commissioner must notify the license holder in writing that the request for an alternative inspection status has been approved. Approval must be granted until the end of the qualifying accreditation period.

(c) The license holder must submit a written request for approval of an alternative inspection status to be renewed one month before the end of the current approval period according to the requirements in paragraph (a). If the license holder does not submit a request to renew approval of an alternative inspection status as required, the commissioner must conduct a licensing inspection.

Subd. 4. **Programs approved for alternative licensing inspection; deemed compliance licensing requirements.** (a) A license holder approved for alternative licensing inspection under this section is required to maintain compliance with all licensing standards according to this chapter.

(b) A license holder approved for alternative licensing inspection under this section is deemed to be in compliance with all the requirements of this chapter, and the commissioner must not perform routine licensing inspections.

(c) Upon receipt of a complaint regarding the services of a license holder approved for alternative licensing inspection under this section, the commissioner must investigate the complaint and may take any action as provided under section 245A.06 or 245A.07.

Subd. 5. **Investigations of alleged or suspected maltreatment.** Nothing in this section changes the commissioner's responsibilities to investigate alleged or suspected maltreatment of a minor under chapter 260E or a vulnerable adult under section 626.557.

Subd. 6. **Termination or denial of subsequent approval.** Following approval of an alternative licensing inspection, the commissioner may terminate or deny subsequent approval of an alternative licensing inspection if the commissioner determines that:

(1) the license holder has not maintained the qualifying accreditation;

(2) the commissioner has substantiated maltreatment for which the license holder or facility is determined to be responsible during the qualifying accreditation period; or

(3) during the qualifying accreditation period, the license holder has been issued an order for conditional license, fine, suspension, or license revocation that has not been reversed upon appeal.

Subd. 7. **Appeals.** The commissioner's decision that the conditions for approval for an alternative licensing inspection have not been met is subject to appeal under the provisions of chapter 14.

Subd. 8. **Commissioner's programs.** Substance use disorder treatment services licensed under this chapter for which the commissioner is the license holder with a qualifying accreditation are excluded from being approved for an alternative licensing inspection.

EFFECTIVE DATE. This section is effective September 1, 2021.

Sec. 9. Minnesota Statutes 2020, section 246.54, subdivision 1b, is amended to read:

Subd. 1b. **Community behavioral health hospitals.** A county's payment of the cost of care provided at state-operated community-based behavioral health hospitals for adults and children shall be according to the following schedule:

(1) 100 percent for each day during the stay, including the day of admission, when the facility determines that it is clinically appropriate for the client to be discharged; and

(2) the county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

Sec. 10. **[254B.17] SCHOOL-LINKED SUBSTANCE ABUSE GRANTS.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish a school-linked substance abuse grant program to provide early identification of and intervention for secondary school students with substance use disorder needs, and to build the capacity of secondary schools to support students with substance use disorder needs in the classroom.

Subd. 2. **Eligible applicant.** (a) An eligible applicant for a school-linked substance abuse grant is an entity or individual that is:

(1) licensed under chapter 245G and in compliance with the general requirements in chapters 245A, 245C, and 260E, section 626.557, and Minnesota Rules, chapter 9544; or

(2) an alcohol and drug counselor licensed under chapter 148F and in compliance with section 245G.11, subdivision 5.

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses may include but are not limited to:

(1) identifying and diagnosing substance use disorders of students;

(2) delivering substance use disorder treatment and services to students and their families, including via telemedicine;

(3) supporting families in meeting their child's needs, including navigating health care, social service, and juvenile justice systems;

(4) providing transportation for students receiving school-linked substance use disorder treatment services when school is not in session;

(5) building the capacity of schools to meet the needs of students with substance use disorder concerns, including school staff development activities for licensed and nonlicensed staff; and

(6) purchasing equipment, connection charges, on-site coordination, setup fees, and site fees in order to deliver school-linked substance use disorder treatment services via telemedicine.

(b) Grantees shall obtain all available third-party reimbursement sources as a condition of receiving a grant. For purposes of the grant program, a third-party reimbursement source excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve each student regardless of the student's health coverage status or ability to pay.

(c) Prior to issuing a request for proposals for grants under this section, the commissioner shall award grants to eligible applicants that are currently providing substance use disorder treatment services in secondary schools or that are currently providing school-linked mental health services but have the demonstrated capacity to provide allowable substance use disorder treatment services in secondary schools.

Subd. 4. **Data collection and outcome measurement.** Grantees shall provide data to the commissioner for the purpose of evaluating the effectiveness of the school-linked substance use disorder treatment grant program.

Sec. 11. Minnesota Statutes 2020, section 256B.0624, subdivision 7, is amended to read:

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; and

(3) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing

which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(c) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization services, the residential staff must include, for at least eight hours per day, at least one individual who meets the qualifications in subdivision 8, paragraph (a), clause (1) or (2). The commissioner shall establish a statewide per diem rate for crisis stabilization services provided under this paragraph to medical assistance enrollees. The rate for a provider shall not exceed the rate charged by that provider for the same service to other payers. Payment shall not be made to more than one entity for each individual for services provided under this paragraph on a given day. The commissioner shall set rates prospectively for the annual rate period. The commissioner shall require providers to submit annual cost reports on a uniform cost reporting form and shall use submitted cost reports to inform the rate-setting process. The commissioner shall recalculate the statewide per diem every year.

(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.

EFFECTIVE DATE. This section is effective August 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 12. Minnesota Statutes 2020, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers certified community behavioral health clinic (CCBHC) services that meet the requirements of section 245.735, subdivision 3.

(b) The commissioner shall ~~establish standards and methodologies for a~~ reimburse CCBHCs on a per-visit basis under the prospective payment system for medical assistance payments ~~for services delivered by a CCBHC, in accordance with guidance issued by the Centers for Medicare and Medicaid Services~~ as described in paragraph (c). The commissioner

shall include a quality ~~bonus~~ incentive payment in the prospective payment system ~~based on federal criteria~~as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC prospective payment system.

(c) ~~Unless otherwise indicated in applicable federal requirements, the prospective payment system must continue to be based on the federal instructions issued for the federal section 223 CCBHC demonstration, except:~~ The commissioner shall ensure that the prospective payment system for CCBHC payments under medical assistance meets the following requirements:

(1) the prospective payment rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable costs for CCBHCs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment shall be limited to one payment per day per medical assistance enrollee for each CCBHC visit eligible for reimbursement. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) new payment rates set by the commissioner for newly certified CCBHCs under section 245.735, subdivision 3, shall be based on rates for established CCBHCs with a similar scope of services. If no comparable CCBHC exists, the commissioner shall establish a clinic-specific rate using audited historical cost report data adjusted for the estimated cost of delivering CCBHC services, including the estimated cost of providing the full scope of services and the projected change in visits resulting from the change in scope;

~~(1)~~ (4) the commissioner shall rebase CCBHC rates ~~at least~~ once every three years and 12 months following an initial rate or a rate change due to a change in the scope of services, whichever is earlier;

~~(2)~~ (5) the commissioner shall provide for a 60-day appeals process after notice of the results of the rebasing;

~~(3) the prohibition against inclusion of new facilities in the demonstration does not apply after the demonstration ends;~~

~~(4)~~ (6) the prospective payment rate under this section does not apply to services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. An entity that receives a prospective payment system rate that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

~~(5)~~ (7) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the prospective payment system in the Medicaid Management Information System (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

~~(6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for changes in the scope of services;~~

~~(7)~~ (8) the prospective payment rate for each CCBHC shall be ~~adjusted annually~~ updated by trending each provider-specific rate by the Medicare Economic Index ~~as defined for the federal section 223 CCBHC demonstration~~ for primary care services. This update shall occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Rate adjustments for changes in scope shall occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

~~(8) the commissioner shall seek federal approval for a CCBHC rate methodology that allows for rate modifications based on changes in scope for an individual CCBHC, including for changes to the type, intensity, or duration of services. Upon federal approval, a CCBHC may submit a change of scope request to the commissioner if the change in scope would result in a change of 2.5 percent or more in the prospective payment system rate currently~~

~~received by the CCBHC. CCBHC change of scope requests must be according to a format and timeline to be determined by the commissioner in consultation with CCBHCs.~~

(d) Managed care plans and county-based purchasing plans shall reimburse CCBHC providers at the prospective payment rate. The commissioner shall monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

(e) The commissioner shall implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments for which the CCBHC is eligible under the prospective payment system described in paragraph (c);

(2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC shall receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner shall notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section shall be submitted directly to, and paid by, the commissioner on the dates specified no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42,

section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by managed care plans.

If the conditions in this paragraph are met between January 1 and June 30 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on January 1 of the following year. If the conditions in this paragraph are met between July 1 and December 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on July 1 of the following year.

Sec. 13. Minnesota Statutes 2020, section 256B.0759, subdivision 2, is amended to read:

Subd. 2. **Provider participation.** (a) Outpatient substance use disorder treatment providers may elect to participate in the demonstration project and meet the requirements of subdivision 3. To participate, a provider must notify the commissioner of the provider's intent to participate in a format required by the commissioner and enroll as a demonstration project provider.

(b) Programs licensed by the Department of Human Services as a residential treatment program according to section 245G.21 that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by June 30, 2025. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(c) Programs licensed by the Department of Human Services as a withdrawal management program according to chapter 245F that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by June 30, 2025. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(d) Out-of-state residential substance use disorder treatment programs that receive payment under this chapter must enroll as a demonstration project provider and meet the requirements of subdivision 3 by June 30, 2025. Programs that do not meet the requirements under this paragraph are ineligible for payment for services provided under section 256B.0625.

(e) Tribally licensed programs may elect to participate in the demonstration project and meet the requirements of subdivision 3. The Department of Human Services must consult

with Tribal nations to discuss participation in the substance use disorder demonstration project.

(f) All rate enhancements for services rendered by voluntarily enrolled demonstration providers enrolled before July 1, 2021, are applicable only to dates of service on or after the effective date of the provider's enrollment in the demonstration project, except as authorized by paragraph (g). The commissioner shall recoup any rate enhancements paid under paragraph (g) to a provider that does not meet the requirements of subdivision 3 by July 1, 2021.

(g) The commissioner may allow providers enrolled before July 1, 2021, to receive any applicable rate enhancements authorized by subdivision 4 for services provided on dates of service no further back than July 22, 2020, for fee-for-service enrollees and no further back than January 1, 2021, to managed care enrollees if the provider meets all of the following requirements:

(1) the provider attests that during the time period for which the provider is seeking the rate enhancement, they took meaningful steps and had a reasonable plan approved by the commissioner to meet the demonstration project requirements in subdivision 3;

(2) the provider submits attestation and evidence, including all information requested by the commissioner, of meeting the requirements of subdivision 3 to the commissioner in a format required by the commissioner; and

(3) the commissioner received the provider's application for enrollment on or before June 1, 2021.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later, except paragraphs (f) and (g) are effective the day following final enactment. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 14. Minnesota Statutes 2020, section 256B.0759, subdivision 4, is amended to read:

Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must be increased for services provided to medical assistance enrollees. To receive a rate increase, participating providers must meet demonstration project requirements and provide evidence of formal referral arrangements with providers delivering step-up or step-down levels of care. Providers that have enrolled in the demonstration project but have not met the provider standards under subdivision 3 as of July 1, 2022, are not eligible for a rate increase under this subdivision until the date that the provider meets the provider standards in subdivision

3. Services provided from July 1, 2022, to the date that the provider meets the provider standards in subdivision 3 shall be reimbursed at rates according to section 254B.05, subdivision 5, paragraph (b).

(b) The commissioner may temporarily suspend payments to the provider according to section 256B.04, subdivision 21, paragraph (d), if provider does not meet the requirements in paragraph (a). Payments withheld from the provider must be made once the commissioner determines that the provider meets the requirements in paragraph (a).

~~(b)~~ (c) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clause (8), provided on or after July 1, 2020, payment rates must be increased by ~~15~~ 35 percent over the rates in effect on December 31, 2019.

~~(c)~~ (d) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clauses (1), (6), and (7), and adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on or after January 1, 2021, payment rates must be increased by ~~ten~~ 30 percent over the rates in effect on December 31, 2020.

~~(d)~~ (e) Effective January 1, 2021, and contingent on annual federal approval, managed care plans and county-based purchasing plans must reimburse providers of the substance use disorder services meeting the criteria described in paragraph (a) who are employed by or under contract with the plan an amount that is at least equal to the fee-for-service base rate payment for the substance use disorder services described in paragraphs ~~(b)~~ (c) and ~~(c)~~ (d). The commissioner must monitor the effect of this requirement on the rate of access to substance use disorder services and residential substance use disorder rates. Capitation rates paid to managed care organizations and county-based purchasing plans must reflect the impact of this requirement. This paragraph expires if federal approval is not received at any time as required under this paragraph.

~~(e)~~ (f) Effective July 1, 2021, contracts between managed care plans and county-based purchasing plans and providers to whom paragraph ~~(d)~~ (e) applies must allow recovery of payments from those providers if, for any contract year, federal approval for the provisions of paragraph ~~(d)~~ (e) is not received, and capitation rates are adjusted as a result. Payment recoveries must not exceed the amount equal to any decrease in rates that results from this provision.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever occurs later, except paragraphs (c) and (d) are effective January 1, 2022, or upon

federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 15. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision to read:

Subd. 6. **Medium intensity residential program participation.** Medium intensity residential programs that qualify to participate in the demonstration project shall use the specified base payment rate of $132.90 per day, and shall be eligible for the rate increases specified in subdivision 4.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2020.

Sec. 16. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision to read:

Subd. 7. **Public access.** The state shall post the final documents, for example, monitoring reports, close out report, approved evaluation design, interim evaluation report, and summative evaluation report, on the state's Medicaid website within 30 calendar days of approval by CMS.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 17. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision to read:

Subd. 8. **Federal approval; demonstration project extension.** The commissioner shall seek all necessary federal authority to extend the demonstration and must submit the request for extension by the federally required date of June 30, 2023.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 18. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision to read:

Subd. 9. **Demonstration project evaluation work group.** Beginning October 1, 2021, the commissioner shall assemble a work group of relevant stakeholders, including but not limited to demonstration project participants and the Minnesota Association of Resources for Recovery and Chemical Health, that shall meet at least quarterly for the duration of the demonstration to evaluate the long-term sustainability of any improvements to quality or access to substance use disorder treatment services caused by participation in the

demonstration project. The work group shall also determine how to implement successful outcomes of the demonstration project once the project expires.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 19. Minnesota Statutes 2020, section 256B.0947, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, as adapted for youth, and are directed to recipients ~~ages 16, 17, 18, 19, or 20~~ who are eight years of age or older and under 26 years of age with a serious mental illness or co-occurring mental illness and substance abuse addiction who require intensive services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

(b) "Co-occurring mental illness and substance abuse addiction" means a dual diagnosis of at least one form of mental illness and at least one substance use disorder. Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine use.

(c) "Diagnostic assessment" has the meaning given to it in Minnesota Rules, part 9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota Rules, part 9505.0372, subpart 1, and for this section must incorporate a determination of the youth's necessary level of care using a standardized functional assessment instrument approved and periodically updated by the commissioner.

(d) "Education specialist" means an individual with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities.

(e) "Housing access support" means an ancillary activity to help an individual find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

(f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring mental illness and substance use disorders by a team of cross-trained clinicians within the same program, and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment.

(g) "Medication education services" means services provided individually or in groups, which focus on:

(1) educating the client and client's family or significant nonfamilial supporters about mental illness and symptoms;

(2) the role and effects of medications in treating symptoms of mental illness; and

(3) the side effects of medications.

Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses with certification in psychiatric and mental health care.

(h) "Peer specialist" means an employed team member who is a mental health certified peer specialist according to section 256B.0615 and also a former children's mental health consumer who:

(1) provides direct services to clients including social, emotional, and instrumental support and outreach;

(2) assists younger peers to identify and achieve specific life goals;

(3) works directly with clients to promote the client's self-determination, personal responsibility, and empowerment;

(4) assists youth with mental illness to regain control over their lives and their developmental process in order to move effectively into adulthood;

(5) provides training and education to other team members, consumer advocacy organizations, and clients on resiliency and peer support; and

(6) meets the following criteria:

(i) is at least 22 years of age;

(ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20, or co-occurring mental illness and substance abuse addiction;

(iii) is a former consumer of child and adolescent mental health services, or a former or current consumer of adult mental health services for a period of at least two years;

(iv) has at least a high school diploma or equivalent;

(v) has successfully completed training requirements determined and periodically updated by the commissioner;

(vi) is willing to disclose the individual's own mental health history to team members and clients; and

(vii) must be free of substance use problems for at least one year.

(i) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.

(j) "Substance use disorders" means one or more of the disorders defined in the diagnostic and statistical manual of mental disorders, current edition.

(k) "Transition services" means:

(1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the client to establish provider relationships;

(2) providing the client with knowledge and skills needed posttransition;

(3) establishing communication between sending and receiving entities;

(4) supporting a client's request for service authorization and enrollment; and

(5) establishing and enforcing procedures and schedules.

A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.

(l) "Treatment team" means all staff who provide services to recipients under this section.

(m) "Family peer specialist" means a staff person qualified under section 256B.0616.

Sec. 20. Minnesota Statutes 2020, section 256B.0947, subdivision 3, is amended to read:

Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

(1) is ~~age 16, 17, 18, 19, or 20~~ eight years of age or older and under 26 years of age; ~~and~~

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance abuse addiction, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a level-of-care determination, using an instrument approved by the commissioner, that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers;

(4) has a functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system ~~within the next two years~~ during adulthood; and

(5) has had a recent diagnostic assessment, as provided in Minnesota Rules, part 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

Sec. 21. Minnesota Statutes 2020, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must be provided by a provider entity as provided in subdivision 4.

(b) The treatment team must have specialized training in providing services to the specific age group of youth that the team serves. An individual treatment team must serve youth who are: (1) at least eight years of age or older and under 16 years of age, or (2) at least 14 years of age or older and under 26 years of age.

~~(b)~~ (c) The treatment team for intensive nonresidential rehabilitative mental health services comprises both permanently employed core team members and client-specific team members as follows:

(1) The core treatment team is an entity that operates under the direction of an independently licensed mental health professional, who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility for clients. Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must include, but is not limited to:

(i) an independently licensed mental health professional, qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, who serves as team leader to provide administrative direction and clinical supervision to the team;

(ii) an advanced-practice registered nurse with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist, either of which must be credentialed to prescribe medications;

(iii) a licensed alcohol and drug counselor who is also trained in mental health interventions; and

(iv) a peer specialist as defined in subdivision 2, paragraph (h).

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a mental health practitioner, as defined in section 245.4871, subdivision 26;

(vi) a case management service provider, as defined in section 245.4871, subdivision 4;

(vii) a housing access specialist; and

(viii) a family peer specialist as defined in subdivision 2, paragraph (m).

(3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc members not employed by the team who consult on a specific client and who must accept overall clinical direction from the treatment team for the duration of the client's placement with the treatment team and must be paid by the provider agency at the rate for a typical session by that provider with that client or at a rate negotiated with the client-specific member. Client-specific treatment team members may include:

(i) the mental health professional treating the client prior to placement with the treatment team;

(ii) the client's current substance abuse counselor, if applicable;

(iii) a lead member of the client's individualized education program team or school-based mental health provider, if applicable;

(iv) a representative from the client's health care home or primary care clinic, as needed to ensure integration of medical and behavioral health care;

(v) the client's probation officer or other juvenile justice representative, if applicable; and

(vi) the client's current vocational or employment counselor, if applicable.

~~(c)~~ (d) The clinical supervisor shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team shall meet with the clinical supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting must include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the individual client's treatment record.

~~(d)~~ (e) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

~~(e)~~ (f) The treatment team shall serve no more than 80 clients at any one time. Should local demand exceed the team's capacity, an additional team must be established rather than exceed this limit.

~~(f)~~ (g) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider shall have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

~~(g)~~ (h) The intensive nonresidential rehabilitative mental health services provider shall participate in evaluation of the assertive community treatment for youth (Youth ACT) model as conducted by the commissioner, including the collection and reporting of data and the reporting of performance measures as specified by contract with the commissioner.

~~(h)~~ (i) A regional treatment team may serve multiple counties.

Sec. 22. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team must use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) Services must be age-appropriate and meet the specific needs of the client.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every six months or prior to discharge from the service, whichever comes first.

(e) The treatment team must complete an individual treatment plan for each client and the individual treatment plan must:

(1) be based on the information in the client's diagnostic assessment and baselines;

(2) identify goals and objectives of treatment, a treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;

(3) be developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;

(4) be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessments, and treatment planning;

(5) be reviewed at least once every six months and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment;

(6) be signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;

(7) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan;

(8) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports;

(ii) be reviewed at least once every 90 days and revised, if necessary;

(9) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and

(10) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.

(f) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(g) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(h) The treatment team shall provide interventions to promote positive interpersonal relationships.

Sec. 23. Minnesota Statutes 2020, section 297E.02, subdivision 3, is amended to read:

Subd. 3. **Collection; disposition.** (a) Taxes imposed by this section are due and payable to the commissioner when the gambling tax return is required to be filed. Distributors must file their monthly sales figures with the commissioner on a form prescribed by the commissioner. Returns covering the taxes imposed under this section must be filed with the commissioner on or before the 20th day of the month following the close of the previous calendar month. The commissioner shall prescribe the content, format, and manner of returns or other documents pursuant to section 270C.30. The proceeds, along with the revenue received from all license fees and other fees under sections 349.11 to 349.191, 349.211,

and 349.213, must be paid to the commissioner of management and budget for deposit in the general fund.

(b) The sales tax imposed by chapter 297A on the sale of pull-tabs and tipboards by the distributor is imposed on the retail sales price. The retail sale of pull-tabs or tipboards by the organization is exempt from taxes imposed by chapter 297A and is exempt from all local taxes and license fees except a fee authorized under section 349.16, subdivision 8.

(c) One-half of one percent of the revenue deposited in the general fund under paragraph (a), is appropriated to the commissioner of human services for the compulsive gambling treatment program established under section 245.98. One-half of one percent of the revenue deposited in the general fund under paragraph (a), is appropriated to the commissioner of human services for a grant to the state affiliate recognized by the National Council on Problem Gambling to increase public awareness of problem gambling, education and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research relating to problem gambling. Money appropriated by this paragraph must supplement and must not replace existing state funding for these programs.

(d) The commissioner of human services must provide to the state affiliate recognized by the National Council on Problem Gambling a monthly statement of the amounts deposited under paragraph (c). Beginning January 1, 2022, the commissioner of human services must provide to the chairs and ranking minority members of the legislative committees with jurisdiction over treatment for problem gambling and to the state affiliate recognized by the National Council on Problem Gambling an annual reconciliation of the amounts deposited under paragraph (c). The annual reconciliation under this paragraph must include the amount allocated to the commissioner of human services for the compulsive gambling treatment program established under section 245.98, and the amount allocated to the state affiliate recognized by the National Council on Problem Gambling.

Sec. 24. **SUBSTANCE USE DISORDER TREATMENT PATHFINDER COMPANION PILOT PROJECT.**

(a) Anoka County and an academic institution acting as a research partner, in consultation with the North Metro Mental Health Roundtable, shall conduct a one-year pilot project beginning September 1, 2021, to evaluate the effects on treatment outcomes of the use by individuals in substance use disorder recovery of the telephone-based Pathfinder Companion application, which allows individuals in recovery to connect with peers, resources, providers, and others helping with recovery after an individual is discharged from treatment, and the use by providers of the computer-based Pathfinder Bridge application, which allows providers

to prioritize care, connect directly with patients, and monitor long-term outcomes and recovery effectiveness.

(b) Prior to launching the program, Anoka County must secure the participation of an academic research institution as a research partner and the project must receive approval from the institution's institutional review board.

(c) The pilot project must monitor and evaluate the effects on treatment outcomes of using the Pathfinder Companion and Pathfinder Bridge applications in order to determine whether the addition of digital recovery support services alongside traditional methods of recovery treatment improves treatment outcomes. The participating research partner shall design and conduct the program evaluation.

(d) Anoka County and the participating research partner, in consultation with the North Metro Mental Health Roundtable, shall report to the commissioner of human services and the chairs and ranking minority members of the legislative committees with jurisdiction over substance use disorder treatment by January 15, 2023, on the results of the pilot project.

Sec. 25. **FIRST EPISODE OF PSYCHOSIS GRANT PROGRAM; AUTHORIZED USES OF GRANT FUNDS.**

(a) Grant funds awarded by the commissioner of human services pursuant to Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (15), must be used to:

(1) provide intensive treatment and support for adolescents and adults experiencing or at risk of experiencing a first psychotic episode. Intensive treatment and support includes medication management, psychoeducation for an individual and an individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer support, crisis planning, and stress management. Projects must use all available funding streams;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinics, on early psychosis symptoms, screening tools, and best practices; and

(3) ensure access for individuals to first psychotic episode services under this section, including ensuring access to first psychotic episode services for individuals who live in rural areas.

(b) Grant funds may also be used to pay for housing or travel expenses or to address other barriers preventing individuals and their families from participating in first psychotic episode services.

Sec. 26. **EMERGING MOOD DISORDER GRANT PROGRAM; AUTHORIZED USES OF GRANT FUNDS.**

(a) Grant funds awarded by the commissioner of human services pursuant to Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (18), must be used to:

(1) provide intensive treatment and support to adolescents and young adults experiencing or at risk of experiencing an emerging mood disorder. Intensive treatment and support includes medication management, psychoeducation for the individual and the individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer support, crisis planning, and stress management. Grant recipients must use all available funding streams;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinics, on early symptoms of mood disorders, screening tools, and best practices; and

(3) ensure access for individuals to emerging mood disorder services under this section, including ensuring access to services for individuals who live in rural areas.

(b) Grant funds may also be used by the grant recipient to evaluate the efficacy for providing intensive services and supports to people with emerging mood disorders.

Sec. 27. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MENTAL HEALTH GRANT PROGRAMS STATUTE REVISION.**

The commissioner of human services, in coordination with the Office of Senate Counsel, Research, and Fiscal Analysis, the Office of the House Research Department, and the revisor of statutes, shall prepare legislation for the 2022 legislative session to enact as statutes the grant programs authorized and funded under Minnesota Statutes, section 245.4661, subdivision 9. The draft statutes shall at least include the eligibility criteria, target populations, authorized uses of grant funds, and outcome measures for each grant. The commissioner shall provide a courtesy copy of the proposed legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health grants.

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

Sec. 28. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER TREATMENT PAPERWORK REDUCTION.**

(a) The commissioner of human services, in consultation with counties, tribes, managed care organizations, substance use disorder treatment professional associations, and other

relevant stakeholders, shall develop, assess, and recommend systems improvements to minimize regulatory paperwork and improve systems for substance use disorder programs licensed under Minnesota Statutes, chapter 245A, and regulated under Minnesota Statutes, chapters 245F and 245G, and Minnesota Rules, chapters 2960 and 9530. The commissioner of human services shall make available any resources needed from other divisions within the department to implement systems improvements.

(b) The commissioner of health shall make available needed information and resources from the Division of Health Policy.

(c) The Office of MN.IT Services shall provide advance consultation and implementation of the changes needed in data systems.

(d) The commissioner of human services shall contract with a vendor that has experience with developing statewide system changes for multiple states at the payer and provider levels. If the commissioner, after exercising reasonable diligence, is unable to secure a vendor with the requisite qualifications, the commissioner may select the best qualified vendor available. When developing recommendations, the commissioner shall consider input from all stakeholders. The commissioner's recommendations shall maximize benefits for clients and utility for providers, regulatory agencies, and payers.

(e) The commissioner of human services and the contracted vendor shall follow the recommendations from the report issued in response to Laws 2019, First Special Session chapter 9, article 6, section 76.

(f) By December 15, 2022, the commissioner of human services shall take steps to implement paperwork reductions and systems improvements within the commissioner's authority and submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a report that includes recommendations for changes in statutes that would further enhance systems improvements to reduce paperwork. The report shall include a summary of the approaches developed and assessed by the commissioner of human services and stakeholders and the results of any assessments conducted.

Sec. 29. **DIRECTION TO THE COMMISSIONER; SOBER HOUSING PROGRAM RECOMMENDATIONS.**

(a) The commissioner of human services, in consultation with stakeholders, must develop recommendations on:

(1) increasing access to sober housing programs;

(2) promoting person-centered practices and cultural responsiveness in sober housing programs;

(3) potential oversight of sober housing programs; and

(4) providing consumer protections for individuals in sober housing programs with substance use disorders and individuals with co-occurring mental illnesses.

(b) Stakeholders include but are not limited to the Minnesota Association of Sober Homes, the Minnesota Association of Resources for Recovery and Chemical Health, Minnesota Recovery Connection, NAMI Minnesota, and residents and former residents of sober housing programs based in Minnesota. Stakeholders must equitably represent geographic areas of the state, and must include individuals in recovery and providers representing Black, Indigenous, people of color, or immigrant communities.

(c) The commissioner must complete and submit a report on the recommendations in this section to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on or before September 1, 2022.

Sec. 30. **DIRECTION TO COMMISSIONERS OF HEALTH AND HUMAN SERVICES; COMPULSIVE GAMBLING PROGRAMMING AND FUNDING.**

By September 1, 2022, the commissioner of human services shall consult with the commissioner of health and report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services with a recommendation on whether the revenue appropriated to the commissioner of human services for a grant to the state affiliate recognized by the National Council on Problem Gambling under Minnesota Statutes, section 297E.02, subdivision 3, paragraph (c), is more properly appropriated to and managed by an agency other than the Department of Human Services. The commissioners shall also recommend whether the compulsive gambling treatment program in Minnesota Statutes, section 245.98, should continue to be managed by the Department of Human Services or be managed by another agency.

Sec. 31. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; SUD DEMONSTRATION PROJECT ENROLLMENT REPORT.**

Beginning with the November 2021 budget forecast and for each budget forecast thereafter, the commissioner of human services shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services on the number

of institutions for mental disease providers enrolled in the demonstration project under Minnesota Statutes, section 256B.0759, and the amount of the federal financial participation for institutions for mental disease providers enrolled in the demonstration project and the amount of the federal financial participation that exceeds the commissioner's projected enrollment as of the November 2021 forecast. This report shall be provided for the duration of the demonstration project.

Sec. 32. **FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT ALLOCATION; CHILDREN'S MENTAL HEALTH GRANTS FOR EMERGING MOOD DISORDERS PROGRAMS.**

From the amount that Minnesota received under title II of the federal Consolidated Appropriations Act, Public Law 116-260, for the community mental health services block grant, the commissioner of human services shall allocate $400,000 in fiscal year 2022, $400,000 in fiscal year 2023, $400,000 in fiscal year 2024, and $400,000 in fiscal year 2025, for children's mental health grants for emerging mood disorder programs under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (18).

Sec. 33. **FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT ALLOCATION; CHILDREN'S MENTAL HEALTH GRANTS FOR FIRST EPISODE OF PSYCHOSIS PROGRAMS.**

(a) From the amount that Minnesota received under title II of the federal Consolidated Appropriations Act, Public Law 116-260, for the community mental health services block grant, the commissioner of human services shall allocate $1,600,000 in fiscal year 2022, $1,500,000 in fiscal year 2023, and $222,000 in fiscal year 2024, for children's mental health grants for first episode of psychosis programs under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (15).

(b) From the amount that Minnesota received under section 2701 of the federal American Rescue Plan Act, Public Law 117-2, for the community mental health services block grant, the commissioner of human services shall allocate $1,278,000 in fiscal year 2024 and $1,500,000 in fiscal year 2025, for children's mental health grants for first episode of psychosis programs under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (15).

(c) From the amount that Minnesota received under section 2701 of the federal American Rescue Plan Act, Public Law 117-2, for the community mental health services block grant, the commissioner of human services shall allocate $200,000 in fiscal year 2022 and $200,000

in fiscal year 2023, for additional funding to four existing first episode of psychosis programs that receive children's mental health grants funding under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (15).

(d) From the amount that Minnesota received under title II of the federal Consolidated Appropriations Act, Public Law 116-260, for the community mental health services block grant, the commissioner of human services shall allocate $200,000 in fiscal year 2024 and $200,000 in fiscal year 2025, for additional funding to four existing first episode of psychosis programs that receive children's mental health grants funding under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (15).

Sec. 34. **FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT ALLOCATION; ADULT MENTAL HEALTH INITIATIVE GRANTS.**

(a) From the amount that Minnesota received under title II of the federal Consolidated Appropriations Act, Public Law 116-260, for the community mental health services block grant, the commissioner of human services shall allocate $2,350,000 in fiscal year 2022 and $2,350,000 in fiscal year 2023, for adult mental health initiative grants under Minnesota Statutes, section 245.4661, subdivision 1.

(b) From the amount that Minnesota received under section 2701 of the federal American Rescue Plan Act, Public Law 117-2, the commissioner of human services shall allocate $2,350,000 in fiscal year 2024 and $2,350,000 in fiscal year 2025, for the adult mental health initiative grants under Minnesota Statutes, section 245.4661, subdivision 1.

Sec. 35. **FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT ALLOCATION; SCHOOL-LINKED MENTAL HEALTH GRANTS.**

(a) From the amount that Minnesota received under title II of the federal Consolidated Appropriations Act, Public Law 116-260, for the community mental health services block grant, the commissioner of human services shall allocate $2,500,000 in fiscal year 2022 and $2,500,000 in fiscal year 2023 for school-linked mental health grants under Minnesota Statutes, section 245.4901.

(b) From the amount that Minnesota received under section 2701 of the federal American Rescue Plan Act, Public Law 117-2, for the community mental health services block grant, the commissioner of human services shall allocate $2,500,000 in fiscal year 2024 and $2,500,000 in fiscal year 2025, for school-linked mental health grants under Minnesota Statutes, section 245.4901.

Sec. 36. **FEDERAL SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT ALLOCATION; SCHOOL-LINKED SUBSTANCE ABUSE GRANTS.**

(a) From the amount that Minnesota received under title II of the federal Consolidated Appropriations Act of 2020, Public Law 116-260, for the substance abuse prevention and treatment block grant, the commissioner of human services shall allocate $1,500,000 in fiscal year 2022, $1,500,000 in fiscal year 2023, and $1,079,000 in fiscal year 2024, for school-linked substance abuse grants under Minnesota Statutes, section 245.4901.

(b) From the amount that Minnesota received under section 2702 of the federal American Rescue Plan Act, Public Law 117-2, for the substance abuse prevention and treatment block grant, the commissioner shall allocate $421,000 in fiscal year 2024 and $1,500,000 in fiscal year 2025, for school-linked substance abuse grants under Minnesota Statutes, section 245.4901.

Sec. 37. **FEDERAL SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT ALLOCATION; SUBSTANCE USE DISORDER TREATMENT PATHFINDER COMPANION PILOT PROJECT.**

(a) From the amount that Minnesota received under title II of the federal Consolidated Appropriations Act of 2020, Public Law 116-260, for the substance abuse prevention and treatment block grant, the commissioner of human services shall allocate $250,000 in fiscal year 2022 for a grant to Anoka County to conduct a substance use disorder treatment pathfinder companion pilot project. This is a onetime allocation and is available until January 15, 2023.

(b) Of this allocation, up to $200,000 is for licensed use of the pathfinder companion application for individuals participating in the pilot project and up to $50,000 is for licensed use of the pathfinder bridge application for providers participating in the pilot project.

(c) From the amount that Minnesota received under section 2702 of the federal American Rescue Plan Act, Public Law 117-2, for the substance abuse prevention and treatment block grant, the commissioner shall allocate $300,000 in fiscal year 2022 for a grant to Anoka County to conduct the substance use disorder treatment pathfinder companion pilot project. This is a onetime allocation and is available until January 15, 2023.

Sec. 38. **FEDERAL SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT ALLOCATION; OPIOID EPIDEMIC RESPONSE GRANTS.**

(a) From the amount that Minnesota received under title II of the federal Consolidated Appropriations Act of 2020, Public Law 116-260, for the substance abuse prevention and treatment block grant, the commissioner of human services shall allocate $3,500,000 in fiscal year 2022 and $3,500,000 in fiscal year 2023, for grants to be awarded according to recommendations of the Opioid Epidemic Response Advisory Council under Minnesota Statutes, section 256.042.

(b) From the amount that Minnesota received under Section 2702 of the federal American Rescue Plan Act, Public Law 117-2, for the substance abuse prevention and treatment block grant, the commissioner shall allocate $3,500,000 in fiscal year 2024 and $3,500,000 in fiscal year 2025, for grants to be awarded according to recommendations of the Opioid Epidemic Response Advisory Council under Minnesota Statutes, section 256.042.

(c) The commissioner shall include information on the grants awarded under this section in the annual report under Minnesota Statutes, section 256.042, subdivision 5, paragraph (a).

Sec. 39. **FEDERAL SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT ALLOCATION; RECOVERY COMMUNITY ORGANIZATION INFRASTRUCTURE GRANTS.**

(a) From the amount that Minnesota received under title II of the federal Consolidated Appropriations Act of 2020, Public Law 116-260, for the substance abuse prevention and treatment block grant, the commissioner of human services shall allocate $2,000,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023, for grants to recovery community organizations, as defined in Minnesota Statutes, section 254B.01, subdivision 8, to provide community-based peer recovery support services that are not otherwise eligible for reimbursement under Minnesota Statutes, section 254B.05.

(b) From the amount that Minnesota received under Section 2702 of the federal American Rescue Plan Act, Public Law 117-2, for the substance abuse prevention and treatment block grant for grants, the commissioner of human services shall allocate $2,000,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025, to recovery community organizations, as defined in Minnesota Statutes, section 254B.01, subdivision 8, to provide community-based peer recovery support services that are not otherwise eligible for reimbursement under Minnesota Statutes, section 254B.05.

Sec. 40. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER TREATMENT RATE RESTRUCTURE.**

(a) By January 1, 2022, the commissioner shall issue a request for proposal for frameworks and modeling of substance use disorder rates. Rates must be predicated on a uniform methodology that is transparent, culturally responsive, supports staffing needed to treat a patient's assessed need, and promotes quality service delivery and patient choice. The commissioner must consult with substance use disorder treatment programs across the spectrum of services, substance use disorder treatment programs from across each region of the state, and culturally responsive providers in the development of the request for proposal process and for the duration of the contract.

(b) By January 15, 2023, the commissioner of human services shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance on the results of the vendor's work. The report must include legislative language necessary to implement a new substance use disorder treatment rate methodology and a detailed fiscal analysis.

Sec. 41. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER TECHNICAL ASSISTANCE CENTERS.**

The commissioner shall establish one or more community-based technical assistance centers for substance use disorder treatment providers that offer both virtual learning environments and in-person opportunities. The technical assistance centers must provide guidance to substance use disorder providers concerning the enrollment process for the substance use disorder reform demonstration project under Minnesota Statutes, section 256B.0759, and provide advice concerning bringing the provider's treatment practices into compliance with American Society of Addiction Medicine standards during the one-year transition period. Technical assistance centers may also promote awareness of new and evidence-based practices and services for the treatment of substance use disorders, and offer education, training, resources, and information for the behavioral health care workforce. The commissioner must award funding to technical assistance centers by March 1, 2022, to initiate operations.

Sec. 42. **REVISOR INSTRUCTION.**

The revisor of statutes shall replace "EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT" with "CERTIFIED COMMUNITY BEHAVIORAL

HEALTH CLINIC SERVICES" in the section headnote for Minnesota Statutes, section 245.735.

Sec. 43. **REPEALER.**

(a) Minnesota Statutes 2020, section 245.735, subdivisions 1, 2, and 4, are repealed.

(b) Minnesota Rules, parts 9530.6800; and 9530.6810, are repealed.

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

ARTICLE 5
DISABILITY SERVICES AND CONTINUING CARE FOR OLDER ADULTS

Section 1. Minnesota Statutes 2020, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health MDS assessments that conform with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment;

(2) an annual assessment which must have an assessment reference date (ARD) within 92 days of the previous assessment and the previous comprehensive assessment;

(3) a significant change in status assessment must be completed within 14 days of the identification of a significant change, whether improvement or decline, and regardless of the amount of time since the last significant change in status assessment;

(4) all quarterly assessments must have an assessment reference date (ARD) within 92 days of the ARD of the previous assessment;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; and

(6) any significant correction to a prior quarterly assessment, if the assessment being corrected is the current one being used for RUG classification.

(c) In addition to the assessments listed in paragraph (b), a significant change in status assessment is required when:

(1) all speech, occupational, and physical therapies have ended. The assessment reference date of this assessment must be set on day eight after all therapy services have ended; and

(2) isolation for an active infectious disease has ended. The assessment reference date of this assessment must be set on day 15 after isolation has ended.

(d) In addition to the assessments listed in ~~paragraph~~ paragraphs (b) and (c), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by the Senior LinkAge Line or other organization under contract with the Minnesota Board on Aging; and

(2) a nursing facility level of care determination as provided for under section 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment completed under section 256B.0911, by a county, tribe, or managed care organization under contract with the Department of Human Services.

EFFECTIVE DATE. This section is effective for all assessments with an assessment reference date of July 1, 2021, or later.

Sec. 2. Minnesota Statutes 2020, section 144A.073, subdivision 2, is amended to read:

Subd. 2. **Request for proposals.** At the authorization by the legislature of additional medical assistance expenditures for exceptions to the moratorium on nursing homes, the commissioner shall publish in the State Register a request for proposals for nursing home and certified boarding care home projects for conversion, relocation, renovation, replacement, upgrading, or addition. The public notice of this funding and the request for proposals must specify how the approval criteria will be prioritized by the commissioner. The notice must describe the information that must accompany a request and state that proposals must be submitted to the commissioner within 150 days of the date of publication. The notice must include the amount of the legislative appropriation available for the additional costs to the medical assistance program of projects approved under this section. If money is appropriated, the commissioner shall initiate the application and review process described in this section at least once each biennium. A second application and review process must occur if remaining funds are either greater than $300,000 or more than 50 percent of the baseline appropriation

for the biennium. Authorized funds may be awarded in full in the first review process of the biennium. Appropriated funds not encumbered within a biennium shall carry forward ~~to the following biennium~~. To be considered for approval, a proposal must include the following information:

(1) whether the request is for renovation, replacement, upgrading, conversion, addition, or relocation;

(2) a description of the problems the project is designed to address;

(3) a description of the proposed project;

(4) an analysis of projected costs of the nursing facility proposed project, including:

(i) initial construction and remodeling costs;

(ii) site preparation costs;

(iii) equipment and technology costs;

(iv) financing costs, the current estimated long-term financing costs of the proposal, which is to include details of any proposed funding mechanism already arranged or being considered, including estimates of the amount and sources of money, reserves if required, annual payments schedule, interest rates, length of term, closing costs and fees, insurance costs, any completed marketing study or underwriting review; and

(v) estimated operating costs during the first two years after completion of the project;

(5) for proposals involving replacement of all or part of a facility, the proposed location of the replacement facility and an estimate of the cost of addressing the problem through renovation;

(6) for proposals involving renovation, an estimate of the cost of addressing the problem through replacement;

(7) the proposed timetable for commencing construction and completing the project;

(8) a statement of any licensure or certification issues, such as certification survey deficiencies;

(9) the proposed relocation plan for current residents if beds are to be closed according to section 144A.161; and

(10) other information required by permanent rule of the commissioner of health in accordance with subdivisions 4 and 8.

Sec. 3. Minnesota Statutes 2020, section 144A.073, is amended by adding a subdivision to read:

Subd. 17. **Moratorium exception funding.** (a) During the biennium beginning July 1, 2021, and during each biennium thereafter, the commissioner of health may approve moratorium exception projects under this section for which the full biennial state share of medical assistance costs does not exceed $10,000,000, plus any carryover of previous appropriations for this purpose.

(b) For the purposes of this subdivision, "biennium" has the meaning given in section 16A.011, subdivision 6.

Sec. 4. Minnesota Statutes 2020, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (h), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no

longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; ~~or~~

(5) new foster care licenses or community residential setting licenses for people receiving services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and for which a license is required. This exception does not apply to people living in their own home. For purposes of this clause, there is a presumption that a foster care or community residential setting license is required for services provided to three or more people in a dwelling unit when the setting is controlled by the provider. A license holder subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2018. This exception is available when:

(i) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and

(ii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the unlicensed setting as determined by the lead agency~~.~~; or

(6) new foster care licenses or community residential setting licenses for people receiving customized living or 24-hour customized living services under the brain injury or community access for disability inclusion waiver plans under section 256B.49 and residing in the customized living setting before July 1, 2022, for which a license is required. A customized living service provider subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2023. This exception is available when:

(i) the person's customized living services are provided in a customized living service setting serving four or fewer people under the brain injury or community access for disability inclusion waiver plans under section 256B.49 in a single-family home operational on or before June 30, 2021. Operational is defined in section 256B.49, subdivision 28;

(ii) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and

(iii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the customized living setting as determined by the lead agency.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department may decrease the statewide licensed capacity for adult foster care settings.

(d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (c) shall be exempt if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity determined under section 256B.493 will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet the informed decisions of those people who want to move out of corporate foster care or community residential settings, long-term service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term services and supports reports and statewide data and information.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are

required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(g) License holders of foster care homes identified under paragraph (f) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services.

(h) The commissioner may adjust capacity to address needs identified in section 144A.351. Under this authority, the commissioner may approve new licensed settings or delicense existing settings. Delicensing of settings will be accomplished through a process identified in section 256B.493. Annually, by August 1, the commissioner shall provide information and data on capacity of licensed long-term services and supports, actions taken under the subdivision to manage statewide long-term services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over the health and human services budget.

(i) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds. If a request for reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

(j) The commissioner shall not issue an initial license for children's residential treatment services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter for a program that Centers for Medicare and Medicaid Services would consider an institution for mental diseases. Facilities that serve only private pay clients are exempt from the moratorium described in this paragraph. The commissioner has the authority to manage

existing statewide capacity for children's residential treatment services subject to the moratorium under this paragraph and may issue an initial license for such facilities if the initial license would not increase the statewide capacity for children's residential treatment services subject to the moratorium under this paragraph.

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

Sec. 5. Minnesota Statutes 2020, section 245C.03, is amended by adding a subdivision to read:

Subd. 15. **Early intensive developmental and behavioral intervention providers.** The commissioner shall conduct background studies according to this chapter when initiated by an early intensive developmental and behavioral intervention provider under section 256B.0949.

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

Sec. 6. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 17. **Early intensive developmental and behavioral intervention providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 15, for the purposes of early intensive developmental and behavioral intervention under section 256B.0949, through a fee of no more than $20 per study charged to the enrolled agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

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

Sec. 7. Minnesota Statutes 2020, section 256.477, is amended to read:

256.477 SELF-ADVOCACY GRANTS.

Subdivision 1. **The Rick Cardenas Statewide Self-Advocacy Network.** (a) The commissioner shall make available a grant for the purposes of establishing and maintaining ~~a~~ the Rick Cardenas Statewide Self-Advocacy Network for persons with intellectual and developmental disabilities. The Rick Cardenas Statewide Self-Advocacy Network shall:

(1) ensure that persons with intellectual and developmental disabilities are informed of their rights in employment, housing, transportation, voting, government policy, and other issues pertinent to the intellectual and developmental disability community;

(2) provide public education and awareness of the civil and human rights issues persons with intellectual and developmental disabilities face;

(3) provide funds, technical assistance, and other resources for self-advocacy groups across the state; ~~and~~

(4) organize systems of communications to facilitate an exchange of information between self-advocacy groups;

(5) train and support the activities of a statewide network of peer-to-peer mentors for persons with developmental disabilities focused on building awareness among people with developmental disabilities of service options; assisting people with developmental disabilities choose service options; and developing the advocacy skills of people with developmental disabilities necessary for them to move toward full inclusion in community life, including by developing and delivering a curriculum to support the peer-to-peer network;

(6) provide outreach activities, including statewide conferences and disability networking opportunities, focused on self-advocacy, informed choice, and community engagement skills; and

(7) provide an annual leadership program for persons with intellectual and developmental disabilities.

(b) An organization receiving a grant under paragraph (a) must be an organization governed by people with intellectual and developmental disabilities that administers a statewide network of disability groups in order to maintain and promote self-advocacy services and supports for persons with intellectual and developmental disabilities throughout the state.

(c) An organization receiving a grant under this subdivision may use a portion of grant revenue determined by the commissioner for administration and general operating costs.

Subd. 2. **Subgrants for outreach to persons in institutional settings.** The commissioner shall make available to an organization described under subdivision 1 a grant for subgrants to organizations in Minnesota to conduct outreach to persons working and living in institutional settings to provide education and information about community options. Subgrant funds must be used to deliver peer-led skill training sessions in six regions of the state to help persons with intellectual and developmental disabilities understand community service options related to:

(1) housing;

(2) employment;

(3) education;

(4) transportation;

(5) emerging service reform initiatives contained in the state's Olmstead plan; the Workforce Innovation and Opportunity Act, Public Law 113-128; and federal home and community-based services regulations; and

(6) connecting with individuals who can help persons with intellectual and developmental disabilities make an informed choice and plan for a transition in services.

Sec. 8. **[256.4772] MINNESOTA INCLUSION INITIATIVE GRANT.**

Subdivision 1. **Grant program established.** The commissioner of human services shall establish the Minnesota inclusion initiative grant program to encourage self-advocacy groups of persons with intellectual and developmental disabilities to develop and organize projects that increase the inclusion of persons with intellectual and developmental disabilities in the community, improve community integration outcomes, educate decision-makers and the public about persons with intellectual and developmental disabilities, including the systemic barriers that prevent them from being included in the community, and to advocate for changes that increase access to formal and informal supports and services necessary for greater inclusion of persons with intellectual and developmental disabilities in the community.

Subd. 2. **Administration.** The commissioner of human services, as authorized by section 256.01, subdivision 2, paragraph (a), clause (6), shall issue a request for proposals to contract with a public or private entity to (1) serve as a fiscal host for the money appropriated for the purposes described in this section, and (2) develop guidelines, criteria, and procedures for awarding grants. The fiscal host shall establish an advisory committee consisting of self-advocates, nonprofit advocacy organizations, and Department of Human Services staff to review applications and award grants under this section.

Subd. 3. **Applications.** (a) Entities seeking grants under this section shall apply to the advisory committee of the fiscal host under contract with the commissioner. The grant applicant must include a description of the project that the applicant is proposing, the amount of money that the applicant is seeking, and a proposed budget describing how the applicant will spend the grant money.

(b) The advisory committee may award grants to applicants only for projects that meet the requirements of subdivision 4.

Subd. 4. **Use of grant money.** Projects funded by grant money must have person-centered goals, call attention to issues that limit inclusion of persons with intellectual and

developmental disabilities, address barriers to inclusion that persons with intellectual and developmental disabilities face in their communities, or increase the inclusion of persons with intellectual and developmental disabilities in their communities. Applicants may propose strategies to increase inclusion of persons with intellectual and developmental disabilities in their communities by:

(1) decreasing barriers to workforce participation experienced by persons with intellectual and developmental disabilities;

(2) overcoming barriers to accessible and reliable transportation options for persons with intellectual and developmental disabilities;

(3) identifying and addressing barriers to voting experienced by persons with intellectual and developmental disabilities;

(4) advocating for increased accessible housing for persons with intellectual and developmental disabilities;

(5) working with governmental agencies or businesses on accessibility issues under the Americans with Disabilities Act;

(6) increasing collaboration between self-advocacy groups and other organizations to effectively address systemic issues that impact persons with intellectual and developmental disabilities;

(7) increasing capacity for inclusion in a community; or

(8) providing public education and awareness of the civil and human rights of persons with intellectual and developmental disabilities.

Subd. 5. **Reports.** (a) Grant recipients shall provide the advisory committee with a report about the activities funded by the grant program in a format and at a time specified by the advisory committee. The advisory committee shall require grant recipients to include in the grant recipient's report at least the information necessary for the advisory committee to meet the advisory committee's obligation under paragraph (b).

(b) The advisory committee shall provide the commissioner with a report that describes all of the activities and outcomes of projects funded by the grant program in a format and at a time determined by the commissioner.

Sec. 9. **[256.4776] PARENT-TO-PARENT PEER SUPPORT.**

(a) The commissioner shall make a grant to an alliance member of Parent to Parent USA to support the alliance member's parent-to-parent peer support program for families of

children with any type of disability or special health care needs. An eligible alliance member must have an established parent-to-parent peer support program that is statewide and represents diverse cultures and geographic locations, that conducts outreach and provides individualized support to any parent or guardian of a child with a disability or special health care need, including newly identified parents of such a child or parents experiencing transitions or changes in their child's care, and that implements best practices for peer-to-peer support, including providing support from trained parent staff and volunteer support parents who have received Parent to Parent USA's specialized parent-to-parent peer support training.

(b) Grant recipients must use grant money for the purposes specified in paragraph (a).

(c) For purposes of this section, "special health care needs" means disabilities, chronic illnesses or conditions, health-related educational or behavioral problems, or the risk of developing disabilities, conditions, illnesses, or problems.

(d) Grant recipients must report to the commissioner of human services annually by January 15 about the services and programs funded by this appropriation. The report must include measurable outcomes from the previous year, including the number of families served by the organization's parent-to-parent programs and the number of volunteer support parents trained by the organization's parent-to-parent programs.

Sec. 10. Minnesota Statutes 2020, section 256B.0653, is amended by adding a subdivision to read:

Subd. 8. **Payment rates for home health agency services.** The commissioner shall annually adjust payments for home health agency services to reflect the change in the federal Centers for Medicare and Medicaid Services Home Health Agency Market Basket. The commissioner shall use the indices as forecasted for the midpoint of the prior rate year to the midpoint of the current rate year.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever occurs later, for services delivered on or after January 1, 2022. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. Minnesota Statutes 2020, section 256B.0654, is amended by adding a subdivision to read:

Subd. 5. **Payment rates for home care nursing services.** The commissioner shall annually adjust payments for home care nursing services to reflect the change in the federal Centers for Medicare and Medicaid Services Home Health Agency Market Basket. The

commissioner shall use the indices as forecasted for the midpoint of the prior rate year to the midpoint of the current rate year.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever occurs later, for services delivered on or after January 1, 2022. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 12. Minnesota Statutes 2020, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

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

(ii) disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional, physician, or advanced practice registered nurse;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient; and

(10) be limited to providing and being paid for up to 310 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents, stepparents, and legal guardians of minors; spouses; paid legal guardians of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of a residential setting.

(d) Personal care assistance services qualify for the enhanced rate described in subdivision 17a if the personal care assistant providing the services:

(1) provides covered services to a recipient who qualifies for ~~12~~ ten or more hours per day of personal care assistance services; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever occurs later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 13. Minnesota Statutes 2020, section 256B.0659, subdivision 17a, is amended to read:

Subd. 17a. **Enhanced rate.** An enhanced rate of 107.5 percent of the rate paid for personal care assistance services shall be paid for services provided to persons who qualify for ~~12~~ ten or more hours of personal care assistance services per day when provided by a personal care assistant who meets the requirements of subdivision 11, paragraph (d). The enhanced rate for personal care assistance services includes, and is not in addition to, any rate adjustments implemented by the commissioner on July 1, 2019, to comply with the terms of a collective bargaining agreement between the state of Minnesota and an exclusive representative of individual providers under section 179A.54, that provides for wage increases for individual providers who serve participants assessed to need 12 or more hours of personal care assistance services per day.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever occurs later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 14. Minnesota Statutes 2020, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, conversation-based, person-centered assessment.

The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a person-centered community support plan that meets the individual's needs and preferences.

(d) The assessment must be conducted by a certified assessor in a face-to-face conversational interview with the person being assessed. The person's legal representative must provide input during the assessment process and may do so remotely if requested. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under chapter 256S, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs the person completed in consultation with someone who is known to the person and has interaction with the person on a regular basis. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

(e) The certified assessor and the individual responsible for developing the coordinated service and support plan must complete the community support plan and the coordinated service and support plan no more than 60 calendar days from the assessment visit. The person or the person's legal representative must be provided with a written community support plan within the timelines established by the commissioner, regardless of whether the person is eligible for Minnesota health care programs.

(f) For a person being assessed for elderly waiver services under chapter 256S, a provider who submitted information under paragraph (d) shall receive the final written community support plan when available and the Residential Services Workbook.

(g) The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including:

(i) all available options for case management services and providers;

(ii) all available options for employment services, settings, and providers;

(iii) all available options for living arrangements;

(iv) all available options for self-directed services and supports, including self-directed budget options; and

(v) service provided in a non-disability-specific setting;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(h) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(i) The person has the right to make the final decision:

(1) between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

(2) between community placement in a setting controlled by a provider and living independently in a setting not controlled by a provider;

(3) between day services and employment services; and

(4) regarding available options for self-directed services and supports, including self-directed funding options.

(j) The lead agency must give the person receiving long-term care consultation services or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section

256.045, subdivision 3. The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated; and

(10) documentation that available options for employment services, independent living, and self-directed services and supports were described to the individual.

(k) Face-to-face assessment completed as part of an eligibility determination for multiple programs for the alternative care, elderly waiver, developmental disabilities, community access for disability inclusion, community alternative care, and brain injury waiver programs under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(l) The effective eligibility start date for programs in paragraph (k) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (k) cannot be prior to the date the most recent updated assessment is completed.

(m) If an eligibility update is completed within 90 days of the previous face-to-face assessment and documented in the department's Medicaid Management Information System (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date of the previous face-to-face assessment when all other eligibility requirements are met.

(n) If a person who receives home and community-based waiver services under section 256B.0913, 256B.092, or 256B.49 or chapter 256S temporarily enters for 121 days or fewer a hospital, institution of mental disease, nursing facility, intensive residential treatment services program, transitional care unit, or inpatient substance use disorder treatment setting, the person may return to the community with home and community-based waiver services under the same waiver, without requiring an assessment or reassessment under this section, unless the person's annual reassessment is otherwise due. Nothing in this paragraph shall change annual long-term care consultation reassessment requirements, payment for institutional or treatment services, medical assistance financial eligibility, or any other law.

~~(n)~~ (o) At the time of reassessment, the certified assessor shall assess each person receiving waiver residential supports and services currently residing in a community residential setting, licensed adult foster care home that is either not the primary residence of the license holder or in which the license holder is not the primary caregiver, family adult

foster care residence, customized living setting, or supervised living facility to determine if that person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23, in a setting not controlled by a provider, or to receive integrated community supports as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified assessor shall offer the person, through a person-centered planning process, the option to receive alternative housing and service options.

~~(o)~~ (p) At the time of reassessment, the certified assessor shall assess each person receiving waiver day services to determine if that person would prefer to receive employment services as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified assessor shall describe to the person through a person-centered planning process the option to receive employment services.

~~(p)~~ (q) At the time of reassessment, the certified assessor shall assess each person receiving non-self-directed waiver services to determine if that person would prefer an available service and setting option that would permit self-directed services and supports. The certified assessor shall describe to the person through a person-centered planning process the option to receive self-directed services and supports.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 15. Minnesota Statutes 2020, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. **Payment for long-term care consultation services.** ~~(a) Until September 30, 2013, payment for long-term care consultation face-to-face assessment shall be made as described in this subdivision.~~

~~(b) The total payment for each county must be paid monthly by Certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.~~

~~(c) The commissioner shall include the total annual payment determined under paragraph (b) for each nursing facility reimbursed under section 256B.431 or 256B.434 or chapter 256R.~~

~~(d) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph (c) and may adjust the monthly payment amount in paragraph (b). The effective date of an adjustment made under this paragraph shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.~~

~~(e)~~ (a) Payments for long-term care consultation services are available to ~~the county or~~ counties and Tribal nations that are lead agencies to cover staff salaries and expenses to provide the services described in subdivision 1a. The county or Tribal nation shall employ, or contract with other agencies to employ, ~~within the limits of available funding,~~ sufficient personnel to provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in subdivision 1. The county or Tribal nation shall be accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan on a form provided by the commissioner.

~~(f) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.~~

~~(g) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local consultation teams.~~

~~(h) Until the alternative payment methodology in paragraph (i) is implemented, the county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs.~~

(b) No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

~~(i)~~ (c) The commissioner shall develop an alternative payment methodology, effective on October 1, 2013, for long-term care consultation services that includes the funding available under this subdivision, and for assessments authorized under sections 256B.092 and 256B.0659. In developing the new payment methodology, the commissioner shall consider the maximization of other funding sources, including federal administrative reimbursement through federal financial participation funding, for all long-term care consultation activity. The alternative payment methodology shall include the use of the appropriate time studies and the state financing of nonfederal share as part of the state's medical assistance program. Between July 1, 2017, and June 30, 2019, the state shall pay

84.3 percent of the nonfederal share as reimbursement to the counties. Beginning July 1, 2019, the state shall pay 81.9 percent of the nonfederal share as reimbursement to the counties.

Sec. 16. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision to read:

Subd. 6b. **Payment for long-term care consultation services; transition to tiered rates.** (a) Notwithstanding subdivision 6, paragraph (c), beginning July 1, 2021, for each fiscal year through fiscal year 2025, the state shall pay to each county and Tribal nation as reimbursement for services provided under this section a percentage of the nonfederal share equal to the value of the county's or the Tribal nation's prorated share of the nonfederal share paid to counties and Tribal nations as reimbursement for services provided under subdivision 6, paragraph (c), during fiscal year 2019.

(b) Beginning October 1, 2022, each county or Tribal nation reimbursed under paragraph (a) must submit to the commissioner by October 1 an annual report documenting the total number of assessments performed under this section, the number of assessments by type of assessment, amount of time spent on each assessment, amount of time spent preparing for each assessment, amount of time spent finalizing a community support plan following each assessment, and amount of time an assessor spent on other assessment-related activities for each assessment. In its annual report, each county and Tribal nation must distinguish between services provided to people who were eligible for medical assistance at the time the services were provided and services provided to those who were not.

(c) This subdivision expires July 1, 2025.

Sec. 17. Minnesota Statutes 2020, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written person-centered coordinated service and support plan that:

(1) is developed with and signed by the recipient within the timelines established by the commissioner and section 256B.0911, subdivision 3a, paragraph (e);

(2) includes the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and welfare of the recipient;

(4) identifies the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor, including the person's choices made on self-directed options, services and supports to achieve employment goals, and living arrangements;

(5) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (o), of service and support providers, and identifies all available options for case management services and providers;

(6) identifies long-range and short-range goals for the person;

(7) identifies specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The person-centered coordinated service and support plan shall also specify other services the person needs that are not available and indicate in a clear and accessible manner the total monetary resources available to meet the assessed needs and preferences of the individual;

(8) identifies the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

(9) identifies provider responsibilities to implement and make recommendations for modification to the coordinated service and support plan;

(10) includes notice of the right to request a conciliation conference or a hearing under section 256.045;

(11) is agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative;

(12) is reviewed by a health professional if the person has overriding medical needs that impact the delivery of services; and

(13) includes the authorized annual and monthly amounts for the services.

(b) In developing the person-centered coordinated service and support plan, the case manager is encouraged to include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

(c) Approved, written, and signed changes to a consumer's services that meet the criteria in this subdivision shall be an addendum to that consumer's individual service plan.

Sec. 18. Minnesota Statutes 2020, section 256B.0949, is amended by adding a subdivision to read:

Subd. 16a. **Background studies.** An early intensive developmental and behavioral intervention services agency must fulfill any background studies requirements in this section by initiating a background study using the commissioner's NETStudy system as provided under sections 245C.03, subdivision 15, and 245C.10, subdivision 17.

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

Sec. 19. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision to read:

Subd. 7. **Regional quality councils and systems improvement.** The commissioner of human services shall maintain the regional quality councils initially established under Minnesota Statutes 2020, section 256B.097, subdivision 4. The regional quality councils shall:

(1) support efforts and initiatives that drive overall systems and social change to promote inclusion of people who have disabilities in the state of Minnesota;

(2) improve person-centered outcomes in disability services; and

(3) identify or enhance quality of life indicators for people who have disabilities.

Sec. 20. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision to read:

Subd. 8. **Membership and staff.** (a) Regional quality councils shall be comprised of key stakeholders including, but not limited to:

(1) individuals who have disabilities;

(2) family members of people who have disabilities;

(3) disability service providers;

(4) disability advocacy groups;

(5) lead agency staff; and

(6) staff of state agencies with jurisdiction over special education and disability services.

(b) Membership in a regional quality council must be representative of the communities in which the council operates, with an emphasis on individuals with lived experience from diverse racial and cultural backgrounds.

(c) Each regional quality council may hire staff to perform the duties assigned in subdivision 9.

Sec. 21. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision to read:

Subd. 9. **Duties.** (a) Each regional quality council shall:

(1) identify issues and barriers that impede Minnesotans who have disabilities from optimizing choice of home and community-based services;

(2) promote informed-decision making, autonomy, and self-direction;

(3) analyze and review quality outcomes and critical incident data, and immediately report incidents of life safety concerns to the Department of Human Services Licensing Division;

(4) inform a comprehensive system for effective incident reporting, investigation, analysis, and follow-up;

(5) collaborate on projects and initiatives to advance priorities shared with state agencies, lead agencies, educational institutions, advocacy organizations, community partners, and other entities engaged in disability service improvements;

(6) establish partnerships and working relationships with individuals and groups in the regions;

(7) identify and implement regional and statewide quality improvement projects;

(8) transform systems and drive social change in alignment with the disability rights and disability justice movements identified by leaders who have disabilities;

(9) provide information and training programs for persons who have disabilities and their families and legal representatives on formal and informal support options and quality expectations;

(10) make recommendations to state agencies and other key decision-makers regarding disability services and supports;

(11) submit every two years a report to legislative committees with jurisdiction over disability services on the status, outcomes, improvement priorities, and activities in the region;

(12) support people by advocating to resolve complaints between the counties, providers, persons receiving services, and their families and legal representatives; and

(13) recruit, train, and assign duties to regional quality council teams, including council members, interns, and volunteers, taking into account the skills necessary for the team members to be successful in this work.

(b) Each regional quality council may engage in quality improvement initiatives related to, but not limited to:

(1) the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, or section 256B.49, including brain injuries and services for those persons who qualify for nursing facility level of care or hospital facility level of care and any other services licensed under chapter 245D;

(2) home care services under section 256B.0651;

(3) family support grants under section 252.32;

(4) consumer support grants under section 256.476;

(5) semi-independent living services under section 252.275; and

(6) services provided through an intermediate care facility for persons with developmental disabilities.

(c) Each regional quality council's work must be informed and directed by the needs and desires of persons who have disabilities in the region in which the council operates.

Sec. 22. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision to read:

Subd. 10. **Compensation.** (a) A member of a regional quality council who does not receive a salary or wages from an employer may be paid a per diem and reimbursed for expenses related to the member's participation in efforts and initiatives described in subdivision 9 in the same manner and in an amount not to exceed the amount authorized by the commissioner's plan adopted under section 43A.18, subdivision 2.

(b) Regional quality councils may charge fees for their services.

Sec. 23. Minnesota Statutes 2020, section 256B.19, subdivision 1, is amended to read:

Subdivision 1. **Division of cost.** The state and county share of medical assistance costs not paid by federal funds shall be as follows:

(1) beginning January 1, 1992, 50 percent state funds and 50 percent county funds for the cost of placement of severely emotionally disturbed children in regional treatment centers;

(2) beginning January 1, 2003, 80 percent state funds and 20 percent county funds for the costs of nursing facility placements of persons with disabilities under the age of 65 that have exceeded 90 days. This clause shall be subject to chapter 256G and shall not apply to placements in facilities not certified to participate in medical assistance;

(3) beginning July 1, 2004, 90 percent state funds and ten percent county funds for the costs of placements that have exceeded 90 days in intermediate care facilities for persons with developmental disabilities that have seven or more beds. This provision includes pass-through payments made under section 256B.5015; ~~and~~

(4) beginning July 1, 2004, when state funds are used to pay for a nursing facility placement due to the facility's status as an institution for mental diseases (IMD), the county shall pay 20 percent of the nonfederal share of costs that have exceeded 90 days. This clause is subject to chapter 256G.~~;~~

(5) for any individual who has not been continuously receiving services in an intermediate care facility for persons with developmental disabilities since December 31, 2021, 90 percent state funds and ten percent county funds for the costs of any placement of an individual 18 years of age or older and under 27 years of age exceeding 90 days in any intermediate care facility for persons with developmental disabilities. This provision includes pass-through payments made under section 256B.5015. This provision is not in addition to the division of costs under clause (3). This provision continues to apply to an individual after the individual reaches the age of 27 and until the individual transitions to a community setting; and

(6) for any individual who has not been continuously receiving residential support services since December 31, 2021, 90 percent state funds and ten percent county funds for the costs of residential support services when authorized for an individual 18 years of age or older and under 27 years of age. This provision continues to apply to an individual after the individual reaches the age of 27 and until the individual no longer receives residential support services. For the purposes of this clause, "residential support services" means residential support services reimbursed under section 256B.4914, community residential services, customized living services, and 24-hour customized living services.

For counties that participate in a Medicaid demonstration project under sections 256B.69 and 256B.71, the division of the nonfederal share of medical assistance expenses for

payments made to prepaid health plans or for payments made to health maintenance organizations in the form of prepaid capitation payments, this division of medical assistance expenses shall be 95 percent by the state and five percent by the county of financial responsibility.

In counties where prepaid health plans are under contract to the commissioner to provide services to medical assistance recipients, the cost of court ordered treatment ordered without consulting the prepaid health plan that does not include diagnostic evaluation, recommendation, and referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

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

Sec. 24. Minnesota Statutes 2020, section 256B.49, subdivision 23, is amended to read:

Subd. 23. **Community-living settings.** (a) For the purposes of this chapter, "community-living settings" means a single-family home or multifamily dwelling unit where a service recipient or a service recipient's family owns or rents, and maintains control over the individual unit as demonstrated by a lease agreement. Community-living settings does not include a home or dwelling unit that the service provider owns, operates, or leases or in which the service provider has a direct or indirect financial interest.

(b) To ensure a service recipient or the service recipient's family maintains control over the home or dwelling unit, community-living settings are subject to the following requirements:

(1) service recipients must not be required to receive services or share services;

(2) service recipients must not be required to have a disability or specific diagnosis to live in the community-living setting;

(3) service recipients may hire service providers of their choice;

(4) service recipients may choose whether to share their household and with whom;

(5) the home or multifamily dwelling unit must include living, sleeping, bathing, and cooking areas;

(6) service recipients must have lockable access and egress;

(7) service recipients must be free to receive visitors and leave the settings at times and for durations of their own choosing;

(8) leases must comply with chapter 504B;

(9) landlords must not charge different rents to tenants who are receiving home and community-based services; and

(10) access to the greater community must be easily facilitated based on the service recipient's needs and preferences.

(c) Nothing in this section prohibits a service recipient from having another person or entity not affiliated with the service provider cosign a lease. Nothing in this section prohibits a service recipient, during any period in which a service provider has cosigned the service recipient's lease, from modifying services with an existing cosigning service provider and, subject to the approval of the landlord, maintaining a lease cosigned by the service provider. Nothing in this section prohibits a service recipient, during any period in which a service provider has cosigned the service recipient's lease, from terminating services with the cosigning service provider, receiving services from a new service provider, and, subject to the approval of the landlord, maintaining a lease cosigned by the new service provider.

(d) A lease cosigned by a service provider meets the requirements of paragraph (a) if the service recipient and service provider develop and implement a transition plan which must provide that, within two years of cosigning the initial lease, the service provider shall transfer the lease to the service recipient and other cosigners, if any.

(e) In the event the landlord has not approved the transfer of the lease within two years of the service provider cosigning the initial lease, the service provider must submit a time-limited extension request to the commissioner of human services to continue the cosigned lease arrangement. The extension request must include:

(1) the reason the landlord denied the transfer;

(2) the plan to overcome the denial to transfer the lease;

(3) the length of time needed to successfully transfer the lease, not to exceed an additional two years;

(4) a description of how the transition plan was followed, what occurred that led to the landlord denying the transfer, and what changes in circumstances or condition, if any, the service recipient experienced; and

(5) a revised transition plan to transfer the cosigned lease between the service provider and the service recipient to the service recipient.

The commissioner must approve an extension within sufficient time to ensure the continued occupancy by the service recipient.

(f) In the event that a landlord has not approved a transfer of the lease within the timelines of any approved time-limited extension request, a service provider must submit another time-limited extension request to the commissioner of human services to continue a cosigned lease arrangement. A time-limited extension request submitted under this paragraph must include the same information required for an initial time-limited extension request under paragraph (e). The commissioner must approve of an extension within sufficient time to ensure continued occupancy by the service recipient.

Sec. 25. Minnesota Statutes 2020, section 256B.49, is amended by adding a subdivision to read:

Subd. 28. **Customized living moratorium for brain injury and community access for disability inclusion waivers.** (a) Notwithstanding section 245A.03, subdivision 2, paragraph (a), clause (23), to prevent new development of customized living settings that otherwise meet the residential program definition under section 245A.02, subdivision 14, the commissioner shall not enroll new customized living settings serving four or fewer people in a single-family home to deliver customized living services as defined under the brain injury or community access for disability inclusion waiver plans under section 256B.49.

(b) The commissioner may approve an exception to paragraph (a) when an existing customized living setting changes ownership at the same address.

(c) Customized living settings operational on or before June 30, 2021, are considered existing customized living settings.

(d) For any new customized living settings serving four or fewer people in a single-family home to deliver customized living services as defined in paragraph (a) and that was not operational on or before June 30, 2021, the authorizing lead agency is financially responsible for all home and community-based service payments in the setting.

(e) For purposes of this subdivision, "operational" means customized living services are authorized and delivered to a person in the customized living setting.

EFFECTIVE DATE. This section is effective July 1, 2021. This section applies only to customized living services as defined under the brain injury or community access for disability inclusion waiver plans under Minnesota Statutes, section 256B.49.

Sec. 26. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision to read:

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

(b) "Informed choice" means a choice that adults who have disabilities and, with support from their families or legal representatives, that children who have disabilities make regarding services and supports that best meets the adult's or child's needs and preferences. Before making an informed choice, an individual who has disabilities must be provided, in an accessible format and manner that meets the individual's needs, the tools, information, and opportunities the individual requests or requires to understand all of the individual's options.

(c) "HCBS" means home and community-based services covered under this chapter by the medical assistance state plan, and the home and community-based waiver services covered under sections 256B.092 and 256B.49.

Sec. 27. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision to read:

Subd. 2a. **Informed choice policy.** It is the policy of this state that all adults who have disabilities and, with support from their families or legal representatives, all children who have disabilities:

(1) can make informed choices to select and utilize disability services and supports; and

(2) will be offered an informed decision-making process sufficient to make informed choices.

Sec. 28. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision to read:

Subd. 3a. **Informed decision making.** (a) The commissioner of human services and lead agencies shall ensure that:

(1) disability services support the presumption that adults who have disabilities and, with support from their families or legal representatives, children who have disabilities can make informed choices;

(2) all adults who have disabilities and are accessing HCBS and all families of children who have disabilities and are accessing HCBS are provided an informed decision-making process satisfying the requirements of paragraph (b);

(3) all adults who have disabilities and are accessing HCBS and all families of children who have disabilities and are accessing HCBS are provided the opportunity to revisit or change any decision or choice at any time of the adult's or family's choosing; and

(4) services or supports necessary to accomplish each step of an informed decision-making process or to make an informed choice to utilize disability services are authorized and implemented within a reasonable time frame for individuals accessing HCBS.

(b) The commissioner of human services must develop and ensure compliance with an informed decision-making standard that provides accessible, correct, and complete information to help an individual accessing HCBS make an informed choice. This information must be accessible and understandable to the person so that the person can demonstrate understanding of the options. Any written information provided in the process must be accessible and the process must be experiential whenever possible. The process must also consider and offer to the person, in a person-centered manner, the following:

(1) reasonable accommodations as needed or requested by the person to fully participate in the informed decision-making process and acquire the information necessary to make an informed choice;

(2) discussion of the person's own preferences, abilities, goals, and objectives;

(3) identification of the person's cultural needs and access to culturally responsive services and providers;

(4) information about the benefits of inclusive and individualized services and supports;

(5) presentation and discussion of all options with the person;

(6) documentation, in a manner prescribed by the commissioner, of each option discussed;

(7) exploration and development of new or other options;

(8) facilitation of opportunities to visit alternative locations or to engage in experiences to understand how any service option might work for the person;

(9) opportunities to meet with other individuals with disabilities who live, work, and receive services different from the person's own services;

(10) development of a transition plan, when needed or requested by the person, to facilitate the choice to move from one service type or setting to another, and authorization of the services and supports necessary to effectuate the plan;

(11) identification of any barriers to assisting or implementing the person's informed choice and authorization of the services and supports necessary to overcome those barriers; and

(12) ample time and timely opportunity to consider available options before the individual makes a final choice or changes a choice.

(c) The commissioner shall ensure that individuals accessing HCBS have access to an informed decision-making process at least annually by:

(1) updating informed choice protocols for HCBS to reflect the informed choice definition in subdivision 1a, paragraph (b), and the informed decision-making process outlined in paragraph (b);

(2) developing a survey designed for individuals accessing HCBS to assess their experience with informed choice and the informed decision-making process, including how frequently it is offered and how well it meets the standard in paragraph (b). The survey shall be administered and results used to determine the quality and frequency of informed choice and informed decision making consistent with this section. The commissioner shall utilize survey results to increase the frequency and quality of informed decision making and informed choice as experienced by individuals accessing HCBS;

(3) creating an option for interested persons to file incident reports regarding access to and the quality of informed choice and informed decision making experienced by an individual accessing HCBS, and implementing appropriate processes upon receipt of the reports;

(4) updating informed choice, informed decision making, and other relevant training tools for lead agency and provider staff to reflect the informed choice definition in subdivision 1a, paragraph (b), informed decision-making process outlined in paragraph (b), and other requirements of this section; and

(5) mandating informed choice training for lead agency staff who support individuals accessing HCBS.

Sec. 29. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision to read:

Subd. 4a. **Informed choice in employment policy.** It is the policy of this state that working-age individuals who have disabilities:

(1) can work and achieve competitive integrated employment with appropriate services and supports, as needed;

(2) make informed choices about their postsecondary education, work, and career goals; and

(3) will be offered the opportunity to make an informed choice, at least annually, to pursue postsecondary education or to work and earn a competitive wage.

Sec. 30. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision to read:

Subd. 5a. **Informed choice in employment implementation.** (a) The commissioner of human services and lead agencies shall ensure that disability services align with the employment first policy adopted by the Olmstead subcabinet on September 29, 2014, or successor policies.

(b) The commissioner and lead agencies shall implement the provisions of subdivision 3a, paragraph (c), and take other appropriate actions to ensure that all working-age individuals who have disabilities and are accessing HCBS are offered an informed decision-making process that will help them make an informed choice about postsecondary education offering meaningful credentials; and about working and earning, with appropriate services and supports, a competitive wage in work or a career that the individual chooses before being offered exclusively day services as defined in section 245D.03, subdivision 1, paragraph (c), clause (4), or successor provisions.

Sec. 31. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision to read:

Subd. 7. **Informed choice in community living policy.** It is the policy of this state that all adults who have disabilities:

(1) can live in the communities of the individual's choosing with appropriate services and supports as needed; and

(2) have the right, at least annually, to make an informed decision-making process that can help them make an informed choice to live outside of a provider-controlled setting.

Sec. 32. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision to read:

Subd. 8. **Informed choice in community living implementation.** (a) The commissioner of human services and lead agencies shall ensure that disability services support the presumption that all adults who have disabilities can and want to live in the communities of the individual's choosing with services and supports as needed.

(b) The commissioner and lead agencies shall implement the provisions of subdivision 3a, paragraph (c), and take any appropriate action to ensure that all adults who have disabilities and are accessing HCBS are offered, after an informed decision-making process and during a person-centered planning process, the services and supports the individual needs to live as the individual chooses, including in a non-provider-controlled setting. Provider-controlled settings include customized living services provided in a single-family home or residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), or successor provisions, unless the residential services and supports are provided in a family adult foster care residence under a shared living option as described in Laws 2013, chapter 108, article 7, section 62.

Sec. 33. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision to read:

Subd. 9. **Informed choice in self-direction policy.** It is the policy of this state that adults who have disabilities and families of children who have disabilities:

(1) can direct the adult's or child's needed services and supports; and

(2) have the right to make an informed choice to self-direct the adult's or child's services and supports before being offered options that do not allow the adult or family to self-direct the adult's or child's services and supports.

Sec. 34. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision to read:

Subd. 10. **Informed choice in self-direction implementation.** (a) The commissioner of human services and lead agencies shall ensure that disability services support the presumption that adults who have disabilities and families of children who have disabilities can direct all of the adult's or child's services and supports, including control over the funding of the adult's or child's services and supports.

(b) The commissioner and lead agencies shall implement the provisions of subdivision 3a, paragraph (c), and take any other appropriate actions to ensure that at intervals described in paragraph (c), adults who have disabilities and are accessing HCBS and families of children who have disabilities and are accessing HCBS are offered, after an informed decision-making process and during a person-centered planning process, the option to direct the adult's or child's services and supports, including the option to have control over the funding of the adult's or child's services and supports.

(c) The commissioner or lead agency shall offer adults who have disabilities and families of children who have disabilities the options described in paragraph (b) at least annually during regularly scheduled planning meetings or more frequently when:

(1) the adults who have disabilities or families of children who have disabilities requests or suggests the options described in paragraph (b) or when the adult or family expresses dissatisfaction with services and supports that do not allow for self-direction;

(2) the family or a legal representative of the individual with disabilities requests or suggests the options described in paragraph (b);

(3) any member of the individual's service planning team or expanded service planning team requests or suggests the options described in paragraph (b); or

(4) self-directed services and supports could enhance the individual's independence or quality of life.

Sec. 35. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision to read:

Subd. 11. **Informed choice in technology policy.** It is the policy of this state that all adults who have disabilities and children who have disabilities:

(1) can use assistive technology, remote supports, or a combination of both to enhance the adult's or child's independence and quality of life; and

(2) have the right, at least annually, to make an informed choice about the adult's or child's use of assistive technology and remote supports.

Sec. 36. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision to read:

Subd. 12. **Informed choice in technology implementation.** (a) The commissioner of human services and lead agencies shall ensure that disability services support the presumption

that adults who have disabilities and children who have disabilities can use or benefit from assistive technology, remote supports, or both.

(b) The commissioner and lead agencies shall implement the provisions of subdivision 3a, paragraph (c), and take any other appropriate actions to ensure that at intervals described in paragraph (c), adults who have disabilities and are accessing HCBS and families of children who have disabilities and are accessing HCBS are offered, after an informed decision-making process and during a person-centered planning process, the opportunity to choose assistive technology, remote support, or both, to ensure equitable access.

(c) The commissioner or lead agency shall offer adults who have disabilities and families of children who have disabilities the options described in paragraph (b) at least annually during a regularly scheduled planning meeting or more frequently when:

(1) the adult who has disabilities or the family of a child who has disabilities requests or suggests the options described in paragraph (b) or when the adult or family expresses dissatisfaction with in-person services and supports;

(2) the family or a legal representative of the individual with disabilities requests or suggests the options described in paragraph (b);

(3) any member of the individual's service planning team or expanded service planning team requests or suggests the options described in paragraph (b); or

(4) assistive technology, remote supports, or both could enhance the individual's independence or quality of life.

(d) The availability of assistive technology, remote supports, or both, shall not preclude an individual with disabilities from accessing in-person supports and services, nor shall it result in a denial of in-person supports and services.

Sec. 37. Minnesota Statutes 2020, section 256B.4914, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them, unless the context clearly indicates otherwise.

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

(c) "Comparable occupations" means the occupations, excluding direct care staff, as represented by the Bureau of Labor Statistics standard occupational classification codes that have the same classification for:

(1) typical education needed for entry;

(2) work experience in a related occupation; and

(3) typical on-the-job training competency as the most predominant classification for direct care staff.

(d) "Component value" means underlying factors that are part of the cost of providing services that are built into the waiver rates methodology to calculate service rates.

(e) "Customized living tool" means a methodology for setting service rates that delineates and documents the amount of each component service included in a recipient's customized living service plan.

(f) "Direct care staff" means employees providing direct service to people receiving services under this section. Direct care staff excludes executive, managerial, and administrative staff.

(g) "Disability waiver rates system" means a statewide system that establishes rates that are based on uniform processes and captures the individualized nature of waiver services and recipient needs.

(h) "Individual staffing" means the time spent as a one-to-one interaction specific to an individual recipient by staff to provide direct support and assistance with activities of daily living, instrumental activities of daily living, and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's needs must also be considered.

(i) "Lead agency" means a county, partnership of counties, or tribal agency charged with administering waivered services under sections 256B.092 and 256B.49.

(j) "Median" means the amount that divides distribution into two equal groups, one-half above the median and one-half below the median.

(k) "Payment or rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

(l) "Rates management system" means a web-based software application that uses a framework and component values, as determined by the commissioner, to establish service rates.

(m) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

(n) "Shared staffing" means time spent by employees, not defined under paragraph (f), providing or available to provide more than one individual with direct support and assistance with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (i); ancillary activities needed to support individual services; and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider observation of an individual's service need. Total shared staffing hours are divided proportionally by the number of individuals who receive the shared service provisions.

(o) "Staffing ratio" means the number of recipients a service provider employee supports during a unit of service based on a uniform assessment tool, provider observation, case history, and the recipient's services of choice, and not based on the staffing ratios under section 245D.31.

(p) "Unit of service" means the following:

(1) for residential support services under subdivision 6, a unit of service is a day. Any portion of any calendar day, within allowable Medicaid rules, where an individual spends time in a residential setting is billable as a day;

(2) for day services under subdivision 7:

(i) for day training and habilitation services, a unit of service is either:

(A) a day unit of service is defined as six or more hours of time spent providing direct services and transportation; or

(B) a partial day unit of service is defined as fewer than six hours of time spent providing direct services and transportation; and

(C) for new day service recipients after January 1, 2014, 15 minute units of service must be used for fewer than six hours of time spent providing direct services and transportation;

(ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct services;

(iii) for day support services, a unit of service is 15 minutes; and

(iv) for prevocational services, a unit of service is a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct service;

(3) for unit-based services with programming under subdivision 8:

(i) for supported living services, a unit of service is a day or 15 minutes. When a day rate is authorized, any portion of a calendar day where an individual receives services is billable as a day; ~~and~~

(ii) for individualized home supports with training, a unit of service is a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct service; and

(iii) for all other services, a unit of service is 15 minutes; and

(4) for unit-based services without programming under subdivision 9, a unit of service is 15 minutes.

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

Sec. 38. Minnesota Statutes 2020, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC code 31-1014); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for adult day services, 70 percent of the median wage for nursing assistant (SOC code 31-1014); and 30 percent of the median wage for personal care aide (SOC code 39-9021);

(3) for day services, day support services, and prevocational services, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(4) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota for large employers, except in a family foster care setting, the wage is 36 percent of the minimum wage in Minnesota for large employers;

(5) for positive supports analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(6) for positive supports professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(7) for positive supports specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(8) for supportive living services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(9) for housing access coordination staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099);

(10) for in-home family support and individualized home supports with family training staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for individualized home supports with training services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(12) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(13) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(14) for employment exploration services staff, 50 percent of the median wage for ~~rehabilitation counselor (SOC code 21-1015)~~ education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(15) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(16) for individualized home support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(17) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(18) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(19) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(20) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(21) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of positive supports professional, positive supports analyst, and positive supports specialists, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(22) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

(23) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for corporate foster care services, corporate supportive living services daily, community residential services, and integrated community support services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

(c) Component values for family foster care are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 3.3 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence factor: 1.7 percent.

(d) Component values for day training and habilitation, day support services, and prevocational services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: ten percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(e) Component values for day support services and prevocational services delivered remotely are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 10.37 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(f) Component values for adult day services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 7.4 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

~~(f)~~ (g) Component values for unit-based services with programming are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan supports ratio: 15.5 percent;

(6) client programming and supports ratio: 4.7 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 6.1 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

~~(g)~~ (h) Component values for unit-based services with programming delivered remotely are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan supports ratio: 15.5 percent;

(6) client programming and supports ratio: 4.7 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 6.1 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(i) Component values for unit-based services without programming except respite are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 7.0 percent;

(6) client programming and support ratio: 2.3 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(j) Component values for unit-based services without programming delivered remotely, except respite, are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 7.0 percent;

(6) client programming and support ratio: 2.3 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

~~(h)~~ (k) Component values for unit-based services without programming for respite are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 2.9 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

~~(i)~~ (l) On July 1, 2022, and every two years thereafter, the commissioner shall update the base wage index in paragraph (a) based on wage data by SOC from the Bureau of Labor Statistics available 30 months and one day prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

~~(j)~~ (m) Beginning February 1, 2021, and every two years thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance an analysis

of the competitive workforce factor. The report must include recommendations to update the competitive workforce factor using:

(1) the most recently available wage data by SOC code for the weighted average wage for direct care staff for residential services and direct care staff for day services;

(2) the most recently available wage data by SOC code of the weighted average wage of comparable occupations; and

(3) workforce data as required under subdivision 10a, paragraph (g).

The commissioner shall not recommend an increase or decrease of the competitive workforce factor from the current value by more than two percentage points. If, after a biennial analysis for the next report, the competitive workforce factor is less than or equal to zero, the commissioner shall recommend a competitive workforce factor of zero.

~~(k)~~ (n) On July 1, 2022, and every two years thereafter, the commissioner shall update the framework components in paragraph (d), clause (6); paragraph (e), clause (6); paragraph (f), clause (6); and paragraph (g), clause (6); paragraph (h), clause (6); paragraph (i), clause (6); paragraph (j), clause (6); subdivision 6, paragraphs (b), clauses (9) and (10), and (e), clause (10); and subdivision 7, clauses (11), (17), and (18), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the data available 30 months and one day prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

~~(l)~~ (o) Upon the implementation of the updates under paragraphs ~~(i) and (k)~~ (l) and (n), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013, chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall be removed from service rates calculated under this section.

~~(m)~~ (p) Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section shall be removed from rate calculations upon implementation of the updates under paragraphs ~~(i) and (k)~~ (l) and (n).

~~(n)~~ (q) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

EFFECTIVE DATE. This section is effective January 1, 2022, six months after the end of the federal public health emergency, or upon federal approval, whichever is later.

The commissioner of human services shall notify the revisor of statutes when the federal public health emergency ends and when federal approval is obtained.

Sec. 39. Minnesota Statutes 2020, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Payments for residential support services.** (a) For purposes of this subdivision, residential support services includes 24-hour customized living services, community residential services, customized living services, family residential services, foster care services, integrated community supports, and supportive living services daily.

(b) Payments for community residential services, corporate foster care services, corporate supportive living services daily, family residential services, and family foster care services must be calculated as follows:

(1) determine the number of shared staffing and individual direct staff hours to meet a recipient's needs provided on site or through monitoring technology;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (b), clause (1);

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages;

(6) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (3). This is defined as the direct staffing cost;

(8) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (4);

(9) for client programming and supports, the commissioner shall add $2,179; and

(10) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport, based on the resident with the highest assessed need.

(c) The total rate must be calculated using the following steps:

(1) subtotal paragraph (b), clauses (8) to (10), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause (8);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(d) The payment methodology for customized living~~,~~ and 24-hour customized living, ~~and residential care~~ services must be the customized living tool. ~~Revisions to~~ The commissioner shall revise the customized living tool ~~must be made~~ to reflect the services and activities unique to disability-related recipient needs, adjust for regional differences in the cost of providing services, and the rate adjustments described in section 256S.205. Customized living and 24-hour customized living rates determined under this section shall not include more than 24 hours of support in a daily unit. The commissioner shall establish acuity-based input limits, based on case mix, for customized living and 24-hour customized living rates determined under this section.

(e) Payments for integrated community support services must be calculated as follows:

(1) the base shared staffing ~~shall~~ must be eight hours divided by the number of people receiving support in the integrated community support setting;

(2) the individual staffing hours ~~shall~~ must be the average number of direct support hours provided directly to the service recipient;

(3) the personnel hourly wage rate must be based on the most recent Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(4) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (3) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (b), clause (1);

(5) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (4);

(6) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the appropriate staff wages;

(7) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the product of the supervisory span of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervisory wage in subdivision 5, paragraph (a), clause (21);

(8) combine the results of clauses (6) and (7) and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (3). This is defined as the direct staffing cost;

(9) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (4); and

(10) for client programming and supports, the commissioner shall add $2,260.21 divided by 365.

(f) The total rate must be calculated as follows:

(1) add the results of paragraph (e), clauses (9) and (10);

(2) add the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

~~(g) The payment methodology for customized living and 24-hour customized living services must be the customized living tool. The commissioner shall revise the customized~~

~~living tool to reflect the services and activities unique to disability-related recipient needs and adjust for regional differences in the cost of providing services.~~

~~(h)~~ (g) The number of days authorized for all individuals enrolling in residential services must include every day that services start and end.

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

Sec. 40. Minnesota Statutes 2020, section 256B.4914, subdivision 7, is amended to read:

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day services, day treatment and habilitation, day support services, prevocational services, and structured day services provided in person or remotely must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (d), clause (1);

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of day program direct staff hours and nursing hours by the appropriate staff wage;

(6) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause (2), for in-person services or

subdivision 5, paragraph (e), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause (3), for in-person services or subdivision 5, paragraph (e), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio in subdivision 5, paragraph (d), clause (5), for in-person services or subdivision 5, paragraph (e), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph (d), clause (4), for in-person services or subdivision 5, paragraph (e), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio in subdivision 5, paragraph (d), clause (6), for in-person services or subdivision 5, paragraph (e), clause (6), for remote services;

(11) for program facility costs, add ~~$19.30~~ $20.02 per week with consideration of staffing ratios to meet individual needs;

(12) for adult day bath services, add $7.01 per 15 minute unit;

(13) this is the subtotal rate;

(14) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(15) divide the result of clause (13) by one minus the result of clause (14). This is the total payment amount;

(16) adjust the result of clause (15) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

(17) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

(18) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

EFFECTIVE DATE. This section is effective January 1, 2022, six months after the end of the federal public health emergency, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when the federal public health emergency ends and when federal approval is obtained.

Sec. 41. Minnesota Statutes 2020, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including employment exploration services, employment development services, housing access coordination, individualized home supports with family training, individualized home supports with training, in-home family support, independent living skills training, and hourly supported living services provided to an individual outside of any day or residential service plan provided in person or remotely must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph ~~(f)~~ (g), clause (1);

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of direct staff hours by the appropriate staff wage;

(6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (2), for in-person services or subdivision 5, paragraph (h), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (3), for in-person services or subdivision 5, paragraph (h), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan supports ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (5), for in-person services or subdivision 5, paragraph (h), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (4), for in-person services or subdivision 5, paragraph (h), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and supports ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (6), for in-person services or subdivision 5, paragraph (h), clause (6), for remote services;

(11) this is the subtotal rate;

(12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for employment exploration services provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed five. For employment support services provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed six. For independent living skills training~~, individualized home supports with training,~~ and individualized home supports with family training provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed two. For individualized home supports with training, provided in a shared manner, including for a day unit of individualized home supports with training provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed three; and

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. (a) Except for the amendment to clause (14), this section is effective January 1, 2022, six months after the end of the federal public health emergency, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when the federal public health emergency ends and when federal approval is obtained.

(b) The amendment to clause (14) is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 42. Minnesota Statutes 2020, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming, including individualized home supports, night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan provided in person or remotely must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph ~~(g)~~ (i), clause (1);

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of direct staff hours by the appropriate staff wage;

(6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (2), for in-person services or subdivision 5, paragraph (j), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (3), for in-person services or subdivision 5, paragraph (j), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (5), for in-person services or subdivision 5, paragraph (j), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (4), for in-person services or subdivision 5, paragraph (j), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (6), for in-person services or subdivision 5, paragraph (j), clause (6), for remote services;

(11) this is the subtotal rate;

(12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for respite services, determine the number of day units of service to meet an individual's needs;

(15) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(16) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (15) by the product of one plus the competitive workforce factor in subdivision 5, paragraph ~~(h)~~ (k), clause (1);

(17) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (16);

(18) multiply the number of direct staff hours by the appropriate staff wage;

(19) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph ~~(h)~~ (k), clause (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(20) combine the results of clauses (18) and (19), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(h)~~ (k), clause (3). This is defined as the direct staffing rate;

(21) for employee-related expenses, multiply the result of clause (20) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(h)~~ (k), clause (4);

(22) this is the subtotal rate;

(23) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(24) divide the result of clause (22) by one minus the result of clause (23). This is the total payment amount;

(25) for individualized home supports provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed two;

(26) for respite care services provided in a shared manner, divide the total payment amount in clause (24) by the number of service recipients, not to exceed three; and

(27) adjust the result of clauses (13), (25), and (26) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective January 1, 2022, six months after the end of the federal public health emergency, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when the federal public health emergency ends and when federal approval is obtained.

Sec. 43. Minnesota Statutes 2020, section 256B.5012, is amended by adding a subdivision to read:

Subd. 18. **ICF/DD rate increases effective July 1, 2021.** (a) For the rate period beginning July 1, 2021, the commissioner must increase operating payments for each facility reimbursed under this section equal to five percent of the operating payment rates in effect on June 30, 2021.

(b) For each facility, the commissioner must apply the rate increase based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate in effect on June 30, 2021. The total rate increase must include the adjustment provided in section 256B.501, subdivision 12.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 44. Minnesota Statutes 2020, section 256B.5013, subdivision 1, is amended to read:

Subdivision 1. **Variable rate adjustments.** (a) ~~For rate years beginning on or after October 1, 2000,~~ When there is a documented increase in the needs of a current ICF/DD recipient, the county of financial responsibility may recommend a variable rate to enable the facility to meet the individual's increased needs. Variable rate adjustments made under this subdivision replace payments for persons with special needs for crisis intervention services under section 256B.501, subdivision 8a. ~~Effective July 1, 2003, facilities with a base rate above the 50th percentile of the statewide average reimbursement rate for a Class A facility or Class B facility, whichever matches the facility licensure, are not eligible for a variable rate adjustment. Variable rate adjustments may not exceed a 12-month period, except when approved for purposes established in paragraph (b), clause (1).~~ Once approved, variable rate adjustments must continue to remain in place unless there is an identified change in need. A review of needed resources must be done at the time of the individual's annual support plan meeting. Any change in need identified must result in submission of a request to adjust the resources for the individual. Variable rate adjustments approved solely on the basis of changes on a developmental disabilities screening document will end June 30, 2002.

(b) The county of financial responsibility must act on a variable rate request within 30 days and notify the initiator of the request of the county's recommendation in writing.

~~(b)~~ (c) A variable rate may be recommended by the county of financial responsibility for increased needs in the following situations:

(1) a need for resources due to an individual's full or partial retirement from participation in a day training and habilitation service when the individual: (i) has reached the age of 65 or has a change in health condition that makes it difficult for the person to participate in day training and habilitation services over an extended period of time because it is medically contraindicated; and (ii) has expressed a desire for change through the developmental disability screening process under section 256B.092;

(2) a need for additional resources for intensive short-term programming ~~which~~ that is necessary prior to an individual's discharge to a less restrictive, more integrated setting;

(3) a demonstrated medical need that significantly impacts the type or amount of services needed by the individual; ~~or~~

(4) a demonstrated behavioral or cognitive need that significantly impacts the type or amount of services needed by the individual~~.~~; or

~~(c) The county of financial responsibility must justify the purpose, the projected length of time, and the additional funding needed for the facility to meet the needs of the individual.~~

~~(d) The facility shall provide an annual report to the county case manager on the use of the variable rate funds and the status of the individual on whose behalf the funds were approved. The county case manager will forward the facility's report with a recommendation to the commissioner to approve or disapprove a continuation of the variable rate.~~

~~(e) Funds made available through the variable rate process that are not used by the facility to meet the needs of the individual for whom they were approved shall be returned to the state.~~

(5) a demonstrated increased need for staff assistance, changes in the type of staff credentials needed, or a need for expert consultation based on assessments conducted prior to the annual support plan meeting.

(d) Variable rate requests must include the following information:

(1) the service needs change;

(2) the variable rate requested and the difference from the current rate;

(3) a basis for the underlying costs used for the variable rate and any accompanying documentation; and

(4) documentation of the expected outcomes to be achieved and the frequency of progress monitoring associated with the rate increase.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 45. Minnesota Statutes 2020, section 256B.5013, subdivision 6, is amended to read:

Subd. 6. **Commissioner's responsibilities.** The commissioner shall:

(1) make a determination to approve, deny, or modify a request for a variable rate adjustment within 30 days of the receipt of the completed application;

(2) notify the ICF/DD facility and county case manager of the ~~duration and conditions of variable rate adjustment approvals~~ determination; and

(3) modify MMIS II service agreements to reimburse ICF/DD facilities for approved variable rates.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 46. Minnesota Statutes 2020, section 256B.5015, subdivision 2, is amended to read:

Subd. 2. **Services during the day.** (a) Services during the day, as defined in section 256B.501, but excluding day training and habilitation services, shall be paid as a pass-through payment ~~no later than January 1, 2004~~. The commissioner shall establish rates for these services, other than day training and habilitation services, at ~~levels that do not exceed 75~~ 100 percent of a recipient's day training and habilitation service costs prior to the service change.

(b) An individual qualifies for services during the day under paragraph (a) if, through consultation with the individual and the individual's support team or interdisciplinary team:

(1) it has been determined that the individual's needs can best be met through partial or full retirement from:

(i) participation in a day training and habilitation service; or

(ii) the use of services during the day in the individual's home environment; and

(2) an individualized plan has been developed with designated outcomes that:

(i) address the support needs and desires contained in the person-centered plan or individual support plan; and

(ii) include goals that focus on community integration as appropriate for the individual.

(c) When establishing a rate for these services, the commissioner shall also consider an individual recipient's needs as identified in the ~~individualized service~~ individual support plan and the person's need for active treatment as defined under federal regulations. The pass-through payments for services during the day shall be paid separately by the commissioner and shall not be included in the computation of the ICF/DD facility total payment rate.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 47. Minnesota Statutes 2020, section 256B.85, subdivision 7a, is amended to read:

Subd. 7a. **Enhanced rate.** An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ~~12~~ ten or more hours of CFSS per day when provided by a support worker who meets the requirements of subdivision 16, paragraph (e). The enhanced rate for CFSS includes, and is not in addition to, any rate adjustments implemented by the commissioner on July 1, 2019, to comply with the terms of a collective bargaining agreement between the state of Minnesota and an exclusive representative of individual providers under section 179A.54 that provides for wage increases for individual providers who serve participants assessed to need 12 or more hours of CFSS per day.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever occurs later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 48. Minnesota Statutes 2020, section 256B.85, subdivision 16, is amended to read:

Subd. 16. **Support workers requirements.** (a) Support workers shall:

(1) enroll with the department as a support worker after a background study under chapter 245C has been completed and the support worker has received a notice from the commissioner that the support worker:

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

(ii) is disqualified, but has received a set-aside of the disqualification under section 245C.22;

(2) have the ability to effectively communicate with the participant or the participant's representative;

(3) have the skills and ability to provide the services and supports according to the participant's CFSS service delivery plan and respond appropriately to the participant's needs;

(4) complete the basic standardized CFSS training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. CFSS support worker training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of support workers including information about basic body mechanics, emergency preparedness, orientation to positive behavioral practices, orientation to responding to a mental health crisis, fraud issues, time cards and documentation, and an overview of person-centered planning and self-direction. Upon completion of the training components, the support worker must pass the certification test to provide assistance to participants;

(5) complete employer-directed training and orientation on the participant's individual needs;

(6) maintain the privacy and confidentiality of the participant; and

(7) not independently determine the medication dose or time for medications for the participant.

(b) The commissioner may deny or terminate a support worker's provider enrollment and provider number if the support worker:

(1) does not meet the requirements in paragraph (a);

(2) fails to provide the authorized services required by the employer;

(3) has been intoxicated by alcohol or drugs while providing authorized services to the participant or while in the participant's home;

(4) has manufactured or distributed drugs while providing authorized services to the participant or while in the participant's home; or

(5) has been excluded as a provider by the commissioner of human services, or by the United States Department of Health and Human Services, Office of Inspector General, from participation in Medicaid, Medicare, or any other federal health care program.

(c) A support worker may appeal in writing to the commissioner to contest the decision to terminate the support worker's provider enrollment and provider number.

(d) A support worker must not provide or be paid for more than 310 hours of CFSS per month, regardless of the number of participants the support worker serves or the number of agency-providers or participant employers by which the support worker is employed. The department shall not disallow the number of hours per day a support worker works unless it violates other law.

(e) CFSS qualify for an enhanced rate if the support worker providing the services:

(1) provides services, within the scope of CFSS described in subdivision 7, to a participant who qualifies for ~~12~~ ten or more hours per day of CFSS; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever occurs later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 49. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision to read:

Subd. 27. **Personal care assistance and community first services and supports provider agency; required reporting and analysis of cost data.** (a) The commissioner must evaluate on an ongoing basis whether the rates paid for personal care assistance and community first services and supports appropriately address the costs to provide these services. The commissioner must make recommendations to adjust the rates paid as indicated by the evaluation. As determined by the commissioner, in consultation with stakeholders, agencies enrolled to provide personal care assistance and community first services and supports with rates determined under this section must submit requested cost data to the commissioner. Requested cost data may include but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

(11) other data relating to costs necessary to provide services requested by the commissioner.

(b) At least once in any three-year period, a provider must submit cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner shall give each provider notice 90 days prior to the submission due date. If a provider fails to submit the required reporting data, the commissioner shall provide notice to the provider 30 days after the required submission date, and a second notice to a provider who fails to submit the required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to a provider if the provider fails to submit cost data within 90 days after the required submission date. The commissioner shall make withheld payments to the provider once the commissioner receives cost data from the provider.

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy.

(d) The commissioner, in consultation with stakeholders, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (a). The commissioner shall provide dedicated support for providers who meet one of the following criteria:

(1) the provider employs fewer than ten staff to provide the services under this section;

(2) the provider's first language is not English; or

(3) the provider serves a population that includes greater than or equal to 50 percent black people, Indigenous people, or people of color.

Sec. 50. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision to read:

Subd. 28. **Payment rates evaluation.** (a) The commissioner shall assess data collected under subdivision 27 and shall publish evaluation findings in a report to the legislature on August 1, 2024, and once every two years thereafter. Evaluation findings shall include:

(1) the costs that providers incur while providing services under this section;

(2) comparisons between those costs and the costs incurred by providers of comparable services and employers in industries competing in the same labor market;

(3) changes in wages, benefits provided, hours worked, and retention over time; and

(4) recommendations for the rate methodologies paid based on the evaluation findings.

(b) The commissioner shall only release cost data in an aggregate form and shall not release cost data from individual providers except as permitted by current law.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 51. Minnesota Statutes 2020, section 256I.04, subdivision 3, is amended to read:

Subd. 3. **Moratorium on development of housing support beds.** (a) Agencies shall not enter into agreements for new housing support beds with total rates in excess of the MSA equivalent rate except:

(1) for establishments licensed under chapter 245D provided the facility is needed to meet the census reduction targets for persons with developmental disabilities at regional treatment centers;

(2) up to 80 beds in a single, specialized facility located in Hennepin County that will provide housing for chronic inebriates who are repetitive users of detoxification centers and are refused placement in emergency shelters because of their state of intoxication, and planning for the specialized facility must have been initiated before July 1, 1991, in anticipation of receiving a grant from the Housing Finance Agency under section 462A.05, subdivision 20a, paragraph (b);

(3) notwithstanding the provisions of subdivision 2a, for up to 226 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter or discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing

available and lacks the resources and support necessary to access appropriate housing. At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, have been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. If a person meets the requirements of subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the housing support rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the housing support supplementary service rate. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a housing support payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a;

(4) for an additional two beds, resulting in a total of 32 beds, for a facility located in Hennepin County providing services for recovering and chemically dependent men that has had a housing support contract with the county and has been licensed as a board and lodge facility with special services since 1980;

(5) for a housing support provider located in the city of St. Cloud, or a county contiguous to the city of St. Cloud, that operates a 40-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision;

(6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent persons, operated by a housing support provider that currently operates a 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

(7) for a housing support provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, that provide community support and 24-hour-a-day supervision to serve the mental health needs of individuals who have chronically lived unsheltered; ~~and~~

(8) for a facility authorized for recipients of housing support in Hennepin County with a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility

and that until August 1, 2007, operated as a licensed chemical dependency treatment program.;

(9) for an additional 42 beds, resulting in a total of 54 beds, for a recovery community organization and housing support provider that currently operates a 38-bed facility in Olmsted County serving individuals diagnosed with substance use disorder, originally licensed and registered by the Department of Health under section 157.17 in 2019, and will operate a new 14-bed facility in Olmsted County serving individuals diagnosed with substance use disorder; and

(10) for 46 beds for a recovery community organization and housing support provider that as of March 1, 2021, operates three facilities in Blue Earth County licensed and registered by the Department of Health under section 157.17, serving individuals diagnosed with substance use disorder.

(b) An agency may enter into a housing support agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered under a housing support agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from housing support payment, or as a result of the downsizing of a setting authorized for recipients of housing support. The transfer of available beds from one agency to another can only occur by the agreement of both agencies.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 52. Minnesota Statutes 2020, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the ~~county~~ agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the federal Social Security Act; or funding from the medical assistance program under section 256B.0659, for personal care services for residents in the setting; or residing in a setting which receives funding under section 245.73. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section 256B.0659, then the housing support rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service

rate exceed $426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the federal Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

(b) The commissioner is authorized to make cost-neutral transfers from the housing support fund for beds under this section to other funding programs administered by the department after consultation with the ~~county or counties~~ agency in which the affected beds are located. The commissioner may also make cost-neutral transfers from the housing support fund to ~~county human service~~ agencies for beds permanently removed from the housing support census under a plan submitted by the ~~county~~ agency and approved by the commissioner. The commissioner shall report the amount of any transfers under this provision annually to the legislature.

(c) ~~Counties~~ Agencies must not negotiate supplementary service rates with providers of housing support that are licensed as board and lodging with special services and that do not encourage a policy of sobriety on their premises and make referrals to available community services for volunteer and employment opportunities for residents.

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

Sec. 53. Minnesota Statutes 2020, section 256I.05, subdivision 1c, is amended to read:

Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for housing support above those in effect on June 30, 1993, except as provided in paragraphs (a) to (f).

(a) An agency may increase the rates for room and board to the MSA equivalent rate for those settings whose current rate is below the MSA equivalent rate.

(b) An agency may increase the rates for residents in adult foster care whose difficulty of care has increased. The total housing support rate for these residents must not exceed the maximum rate specified in subdivisions 1 and 1a. Agencies must not include nor increase difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding by home and community-based waiver programs under title XIX of the Social Security Act.

(c) An agency must increase the room and board rates ~~will be increased~~ each year when the MSA equivalent rate is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less the amount of the increase in the medical assistance personal needs allowance under section 256B.35.

(d) ~~When housing support pays for an individual's room and board, or other costs necessary to provide room and board, the rate payable to the residence must continue for up to 18 calendar days per incident that the person is temporarily absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences are reported in advance to the county agency's social service staff. Advance reporting is not required for emergency absences due to crisis, illness, or injury.~~

~~(e) For~~ An agency may increase the rates for residents in facilities meeting substantial change criteria within the prior year. Substantial change criteria ~~exists~~ exist if the establishment experiences a 25 percent increase or decrease in the total number of its beds, if the net cost of capital additions or improvements is in excess of 15 percent of the current market value of the residence, or if the residence physically moves, or changes its licensure, and incurs a resulting increase in operation and property costs.

~~(f)~~ (e) Until June 30, 1994, an agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to 9549.0058.

(f) Notwithstanding the provisions of subdivision 1, an agency may increase the monthly room and board rates by $100 per month for residents in settings under section 256I.04, subdivision 2a, paragraph (b), clause (2). Participants in the Minnesota supportive housing demonstration program under section 256I.04, subdivision 3, paragraph (a), clause (3), may not receive the increase under this paragraph.

EFFECTIVE DATE. This section is effective July 1, 2022, except the striking of paragraph (d) is effective July 1, 2021.

Sec. 54. Minnesota Statutes 2020, section 256I.05, subdivision 1q, is amended to read:

Subd. 1q. **Supplemental rate; Olmsted County.** (a) Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in Olmsted County that operates long-term residential facilities with a total of 104 beds that serve chemically dependent men and women and provide 24-hour-a-day supervision and other support services.

(b) Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2021, a county agency shall negotiate a supplemental service rate for 54 total beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision 1a, including any legislatively authorized inflationary adjustments, for a recovery community organization and housing support provider located in Olmsted County serving individuals diagnosed with substance use disorder, originally licensed and registered by the Department of Health under section 157.17 in 2019.

Sec. 55. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision to read:

Subd. 1s. **Supplemental rate; Douglas County.** Notwithstanding subdivisions 1a and 1c, beginning July 1, 2021, a county agency shall negotiate a supplemental rate for up to 20 beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision 1a, including any legislatively authorized inflationary adjustments, for a housing support provider located in Douglas County that operates two facilities and provides room and board and supplementary services to adult males recovering from substance use disorder, mental illness, or housing instability.

Sec. 56. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision to read:

Subd. 1t. **Supplementary services rate; Winona County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2021, a county agency shall negotiate a supplementary services rate in addition to the monthly room and board rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in Winona County that operates a permanent supportive housing facility with 20 one-bedroom apartments for adults with long-term homeless and long-term mental health needs.

Sec. 57. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision to read:

Subd. 1u. **Supplemental rate; Blue Earth County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2021, a county agency shall negotiate a supplemental service rate for 46 beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision 1a, including any legislatively authorized inflationary adjustments, for a recovery community organization and housing support provider that as of March 1, 2021, operates three facilities in Blue Earth County licensed and registered by the Department of Health under section 157.17, serving individuals diagnosed with substance use disorder.

Sec. 58. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision to read:

Subd. 1v. **Supplementary services rate; Steele County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2021, a county agency shall negotiate a supplementary services rate in addition to the monthly room and board rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in Steele County that operates a permanent supportive housing facility with 16 units for adults with long-term homeless and long-term mental health needs.

Sec. 59. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision to read:

Subd. 2a. **Absent days.** (a) When a person receiving housing support is temporarily absent and the absence is reported in advance to the agency's social service staff, the agency must continue to pay on behalf of the person the applicable rate for housing support. Advance reporting is not required for absences due to crisis, illness, or injury. The limit on payments for absence days under this paragraph is 18 calendar days per incident, not to exceed 60 days in a calendar year.

(b) An agency must continue to pay an additional 74 days per incident, not to exceed a total of 92 days in a calendar year, for a person who is temporarily absent due to admission at a residential behavioral health facility, inpatient hospital, or nursing facility.

(c) If a person is temporarily absent due to admission at a residential behavioral health facility, inpatient hospital, or nursing facility for a period of time exceeding the limits described in paragraph (b), the agency may request in a format prescribed by the

commissioner an absence day limit exception to continue housing support payments until the person is discharged.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 60. Minnesota Statutes 2020, section 256I.05, subdivision 11, is amended to read:

Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a cost-neutral transfer of funding from the housing support fund to ~~county human service agencies~~ the agency for emergency shelter beds removed from the housing support census under a biennial plan submitted by the ~~county~~ agency and approved by the commissioner. The plan must describe: (1) anticipated and actual outcomes for persons experiencing homelessness in emergency shelters; (2) improved efficiencies in administration; (3) requirements for individual eligibility; and (4) plans for quality assurance monitoring and quality assurance outcomes. The commissioner shall review the ~~county~~ agency plan to monitor implementation and outcomes at least biennially, and more frequently if the commissioner deems necessary.

(b) The funding under paragraph (a) may be used for the provision of room and board or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding must be allocated annually, and the room and board portion of the allocation shall be adjusted according to the percentage change in the housing support room and board rate. The room and board portion of the allocation shall be determined at the time of transfer. The commissioner or ~~county~~ agency may return beds to the housing support fund with 180 days' notice, including financial reconciliation.

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

Sec. 61. Minnesota Statutes 2020, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the room and board rate for that same month. The housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision ~~1c, paragraph (d)~~ 2a.

(b) For an individual with earned income under paragraph (a), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.

(c) For an individual who receives housing support payments under section 256I.04, subdivision 1, paragraph (c), the amount of the housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 62. Minnesota Statutes 2020, section 256S.203, is amended to read:

256S.203 CUSTOMIZED LIVING SERVICES; MANAGED CARE RATES.

Subdivision 1. **Capitation payments.** The commissioner ~~shall~~ must adjust the elderly waiver capitation payment rates for managed care organizations paid to reflect the monthly service rate limits for customized living services and 24-hour customized living services established under section 256S.202 and the rate adjustments for disproportionate share facilities under section 256S.205.

Subd. 2. **Reimbursement rates.** Medical assistance rates paid to customized living providers by managed care organizations under this chapter ~~shall~~ must not exceed the monthly service rate limits and component rates as determined by the commissioner under sections 256S.15 and 256S.20 to 256S.202, plus any rate adjustment under section 256S.205.

Sec. 63. **[256S.205] CUSTOMIZED LIVING SERVICES; DISPROPORTIONATE SHARE RATE ADJUSTMENTS.**

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

(b) "Application year" means a year in which a facility submits an application for designation as a disproportionate share facility.

(c) "Assisted living facility" or "facility" means an assisted living facility licensed under chapter 144G.

(d) "Disproportionate share facility" means an assisted living facility designated by the commissioner under subdivision 4.

Subd. 2. **Rate adjustment application.** An assisted living facility may apply to the commissioner for designation as a disproportionate share facility. Applications must be submitted annually between October 1 and October 31. The applying facility must apply in a manner determined by the commissioner. The applying facility must document as a percentage the census of elderly waiver participants residing in the facility on October 1 of the application year.

Subd. 3. **Rate adjustment eligibility criteria.** Only facilities with a census of at least 80 percent elderly waiver participants on October 1 of the application year are eligible for designation as a disproportionate share facility.

Subd. 4. **Designation as a disproportionate share facility.** By November 15 of each application year, the commissioner must designate as a disproportionate share facility a facility that complies with the application requirements of subdivision 2 and meets the eligibility criteria of subdivision 3.

Subd. 5. **Rate adjustment; rate floor.** (a) Notwithstanding the 24-hour customized living monthly service rate limits under section 256S.202, subdivision 2, and the component service rates established under section 256S.201, subdivision 4, the commissioner must establish a rate floor equal to $119 per resident per day for 24-hour customized living services provided in a designated disproportionate share facility for the purpose of ensuring the minimal level of staffing required to meet the health and safety need of elderly waiver participants.

(b) The commissioner must adjust the rate floor at least annually in the manner described under section 256S.18, subdivisions 5 and 6.

(c) The commissioner shall not implement the rate floor under this section if the customized living rates established under sections 256S.21 to 256S.215 will be implemented at 100 percent on January 1 of the year following an application year.

Subd. 6. **Budget cap disregard.** The value of the rate adjustment under this section must not be included in an elderly waiver client's monthly case mix budget cap.

EFFECTIVE DATE. This section is effective October 1, 2021, or upon federal approval, whichever is later, and applies to services provided on or after January 1, 2022, or on or after the date upon which federal approval is obtained, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 64. Laws 2019, First Special Session chapter 9, article 5, section 86, subdivision 1, as amended by Laws 2020, First Special Session chapter 2, article 3, section 2, subdivision 1, is amended to read:

Subdivision 1. **Intent.** It is the intent of the legislature to reform the medical assistance waiver programs for people with disabilities to simplify administration of the programs. Disability waiver reconfiguration must incentivize inclusive, person-centered, individualized supports and services; enhance each person's self-determination and personal authority over the person's service choice; align benefits across waivers; ensure equity across programs and populations; assess and address racial and geographical disparities and institutional bias in services and programs; promote long-term sustainability of waiver services; and maintain service stability and continuity of care while prioritizing, promoting, and creating incentives for independent, integrated, and individualized supports and services chosen by each person through an informed decision-making process and person-centered planning.

Sec. 65. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; PLAN FOR ADDRESSING EFFECTS ON COMMUNITY OF CERTAIN STATE-OPERATED SERVICES.**

The commissioner of human services, in consultation with stakeholders, shall develop and submit to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services by January 31, 2022, a plan to ameliorate the effects of repeated incidents, as defined in Minnesota Statutes, section 245D.02, subdivision 11, occurring at Minnesota state-operated community services programs that affect the community in which the program is located and the neighbors of the service site of the program.

Sec. 66. **DIRECTION TO THE COMMISSIONER; INITIAL PACE IMPLEMENTATION FUNDING.**

The commissioner of human services must work with stakeholders to develop recommendations for financing mechanisms to complete the actuarial work and cover the administrative costs of a program of all-inclusive care for the elderly (PACE). The commissioner must recommend a financing mechanism that could begin July 1, 2023. The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health care funding by December 15, 2022, on the commissioner's progress toward developing a recommended financing mechanism.

Sec. 67. **DIRECTION TO COMMISSIONERS; CUSTOMIZED LIVING REPORT.**

(a) By January 15, 2022, the commissioner of human services shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance. The report must include the commissioner's:

(1) assessment of the prevalence of customized living services provided under Minnesota Statutes, section 256B.49, supplanting the provision of residential services and supports licensed under Minnesota Statutes, chapter 245D, and provided in settings licensed under Minnesota Statutes, chapter 245A;

(2) recommendations regarding the continuation of the moratorium on home and community-based services customized living settings under Minnesota Statutes, section 256B.49, subdivision 28;

(3) other policy recommendations to ensure that customized living services are being provided in a manner consistent with the policy objectives of the foster care licensing moratorium under Minnesota Statutes, section 245A.03, subdivision 7; and

(4) recommendations for needed statutory changes to implement the transition from existing four-person or fewer customized living settings to corporate adult foster care or community residential settings.

(b) The commissioner of health shall provide the commissioner of human services with the required data to complete the report in paragraph (a) and implement the moratorium on home and community-based services customized living settings under Minnesota Statutes, section 256B.49, subdivision 28. The data must include, at a minimum, each registered housing with services establishment under Minnesota Statutes, chapter 144D, enrolled as a customized living setting to deliver customized living services as defined under the brain injury or community access for disability inclusion waiver plans under Minnesota Statutes, section 256B.49.

Sec. 68. **HOUSING SUPPORT SUPPLEMENTAL SERVICE RATE REDUCTION DELAY.**

The rate reduction described in Minnesota Statutes, section 256B.051, subdivision 7, does not apply until October 1, 2021, for individuals who receive supplemental services from providers that made a good faith effort to become a Medicaid provider by submitting an application by June 1, 2021.

Sec. 69. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; DIRECT CARE SERVICES DURING SHORT-TERM ACUTE HOSPITAL VISITS.**

The commissioner of human services, in consultation with stakeholders, shall develop a new covered service under Minnesota Statutes, chapter 256B, or develop modifications to existing covered services, that permits receipt of direct care services in an acute care hospital in a manner consistent with the requirements of United States Code, title 42, section 1396a(h). By August 31, 2022, the commissioner must provide to the chairs and ranking minority members of the house of representatives and senate committees and divisions with jurisdiction over direct care services any draft legislation as may be necessary to implement the new or modified covered service.

Sec. 70. **PERSONAL CARE ASSISTANCE COMPENSATION FOR SERVICES PROVIDED BY A PARENT OR SPOUSE.**

(a) Notwithstanding Minnesota Statutes, section 256B.0659, subdivisions 3, paragraph (a), clause (1); 11, paragraph (c); and 19, paragraph (b), clause (3), a parent, stepparent, or legal guardian of a minor who is a personal care assistance recipient or a spouse of a personal care assistance recipient may provide and be paid for providing personal care assistance services.

(b) This section expires upon full implementation and phase-in of the community first services and supports program under Minnesota Statutes, section 256B.85.

EFFECTIVE DATE. This section is effective the day following final enactment, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 71. **PARENTING WITH A DISABILITY; PILOT PROJECT.**

Subdivision 1. **Purpose.** The commissioner of human services shall establish a pilot project to provide grants to personal care assistance provider agencies to provide assistance with child rearing tasks to a parent who is eligible for personal care assistance services under Minnesota Statutes, section 256B.0659, or for services and supports provided through community first services and supports under Minnesota Statutes, section 256B.85. The purpose of this pilot project is to study the benefits of supportive parenting while assisting parents with a disability in child rearing tasks and preventing removal of a child from a parent because the parent has a disability.

Subd. 2. **Definitions.** (a) For the purposes of this section, in addition to the definitions in Minnesota Statutes, section 256B.0659, subdivision 1, applying to the personal care assistance program and the definitions in Minnesota Statutes, section 256B.85, subdivision 2, applying to community first services and supports, the following terms have the meanings given them in this subdivision.

(b) "Adaptive parenting equipment" means a piece of equipment that increases, extends, or improves the parenting capabilities of a parent with a disability.

(c) "Child" means a person under 12 years of age.

(d) "Child rearing task" means a task that assists a parent with a disability to care for a child. Child rearing task includes, but is not limited to: lifting and carrying a child, organizing supplies for a child, preparing meals for a child, washing clothing and bedding for a child, bathing a child, childproofing the home that the parent and child live in, and assisting with transporting a child.

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

(f) "Parent" means a child's biological, foster, or adoptive parent or legal guardian who is legally obligated to care for and support the child.

(g) "Person with a disability" means an individual who has a physical, mental, or psychological impairment or dysfunction that limits independent functioning in a family, community, or employment.

(h) "Personal care assistant" or "PCA" also means support worker.

(i) "Personal care assistance services" also means the services and supports provided by community first services and supports.

(j) "Supportive parenting assistant" or "SPA" means an individual providing supportive parenting services who is also a personal care assistant.

(k) "Supportive parenting service" means a state-funded service that (1) helps a parent with a disability compensate for aspects of the parent's disability that affect the parent's ability to care for the child, and (2) enables the parent to complete parental responsibilities, including child rearing tasks. Supportive parenting service does not include disciplining the parent's child.

Subd. 3. **Grants.** (a) The commissioner shall develop a competitive application process for up to three two-year state-funded grants to personal care assistance provider agencies to provide supportive parenting services described in subdivision 4 and to purchase adaptive

parenting equipment described in subdivision 5. A grant applicant must be a personal care assistance provider agency.

(b) Grant applications must describe how the applicant would recruit families to participate in the pilot project and how the applicant would select families to receive supportive parenting services while giving preference to families in which both parents are receiving personal care assistance services.

(c) Grantees must agree to provide supportive parenting to each selected family for at least one year.

Subd. 4. **Supportive parenting services.** (a) If a parent is eligible for and receiving personal care assistance services, the parent is eligible to receive supportive parenting services funded by a grant under this section. A parent must use one supportive parenting assistant at a time, regardless of the parent's number of children. Supportive parenting services provided under this section are services for the parent and not the child.

(b) An SPA providing supportive parenting services under this section must not perform personal care assistance services while scheduled to provide supportive parenting services. A PCA providing personal care assistance services must not perform supportive parenting services while scheduled to provide personal care assistance services. A PCA providing personal care assistance services and an SPA providing supportive parenting services may be scheduled to support the parent at the same time. The same individual may provide personal care assistance services and supportive parenting assistance to a parent as long as the requirements of this paragraph are met. Supportive parenting services under this section do not count toward a PCA's 310 hours per-month limit on providing personal care assistance services under Minnesota Statutes, section 256B.0659, subdivision 11, paragraph (a), clause (10).

(c) Supportive parenting services under this section must not replace personal care assistance services.

(d) A parent's supportive parenting services shall be limited to 40 hours per month.

Subd. 5. **Adaptive parenting equipment.** A grantee may purchase adaptive parenting equipment at the request of a parent receiving supportive parenting services under subdivision 4. A grantee must not purchase adaptive parenting equipment covered by medical assistance. A grantee must purchase the least costly item to meet the parent's need.

Sec. 72. **DIRECTION TO THE COMMISSIONER; STUDY OF SUPPORTIVE PARENTING SERVICES.**

The commissioner shall study the feasibility of providing supportive parenting services to parents with disabilities and disabling conditions as a covered medical assistance service and submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services by February 15, 2023. The report must contain at a minimum:

(1) the total number of parents that were provided services through the pilot project;

(2) the total cost of developing and providing the services provided under the pilot project;

(3) recommendations on expansion or continuation of the pilot project;

(4) recommendations on seeking federal approval of supportive parenting services as a covered service under medical assistance; and

(5) draft legislative language.

Sec. 73. **DIRECTIONS TO THE COMMISSIONER OF HUMAN SERVICES; WAIVER GROWTH LIMITS.**

Subdivision 1. **Community access for disability inclusion waiver growth limit.** Between July 1, 2021, and June 30, 2025, the commissioner shall allocate to county and Tribal agencies money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in forecasted state spending that is equivalent to limiting the caseload growth of the community access for disability inclusion waiver to zero allocations per year. Limits do not apply to conversions from nursing facilities. Counties and Tribal agencies shall manage the annual allocations made by the commissioner to ensure that persons for whom services are temporarily discontinued for no more than 90 days are reenrolled. If a county or Tribal agency fails to meet the authorization and spending requirements under Minnesota Statutes, section 256B.49, subdivision 27, the commissioner may determine a corrective action plan is unnecessary if the failure to meet the requirements is due to managing the annual allocation for the purposes of allowing people to reenroll after their services are temporarily discontinued.

Subd. 2. **Developmental disabilities waiver growth limit.** Between July 1, 2021, and June 30, 2025, the commissioner shall allocate to county and Tribal agencies money for home and community-based waiver programs under Minnesota Statutes, section 256B.092, to ensure a reduction in forecasted state spending that is equivalent to limiting the caseload

growth of the developmental disabilities waiver to zero allocations per year. Limits do not apply to conversions from intermediate care facilities for persons with developmental disabilities. Counties and Tribal agencies shall manage the annual allocations made by the commissioner to ensure that persons for whom services are temporarily discontinued for no more than 90 days are reenrolled.

Sec. 74. **DIRECTION TO THE COMMISSIONER; LONG-TERM CARE CONSULTATION SERVICE RATES.**

By January 15, 2025, the commissioner of human services shall develop a proposal with legislative language for capitated rates for each type of assessment or activity provided under Minnesota Statutes, section 256B.0911, as determined by the commissioner. The commissioner shall provide the proposal and legislative language to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services policy and finance by January 15, 2025.

Sec. 75. **RETAINER PAYMENTS FOR HOME AND COMMUNITY-BASED SERVICE PROVIDERS.**

Subdivision 1. **Retainer payments.** (a) The commissioner of human services shall make quarterly retainer payments to eligible recipients by July 1, 2021; September 30, 2021; December 31, 2021; March 31, 2022; and June 30, 2022. The value of the first quarterly payment to each eligible recipient shall be equal to a percentage to be determined by the commissioner under subdivision 9 applied to the eligible recipient's total home and community-based service revenue from medical assistance as of May 31, 2021. The value of each subsequent quarterly payment shall be equal to a percentage to be determined by the commissioner under subdivision 9 applied to the eligible recipient's total home and community-based service revenue from medical assistance based on new data for service claims paid as of the first day of the month in which the retainer payment will be made.

(b) The commissioner shall implement retainer payments and the process of making retainer payments under this subdivision without compliance with time-consuming procedures and formalities prescribed in law, such as the following statutes and related policies: Minnesota Statutes, sections 16A.15, subdivision 3; 16B.97; 16B.98, subdivisions 5 and 7; and 16B.98, subdivision 8, the express audit clause requirement.

(c) The commissioner's determination of the retainer amount determined under this subdivision is final and is not subject to appeal. This paragraph does not apply to recoupment by the commissioner under subdivision 8.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given:

(1) "direct care professional" means any individual who while providing an eligible service has direct contact with the person receiving the eligible service. Direct care professional excludes executive, managerial, and administrative staff;

(2) "eligible recipient" means an enrolled provider of eligible services, including the Direct Care and Treatment Division at the Department of Human Services, that meets the attestation and agreement requirements in subdivisions 5 and 6;

(3) "eligible service" means a home and community-based service as defined in section 9817(a)(2)(B) of the federal American Rescue Plan Act, Public Law 117-2, except:

(i) community first services and supports;

(ii) extended community first services and supports;

(iii) personal care assistance services;

(iv) extended personal care assistance service;

(v) consumer-directed community supports;

(vi) consumer support grants;

(vii) home health agency services; and

(viii) home care nursing services;

(4) "recipient" means an enrolled provider of an eligible service that receives a retainer payment under this section; and

(5) "total home and community-based service revenue from medical assistance" includes both fee-for-service revenue and revenue from managed care organizations attributable to the provision of eligible services from April 1, 2021, to March 31, 2022. The commissioner shall determine each eligible provider's total home and community-based service revenue from medical assistance based on data for service claims paid as of the date specified in subdivision 9.

Subd. 3. **Allowable uses of funds.** (a) Recipients must use retainer payments to implement one or more of the following activities to enhance, expand, or strengthen home and community-based services:

(1) temporarily increase wages, salaries, and benefits for direct care professionals and any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation premiums;

(2) provide hazard pay, overtime pay, and shift differential pay for direct care professionals;

(3) pay for paid sick leave, paid family leave, and paid medical leave due to COVID-19 for direct care professionals;

(4) pay for training for direct care professionals that is specific to the COVID-19 public health emergency;

(5) recruit new direct care professionals;

(6) pay for American sign language and other languages interpreters to assist in providing eligible services or to inform the general public about COVID-19;

(7) purchase emergency supplies and equipment to enhance access to eligible services and to protect the health and well-being of direct care professionals;

(8) support family care providers of eligible individuals with needed supplies and equipment, which may include items not typically covered under the Medicaid program, such as personal protective equipment and pay; and

(9) pay for assistive technologies, staffing, and other costs incurred during the COVID-19 public health emergency period to mitigate isolation and ensure an individual's person-centered service plan continues to be fully implemented.

(b) Recipients must:

(1) use at least 50 percent of the additional revenue received in the form of retainer payments for the purposes described in paragraph (a), clauses (1) to (3); and

(2) use any remainder of the additional revenue received in the form of retainer payments for the purposes described in paragraph (a), clauses (4) to (9).

Subd. 4. **Retainer payment requests.** Eligible recipients must request retainer payments under this section no later than June 1, 2022. The commissioner shall develop an expedited request process that includes a form allowing providers to meet the requirements of subdivisions 5 and 6 in as timely a manner as possible. The commissioner shall allow the use of electronic submission of request forms and accept electronic signatures.

Subd. 5. **Attestation.** (a) As a condition of obtaining funds under this section, an eligible recipient must attest to the following on the retainer payment request form:

(1) the intent to provide eligible services through March 31, 2022; and

(2) that the recipient will use the retainer payments only for purposes permitted under this section.

(b) By accepting a retainer payment under this section, the recipient attests to the conditions specified in this subdivision.

Subd. 6. **Agreement.** (a) As a condition of receiving retainer payments under this section, an eligible recipient must agree to the following on the retainer payment request form:

(1) to cooperate with the commissioner of human services to deliver services according to the program and service waivers and modifications issued under the commissioner's authority;

(2) to acknowledge that retention grants may be subject to a special recoupment under this section if a state audit performed under this section determines that the provider used retainer payments for purposes not authorized under this section; and

(3) to acknowledge that a recipient must comply with the distribution requirements described in subdivision 7.

(b) By accepting a retainer payment under this section, the recipient agrees to the conditions specified in this subdivision.

Subd. 7. **Distribution plans.** (a) A recipient must prepare and, upon request, submit to the commissioner, a distribution plan that specifies the anticipated amount and proposed uses of the additional revenue the recipient will receive under this section.

(b) Within 60 days of receipt of the recipient's first retainer payment, the recipient must post the distribution plan and leave it posted for a period of at least six weeks in an area of the recipient's operation to which all direct care professionals have access. The provider must post with the distribution plan instructions on how to contact the commissioner of human services if direct care professionals do not believe they have received the wage increase or benefits required under subdivision 3 specified in the distribution plan. The instructions must include a mailing address, e-mail address, and telephone number that the direct care professional may use to contact the commissioner or the commissioner's representative.

Subd. 8. **Recoupment.** (a) The commissioner may perform an audit under this section up to six years after any retainer payment is made to ensure the funds are utilized solely for the purposes authorized under this section.

(b) If the commissioner determines that a provider used retainer payments for purposes not authorized under this section, the commissioner shall treat any amount used for a purpose not authorized under this section as an overpayment. The commissioner shall recover any overpayment.

Subd. 9. **Calculation of retainer payments.** (a) The commissioner shall determine a percentage to apply to each recipient's total home and community-based service revenue from medical assistance to calculate the value of each quarterly retainer payment.

(b) The commissioner shall make an estimate of the total projected expenditures for eligible services between April 1, 2021, and March 31, 2022, determine a percentage to be applied to the total projected home and community-based service revenue from medical assistance for all providers of eligible services sufficient to expend the total appropriation for retainer payments, and apply this percentage to each recipient's total home and community-based service revenue from medical assistance on the following schedule:

(1) no earlier than July 1, 2021, make a retainer payment by applying the percentage to each recipient's total home and community-based service revenue from medical assistance based on service claims paid as of May 31, 2021;

(2) no later than September 30, 2021, make a retainer payment by applying the percentage to each recipient's total home and community-based service revenue from medical assistance based on new service claims paid as of September 1, 2021, that were not included in the calculation of a prior retainer payment;

(3) no later than December 31, 2021, make a retainer payment by applying the percentage to each recipient's total home and community-based service revenue from medical assistance based on new service claims paid as of December 1, 2021, that were not included in the calculation of a prior retainer payment; and

(4) no later than March 31, 2022, make a retainer payment by applying the percentage to each recipient's total home and community-based service revenue from medical assistance based on new service claims paid as of March 1, 2022, that were not included in the calculation of a prior retainer payment.

(c) The commissioner may redetermine the percentage to be applied to each recipient's total home and community-based services revenue from medical assistance.

(d) By June 30, 2022, the commissioner shall redetermine a percentage to be applied to the total home and community-based service revenue from medical assistance based on new service claims paid as of June 1, 2021, that were not included in the calculation of a

prior retainer payment. The redetermined percentage must be sufficient to expend the total appropriation for retainer payments. No later than June 30, 2022, the commissioner shall make a final retainer payment by applying the redetermined percentage to each recipient's total home and community-based service revenue from medical assistance based on new service claims paid as of June 1, 2021, that were not included in the calculation of a prior retainer payment.

Sec. 76. **DIRECTION TO THE COMMISSIONER; PERSONAL CARE ASSISTANCE SERVICE RATE INCREASES.**

Effective July 1, 2021, the commissioner of human services shall increase the reimbursement rates, individual budgets, grants, and allocations for community first services and supports under Minnesota Statutes, section 256B.85; personal care assistance services under Minnesota Statutes, section 256B.0659; extended personal care assistance service as defined in Minnesota Statutes, section 256B.0605, subdivision 1, paragraph (g); and extended community first services and supports as defined in Minnesota Statutes, section 256B.85, subdivision 2, paragraph (l); and for budgets of individuals utilizing consumer-directed community supports or participating in the consumer support grant program. The commissioner shall determine the amount of the rate increase to ensure that the state share of the increase does not exceed the amount appropriated in each fiscal year for this purpose in this act.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 77. **DIRECTION TO THE COMMISSIONER; HOME CARE SERVICE RATE INCREASE.**

Effective July 1, 2021, the commissioner of human services shall increase service rates for home health agency services under Minnesota Statutes, section 256B.0653, and for home care nursing services under Minnesota Statutes, section 256B.0654. The commissioner shall determine the amount of the rate increase to ensure that the state share of the increase does not exceed the amount appropriated in this act in each fiscal year for this purpose.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 78. **DIRECTION TO THE COMMISSIONER; ELDERLY WAIVER RATE INCREASE.**

The commissioner of human services shall modify the ratio of the blended rate described under Minnesota Statutes, section 256S.2101, to increase statewide service rates and

component service rates. The commissioner shall also adjust service rate limits, monthly service rate limits, and monthly case mix budget caps to accommodate the increased service rates and component service rates established under this section. The commissioner shall modify the blended rates to ensure that the state share of the service rate increase does not exceed the amount appropriated in each fiscal year for this purpose in this act.

Sec. 79. **REVISOR INSTRUCTION.**

(a) The revisor of statutes, in consultation with the Office of Senate Counsel, Research and Fiscal Analysis, the Office of the House Research Department, and the commissioner of human services, shall prepare legislation for the 2022 legislative session to recodify Minnesota Statutes, sections 256.975, subdivisions 7 to 7d, and 256B.0911.

(b) The revisor of statutes, in consultation with the Office of Senate Counsel, Research and Fiscal Analysis, the Office of the House Research Department, and the commissioner of human services, shall to the greatest extent practicable renumber as subdivisions the paragraphs of Minnesota Statutes, section 256B.4914, prior to the publication of the 2021 Supplement of Minnesota Statutes, and shall without changing the meaning or effect of these provisions minimize the use of internal cross-references, including by drafting new technical definitions as substitutes for necessary cross-references or by other means acceptable to the commissioner of human services.

(c) The revisor of statutes shall change the headnote for Minnesota Statutes, section 256B.097, to read "REGIONAL AND SYSTEMS IMPROVEMENT FOR MINNESOTANS WHO HAVE DISABILITIES."

Sec. 80. **REPEALER.**

(a) Minnesota Statutes 2020, section 256B.4905, subdivisions 1, 2, 3, 4, 5, and 6, are repealed.

(b) Minnesota Statutes 2020, section 256B.097, subdivisions 1, 2, 3, 4, 5, and 6, are repealed.

(c) Laws 2019, First Special Session chapter 9, article 5, section 90, is repealed.

ARTICLE 6
COMMUNITY SUPPORTS POLICY

Section 1. Minnesota Statutes 2020, 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 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;

(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, 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 ~~shall be considered private data and the commissioner shall not collect individual 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. 2. Minnesota Statutes 2020, section 245.697, subdivision 1, is amended to read:

Subdivision 1. **Creation.** (a) A State Advisory Council on Mental Health is created. The council must have members appointed by the governor in accordance with federal requirements. In making the appointments, the governor shall consider appropriate representation of communities of color. The council must be composed of:

(1) the assistant commissioner of ~~mental health for~~ the Department of Human Services who oversees behavioral health policy;

(2) a representative of the Department of Human Services responsible for the medical assistance program;

(3) a representative of the Department of Health;

~~(3)~~ (4) one member of each of the following professions:

(i) psychiatry;

(ii) psychology;

(iii) social work;

(iv) nursing;

(v) marriage and family therapy; and

(vi) professional clinical counseling;

~~(4)~~ (5) one representative from each of the following advocacy groups: Mental Health Association of Minnesota, NAMI-MN, ~~Mental Health Consumer/Survivor Network of Minnesota, and~~ Minnesota Disability Law Center, American Indian Mental Health Advisory Council, and a consumer-run mental health advocacy group;

~~(5)~~ (6) providers of mental health services;

~~(6)~~ (7) consumers of mental health services;

~~(7)~~ (8) family members of persons with mental illnesses;

~~(8)~~ (9) legislators;

~~(9)~~ (10) social service agency directors;

~~(10)~~ (11) county commissioners; and

~~(11)~~ (12) other members reflecting a broad range of community interests, including family physicians, or members as the United States Secretary of Health and Human Services may prescribe by regulation or as may be selected by the governor.

(b) The council shall select a chair. Terms, compensation, and removal of members and filling of vacancies are governed by section 15.059. Notwithstanding provisions of section 15.059, the council and its subcommittee on children's mental health do not expire. The commissioner of human services shall provide staff support and supplies to the council.

Sec. 3. Minnesota Statutes 2020, section 252.43, is amended to read:

252.43 COMMISSIONER'S DUTIES.

(a) The commissioner shall supervise lead agencies' provision of day services to adults with disabilities. The commissioner shall:

(1) determine the need for day ~~services~~ programs under ~~section~~ sections 256B.4914 and 252.41 to 252.46;

(2) establish payment rates as provided under section 256B.4914;

(3) adopt rules for the administration and provision of day services under sections 245A.01 to 245A.16~~,~~; 252.28, subdivision 2~~,~~; or 252.41 to 252.46~~,~~; or Minnesota Rules, parts 9525.1200 to 9525.1330;

(4) enter into interagency agreements necessary to ensure effective coordination and provision of day services;

(5) monitor and evaluate the costs and effectiveness of day services; and

(6) provide information and technical help to lead agencies and vendors in their administration and provision of day services.

(b) A determination of need in paragraph (a), clause (1), shall not be required for a change in day service provider name or ownership.

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

Sec. 4. Minnesota Statutes 2020, section 252A.01, subdivision 1, is amended to read:

Subdivision 1. **Policy.** (a) It is the policy of the state of Minnesota to provide a coordinated approach to the supervision, protection, and habilitation of its adult citizens with a developmental disability. In furtherance of this policy, sections 252A.01 to 252A.21 are enacted to authorize the commissioner of human services to:

(1) supervise those adult citizens with a developmental disability who are unable to fully provide for their own needs and for whom no qualified person is willing and able to seek guardianship ~~or conservatorship~~ under sections 524.5-101 to 524.5-502; and

(2) protect adults with a developmental disability from violation of their human and civil rights by ~~assuring~~ ensuring that they receive the full range of needed social, financial, residential, and habilitative services to which they are lawfully entitled.

(b) Public guardianship ~~or conservatorship~~ is the most restrictive form of guardianship ~~or conservatorship~~ and should be imposed only when ~~no other acceptable alternative is available~~ less restrictive alternatives have been attempted and determined to be insufficient to meet the person's needs. Less restrictive alternatives include but are not limited to supported decision making, community or residential services, or appointment of a health care agent.

Sec. 5. Minnesota Statutes 2020, section 252A.02, subdivision 2, is amended to read:

Subd. 2. **Person with a developmental disability.** "Person with a developmental disability" refers to any person age 18 or older who:

(1) has been diagnosed as having ~~significantly subaverage intellectual functioning existing concurrently with demonstrated deficits in adaptive behavior such as to require supervision and protection for the person's welfare or the public welfare.~~ a developmental disability;

(2) is impaired to the extent of lacking sufficient understanding or capacity to make personal decisions; and

(3) is unable to meet personal needs for medical care, nutrition, clothing, shelter, or safety, even with appropriate technological and supported decision-making assistance.

Sec. 6. Minnesota Statutes 2020, section 252A.02, subdivision 9, is amended to read:

Subd. 9. **~~Ward~~ Person subject to public guardianship.** ~~"Ward"~~ "Person subject to public guardianship" means a person with a developmental disability for whom the court has appointed a public guardian.

Sec. 7. Minnesota Statutes 2020, section 252A.02, subdivision 11, is amended to read:

Subd. 11. **Interested person.** "Interested person" means an interested responsible adult, ~~including, but not limited to, a public official, guardian, spouse, parent, adult sibling, legal counsel, adult child, or next of kin of a person alleged to have a developmental disability.~~ including but not limited to:

(1) the person subject to guardianship, protected person, or respondent;

(2) a nominated guardian or conservator;

(3) a legal representative;

(4) the spouse; parent, including stepparent; adult children, including adult stepchildren of a living spouse; and siblings. If no such persons are living or can be located, the next of kin of the person subject to public guardianship or the respondent is an interested person;

(5) a representative of a state ombudsman's office or a federal protection and advocacy program that has notified the commissioner or lead agency that it has a matter regarding the protected person subject to guardianship, person subject to conservatorship, or respondent; and

(6) a health care agent or proxy appointed pursuant to a health care directive as defined in section 145C.01, subdivision 5a; a living will under chapter 145B; or other similar documentation executed in another state and enforceable under the laws of this state.

Sec. 8. Minnesota Statutes 2020, section 252A.02, subdivision 12, is amended to read:

Subd. 12. **Comprehensive evaluation.** (a) "Comprehensive evaluation" ~~shall consist~~ consists of:

(1) a medical report on the health status and physical condition of the proposed ~~ward,~~ person subject to public guardianship prepared under the direction of a licensed physician or advanced practice registered nurse;

(2) a report on the ~~proposed ward's~~ intellectual capacity and functional abilities~~, specifying~~ of the proposed person subject to public guardianship that specifies the tests and other data used in reaching its conclusions~~,~~ and is prepared by a psychologist who is qualified in the diagnosis of developmental disability; and

(3) a report from the case manager that includes:

(i) the most current assessment of ~~individual service~~ coordinated service and support needs as described in rules of the commissioner;

(ii) the most current individual service plan under section 256B.092, subdivision 1b; and

(iii) a description of contacts with and responses of near relatives of the proposed ~~ward~~ person subject to public guardianship notifying ~~them~~ the near relatives that a nomination for public guardianship has been made and advising ~~them~~ the near relatives that they may seek private guardianship.

(b) Each report under paragraph (a), clause (3), shall contain recommendations as to the amount of assistance and supervision required by the proposed ~~ward~~ person subject to public guardianship to function as independently as possible in society. To be considered part of the comprehensive evaluation, the reports must be completed no more than one year before filing the petition under section 252A.05.

Sec. 9. Minnesota Statutes 2020, section 252A.02, is amended by adding a subdivision to read:

Subd. 16. **Protected person.** "Protected person" means a person for whom a guardian or conservator has been appointed or other protective order has been sought. A protected person may be a minor.

Sec. 10. Minnesota Statutes 2020, section 252A.02, is amended by adding a subdivision to read:

Subd. 17. **Respondent.** "Respondent" means an individual for whom the appointment of a guardian or conservator or other protective order is sought.

Sec. 11. Minnesota Statutes 2020, section 252A.02, is amended by adding a subdivision to read:

Subd. 18. **Supported decision making.** "Supported decision making" means assistance to understand the nature and consequences of personal and financial decisions from one or more persons of the individual's choosing to enable the individual to make the personal and financial decisions and, when consistent with the individual's wishes, to communicate a decision once made.

Sec. 12. Minnesota Statutes 2020, section 252A.03, subdivision 3, is amended to read:

Subd. 3. **Standard for acceptance.** The commissioner shall accept the nomination if: ~~the comprehensive evaluation concludes that:~~

~~(1) the person alleged to have developmental disability is, in fact, developmentally disabled;~~ (1) the person's assessment confirms that they are a person with a developmental disability under section 252A.02, subdivision 2;

(2) the person is in need of the supervision and protection of a ~~conservator or~~ guardian; ~~and~~

(3) no qualified person is willing to assume guardianship ~~or conservatorship~~ under sections 524.5-101 to 524.5-502~~.~~; and

(4) the person subject to public guardianship was included in the process prior to the submission of the nomination.

Sec. 13. Minnesota Statutes 2020, section 252A.03, subdivision 4, is amended to read:

Subd. 4. **Alternatives.** (a) Public guardianship ~~or conservatorship~~ may be imposed only when:

(1) the person subject to guardianship is impaired to the extent of lacking sufficient understanding or capacity to make personal decisions;

(2) the person subject to guardianship is unable to meet personal needs for medical care, nutrition, clothing, shelter, or safety, even with appropriate technological and supported decision-making assistance; and

(3) no acceptable, less restrictive form of guardianship ~~or conservatorship~~ is available.

(b) The commissioner shall seek parents, near relatives, and other interested persons to assume guardianship for persons with developmental disabilities who are currently under public guardianship. If a person seeks to become a guardian ~~or conservator~~, costs to the

person may be reimbursed under section 524.5-502. The commissioner must provide technical assistance to parents, near relatives, and interested persons seeking to become guardians ~~or conservators~~.

Sec. 14. Minnesota Statutes 2020, section 252A.04, subdivision 1, is amended to read:

Subdivision 1. **Local agency.** Upon receipt of a written nomination, the commissioner shall promptly order the local agency of the county in which the proposed ~~ward~~ person subject to public guardianship resides to coordinate or arrange for a comprehensive evaluation of the proposed ~~ward~~ person subject to public guardianship.

Sec. 15. Minnesota Statutes 2020, section 252A.04, subdivision 2, is amended to read:

Subd. 2. **Medication; treatment.** A proposed ~~ward~~ person subject to public guardianship who, at the time the comprehensive evaluation is to be performed, has been under medical care shall not be so under the influence or so suffer the effects of drugs, medication, or other treatment as to be hampered in the testing or evaluation process. When in the opinion of the licensed physician or advanced practice registered nurse attending the proposed ~~ward~~ person subject to public guardianship, the discontinuance of medication or other treatment is not in the ~~proposed ward's~~ best interest of the proposed person subject to public guardianship, the physician or advanced practice registered nurse shall record a list of all drugs, medication, or other treatment ~~which~~ that the proposed ~~ward~~ person subject to public guardianship received 48 hours immediately prior to any examination, test, or interview conducted in preparation for the comprehensive evaluation.

Sec. 16. Minnesota Statutes 2020, section 252A.04, subdivision 4, is amended to read:

Subd. 4. **File.** The comprehensive evaluation shall be kept on file at the Department of Human Services and shall be open to the inspection of the proposed ~~ward~~ person subject to public guardianship and ~~such~~ other persons ~~as may be given permission~~ permitted by the commissioner.

Sec. 17. Minnesota Statutes 2020, section 252A.05, is amended to read:

252A.05 COMMISSIONER'S PETITION FOR APPOINTMENT AS PUBLIC GUARDIAN ~~OR PUBLIC CONSERVATOR~~.

In every case in which the commissioner agrees to accept a nomination, the local agency, within 20 working days of receipt of the commissioner's acceptance, shall petition on behalf of the commissioner in the county or court of the county of residence of the person with a

developmental disability for appointment to act as ~~public conservator or~~ public guardian of the person with a developmental disability.

Sec. 18. Minnesota Statutes 2020, section 252A.06, subdivision 1, is amended to read:

Subdivision 1. **Who may file.** ~~The commissioner, the local agency, a person with a developmental disability or any parent, spouse or relative of a person with a developmental disability may file~~ A verified petition alleging that the appointment of a ~~public conservator or~~ public guardian is required may be filed by: the commissioner; the local agency; a person with a developmental disability; or a parent, stepparent, spouse, or relative of a person with a developmental disability.

Sec. 19. Minnesota Statutes 2020, section 252A.06, subdivision 2, is amended to read:

Subd. 2. **Contents.** The petition shall set forth:

(1) the name and address of the petitioner~~,~~ and, in the case of a petition brought by a person other than the commissioner, whether the petitioner is a parent, spouse, or relative ~~of the proposed ward~~ of the proposed person subject to guardianship;

(2) whether the commissioner has accepted a nomination to act as ~~public conservator or~~ public guardian;

(3) the name, address, and date of birth of the proposed ~~ward~~ person subject to public guardianship;

(4) the names and addresses of the nearest relatives and spouse, if any, of the proposed ~~ward~~ person subject to public guardianship;

(5) the probable value and general character of the ~~proposed ward's~~ real and personal property of the proposed person subject to public guardianship and the probable amount of the ~~proposed ward's~~ debts of the proposed person subject to public guardianship; and

(6) the facts supporting the establishment of public ~~conservatorship or~~ guardianship, including that no family member or other qualified individual is willing to assume guardianship ~~or conservatorship~~ responsibilities under sections 524.5-101 to 524.5-502~~;~~ ~~and~~.

~~(7) if conservatorship is requested, the powers the petitioner believes are necessary to protect and supervise the proposed conservatee.~~

Sec. 20. Minnesota Statutes 2020, section 252A.07, subdivision 1, is amended to read:

Subdivision 1. **With petition.** When a petition is brought by the commissioner or local agency, a copy of the comprehensive evaluation shall be filed with the petition. If a petition is brought by a person other than the commissioner or local agency and a comprehensive evaluation has been prepared within a year of the filing of the petition, the local agency shall ~~forward~~ send a copy of the comprehensive evaluation to the court upon notice of the filing of the petition. If a comprehensive evaluation has not been prepared within a year of the filing of the petition, the local agency, upon notice of the filing of the petition, shall arrange for a comprehensive evaluation to be prepared and ~~forwarded~~ provided to the court within 90 days.

Sec. 21. Minnesota Statutes 2020, section 252A.07, subdivision 2, is amended to read:

Subd. 2. **Copies.** A copy of the comprehensive evaluation shall be made available by the court to the proposed ~~ward~~ person subject to public guardianship, the ~~proposed ward's~~ counsel of the proposed person subject to public guardianship, the county attorney, the attorney general, and the petitioner.

Sec. 22. Minnesota Statutes 2020, section 252A.07, subdivision 3, is amended to read:

Subd. 3. **Evaluation required; exception.** (a) No action for the appointment of a public guardian may proceed to hearing unless a comprehensive evaluation has been first filed with the court~~; provided, however, that an action may proceed and a guardian appointed~~.

(b) Paragraph (a) does not apply if the director of the local agency responsible for conducting the comprehensive evaluation has filed an affidavit that the proposed ~~ward~~ person subject to public guardianship refused to participate in the comprehensive evaluation and the court finds on the basis of clear and convincing evidence that the proposed ~~ward~~ person subject to public guardianship is developmentally disabled and in need of the supervision and protection of a guardian.

Sec. 23. Minnesota Statutes 2020, section 252A.081, subdivision 2, is amended to read:

Subd. 2. **Service of notice.** Service of notice on the ~~ward~~ person subject to public guardianship or proposed ~~ward~~ person subject to public guardianship must be made by a nonuniformed person or nonuniformed visitor. To the extent possible, the ~~process server or visitor~~ person or visitor serving the notice shall explain the document's meaning to the proposed ~~ward~~ person subject to public guardianship. In addition to the persons required to

be served under sections 524.5-113, 524.5-205, and 524.5-304, the mailed notice of the hearing must be served on the commissioner, the local agency, and the county attorney.

Sec. 24. Minnesota Statutes 2020, section 252A.081, subdivision 3, is amended to read:

Subd. 3. **Attorney.** In place of the notice of attorney provisions in sections 524.5-205 and 524.5-304, the notice must state that the court will appoint an attorney for the proposed ~~ward~~ person subject to public guardianship unless an attorney is provided by other persons.

Sec. 25. Minnesota Statutes 2020, section 252A.081, subdivision 5, is amended to read:

Subd. 5. **Defective notice of service.** A defect in the service of notice or process, other than personal service upon the proposed ~~ward or conservatee~~ person subject to public guardianship or service upon the commissioner and local agency within the time allowed and the form prescribed in this section and sections 524.5-113, 524.5-205, and 524.5-304, does not invalidate any public guardianship ~~or conservatorship~~ proceedings.

Sec. 26. Minnesota Statutes 2020, section 252A.09, subdivision 1, is amended to read:

Subdivision 1. **Attorney appointment.** Upon the filing of the petition, the court shall appoint an attorney for the proposed ~~ward~~ person subject to public guardianship, unless such counsel is provided by others.

Sec. 27. Minnesota Statutes 2020, section 252A.09, subdivision 2, is amended to read:

Subd. 2. **Representation.** Counsel shall visit with and, to the extent possible, consult with the proposed ~~ward~~ person subject to public guardianship prior to the hearing and shall be given adequate time to prepare ~~therefor~~ for the hearing. Counsel shall be given the full right of subpoena and shall be supplied with a copy of all documents filed with or issued by the court.

Sec. 28. Minnesota Statutes 2020, section 252A.101, subdivision 2, is amended to read:

Subd. 2. **Waiver of presence.** The proposed ~~ward~~ person subject to public guardianship may waive the right to be present at the hearing only if the proposed ~~ward~~ person subject to public guardianship has met with counsel and specifically waived the right to appear.

Sec. 29. Minnesota Statutes 2020, section 252A.101, subdivision 3, is amended to read:

Subd. 3. **Medical care.** If, at the time of the hearing, the proposed ~~ward~~ person subject to public guardianship has been under medical care, the ~~ward~~ person subject to public

guardianship has the same rights regarding limitation on the use of drugs, medication, or other treatment before the hearing that are available under section 252A.04, subdivision 2.

Sec. 30. Minnesota Statutes 2020, section 252A.101, subdivision 5, is amended to read:

Subd. 5. **Findings.** (a) In all cases the court shall make specific written findings of fact, conclusions of law, and direct entry of an appropriate judgment or order. The court shall order the appointment of the commissioner as guardian ~~or conservator~~ if it finds that:

(1) the proposed ~~ward or conservatee~~ person subject to public guardianship is a person with a developmental disability as defined in section 252A.02, subdivision 2;

(2) the proposed ~~ward or conservatee~~ person subject to public guardianship is incapable of exercising specific legal rights, which must be enumerated in ~~its~~ the court's findings;

(3) the proposed ~~ward or conservatee~~ person subject to public guardianship is in need of the supervision and protection of a public guardian ~~or conservator~~; and

(4) no appropriate alternatives to public guardianship ~~or public conservatorship~~ exist that are less restrictive of the person's civil rights and liberties, such as appointing a private guardian, ~~or conservator~~ supported decision maker, or health care agent; or arranging residential or community services under sections 524.5-101 to 524.5-502.

(b) The court shall grant the specific powers that are necessary for the commissioner to act as public guardian ~~or conservator~~ on behalf of the ~~ward or conservatee~~ person subject to public guardianship.

Sec. 31. Minnesota Statutes 2020, section 252A.101, subdivision 6, is amended to read:

Subd. 6. **Notice of order; appeal.** A copy of the order shall be served by mail upon the ~~ward or conservatee~~ person subject to public guardianship and the ~~ward's~~ counsel of the person subject to public guardianship. The order must be accompanied by a notice that advises the ~~ward or conservatee~~ person subject to public guardianship of the right to appeal the guardianship ~~or conservatorship~~ appointment within 30 days.

Sec. 32. Minnesota Statutes 2020, section 252A.101, subdivision 7, is amended to read:

Subd. 7. **Letters of guardianship.** (a) Letters of guardianship ~~or conservatorship~~ must be issued by the court and contain:

(1) the name, address, and telephone number of the ~~ward or conservatee~~ person subject to public guardianship; and

(2) the powers to be exercised on behalf of the ~~ward or conservatee~~ person subject to public guardianship.

(b) The letters under paragraph (a) must be served by mail upon the ~~ward or conservatee~~ person subject to public guardianship, the ~~ward's~~ counsel of the person subject to public guardianship, the commissioner, and the local agency.

Sec. 33. Minnesota Statutes 2020, section 252A.101, subdivision 8, is amended to read:

Subd. 8. **Dismissal.** If upon the completion of the hearing and consideration of the record, the court finds that the proposed ~~ward~~ person subject to public guardianship is not developmentally disabled or is developmentally disabled but not in need of the supervision and protection of a ~~conservator or~~ public guardian, ~~it~~ the court shall dismiss the application and shall notify the proposed ~~ward~~ person subject to public guardianship, the ~~ward's~~ counsel of the person subject to public guardianship, and the petitioner of the court's findings.

Sec. 34. Minnesota Statutes 2020, section 252A.111, subdivision 2, is amended to read:

Subd. 2. **Additional powers.** In addition to the powers contained in sections 524.5-207 and 524.5-313, the powers of a public guardian that the court may grant include:

(1) the power to permit or withhold permission for the ~~ward~~ person subject to public guardianship to marry;

(2) the power to begin legal action or defend against legal action in the name of the ~~ward~~ person subject to public guardianship; and

(3) the power to consent to the adoption of the ~~ward~~ person subject to public guardianship as provided in section 259.24.

Sec. 35. Minnesota Statutes 2020, section 252A.111, subdivision 4, is amended to read:

Subd. 4. **Appointment of conservator.** If the ~~ward~~ person subject to public guardianship has a personal estate beyond that which is necessary for the ~~ward's~~ personal and immediate needs of the person subject to public guardianship, the commissioner shall determine whether a conservator should be appointed. The commissioner shall consult with the parents, spouse, or nearest relative of the ~~ward~~ person subject to public guardianship. The commissioner may petition the court for the appointment of a private conservator of the ~~ward~~ person subject to public guardianship. The commissioner cannot act as conservator for public ~~wards~~ persons subject to public guardianship or public protected persons.

Sec. 36. Minnesota Statutes 2020, section 252A.111, subdivision 6, is amended to read:

Subd. 6. **Special duties.** In exercising powers and duties under this chapter, the commissioner shall:

(1) maintain close contact with the ~~ward~~ person subject to public guardianship, visiting at least twice a year;

(2) protect and exercise the legal rights of the ~~ward~~ person subject to public guardianship;

(3) take actions and make decisions on behalf of the ~~ward~~ person subject to public guardianship that encourage and allow the maximum level of independent functioning in a manner least restrictive of the ~~ward's~~ personal freedom of the person subject to public guardianship consistent with the need for supervision and protection; and

(4) permit and encourage maximum self-reliance on the part of the ~~ward~~ person subject to public guardianship and permit and encourage input by the nearest relative of the ~~ward~~ person subject to public guardianship in planning and decision making on behalf of the ~~ward~~ person subject to public guardianship.

Sec. 37. Minnesota Statutes 2020, section 252A.12, is amended to read:

252A.12 APPOINTMENT OF ~~CONSERVATOR~~ PUBLIC GUARDIAN NOT A FINDING OF INCOMPETENCY.

An appointment of the commissioner as ~~conservator~~ public guardian shall not constitute a judicial finding that the person with a developmental disability is legally incompetent except for the restrictions ~~which~~ that the ~~conservatorship~~ public guardianship places on the ~~conservatee~~ person subject to public guardianship. The appointment of a ~~conservator~~ public guardian shall not deprive the ~~conservatee~~ person subject to public guardianship of the right to vote.

Sec. 38. Minnesota Statutes 2020, section 252A.16, is amended to read:

252A.16 ANNUAL REVIEW.

Subdivision 1. **Review required.** The commissioner shall require an annual review of the physical, mental, and social adjustment and progress of every ~~ward and conservatee~~ person subject to public guardianship. A copy of this review shall be kept on file at the Department of Human Services and may be inspected by the ~~ward or conservatee~~ person subject to public guardianship, the ~~ward's or conservatee's~~ parents, spouse, or relatives of the person subject to public guardianship, and other persons who receive the permission of

the commissioner. The review shall contain information required under Minnesota Rules, part 9525.3065, subpart 1.

Subd. 2. **Assessment of need for continued guardianship.** The commissioner shall annually review the legal status of each ~~ward~~ person subject to public guardianship in light of the progress indicated in the annual review. If the commissioner determines the ~~ward~~ person subject to public guardianship is no longer in need of public guardianship ~~or conservatorship~~ or is capable of functioning under a less restrictive ~~conservatorship~~ guardianship, the commissioner or local agency shall petition the court pursuant to section 252A.19 to restore the ~~ward~~ person subject to public guardianship to capacity or for a modification of the court's previous order.

Sec. 39. Minnesota Statutes 2020, section 252A.17, is amended to read:

252A.17 EFFECT OF SUCCESSION IN OFFICE.

The appointment by the court of the commissioner ~~of human services~~ as public ~~conservator or~~ guardian shall be by the title of the commissioner's office. The authority of the commissioner as public ~~conservator or~~ guardian shall cease upon the termination of the commissioner's term of office and shall vest in a successor or successors in office without further court proceedings.

Sec. 40. Minnesota Statutes 2020, section 252A.19, subdivision 2, is amended to read:

Subd. 2. **Petition.** The commissioner, ~~ward~~ person subject to public guardianship, or any interested person may petition the appointing court or the court to which venue has been transferred ~~for an order to~~:

(1) for an order to remove the guardianship ~~or to~~;

(2) for an order to limit or expand the powers of the guardianship ~~or to~~;

(3) for an order to appoint a guardian ~~or conservator~~ under sections 524.5-101 to 524.5-502 ~~or to~~;

(4) for an order to restore the ~~ward~~ person subject to public guardianship or protected person to full legal capacity ~~or to~~;

(5) to review de novo any decision made by the public guardian ~~or public conservator~~ for or on behalf of a ~~ward~~ person subject to public guardianship or protected person; or

(6) for any other order as the court may deem just and equitable.

Sec. 41. Minnesota Statutes 2020, section 252A.19, subdivision 4, is amended to read:

Subd. 4. **Comprehensive evaluation.** The commissioner shall, at the court's request, arrange for the preparation of a comprehensive evaluation of the ~~ward~~ person subject to public guardianship or protected person.

Sec. 42. Minnesota Statutes 2020, section 252A.19, subdivision 5, is amended to read:

Subd. 5. **Court order.** Upon proof of the allegations of the petition the court shall enter an order removing the guardianship or limiting or expanding the powers of the guardianship or restoring the ~~ward~~ person subject to public guardianship or protected person to full legal capacity or may enter such other order as the court may deem just and equitable.

Sec. 43. Minnesota Statutes 2020, section 252A.19, subdivision 7, is amended to read:

Subd. 7. **Attorney general's role; commissioner's role.** The attorney general may appear and represent the commissioner in such proceedings. The commissioner shall support or oppose the petition if the commissioner deems such action necessary for the protection and supervision of the ~~ward~~ person subject to public guardianship or protected person.

Sec. 44. Minnesota Statutes 2020, section 252A.19, subdivision 8, is amended to read:

Subd. 8. ~~**Court appointed**~~ **Court-appointed counsel.** In all such proceedings, the protected person or ~~ward~~ person subject to public guardianship shall be afforded an opportunity to be represented by counsel, and if neither the protected person or ~~ward~~ person subject to public guardianship nor others provide counsel the court shall appoint counsel to represent the protected person or ~~ward~~ person subject to public guardianship.

Sec. 45. Minnesota Statutes 2020, section 252A.20, is amended to read:

252A.20 COSTS OF HEARINGS.

Subdivision 1. **Witness and attorney fees.** In each proceeding under sections 252A.01 to 252A.21, the court shall allow and order paid to each witness subpoenaed the fees and mileage prescribed by law; to each physician, advanced practice registered nurse, psychologist, or social worker who assists in the preparation of the comprehensive evaluation and who is not ~~in the employ of~~ employed by the local agency or the state Department of Human Services, a reasonable sum for services and for travel; and to the ~~ward's~~ counsel of the person subject to public guardianship, when appointed by the court, a reasonable sum for travel and for each day or portion of a day actually employed in court or actually

consumed in preparing for the hearing. Upon order the county auditor shall issue a warrant on the county treasurer for payment of the amount allowed.

Subd. 2. **Expenses.** When the settlement of the ~~ward~~ person subject to public guardianship is found to be in another county, the court shall transmit to the county auditor a statement of the expenses incurred pursuant to subdivision 1. The auditor shall transmit the statement to the auditor of the county of the ~~ward's~~ settlement of the person subject to public guardianship and this claim shall be paid as other claims against that county. If the auditor to whom this claim is transmitted denies the claim, the auditor shall transmit it, together with the objections thereto, to the commissioner, who shall determine the question of settlement and certify findings to each auditor. If the claim is not paid within 30 days after such certification, an action may be maintained thereon in the district court of the claimant county.

Subd. 3. **Change of venue; cost of proceedings.** Whenever venue of a proceeding has been transferred under sections 252A.01 to 252A.21, the costs of such proceedings shall be reimbursed to the county of the ~~ward's~~ settlement of the person subject to public guardianship by the state.

Sec. 46. Minnesota Statutes 2020, section 252A.21, subdivision 2, is amended to read:

Subd. 2. **Rules.** The commissioner shall adopt rules to implement this chapter. The rules must include standards for performance of guardianship ~~or conservatorship~~ duties including~~,~~ but not limited to: twice a year visits with the ~~ward~~ person subject to public guardianship; a requirement that the duties of guardianship ~~or conservatorship~~ and case management not be performed by the same person; specific standards for action on "do not resuscitate" orders as recommended by a physician, an advanced practice registered nurse, or a physician assistant; sterilization requests; and the use of psychotropic medication and aversive procedures.

Sec. 47. Minnesota Statutes 2020, section 252A.21, subdivision 4, is amended to read:

Subd. 4. **Private guardianships ~~and conservatorships.~~** Nothing in sections 252A.01 to 252A.21 shall impair the right of individuals to establish private guardianships ~~or conservatorships~~ in accordance with applicable law.

Sec. 48. Minnesota Statutes 2020, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical dependency fund is limited to payments for services other than detoxification licensed under

Minnesota Rules, parts 9530.6510 to 9530.6590, ~~that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical dependency treatment or rehabilitation program under sections 245A.01 to 245A.16,~~ services identified in section 254B.05, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving payments from the chemical dependency fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the consolidated chemical dependency treatment fund or through state contracted managed care entities. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors meeting the criteria under section 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment

services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

Sec. 49. Minnesota Statutes 2020, section 256B.051, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** Housing ~~support~~ stabilization services are established to provide housing ~~support~~ stabilization services to an individual with a disability that limits the individual's ability to obtain or maintain stable housing. The services support an individual's transition to housing in the community and increase long-term stability in housing, to avoid future periods of being at risk of homelessness or institutionalization.

Sec. 50. Minnesota Statutes 2020, section 256B.051, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An individual with a disability is eligible for housing ~~support~~ stabilization services if the individual:

(1) is 18 years of age or older;

(2) is enrolled in medical assistance;

(3) has an assessment of functional need that determines a need for services due to limitations caused by the individual's disability;

(4) resides in or plans to transition to a community-based setting as defined in Code of Federal Regulations, title 42, section 441.301 (c); and

(5) has housing instability evidenced by:

(i) being homeless or at-risk of homelessness;

(ii) being in the process of transitioning from, or having transitioned in the past six months from, an institution or licensed or registered setting;

(iii) being eligible for waiver services under chapter 256S or section 256B.092 or 256B.49; or

(iv) having been identified by a long-term care consultation under section 256B.0911 as at risk of institutionalization.

Sec. 51. Minnesota Statutes 2020, section 256B.051, subdivision 5, is amended to read:

Subd. 5. **Housing ~~support~~ stabilization services.** (a) Housing ~~support~~ stabilization services include housing transition services and housing and tenancy sustaining services.

(b) Housing transition services are defined as:

(1) tenant screening and housing assessment;

(2) assistance with the housing search and application process;

(3) identifying resources to cover onetime moving expenses;

(4) ensuring a new living arrangement is safe and ready for move-in;

(5) assisting in arranging for and supporting details of a move; and

(6) developing a housing support crisis plan.

(c) Housing and tenancy sustaining services include:

(1) prevention and early identification of behaviors that may jeopardize continued stable housing;

(2) education and training on roles, rights, and responsibilities of the tenant and the property manager;

(3) coaching to develop and maintain key relationships with property managers and neighbors;

(4) advocacy and referral to community resources to prevent eviction when housing is at risk;

(5) assistance with housing recertification process;

(6) coordination with the tenant to regularly review, update, and modify the housing support and crisis plan; and

(7) continuing training on being a good tenant, lease compliance, and household management.

(d) A housing ~~support~~ stabilization service may include person-centered planning for people who are not eligible to receive person-centered planning through any other service, if the person-centered planning is provided by a consultation service provider that is under contract with the department and enrolled as a Minnesota health care program.

Sec. 52. Minnesota Statutes 2020, section 256B.051, subdivision 6, is amended to read:

Subd. 6. **Provider qualifications and duties.** A provider eligible for reimbursement under this section shall:

(1) enroll as a medical assistance Minnesota health care program provider and meet all applicable provider standards and requirements;

(2) demonstrate compliance with federal and state laws and policies for housing ~~support~~ stabilization services as determined by the commissioner;

(3) comply with background study requirements under chapter 245C and maintain documentation of background study requests and results; ~~and~~

(4) directly provide housing ~~support~~ stabilization services and not use a subcontractor or reporting agent~~.~~; and

(5) complete annual vulnerable adult training.

Sec. 53. Minnesota Statutes 2020, section 256B.051, subdivision 7, is amended to read:

Subd. 7. **Housing support supplemental service rates.** Supplemental service rates for individuals in settings according to sections 144D.025, 256I.04, subdivision 3, paragraph (a), clause (3), and 256I.05, subdivision 1g, shall be reduced by one-half over a two-year period. This reduction only applies to supplemental service rates for individuals eligible for housing ~~support~~ stabilization services under this section.

Sec. 54. Minnesota Statutes 2020, section 256B.051, is amended by adding a subdivision to read:

Subd. 8. **Documentation requirements.** (a) Documentation may be collected and maintained electronically or in paper form by providers and must be produced upon request by the commissioner.

(b) Documentation of a delivered service must be in English and must be legible according to the standard of a reasonable person.

(c) If the service is reimbursed at an hourly or specified minute-based rate, each documentation of the provision of a service, unless otherwise specified, must include:

(1) the date the documentation occurred;

(2) the day, month, and year the service was provided;

(3) the start and stop times with a.m. and p.m. designations, except for person-centered planning services described under subdivision 5, paragraph (d);

(4) the service name or description of the service provided; and

(5) the name, signature, and title, if any, of the provider of service. If the service is provided by multiple staff members, the provider may designate a staff member responsible for verifying services and completing the documentation required by this paragraph.

Sec. 55. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team must use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) Services must be age-appropriate and meet the specific needs of the client.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every six months or prior to discharge from the service, whichever comes first.

(e) The treatment team must complete an individual treatment plan for each client and the individual treatment plan must:

(1) be based on the information in the client's diagnostic assessment and baselines;

(2) identify goals and objectives of treatment, a treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;

(3) be developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;

(4) be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessments, and treatment planning;

(5) be reviewed at least once every six months and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment;

(6) be signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;

(7) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan;

(8) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports;

(ii) be reviewed at least once every 90 days and revised, if necessary;

(9) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and

(10) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.

(f) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(g) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present

or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(h) The treatment team shall provide interventions to promote positive interpersonal relationships.

Sec. 56. Minnesota Statutes 2020, section 256B.4912, subdivision 13, is amended to read:

Subd. 13. **Waiver transportation documentation and billing requirements.** (a) A waiver transportation service must be a waiver transportation service that: (1) is not covered by medical transportation under the Medicaid state plan; and (2) is not included as a component of another waiver service.

(b) In addition to the documentation requirements in subdivision 12, a waiver transportation service provider must maintain:

(1) odometer and other records pursuant to section 256B.0625, subdivision 17b, paragraph (b), clause (3), sufficient to distinguish an individual trip with a specific vehicle and driver for a waiver transportation service that is billed directly by the mile. A common carrier as defined by Minnesota Rules, part 9505.0315, subpart 1, item B, or a publicly operated transit system provider are exempt from this clause; and

(2) documentation demonstrating that a vehicle and a driver meet the ~~standards determined by the Department of Human Services on vehicle and driver qualifications in section 256B.0625, subdivision 17, paragraph (c)~~ transportation waiver service provider standards and qualifications according to the federally approved waiver plan.

Sec. 57. Minnesota Statutes 2020, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B

and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) The commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659 and community first services and supports under section 256B.85.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying

reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization

rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(h) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under

this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(i) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(j) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

(k) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

Sec. 58. Minnesota Statutes 2020, section 256B.85, subdivision 1, is amended to read:

Subdivision 1. **Basis and scope.** (a) Upon federal approval, the commissioner shall establish a state plan option for the provision of home and community-based personal assistance service and supports called "community first services and supports (CFSS)."

(b) CFSS is a participant-controlled method of selecting and providing services and supports that allows the participant maximum control of the services and supports. Participants may choose the degree to which they direct and manage their supports by choosing to have a significant and meaningful role in the management of services and supports including by directly employing support workers with the necessary supports to perform that function.

(c) CFSS is available statewide to eligible people to assist with accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task; and to assist with acquiring, maintaining, and enhancing the skills necessary to accomplish ADLs, IADLs, and health-related procedures and tasks. CFSS allows payment for the participant for certain supports and goods such as environmental modifications and technology that are intended to replace or decrease the need for human assistance.

(d) Upon federal approval, CFSS will replace the personal care assistance program under sections 256.476, 256B.0625, subdivisions 19a and 19c, and 256B.0659.

(e) For the purposes of this section, notwithstanding the provisions of section 144A.43, subdivision 3, supports purchased under CFSS are not considered home care services.

Sec. 59. Minnesota Statutes 2020, section 256B.85, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Activities of daily living" or "ADLs" means ~~eating, toileting, grooming, dressing, bathing, mobility, positioning, and transferring.~~:

(1) dressing, including assistance with choosing, applying, and changing clothing and applying special appliances, wraps, or clothing;

(2) grooming, including assistance with basic hair care, oral care, shaving, applying cosmetics and deodorant, and care of eyeglasses and hearing aids. Grooming includes nail care, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

(4) eating, including assistance with hand washing and applying orthotics required for eating, transfers, or feeding;

(5) transfers, including assistance with transferring the participant from one seating or reclining area to another;

(6) mobility, including assistance with ambulation and use of a wheelchair. Mobility does not include providing transportation for a participant;

(7) positioning, including assistance with positioning or turning a participant for necessary care and comfort; and

(8) toileting, including assistance with bowel or bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.

(c) "Agency-provider model" means a method of CFSS under which a qualified agency provides services and supports through the agency's own employees and policies. The agency must allow the participant to have a significant role in the selection and dismissal of support workers of their choice for the delivery of their specific services and supports.

(d) "Behavior" means a description of a need for services and supports used to determine the home care rating and additional service units. The presence of Level I behavior is used to determine the home care rating.

(e) "Budget model" means a service delivery method of CFSS that allows the use of a service budget and assistance from a financial management services (FMS) provider for a participant to directly employ support workers and purchase supports and goods.

(f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that has been ordered by a physician, advanced practice registered nurse, or physician's assistant and is specified in a community support plan, including:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0651;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician, advanced practice registered nurse, or physician's assistant and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(g) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to accomplish

the task or constant supervision and cueing to accomplish the task, or the purchase of goods as defined in subdivision 7, clause (3), that replace the need for human assistance.

(h) "Community first services and supports service delivery plan" or "CFSS service delivery plan" means a written document detailing the services and supports chosen by the participant to meet assessed needs that are within the approved CFSS service authorization, as determined in subdivision 8. Services and supports are based on the coordinated service and support plan identified in ~~section~~ sections 256B.092, subdivision 1b, and 256S.10.

(i) "Consultation services" means a Minnesota health care program enrolled provider organization that provides assistance to the participant in making informed choices about CFSS services in general and self-directed tasks in particular, and in developing a person-centered CFSS service delivery plan to achieve quality service outcomes.

(j) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

(k) "Dependency" in activities of daily living means a person requires hands-on assistance or constant supervision and cueing to accomplish one or more of the activities of daily living every day or on the days during the week that the activity is performed; however, a child ~~may~~ must not be found to be dependent in an activity of daily living if, because of the child's age, an adult would either perform the activity for the child or assist the child with the activity and the assistance needed is the assistance appropriate for a typical child of the same age.

(l) "Extended CFSS" means CFSS services and supports provided under CFSS that are included in the CFSS service delivery plan through one of the home and community-based services waivers and as approved and authorized under chapter 256S and sections 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants. Extended CFSS excludes the purchase of goods.

(m) "Financial management services provider" or "FMS provider" means a qualified organization required for participants using the budget model under subdivision 13 that is an enrolled provider with the department to provide vendor fiscal/employer agent financial management services (FMS).

(n) "Health-related procedures and tasks" means procedures and tasks related to the specific assessed health needs of a participant that can be taught or assigned by a state-licensed health care or mental health professional and performed by a support worker.

(o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking;

shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community.

(p) "Lead agency" has the meaning given in section 256B.0911, subdivision 1a, paragraph (e).

(q) "Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(r) "Level I behavior" means physical aggression toward ~~towards~~ self or others or destruction of property that requires the immediate response of another person.

(s) "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, and includes any of the following supports listed in clauses (1) to (3) and other types of assistance, except that a support worker ~~may~~ must not determine medication dose or time for medication or inject medications into veins, muscles, or skin:

(1) under the direction of the participant or the participant's representative, bringing medications to the participant including medications given through a nebulizer, opening a container of previously set-up medications, emptying the container into the participant's hand, opening and giving the medication in the original container to the participant, or bringing to the participant liquids or food to accompany the medication;

(2) organizing medications as directed by the participant or the participant's representative; and

(3) providing verbal or visual reminders to perform regularly scheduled medications.

(t) "Participant" means a person who is eligible for CFSS.

(u) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant or participant's legal representative, if any, to serve as a representative in connection with the provision of CFSS. ~~This authorization must be in writing or by another method that clearly indicates the participant's free choice and may be withdrawn at any time. The participant's representative must have no financial interest in the provision of any services included in the participant's CFSS service delivery plan and must be capable of providing the support necessary to assist the participant in the use of CFSS. If through the assessment process described in subdivision 5 a participant is~~

~~determined to be in need of a participant's representative, one must be selected.~~ If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one. ~~Two persons may be designated as a participant's representative for reasons such as divided households and court-ordered custodies. Duties of a participant's representatives may include:~~

~~(1) being available while services are provided in a method agreed upon by the participant or the participant's legal representative and documented in the participant's CFSS service delivery plan;~~

~~(2) monitoring CFSS services to ensure the participant's CFSS service delivery plan is being followed; and~~

~~(3) reviewing and signing CFSS time sheets after services are provided to provide verification of the CFSS services.~~

(v) "Person-centered planning process" means a process that is directed by the participant to plan for CFSS services and supports.

(w) "Service budget" means the authorized dollar amount used for the budget model or for the purchase of goods.

(x) "Shared services" means the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into ~~an~~ a written agreement to receive services at the same time ~~and~~, in the same setting ~~by~~, and through the same ~~employer~~ agency-provider or FMS provider.

(y) "Support worker" means a qualified and trained employee of the agency-provider as required by subdivision 11b or of the participant employer under the budget model as required by subdivision 14 who has direct contact with the participant and provides services as specified within the participant's CFSS service delivery plan.

(z) "Unit" means the increment of service based on hours or minutes identified in the service agreement.

(aa) "Vendor fiscal employer agent" means an agency that provides financial management services.

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

(cc) "Worker training and development" means services provided according to subdivision 18a for developing workers' skills as required by the participant's individual CFSS service delivery plan that are arranged for or provided by the agency-provider or purchased by the participant employer. These services include training, education, direct observation and supervision, and evaluation and coaching of job skills and tasks, including supervision of health-related tasks or behavioral supports.

Sec. 60. Minnesota Statutes 2020, section 256B.85, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) CFSS is available to a person who ~~meets one of the following~~:

~~(1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056, or 256B.057, subdivisions 5 and 9;~~

(1) is determined eligible for medical assistance under this chapter, excluding those under section 256B.057, subdivisions 3, 3a, 3b, and 4;

(2) is a participant in the alternative care program under section 256B.0913;

(3) is a waiver participant as defined under chapter 256S or section 256B.092, 256B.093, or 256B.49; or

(4) has medical services identified in a person's individualized education program and is eligible for services as determined in section 256B.0625, subdivision 26.

(b) In addition to meeting the eligibility criteria in paragraph (a), a person must also meet all of the following:

(1) require assistance and be determined dependent in one activity of daily living or Level I behavior based on assessment under section 256B.0911; and

(2) is not a participant under a family support grant under section 252.32.

(c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as determined under section 256B.0911.

Sec. 61. Minnesota Statutes 2020, section 256B.85, subdivision 4, is amended to read:

Subd. 4. **Eligibility for other services.** Selection of CFSS by a participant must not restrict access to other medically necessary care and services furnished under the state plan benefit or other services available through the alternative care program.

Sec. 62. Minnesota Statutes 2020, section 256B.85, subdivision 5, is amended to read:

Subd. 5. **Assessment requirements.** (a) The assessment of functional need must:

(1) be conducted by a certified assessor according to the criteria established in section 256B.0911, subdivision 3a;

(2) be conducted face-to-face, initially and at least annually thereafter, or when there is a significant change in the participant's condition or a change in the need for services and supports, or at the request of the participant when the participant experiences a change in condition or needs a change in the services or supports; and

(3) be completed using the format established by the commissioner.

(b) The results of the assessment and any recommendations and authorizations for CFSS must be determined and communicated in writing by the lead agency's ~~certified~~ assessor as defined in section 256B.0911 to the participant ~~and the agency-provider or FMS provider chosen by the participant~~ or the participant's representative and chosen CFSS providers within ~~40 calendar~~ ten business days and must include the participant's right to appeal the assessment under section 256.045, subdivision 3.

(c) The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model. The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model without using the assessment process described in this subdivision. Authorization for a temporary level of CFSS services under the agency-provider model is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this paragraph shall have no bearing on a future authorization. ~~Participants approved for a temporary authorization shall access the consultation service~~ For CFSS services needed beyond the 45-day temporary authorization, the lead agency must conduct an assessment as described in this subdivision and participants must use consultation services to complete their orientation and selection of a service model.

Sec. 63. Minnesota Statutes 2020, section 256B.85, subdivision 6, is amended to read:

Subd. 6. **Community first services and supports service delivery plan.** (a) The CFSS service delivery plan must be developed and evaluated through a person-centered planning process by the participant, or the participant's representative or legal representative who may be assisted by a consultation services provider. The CFSS service delivery plan must reflect the services and supports that are important to the participant and for the participant to meet the needs assessed by the certified assessor and identified in the coordinated service

and support plan identified in ~~section~~ sections 256B.092, subdivision 1b, and 256S.10. The CFSS service delivery plan must be reviewed by the participant, the consultation services provider, and the agency-provider or FMS provider prior to starting services and at least annually upon reassessment, or when there is a significant change in the participant's condition, or a change in the need for services and supports.

(b) The commissioner shall establish the format and criteria for the CFSS service delivery plan.

(c) The CFSS service delivery plan must be person-centered and:

(1) specify the consultation services provider, agency-provider, or FMS provider selected by the participant;

(2) reflect the setting in which the participant resides that is chosen by the participant;

(3) reflect the participant's strengths and preferences;

(4) include the methods and supports used to address the needs as identified through an assessment of functional needs;

(5) include the participant's identified goals and desired outcomes;

(6) reflect the services and supports, paid and unpaid, that will assist the participant to achieve identified goals, including the costs of the services and supports, and the providers of those services and supports, including natural supports;

(7) identify the amount and frequency of face-to-face supports and amount and frequency of remote supports and technology that will be used;

(8) identify risk factors and measures in place to minimize them, including individualized backup plans;

(9) be understandable to the participant and the individuals providing support;

(10) identify the individual or entity responsible for monitoring the plan;

(11) be finalized and agreed to in writing by the participant and signed by ~~all~~ individuals and providers responsible for its implementation;

(12) be distributed to the participant and other people involved in the plan;

(13) prevent the provision of unnecessary or inappropriate care;

(14) include a detailed budget for expenditures for budget model participants or participants under the agency-provider model if purchasing goods; and

(15) include a plan for worker training and development provided according to subdivision 18a detailing what service components will be used, when the service components will be used, how they will be provided, and how these service components relate to the participant's individual needs and CFSS support worker services.

(d) The CFSS service delivery plan must describe the units or dollar amount available to the participant. The total units of agency-provider services or the service budget amount for the budget model include both annual totals and a monthly average amount that cover the number of months of the service agreement. The amount used each month may vary, but additional funds must not be provided above the annual service authorization amount, determined according to subdivision 8, unless a change in condition is assessed and authorized by the certified assessor and documented in the coordinated service and support plan and CFSS service delivery plan.

(e) In assisting with the development or modification of the CFSS service delivery plan during the authorization time period, the consultation services provider shall:

(1) consult with the FMS provider on the spending budget when applicable; and

(2) consult with the participant or participant's representative, agency-provider, and case manager~~/~~ or care coordinator.

(f) The CFSS service delivery plan must be approved by the consultation services provider for participants without a case manager or care coordinator who is responsible for authorizing services. A case manager or care coordinator must approve the plan for a waiver or alternative care program participant.

Sec. 64. Minnesota Statutes 2020, section 256B.85, subdivision 7, is amended to read:

Subd. 7. **Community first services and supports; covered services.** Services and supports covered under CFSS include:

(1) assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task;

(2) assistance to acquire, maintain, or enhance the skills necessary for the participant to accomplish activities of daily living, instrumental activities of daily living, or health-related tasks;

(3) expenditures for items, services, supports, environmental modifications, or goods, including assistive technology. These expenditures must:

(i) relate to a need identified in a participant's CFSS service delivery plan; and

(ii) increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance for the participant's assessed needs;

(4) observation and redirection for behavior or symptoms where there is a need for assistance;

(5) back-up systems or mechanisms, such as the use of pagers or other electronic devices, to ensure continuity of the participant's services and supports;

(6) services provided by a consultation services provider as defined under subdivision 17, that is under contract with the department and enrolled as a Minnesota health care program provider;

(7) services provided by an FMS provider as defined under subdivision 13a, that is an enrolled provider with the department;

(8) CFSS services provided by a support worker who is a parent, stepparent, or legal guardian of a participant under age 18, or who is the participant's spouse. These support workers shall not:

(i) provide any medical assistance home and community-based services in excess of 40 hours per seven-day period regardless of the number of parents providing services, combination of parents and spouses providing services, or number of children who receive medical assistance services; and

(ii) have a wage that exceeds the current rate for a CFSS support worker including the wage, benefits, and payroll taxes; and

(9) worker training and development services as described in subdivision 18a.

Sec. 65. Minnesota Statutes 2020, section 256B.85, subdivision 8, is amended to read:

Subd. 8. **Determination of CFSS service authorization amount.** (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin. The authorization for CFSS must be completed as soon as possible following an assessment but no later than 40 calendar days from the date of the assessment.

(b) The amount of CFSS authorized must be based on the participant's home care rating described in paragraphs (d) and (e) and any additional service units for which the participant qualifies as described in paragraph (f).

(c) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for a participant:

(1) the total number of dependencies of activities of daily living;

(2) the presence of complex health-related needs; and

(3) the presence of Level I behavior.

(d) The methodology to determine the total service units for CFSS for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the PCA program.

(e) Each home care rating is designated by the letters P through Z and EN and has the following base number of service units assigned:

(1) P home care rating requires Level I behavior or one to three dependencies in ADLs and qualifies the person for five service units;

(2) Q home care rating requires Level I behavior and one to three dependencies in ADLs and qualifies the person for six service units;

(3) R home care rating requires a complex health-related need and one to three dependencies in ADLs and qualifies the person for seven service units;

(4) S home care rating requires four to six dependencies in ADLs and qualifies the person for ten service units;

(5) T home care rating requires four to six dependencies in ADLs and Level I behavior and qualifies the person for 11 service units;

(6) U home care rating requires four to six dependencies in ADLs and a complex health-related need and qualifies the person for 14 service units;

(7) V home care rating requires seven to eight dependencies in ADLs and qualifies the person for 17 service units;

(8) W home care rating requires seven to eight dependencies in ADLs and Level I behavior and qualifies the person for 20 service units;

(9) Z home care rating requires seven to eight dependencies in ADLs and a complex health-related need and qualifies the person for 30 service units; and

(10) EN home care rating includes ventilator dependency as defined in section 256B.0651, subdivision 1, paragraph (g). A person who meets the definition of ventilator-dependent

and the EN home care rating and utilize a combination of CFSS and home care nursing services is limited to a total of 96 service units per day for those services in combination. Additional units may be authorized when a person's assessment indicates a need for two staff to perform activities. Additional time is limited to 16 service units per day.

(f) Additional service units are provided through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living;

(2) 30 additional minutes per day for each complex health-related need; and

(3) 30 additional minutes per day ~~when the~~ for each behavior under this clause that requires assistance at least four times per week ~~for one or more of the following behaviors~~:

(i) level I behavior that requires the immediate response of another person;

(ii) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(iii) increased need for assistance for participants who are verbally aggressive or resistive to care so that the time needed to perform activities of daily living is increased.

(g) The service budget for budget model participants shall be based on:

(1) assessed units as determined by the home care rating; and

(2) an adjustment needed for administrative expenses.

Sec. 66. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision to read:

Subd. 8a. **Authorization; exceptions.** All CFSS services must be authorized by the commissioner or the commissioner's designee as described in subdivision 8 except when:

(1) the lead agency temporarily authorizes services in the agency-provider model as described in subdivision 5, paragraph (c);

(2) CFSS services in the agency-provider model were required to treat an emergency medical condition that if not immediately treated could cause a participant serious physical or mental disability, continuation of severe pain, or death. The CFSS agency provider must request retroactive authorization from the lead agency no later than five working days after providing the initial emergency service. The CFSS agency provider must be able to substantiate the emergency through documentation such as reports, notes, and admission

or discharge histories. A lead agency must follow the authorization process in subdivision 5 after the lead agency receives the request for authorization from the agency provider;

(3) the lead agency authorizes a temporary increase to the amount of services authorized in the agency or budget model to accommodate the participant's temporary higher need for services. Authorization for a temporary level of CFSS services is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this clause shall have no bearing on a future authorization;

(4) a participant's medical assistance eligibility has lapsed, is then retroactively reinstated, and an authorization for CFSS services is completed based on the date of a current assessment, eligibility, and request for authorization;

(5) a third-party payer for CFSS services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(6) the commissioner has determined that a lead agency or state human services agency has made an error; or

(7) a participant enrolled in managed care experiences a temporary disenrollment from a health plan, in which case the commissioner shall accept the current health plan authorization for CFSS services for up to 60 days. The request must be received within the first 30 days of the disenrollment. If the recipient's reenrollment in managed care is after the 60 days and before 90 days, the provider shall request an additional 30-day extension of the current health plan authorization, for a total limit of 90 days from the time of disenrollment.

Sec. 67. Minnesota Statutes 2020, section 256B.85, subdivision 9, is amended to read:

Subd. 9. **Noncovered services.** (a) Services or supports that are not eligible for payment under this section include those that:

(1) are not authorized by the certified assessor or included in the CFSS service delivery plan;

(2) are provided prior to the authorization of services and the approval of the CFSS service delivery plan;

(3) are duplicative of other paid services in the CFSS service delivery plan;

(4) supplant natural unpaid supports that appropriately meet a need in the CFSS service delivery plan, are provided voluntarily to the participant, and are selected by the participant in lieu of other services and supports;

(5) are not effective means to meet the participant's needs; and

(6) are available through other funding sources, including~~,~~ but not limited to~~,~~ funding through title IV-E of the Social Security Act.

(b) Additional services, goods, or supports that are not covered include:

(1) those that are not for the direct benefit of the participant, except that services for caregivers such as training to improve the ability to provide CFSS are considered to directly benefit the participant if chosen by the participant and approved in the support plan;

(2) any fees incurred by the participant, such as Minnesota health care programs fees and co-pays, legal fees, or costs related to advocate agencies;

(3) insurance, except for insurance costs related to employee coverage;

(4) room and board costs for the participant;

(5) services, supports, or goods that are not related to the assessed needs;

(6) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

(7) assistive technology devices and assistive technology services other than those for back-up systems or mechanisms to ensure continuity of service and supports listed in subdivision 7;

(8) medical supplies and equipment covered under medical assistance;

(9) environmental modifications, except as specified in subdivision 7;

(10) expenses for travel, lodging, or meals related to training the participant or the participant's representative or legal representative;

(11) experimental treatments;

(12) any service or good covered by other state plan services, including prescription and over-the-counter medications, compounds, and solutions and related fees, including premiums and co-payments;

(13) membership dues or costs, except when the service is necessary and appropriate to treat a health condition or to improve or maintain the adult participant's health condition.

The condition must be identified in the participant's CFSS service delivery plan and monitored by a Minnesota health care program enrolled physician, advanced practice registered nurse, or physician's assistant;

(14) vacation expenses other than the cost of direct services;

(15) vehicle maintenance or modifications not related to the disability, health condition, or physical need;

(16) tickets and related costs to attend sporting or other recreational or entertainment events;

(17) services provided and billed by a provider who is not an enrolled CFSS provider;

(18) CFSS provided by a participant's representative or paid legal guardian;

(19) services that are used solely as a child care or babysitting service;

(20) services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules;

(21) sterile procedures;

(22) giving of injections into veins, muscles, or skin;

(23) homemaker services that are not an integral part of the assessed CFSS service;

(24) home maintenance or chore services;

(25) home care services, including hospice services if elected by the participant, covered by Medicare or any other insurance held by the participant;

(26) services to other members of the participant's household;

(27) services not specified as covered under medical assistance as CFSS;

(28) application of restraints or implementation of deprivation procedures;

(29) assessments by CFSS provider organizations or by independently enrolled registered nurses;

(30) services provided in lieu of legally required staffing in a residential or child care setting; ~~and~~

(31) services provided by ~~the residential or program~~ a foster care license holder ~~in a residence for more than four participants.~~ except when the home of the person receiving services is the licensed foster care provider's primary residence;

(32) services that are the responsibility of the foster care provider under the terms of the foster care placement agreement, assessment under sections 256N.24 and 260C.4411, and administrative rules under sections 256N.24 and 260C.4411;

(33) services in a setting that has a licensed capacity greater than six, unless all conditions for a variance under section 245A.04, subdivision 9a, are satisfied for a sibling, as defined in section 260C.007, subdivision 32;

(34) services from a provider who owns or otherwise controls the living arrangement, except when the provider of services is related by blood, marriage, or adoption or when the provider is a licensed foster care provider who is not prohibited from providing services under clauses (31) to (33);

(35) instrumental activities of daily living for children younger than 18 years of age, except when immediate attention is needed for health or hygiene reasons integral to an assessed need for assistance with activities of daily living, health-related procedures, and tasks or behaviors; or

(36) services provided to a resident of a nursing facility, hospital, intermediate care facility, or health care facility licensed by the commissioner of health.

Sec. 68. Minnesota Statutes 2020, section 256B.85, subdivision 10, is amended to read:

Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a) Agency-providers identified in subdivision 11 and FMS providers identified in subdivision 13a shall:

(1) enroll as a medical assistance Minnesota health care programs provider and meet all applicable provider standards and requirements including completion of required provider training as determined by the commissioner;

(2) demonstrate compliance with federal and state laws and policies for CFSS as determined by the commissioner;

(3) comply with background study requirements under chapter 245C and maintain documentation of background study requests and results;

(4) verify and maintain records of all services and expenditures by the participant, including hours worked by support workers;

(5) not engage in any agency-initiated direct contact or marketing in person, by telephone, or other electronic means to potential participants, guardians, family members, or participants' representatives;

(6) directly provide services and not use a subcontractor or reporting agent;

(7) meet the financial requirements established by the commissioner for financial solvency;

(8) have never had a lead agency contract or provider agreement discontinued due to fraud, or have never had an owner, board member, or manager fail a state or FBI-based criminal background check while enrolled or seeking enrollment as a Minnesota health care programs provider; and

(9) have an office located in Minnesota.

(b) In conducting general duties, agency-providers and FMS providers shall:

(1) pay support workers based upon actual hours of services provided;

(2) pay for worker training and development services based upon actual hours of services provided or the unit cost of the training session purchased;

(3) withhold and pay all applicable federal and state payroll taxes;

(4) make arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(5) enter into a written agreement with the participant, participant's representative, or legal representative that assigns roles and responsibilities to be performed before services, supports, or goods are provided and that meets the requirements of subdivisions 20a, 20b, and 20c for agency-providers;

(6) report maltreatment as required under section 626.557 and chapter 260E;

(7) comply with the labor market reporting requirements described in section 256B.4912, subdivision 1a;

(8) comply with any data requests from the department consistent with the Minnesota Government Data Practices Act under chapter 13; ~~and~~

(9) maintain documentation for the requirements under subdivision 16, paragraph (e), clause (2), to qualify for an enhanced rate under this section~~.~~; and

(10) request reassessments 60 days before the end of the current authorization for CFSS on forms provided by the commissioner.

Sec. 69. Minnesota Statutes 2020, section 256B.85, subdivision 11, is amended to read:

Subd. 11. **Agency-provider model.** (a) The agency-provider model includes services provided by support workers and staff providing worker training and development services who are employed by an agency-provider that meets the criteria established by the commissioner, including required training.

(b) The agency-provider shall allow the participant to have a significant role in the selection and dismissal of the support workers for the delivery of the services and supports specified in the participant's CFSS service delivery plan. The agency must make a reasonable effort to fulfill the participant's request for the participant's preferred support worker.

(c) A participant may use authorized units of CFSS services as needed within a service agreement that is not greater than 12 months. Using authorized units in a flexible manner in either the agency-provider model or the budget model does not increase the total amount of services and supports authorized for a participant or included in the participant's CFSS service delivery plan.

(d) A participant may share CFSS services. Two or three CFSS participants may share services at the same time provided by the same support worker.

(e) The agency-provider must use a minimum of 72.5 percent of the revenue generated by the medical assistance payment for CFSS for support worker wages and benefits, except all of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. The agency-provider must document how this requirement is being met. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services must not be used in making this calculation.

(f) The agency-provider model must be used by ~~individuals~~ participants who are restricted by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

(g) Participants purchasing goods under this model, along with support worker services, must:

(1) specify the goods in the CFSS service delivery plan and detailed budget for expenditures that must be approved by the consultation services provider, case manager, or care coordinator; and

(2) use the FMS provider for the billing and payment of such goods.

Sec. 70. Minnesota Statutes 2020, section 256B.85, subdivision 11b, is amended to read:

Subd. 11b. **Agency-provider model; support worker competency.** (a) The agency-provider must ensure that support workers are competent to meet the participant's assessed needs, goals, and additional requirements as written in the CFSS service delivery plan. ~~Within 30 days of any support worker beginning to provide services for a participant,~~ The agency-provider must evaluate the competency of the support worker through direct observation of the support worker's performance of the job functions in a setting where the participant is using CFSS~~.~~ within 30 days of:

(1) any support worker beginning to provide services for a participant; or

(2) any support worker beginning to provide shared services.

(b) The agency-provider must verify and maintain evidence of support worker competency, including documentation of the support worker's:

(1) education and experience relevant to the job responsibilities assigned to the support worker and the needs of the participant;

(2) relevant training received from sources other than the agency-provider;

(3) orientation and instruction to implement services and supports to participant needs and preferences as identified in the CFSS service delivery plan; ~~and~~

(4) orientation and instruction delivered by an individual competent to perform, teach, or assign the health-related tasks for tracheostomy suctioning and services to participants on ventilator support, including equipment operation and maintenance; and

~~(4)~~ (5) periodic performance reviews completed by the agency-provider at least annually, including any evaluations required under subdivision 11a, paragraph (a). If a support worker is a minor, all evaluations of worker competency must be completed in person and in a setting where the participant is using CFSS.

(c) The agency-provider must develop a worker training and development plan with the participant to ensure support worker competency. The worker training and development plan must be updated when:

(1) the support worker begins providing services;

(2) the support worker begins providing shared services;

~~(2)~~ (3) there is any change in condition or a modification to the CFSS service delivery plan; or

~~(3)~~ (4) a performance review indicates that additional training is needed.

Sec. 71. Minnesota Statutes 2020, section 256B.85, subdivision 12, is amended to read:

Subd. 12. **Requirements for enrollment of CFSS agency-providers.** (a) All CFSS agency-providers must provide, at the time of enrollment, reenrollment, and revalidation as a CFSS agency-provider in a format determined by the commissioner, information and documentation that includes~~,~~ but is not limited to~~,~~ the following:

(1) the CFSS agency-provider's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the agency-provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the agency-provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the agency-provider must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000 per provider location;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a ~~description~~ copy of the CFSS agency-provider's ~~organization~~ organizational chart identifying the names and roles of all owners, managing employees, staff, board of directors, and ~~the~~ additional documentation reporting any affiliations of the directors and owners to other service providers;

(7) ~~a copy of~~ proof that the CFSS ~~agency-provider's~~ agency-provider has written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety, including the process for notification and resolution of participant grievances, incident response, identification and prevention of communicable diseases, and employee misconduct;

(8) ~~copies of all other forms~~ proof that the CFSS agency-provider ~~uses in the course of daily business including, but not limited to~~ has all of the following forms and documents:

(i) a copy of the CFSS agency-provider's time sheet; and

(ii) a copy of the participant's individual CFSS service delivery plan;

(9) a list of all training and classes that the CFSS agency-provider requires of its staff providing CFSS services;

(10) documentation that the CFSS agency-provider and staff have successfully completed all the training required by this section;

(11) documentation of the agency-provider's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that are used or could be used for providing home care services;

(13) documentation that the agency-provider will use at least the following percentages of revenue generated from the medical assistance rate paid for CFSS services for CFSS support worker wages and benefits: 72.5 percent of revenue from CFSS providers, except 100 percent of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services shall not be used in making this calculation; and

(14) documentation that the agency-provider does not burden participants' free exercise of their right to choose service providers by requiring CFSS support workers to sign an agreement not to work with any particular CFSS participant or for another CFSS agency-provider after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) CFSS agency-providers shall provide to the commissioner the information specified in paragraph (a).

(c) All CFSS agency-providers shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a CFSS agency-provider do not need to repeat the required training if they are hired by another agency~~, if~~ and they have completed the training within the past three years. CFSS agency-provider billing staff shall complete training about CFSS program financial management. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency.

~~(d) The commissioner shall send annual review notifications to agency-providers 30 days prior to renewal. The notification must:~~

~~(1) list the materials and information the agency-provider is required to submit;~~

~~(2) provide instructions on submitting information to the commissioner; and~~

~~(3) provide a due date by which the commissioner must receive the requested information.~~

~~Agency-providers shall submit all required documentation for annual review within 30 days of notification from the commissioner. If an agency-provider fails to submit all the required documentation, the commissioner may take action under subdivision 23a.~~

(d) Agency-providers shall submit all required documentation in this section within 30 days of notification from the commissioner. If an agency-provider fails to submit all the required documentation, the commissioner may take action under subdivision 23a.

Sec. 72. Minnesota Statutes 2020, section 256B.85, subdivision 12b, is amended to read:

Subd. 12b. **CFSS agency-provider requirements; notice regarding termination of services.** (a) An agency-provider must provide written notice when it intends to terminate services with a participant at least ~~ten~~ 30 calendar days before the proposed service termination is to become effective, except in cases where:

(1) the participant engages in conduct that significantly alters the terms of the CFSS service delivery plan with the agency-provider;

(2) the participant or other persons at the setting where services are being provided engage in conduct that creates an imminent risk of harm to the support worker or other agency-provider staff; or

(3) an emergency or a significant change in the participant's condition occurs within a 24-hour period that results in the participant's service needs exceeding the participant's identified needs in the current CFSS service delivery plan so that the agency-provider cannot safely meet the participant's needs.

(b) When a participant initiates a request to terminate CFSS services with the agency-provider, the agency-provider must give the participant a written ~~acknowledgement~~ acknowledgment of the participant's service termination request that includes the date the request was received by the agency-provider and the requested date of termination.

(c) The agency-provider must participate in a coordinated transfer of the participant to a new agency-provider to ensure continuity of care.

Sec. 73. Minnesota Statutes 2020, section 256B.85, subdivision 13, is amended to read:

Subd. 13. **Budget model.** (a) Under the budget model participants exercise responsibility and control over the services and supports described and budgeted within the CFSS service delivery plan. Participants must use services specified in subdivision 13a provided by an FMS provider. Under this model, participants may use their approved service budget allocation to:

(1) directly employ support workers, and pay wages, federal and state payroll taxes, and premiums for workers' compensation, liability, and health insurance coverage; and

(2) obtain supports and goods as defined in subdivision 7.

(b) Participants who are unable to fulfill any of the functions listed in paragraph (a) may authorize a legal representative or participant's representative to do so on their behalf.

(c) If two or more participants using the budget model live in the same household and have the same support worker, the participants must use the same FMS provider.

(d) If the FMS provider advises that there is a joint employer in the budget model, all participants associated with that joint employer must use the same FMS provider.

~~(c)~~ (e) The commissioner shall disenroll or exclude participants from the budget model and transfer them to the agency-provider model under, but not limited to, the following circumstances:

(1) when a participant has been restricted by the Minnesota restricted recipient program, in which case the participant may be excluded for a specified time period under Minnesota Rules, parts 9505.2160 to 9505.2245;

(2) when a participant exits the budget model during the participant's service plan year. Upon transfer, the participant shall not access the budget model for the remainder of that service plan year; or

(3) when the department determines that the participant or participant's representative or legal representative is unable to fulfill the responsibilities under the budget model, as specified in subdivision 14.

~~(d)~~ (f) A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision under paragraph ~~(c)~~ (e), clause (3), to disenroll or exclude the participant from the budget model.

Sec. 74. Minnesota Statutes 2020, section 256B.85, subdivision 13a, is amended to read:

Subd. 13a. **Financial management services.** (a) Services provided by an FMS provider include but are not limited to: filing and payment of federal and state payroll taxes on behalf of the participant; initiating and complying with background study requirements under chapter 245C and maintaining documentation of background study requests and results; billing for approved CFSS services with authorized funds; monitoring expenditures; accounting for and disbursing CFSS funds; providing assistance in obtaining and filing for liability, workers' compensation, and unemployment coverage; and providing participant instruction and technical assistance to the participant in fulfilling employer-related requirements in accordance with section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1.

(b) Agency-provider services shall not be provided by the FMS provider.

(c) The FMS provider shall provide service functions as determined by the commissioner for budget model participants that include but are not limited to:

(1) assistance with the development of the detailed budget for expenditures portion of the CFSS service delivery plan as requested by the consultation services provider or participant;

(2) data recording and reporting of participant spending;

(3) other duties established by the department, including with respect to providing assistance to the participant, participant's representative, or legal representative in performing employer responsibilities regarding support workers. The support worker shall not be considered the employee of the FMS provider; and

(4) billing, payment, and accounting of approved expenditures for goods.

(d) The FMS provider shall obtain an assurance statement from the participant employer agreeing to follow state and federal regulations and CFSS policies regarding employment of support workers.

(e) The FMS provider shall:

(1) not limit or restrict the participant's choice of service or support providers or service delivery models consistent with any applicable state and federal requirements;

(2) provide the participant, consultation services provider, and case manager or care coordinator, if applicable, with a monthly written summary of the spending for services and supports that were billed against the spending budget;

(3) be knowledgeable of state and federal employment regulations, including those under the Fair Labor Standards Act of 1938, and comply with the requirements under section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1, regarding agency employer tax liability for vendor fiscal/employer agent, and any requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

(4) have current and adequate liability insurance and bonding and sufficient cash flow as determined by the commissioner and have on staff or under contract a certified public accountant or an individual with a baccalaureate degree in accounting;

(5) assume fiscal accountability for state funds designated for the program and be held liable for any overpayments or violations of applicable statutes or rules, including but not limited to the Minnesota False Claims Act, chapter 15C; ~~and~~

(6) maintain documentation of receipts, invoices, and bills to track all services and supports expenditures for any goods purchased and maintain time records of support workers. The documentation and time records must be maintained for a minimum of five years from the claim date and be available for audit or review upon request by the commissioner. Claims submitted by the FMS provider to the commissioner for payment must correspond with services, amounts, and time periods as authorized in the participant's service budget and service plan and must contain specific identifying information as determined by the commissioner~~.~~; and

(7) provide written notice to the participant or the participant's representative at least 30 calendar days before a proposed service termination becomes effective.

(f) The commissioner ~~of human services~~ shall:

(1) establish rates and payment methodology for the FMS provider;

(2) identify a process to ensure quality and performance standards for the FMS provider and ensure statewide access to FMS providers; and

(3) establish a uniform protocol for delivering and administering CFSS services to be used by eligible FMS providers.

Sec. 75. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision to read:

Subd. 14a. **Participant's representative responsibilities.** (a) If a participant is unable to direct the participant's own care, the participant must use a participant's representative to receive CFSS services. A participant's representative is required if:

(1) the person is under 18 years of age;

(2) the person has a court-appointed guardian; or

(3) an assessment according to section 256B.0659, subdivision 3a, determines that the participant is in need of a participant's representative.

(b) A participant's representative must:

(1) be at least 18 years of age;

(2) actively participate in planning and directing CFSS services;

(3) have sufficient knowledge of the participant's circumstances to use CFSS services consistent with the participant's health and safety needs identified in the participant's service delivery plan;

(4) not have a financial interest in the provision of any services included in the participant's CFSS service delivery plan; and

(5) be capable of providing the support necessary to assist the participant in the use of CFSS services.

(c) A participant's representative must not be the:

(1) support worker;

(2) worker training and development service provider;

(3) agency-provider staff, unless related to the participant by blood, marriage, or adoption;

(4) consultation service provider, unless related to the participant by blood, marriage, or adoption;

(5) FMS staff, unless related to the participant by blood, marriage, or adoption;

(6) FMS owner or manager; or

(7) lead agency staff acting as part of employment.

(d) A licensed family foster parent who lives with the participant may be the participant's representative if the family foster parent meets the other participant's representative requirements.

(e) There may be two persons designated as the participant's representative, including instances of divided households and court-ordered custodies. Each person named as the participant's representative must meet the program criteria and responsibilities.

(f) The participant or the participant's legal representative shall appoint a participant's representative. The participant's representative must be identified at the time of assessment and listed on the participant's service agreement and CFSS service delivery plan.

(g) A participant's representative must enter into a written agreement with an agency-provider or FMS on a form determined by the commissioner and maintained in the participant's file, to:

(1) be available while care is provided using a method agreed upon by the participant or the participant's legal representative and documented in the participant's service delivery plan;

(2) monitor CFSS services to ensure the participant's service delivery plan is followed;

(3) review and sign support worker time sheets after services are provided to verify the provision of services;

(4) review and sign vendor paperwork to verify receipt of goods; and

(5) in the budget model, review and sign documentation to verify worker training and development expenditures.

(h) A participant's representative may delegate responsibility to another adult who is not the support worker during a temporary absence of at least 24 hours but not more than six months. To delegate responsibility, the participant's representative must:

(1) ensure that the delegate serving as the participant's representative satisfies the requirements of the participant's representative;

(2) ensure that the delegate performs the functions of the participant's representative;

(3) communicate to the CFSS agency-provider or FMS provider about the need for a delegate by updating the written agreement to include the name of the delegate and the delegate's contact information; and

(4) ensure that the delegate protects the participant's privacy according to federal and state data privacy laws.

(i) The designation of a participant's representative remains in place until:

(1) the participant revokes the designation;

(2) the participant's representative withdraws the designation or becomes unable to fulfill the duties;

(3) the legal authority to act as a participant's representative changes; or

(4) the participant's representative is disqualified.

(j) A lead agency may disqualify a participant's representative who engages in conduct that creates an imminent risk of harm to the participant, the support workers, or other staff. A participant's representative who fails to provide support required by the participant must be referred to the common entry point.

Sec. 76. Minnesota Statutes 2020, section 256B.85, subdivision 15, is amended to read:

Subd. 15. **Documentation of support services provided; time sheets.** (a) CFSS services provided to a participant by a support worker employed by either an agency-provider or the participant employer must be documented daily by each support worker, on a time sheet. Time sheets may be created, submitted, and maintained electronically. Time sheets must be submitted by the support worker at least once per month to the:

(1) agency-provider when the participant is using the agency-provider model. The agency-provider must maintain a record of the time sheet and provide a copy of the time sheet to the participant; or

(2) participant and the participant's FMS provider when the participant is using the budget model. The participant and the FMS provider must maintain a record of the time sheet.

(b) The documentation on the time sheet must correspond to the participant's assessed needs within the scope of CFSS covered services. The accuracy of the time sheets must be verified by the:

(1) agency-provider when the participant is using the agency-provider model; or

(2) participant employer and the participant's FMS provider when the participant is using the budget model.

(c) The time sheet must document the time the support worker provides services to the participant. The following elements must be included in the time sheet:

(1) the support worker's full name and individual provider number;

(2) the agency-provider's name and telephone numbers, when responsible for the CFSS service delivery plan;

(3) the participant's full name;

(4) the dates within the pay period established by the agency-provider or FMS provider, including month, day, and year, and arrival and departure times with a.m. or p.m. notations for days worked within the established pay period;

(5) the covered services provided to the participant on each date of service;

(6) ~~a~~ the signature ~~line for~~ of the participant or the participant's representative and a statement that the participant's or participant's representative's signature is verification of the time sheet's accuracy;

(7) the ~~personal~~ signature of the support worker;

(8) any shared care provided, if applicable;

(9) a statement that it is a federal crime to provide false information on CFSS billings for medical assistance payments; and

(10) dates and location of participant stays in a hospital, care facility, or incarceration occurring within the established pay period.

Sec. 77. Minnesota Statutes 2020, section 256B.85, subdivision 17a, is amended to read:

Subd. 17a. **Consultation services provider qualifications and requirements.** Consultation services providers must meet the following qualifications and requirements:

(1) meet the requirements under subdivision 10, paragraph (a), excluding clauses (4) and (5);

(2) are under contract with the department;

(3) are not the FMS provider, the lead agency, or the CFSS or home and community-based services waiver vendor or agency-provider to the participant;

(4) meet the service standards as established by the commissioner;

(5) have proof of surety bond coverage. Upon new enrollment, or if the consultation service provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the consultation service provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the consultation service provider must purchase a surety bond of $100,000. The surety bond

must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

~~(5)~~ (6) employ lead professional staff with a minimum of ~~three~~ two years of experience in providing services such as support planning, support broker, case management or care coordination, or consultation services and consumer education to participants using a self-directed program using FMS under medical assistance;

(7) report maltreatment as required under chapter 260E and section 626.557;

~~(6)~~ (8) comply with medical assistance provider requirements;

~~(7)~~ (9) understand the CFSS program and its policies;

~~(8)~~ (10) are knowledgeable about self-directed principles and the application of the person-centered planning process;

~~(9)~~ (11) have general knowledge of the FMS provider duties and the vendor fiscal/employer agent model, including all applicable federal, state, and local laws and regulations regarding tax, labor, employment, and liability and workers' compensation coverage for household workers; and

~~(10)~~ (12) have all employees, including lead professional staff, staff in management and supervisory positions, and owners of the agency who are active in the day-to-day management and operations of the agency, complete training as specified in the contract with the department.

Sec. 78. Minnesota Statutes 2020, section 256B.85, subdivision 18a, is amended to read:

Subd. 18a. **Worker training and development services.** (a) The commissioner shall develop the scope of tasks and functions, service standards, and service limits for worker training and development services.

(b) Worker training and development costs are in addition to the participant's assessed service units or service budget. Services provided according to this subdivision must:

(1) help support workers obtain and expand the skills and knowledge necessary to ensure competency in providing quality services as needed and defined in the participant's CFSS service delivery plan and as required under subdivisions 11b and 14;

(2) be provided or arranged for by the agency-provider under subdivision 11, or purchased by the participant employer under the budget model as identified in subdivision 13; ~~and~~

(3) be delivered by an individual competent to perform, teach, or assign the tasks, including health-related tasks, identified in the plan through education, training, and work experience relevant to the person's assessed needs; and

~~(3)~~ (4) be described in the participant's CFSS service delivery plan and documented in the participant's file.

(c) Services covered under worker training and development shall include:

(1) support worker training on the participant's individual assessed needs and condition, provided individually or in a group setting by a skilled and knowledgeable trainer beyond any training the participant or participant's representative provides;

(2) tuition for professional classes and workshops for the participant's support workers that relate to the participant's assessed needs and condition;

(3) direct observation, monitoring, coaching, and documentation of support worker job skills and tasks, beyond any training the participant or participant's representative provides, including supervision of health-related tasks or behavioral supports that is conducted by an appropriate professional based on the participant's assessed needs. These services must be provided at the start of services or the start of a new support worker except as provided in paragraph (d) and must be specified in the participant's CFSS service delivery plan; and

(4) the activities to evaluate CFSS services and ensure support worker competency described in subdivisions 11a and 11b.

(d) The services in paragraph (c), clause (3), are not required to be provided for a new support worker providing services for a participant due to staffing failures, unless the support worker is expected to provide ongoing backup staffing coverage.

(e) Worker training and development services shall not include:

(1) general agency training, worker orientation, or training on CFSS self-directed models;

(2) payment for preparation or development time for the trainer or presenter;

(3) payment of the support worker's salary or compensation during the training;

(4) training or supervision provided by the participant, the participant's support worker, or the participant's informal supports, including the participant's representative; or

(5) services in excess of ~~96 units~~ the limit set by the commissioner per annual service agreement, unless approved by the department.

Sec. 79. Minnesota Statutes 2020, section 256B.85, subdivision 20b, is amended to read:

Subd. 20b. **Service-related rights under an agency-provider.** A participant receiving CFSS from an agency-provider has service-related rights to:

(1) participate in and approve the initial development and ongoing modification and evaluation of CFSS services provided to the participant;

(2) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(3) before services are initiated, be told the limits to the services available from the agency-provider, including the agency-provider's knowledge, skill, and ability to meet the participant's needs identified in the CFSS service delivery plan;

(4) a coordinated transfer of services when there will be a change in the agency-provider;

(5) before services are initiated, be told what the agency-provider charges for the services;

(6) before services are initiated, be told to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the participant may be responsible for paying;

(7) receive services from an individual who is competent and trained, who has professional certification or licensure, as required, and who meets additional qualifications identified in the participant's CFSS service delivery plan;

(8) have the participant's preferences for support workers identified and documented, and have those preferences met when possible; and

(9) before services are initiated, be told the choices that are available from the agency-provider for meeting the participant's assessed needs identified in the CFSS service delivery plan, including but not limited to which support worker staff will be providing services ~~and~~, the proposed frequency and schedule of visits, and any agreements for shared services.

Sec. 80. Minnesota Statutes 2020, section 256B.85, subdivision 23, is amended to read:

Subd. 23. **Commissioner's access.** (a) When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the agency-provider, consultation services provider, or FMS provider's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. ~~Denying the commissioner access to records is cause for immediate suspension of payment and terminating~~ If the ~~agency-provider's~~

~~enrollment or~~ agency-provider, FMS ~~provider's enrollment~~ provider, or consultation services provider denies the commissioner access to records, the provider's payment may be immediately suspended or the provider's enrollment may be terminated according to section 256B.064 ~~or terminating the consultation services provider contract~~.

(b) The commissioner has the authority to request proof of compliance with laws, rules, and policies from agency-providers, consultation services providers, FMS providers, and participants.

(c) When relevant to an investigation conducted by the commissioner, the commissioner must be given access to the business office, documents, and records of the agency-provider, consultation services provider, or FMS provider, including records maintained in electronic format; participants served by the program; and staff during regular business hours. The commissioner must be given access without prior notice and as often as the commissioner considers necessary if the commissioner is investigating an alleged violation of applicable laws or rules. The commissioner may request and shall receive assistance from lead agencies and other state, county, and municipal agencies and departments. The commissioner's access includes being allowed to photocopy, photograph, and make audio and video recordings at the commissioner's expense.

Sec. 81. Minnesota Statutes 2020, section 256B.85, subdivision 23a, is amended to read:

Subd. 23a. **Sanctions; information for participants upon termination of services.** (a) The commissioner may withhold payment from the provider or suspend or terminate the provider enrollment number if the provider fails to comply fully with applicable laws or rules. The provider has the right to appeal the decision of the commissioner under section 256B.064.

(b) Notwithstanding subdivision 13, paragraph (c), if a participant employer fails to comply fully with applicable laws or rules, the commissioner may disenroll the participant from the budget model. A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision to disenroll the participant from the budget model.

(c) Agency-providers of CFSS services or FMS providers must provide each participant with a copy of participant protections in subdivision 20c at least 30 days prior to terminating services to a participant, if the termination results from sanctions under this subdivision or section 256B.064, such as a payment withhold or a suspension or termination of the provider enrollment number. If a CFSS agency-provider ~~or~~, FMS provider, or consultation services provider determines it is unable to continue providing services to a participant because of

an action under this subdivision or section 256B.064, the agency-provider ~~or~~, FMS provider, or consultation services provider must notify the participant, the participant's representative, and the commissioner 30 days prior to terminating services to the participant, and must assist the commissioner and lead agency in supporting the participant in transitioning to another CFSS agency-provider ~~or~~, FMS provider, or consultation services provider of the participant's choice.

(d) In the event the commissioner withholds payment from a CFSS agency-provider ~~or~~, FMS provider, or consultation services provider, or suspends or terminates a provider enrollment number of a CFSS agency-provider ~~or~~, FMS provider, or consultation services provider under this subdivision or section 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care and the lead agencies for all participants with active service agreements with the agency-provider ~~or~~, FMS provider, or consultation services provider. At the commissioner's request, the lead agencies must contact participants to ensure that the participants are continuing to receive needed care, and that the participants have been given free choice of agency-provider ~~or~~, FMS provider, or consultation services provider if they transfer to another CFSS agency-provider ~~or~~, FMS provider, or consultation services provider. In addition, the commissioner or the commissioner's delegate may directly notify participants who receive care from the agency-provider ~~or~~, FMS provider, or consultation services provider that payments have been or will be withheld or that the provider's participation in medical assistance has been or will be suspended or terminated, if the commissioner determines that the notification is necessary to protect the welfare of the participants.

Sec. 82. Minnesota Statutes 2020, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of special education services, home care nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, community first services and supports under Minnesota Statutes, section 256B.85, behavioral health home services under section 256B.0757, housing stabilization services under section 256B.051, and nursing home or intermediate care facilities services.

(b) No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment

of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

(c) Covered health services shall be expanded as provided in this section.

(d) For the purposes of covered health services under this section, "child" means an individual younger than 19 years of age.

Sec. 83. **REVISOR INSTRUCTION.**

(a) In Minnesota Statutes, sections 245A.191, paragraph (a); 245G.02, subdivision 3; 246.18, subdivision 2; 246.23, subdivision 2; 246.64, subdivision 3; 254A.03, subdivision 3; 254A.19, subdivision 4; 254B.03, subdivision 2; 254B.04, subdivision 1; 254B.05, subdivisions 1a and 4; 254B.051; 254B.06, subdivision 1; 254B.12, subdivisions 1 and 2; 254B.13, subdivisions 2a and 5; 254B.14, subdivision 5; 256L.03, subdivision 2; and 295.53, subdivision 1, the revisor of statutes must change the term "consolidated chemical dependency treatment fund" or similar terms to "behavioral health fund." The revisor may make grammatical changes related to the term change.

(b) In Minnesota Statutes, sections 245C.03, subdivision 13, and 256B.051, the revisor of statutes must change the term "housing support services" or similar terms to "housing stabilization services." The revisor may make grammatical changes related to the term change.

(c) In Minnesota Statutes, section 245C.03, subdivision 10, the revisor of statutes must change the term "group residential housing" to "housing support." The revisor may make grammatical changes related to the term change.

Sec. 84. **REPEALER.**

(a) Minnesota Statutes 2020, section 252.28, subdivisions 1 and 5, are repealed.

(b) Minnesota Statutes 2020, sections 252A.02, subdivisions 8 and 10; and 252A.21, subdivision 3, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective the day following final enactment. Paragraph (b) is effective August 1, 2021.

ARTICLE 7
MISCELLANEOUS

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

Subd. 4a. **Background study required.** (a) The board must initiate background studies under section 245C.03 of:

(1) each navigator;

(2) each in-person assister; and

(3) each certified application counselor.

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

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

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

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

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

Sec. 2. Minnesota Statutes 2020, section 119B.11, subdivision 2a, is amended to read:

Subd. 2a. **Recovery of overpayments.** (a) An amount of child care assistance paid to a recipient or provider in excess of the payment due is recoverable by the county agency under paragraphs (b) and (c), even when the overpayment was caused by ~~agency error or~~ circumstances outside the responsibility and control of the family or provider. Overpayments designated solely as agency error, and not the result of acts or omissions on the part of a provider or recipient, must not be established or collected.

(b) An overpayment must be recouped or recovered from the family if the overpayment benefited the family by causing the family to pay less for child care expenses than the family otherwise would have been required to pay under child care assistance program requirements.

If the family remains eligible for child care assistance, the overpayment must be recovered through recoupment as identified in Minnesota Rules, part 3400.0187, except that the overpayments must be calculated and collected on a service period basis. If the family no longer remains eligible for child care assistance, the county may choose to initiate efforts to recover overpayments from the family for overpayment less than $50. If the overpayment is greater than or equal to $50, the county shall seek voluntary repayment of the overpayment from the family. If the county is unable to recoup the overpayment through voluntary repayment, the county shall initiate civil court proceedings to recover the overpayment unless the county's costs to recover the overpayment will exceed the amount of the overpayment. A family with an outstanding debt under this subdivision is not eligible for child care assistance until: (1) the debt is paid in full; or (2) satisfactory arrangements are made with the county to retire the debt consistent with the requirements of this chapter and Minnesota Rules, chapter 3400, and the family is in compliance with the arrangements.

(c) The county must recover an overpayment from a provider if the overpayment did not benefit the family by causing it to receive more child care assistance or to pay less for child care expenses than the family otherwise would have been eligible to receive or required to pay under child care assistance program requirements, and benefited the provider by causing the provider to receive more child care assistance than otherwise would have been paid on the family's behalf under child care assistance program requirements. If the provider continues to care for children receiving child care assistance, the overpayment must be recovered through reductions in child care assistance payments for services as described in an agreement with the county. The provider may not charge families using that provider more to cover the cost of recouping the overpayment. If the provider no longer cares for children receiving child care assistance, the county may choose to initiate efforts to recover overpayments of less than $50 from the provider. If the overpayment is greater than or equal to $50, the county shall seek voluntary repayment of the overpayment from the provider. If the county is unable to recoup the overpayment through voluntary repayment, the county shall initiate civil court proceedings to recover the overpayment unless the county's costs to recover the overpayment will exceed the amount of the overpayment. A provider with an outstanding debt under this subdivision is not eligible to care for children receiving child care assistance until:

(1) the debt is paid in full; or

(2) satisfactory arrangements are made with the county to retire the debt consistent with the requirements of this chapter and Minnesota Rules, chapter 3400, and the provider is in compliance with the arrangements.

(d) When both the family and the provider acted together to intentionally cause the overpayment, both the family and the provider are jointly liable for the overpayment regardless of who benefited from the overpayment. The county must recover the overpayment as provided in paragraphs (b) and (c). When the family or the provider is in compliance with a repayment agreement, the party in compliance is eligible to receive child care assistance or to care for children receiving child care assistance despite the other party's noncompliance with repayment arrangements.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 3. **[119B.195] RETAINING EARLY EDUCATORS THROUGH ATTAINING INCENTIVES NOW (REETAIN) GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The retaining early educators through attaining incentives now (REETAIN) grant program is established to provide competitive grants to incentivize well-trained child care professionals to remain in the workforce. The overall goal of the REETAIN grant program is to create more consistent care for children over time.

Subd. 2. **Administration.** The commissioner shall administer the REETAIN grant program through a grant to a nonprofit with the demonstrated ability to manage benefit programs for child care professionals. Up to ten percent of grant money may be used for administration of the grant program.

Subd. 3. **Application.** Applicants must apply for the REETAIN grant program using the forms and according to timelines established by the commissioner.

Subd. 4. **Eligibility.** (a) To be eligible for a grant, an applicant must:

(1) be licensed to provide child care or work for a licensed child care program;

(2) work directly with children at least 30 hours per week;

(3) have worked in the applicant's current position for at least 12 months;

(4) agree to work in the early childhood care and education field for at least 12 months upon receiving a grant under this section;

(5) have a career lattice step of five or higher;

(6) not be a current teacher education and compensation helps scholarship recipient; and

(7) meet any other requirements determined by the commissioner.

(b) Grant recipients must sign a contract agreeing to remain in the early childhood care and education field for 12 months.

Subd. 5. **Grant awards.** Grant awards must be made annually and may be made up to an amount per recipient determined by the commissioner. Grant recipients may use grant money for program supplies, training, or personal expenses.

Subd. 6. **Report.** By January 1 each year, the commissioner must report to the legislative committees with jurisdiction over child care about the number of grants awarded to recipients and outcomes of the grant program since the last report.

Sec. 4. **[119B.27] OMBUDSPERSON FOR CHILD CARE PROVIDERS.**

Subdivision 1. **Appointment.** The commissioner of human services shall appoint two ombudspersons in the classified service to assist child care providers, including family child care providers and legal nonlicensed child care providers, with licensing, compliance, and other issues facing child care providers. Each ombudsperson must be selected without regard to the person's political affiliation, and at least one ombudsperson must have been a licensed family child care provider for at least three years. Each ombudsperson shall serve a term of four years and may be removed prior to the end of the term for just cause.

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

(1) advocating on behalf of a child care provider to address all areas of concern related to the provision of child care services, including licensing actions, correction orders, penalty assessments, complaint investigations, and other interactions with state and county staff;

(2) providing recommendations to the commissioner or providers for child care program improvement or child care provider education;

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

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

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

Subd. 3. **Staff.** The ombudspersons may appoint and compensate from available funds a deputy, confidential secretary, and other employees in the unclassified service as authorized

by law. Each ombudsperson and the full-time staff are members of the Minnesota State Retirement Association. The ombudspersons may delegate to members of the staff any authority or duties of the office except the duty to provide reports to the governor, commissioner, or legislature.

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

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

(c) The commissioner of human services and county agencies must provide ombudspersons with copies of all correction orders, fix-it tickets, and licensing actions issued to child care providers.

Subd. 5. **Independence of action.** When carrying out duties under this section, ombudspersons must act independently of the department to provide testimony to the legislature, make periodic reports to the legislature, and address areas of concern to child care providers.

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

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

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

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

(b) Ombudspersons must approve of all posting and notice required by the department and counties under this subdivision.

Sec. 5. Minnesota Statutes 2020, section 122A.18, subdivision 8, is amended to read:

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

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

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

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

(c) The Professional Educator Licensing and Standards Board ~~must contract with~~ may initiate criminal history background studies through the commissioner of human services according to section 245C.03 to ~~conduct background checks and~~ obtain background ~~check~~ study data required under this chapter.

Sec. 6. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 23. **Family or group family child care program.** "Family or group family child care program" means a licensed child care program operated in the residence in which the license holder lives. The license holder is the primary provider of care and may only hold one family child care license.

Sec. 7. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 24. **Special family child care program.** "Special family child care program" means a licensed child care program operated in a residence in which the license holder does not live. The license holder is the primary provider of care.

Sec. 8. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to read:

Subd. 25. **Nonresidential family child care program.** "Nonresidential family child care program" means a licensed child care program operated in a location other than the license holder's own residence, excluding licensed child care centers. The license holder is one of the individuals or entities listed in section 245A.141, subdivision 1, paragraph (a).

Sec. 9. Minnesota Statutes 2020, section 245A.03, is amended by adding a subdivision to read:

Subd. 10. **Group family day care licensed capacity; child-to-adult capacity ratios; age distribution restrictions.** (a) Notwithstanding Minnesota Rules, parts 9502.0365, subpart 1, and 9502.0367, item C, the commissioner shall issue licenses for group family day care according to the capacity limits, child-to-adult ratios, and age distribution restrictions in this subdivision.

(b) For purposes of this subdivision, "group family day care" means day care for no more than 16 children at any one time. The licensed capacity of a group family day care must include all children of any caregiver when the children are present in the residence, except notwithstanding Minnesota Rules, part 9502.0365, subpart 1, item A, the licensed capacity does not include the license holder's biological or adopted children who are nine years old or older.

(c) Notwithstanding Minnesota Rules, part 9502.0367, item C, subitem (1), for a group family day care program with a licensed capacity of ten children, one adult caregiver shall

serve no more than ten children younger than 11 years of age. Of those ten, no more than seven may be younger than four years of age. Of those seven, no more than three may be younger than 18 months of age. Of those three, no more than two may be infants.

(d) Notwithstanding Minnesota Rules, part 9502.0367, item C, subitem (2), for a group family day care program with a licensed capacity of 12 children, one adult caregiver shall serve no more than 12 children younger than 11 years of age. Of those 12, no more than nine may be younger than four years of age. Of those nine, no more than two may be younger than 18 months of age.

(e) Notwithstanding Minnesota Rules, part 9502.0367, item C, subitem (3), for a group family day care program with a licensed capacity of 16 children, two adult caregivers shall serve no more than 16 children younger than 11 years of age. Of those 16, no more than 11 may be younger than four years of age. Of those 11, no more than four may be younger than 18 months of age. Of those four, no more than three may be infants. A helper may be used in place of a second adult caregiver when there is no more than one child younger than 18 months of age present.

Sec. 10. Minnesota Statutes 2020, section 245A.05, is amended to read:

245A.05 DENIAL OF APPLICATION.

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

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

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

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

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

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

(6) is associated with an individual who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to

children or vulnerable adults, and who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted;

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

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2020, section 245A.07, subdivision 1, is amended to read:

Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional under section 245A.06, the commissioner may suspend or revoke the license, impose a fine, or secure an injunction against the continuing operation of the program of a license holder who does not comply with applicable law or rule, or who has nondisqualifying background study information, as described in section 245C.05, subdivision 4, that reflects on the license holder's ability to safely provide care to foster children. When applying sanctions authorized under this section, the commissioner shall consider the nature, chronicity, or severity of the

violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

(b) If a license holder appeals the suspension or revocation of a license and the license holder continues to operate the program pending a final order on the appeal, the commissioner shall issue the license holder a temporary provisional license. Unless otherwise specified by the commissioner, variances in effect on the date of the license sanction under appeal continue under the temporary provisional license. If a license holder fails to comply with applicable law or rule while operating under a temporary provisional license, the commissioner may impose additional sanctions under this section and section 245A.06, and may terminate any prior variance. If a temporary provisional license is set to expire, a new temporary provisional license shall be issued to the license holder upon payment of any fee required under section 245A.10. The temporary provisional license shall expire on the date the final order is issued. If the license holder prevails on the appeal, a new nonprovisional license shall be issued for the remainder of the current license period.

(c) If a license holder is under investigation and the license issued under this chapter is due to expire before completion of the investigation, the program shall be issued a new license upon completion of the reapplication requirements and payment of any applicable license fee. Upon completion of the investigation, a licensing sanction may be imposed against the new license under this section, section 245A.06, or 245A.08.

(d) Failure to reapply or closure of a license issued under this chapter by the license holder prior to the completion of any investigation shall not preclude the commissioner from issuing a licensing sanction under this section or section 245A.06 at the conclusion of the investigation.

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

Sec. 12. Minnesota Statutes 2020, section 245A.08, subdivision 4, is amended to read:

Subd. 4. **Recommendation or decision of administrative law judge.** (a) Except as provided in paragraph (b), the administrative law judge shall recommend whether or not the commissioner's order should be affirmed. The recommendations must be consistent with this chapter and the rules of the commissioner. The recommendations must be in writing and accompanied by findings of fact and conclusions and must be mailed to the parties by certified mail to their last known addresses as shown on the license or application.

(b) Following a hearing relating to the license of a family child care provider or group family child care provider, the administrative law judge shall decide whether the

commissioner's order should be affirmed. The decision of the administrative law judge is binding on both parties to the proceeding and is the final decision of the commissioner. The decision of the administrative law judge must be:

(1) consistent with this chapter and the applicable licensing rules;

(2) in writing and accompanied by findings of fact and conclusions of law;

(3) mailed to the family child care provider or group family child care provider by certified mail to the last known address shown on the license or application, or, if service by certified mail is waived by the provider, served in accordance with Minnesota Rules, part 1400.8610; and

(4) served in accordance with Minnesota Rules, part 1400.8610, on the Department of Human Services and any other party.

Any person aggrieved by a final decision under this paragraph is entitled to seek judicial review of the decision under the provisions of sections 14.63 to 14.68.

Sec. 13. Minnesota Statutes 2020, section 245A.08, subdivision 5, is amended to read:

Subd. 5. **Notice of commissioner's final order.** After considering the findings of fact, conclusions, and recommendations of the administrative law judge, the commissioner shall issue a final order. The commissioner shall consider, but shall not be bound by, the recommendations of the administrative law judge. The appellant must be notified of the commissioner's final order as required by chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The notice must also contain information about the appellant's rights under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The institution of proceedings for judicial review of the commissioner's final order shall not stay the enforcement of the final order except as provided in section 14.65. This subdivision does not apply to hearings relating to the license of a family child care provider or group family child care provider.

Sec. 14. Minnesota Statutes 2020, section 245A.14, subdivision 1, is amended to read:

Subdivision 1. **Permitted single-family residential use.** A licensed nonresidential program with a licensed capacity of 12 or fewer persons and a group family day care facility licensed under Minnesota Rules, parts 9502.0315 to 9502.0445, to serve ~~14~~ 16 or fewer children shall be considered a permitted single-family residential use of property for the purposes of zoning and other land use regulations.

Sec. 15. Minnesota Statutes 2020, section 245A.14, subdivision 4, is amended to read:

Subd. 4. **Special family ~~day~~ child care homes.** (a) ~~Nonresidential child~~ Child care programs serving ~~14~~ 16 or fewer children that are conducted at a location other than the license holder's own residence shall be licensed under this section and the rules governing family day care or group family day care if~~:~~

~~(a)~~ the license holder is the primary provider of care and the nonresidential child care program is conducted in a dwelling other than the license holder's own residence that is located on a residential lot~~;~~.

~~(b) the license holder is an employer who may or may not be the primary provider of care, and the purpose for the child care program is to provide child care services to children of the license holder's employees;~~

~~(c) the license holder is a church or religious organization;~~

~~(d) the license holder is a community collaborative child care provider. For purposes of this subdivision, a community collaborative child care provider is a provider participating in a cooperative agreement with a community action agency as defined in section 256E.31;~~

~~(e) the license holder is a not-for-profit agency that provides child care in a dwelling located on a residential lot and the license holder maintains two or more contracts with community employers or other community organizations to provide child care services. The county licensing agency may grant a capacity variance to a license holder licensed under this paragraph to exceed the licensed capacity of 14 children by no more than five children during transition periods related to the work schedules of parents, if the license holder meets the following requirements:~~

~~(1) the program does not exceed a capacity of 14 children more than a cumulative total of four hours per day;~~

~~(2) the program meets a one to seven staff-to-child ratio during the variance period;~~

~~(3) all employees receive at least an extra four hours of training per year than required in the rules governing family child care each year;~~

~~(4) the facility has square footage required per child under Minnesota Rules, part 9502.0425;~~

~~(5) the program is in compliance with local zoning regulations;~~

~~(6) the program is in compliance with the applicable fire code as follows:~~

~~(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2015, Section 202; or~~

~~(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code 2015, Section 202, unless the rooms in which the children are cared for are located on a level of exit discharge and each of these child care rooms has an exit door directly to the exterior, then the applicable fire code is Group E occupancies, as provided in the Minnesota State Fire Code 2015, Section 202; and~~

~~(7) any age and capacity limitations required by the fire code inspection and square footage determinations shall be printed on the license; or~~

~~(f) the license holder is the primary provider of care and has located the licensed child care program in a commercial space, if the license holder meets the following requirements:~~

~~(1) the program is in compliance with local zoning regulations;~~

~~(2) the program is in compliance with the applicable fire code as follows:~~

~~(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2015, Section 202; or~~

~~(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire Code 2015, Section 202;~~

~~(3) any age and capacity limitations required by the fire code inspection and square footage determinations are printed on the license; and~~

~~(4) the license holder prominently displays the license issued by the commissioner which contains the statement "This special family child care provider is not licensed as a child care center."~~

~~(g) The commissioner may approve two or more licenses under paragraphs (a) to (f) to be issued at the same location or under one contiguous roof, if each license holder is able to demonstrate compliance with all applicable rules and laws. Each license holder must operate the license holder's respective licensed program as a distinct program and within the capacity, age, and ratio distributions of each license.~~

~~(h)~~ (b) The commissioner may grant variances to this section to allow a primary provider of care~~, a not-for-profit organization, a church or religious organization, an employer, or a community collaborative~~ to be licensed to provide child care under ~~paragraphs (e) and (f)~~ section 245A.141, subdivision 1, paragraph (a), clauses (4) and (5), if the license holder meets the other requirements of the statute.

Sec. 16. **[245A.141] NONRESIDENTIAL FAMILY CHILD CARE PROGRAM LICENSING.**

Subdivision 1. **Nonresidential family child care programs.** (a) The following child care programs serving 16 or fewer children that are conducted at a location other than the license holder's own residence shall be licensed under this section:

(1) the license holder is an employer who may or may not be the primary provider of care, and the purpose for the child care program is to provide child care services to children of the license holder's employees;

(2) the license holder is a church or religious organization;

(3) the license holder is a community collaborative child care provider. For purposes of this subdivision, a community collaborative child care provider is a provider participating in a cooperative agreement with a community action agency as defined in section 256E.31;

(4) the license holder is a not-for-profit agency that provides child care in a dwelling located on a residential lot and the license holder maintains two or more contracts with community employers or other community organizations to provide child care services. The county licensing agency may grant a capacity variance to a license holder licensed under this paragraph to exceed the licensed capacity of 16 children by no more than five children during transition periods related to the work schedules of parents, if the license holder meets the following requirements:

(i) the program does not exceed a capacity of 16 children more than a cumulative total of four hours per day;

(ii) the program meets a one-to-eight staff-to-child ratio during the variance period;

(iii) all employees receive at least an extra four hours of training per year than are required in the rules governing family child care each year;

(iv) the facility has square footage required per child under Minnesota Rules, part 9502.0425;

(v) the program is in compliance with local zoning regulations;

(vi) the program is in compliance with the applicable fire code as follows:

(A) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or younger, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2015, Section 202; or

(B) if the program serves more than five children 2-1/2 years of age or younger, the applicable fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code 2015, Section 202, unless the rooms in which the children are cared for are located on a level of exit discharge and each of these child care rooms has an exit door directly to the exterior, then the applicable fire code is Group E Occupancies, as provided in the Minnesota State Fire Code 2015, Section 202; and

(vii) any age and capacity limitations required by the fire code inspection and square footage determinations shall be printed on the license; or

(5) the license holder is the primary provider of care and has located the licensed child care program in a commercial space, if the license holder meets the following requirements:

(i) the program is in compliance with local zoning regulations;

(ii) the program is in compliance with the applicable fire code as follows:

(A) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or younger, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2015, Section 202; or

(B) if the program serves more than five children 2-1/2 years of age or younger, the applicable fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire Code 2015, Section 202;

(iii) any age and capacity limitations required by the fire code inspection and square footage determinations are printed on the license; and

(iv) the license holder prominently displays the license issued by the commissioner that contains the statement "This special family child care provider is not licensed as a child care center."

(b) Programs licensed under this section shall be subject to the rules governing family day care or group family day care.

(c) Programs licensed under this section shall be monitored by county licensing agencies under section 245A.16.

Subd. 2. **Multiple license approval.** The commissioner may approve up to four licenses under subdivision 1, paragraph (a), clause (1) or (2), to be issued at the same location or under one contiguous roof, if each license holder is able to demonstrate compliance with all applicable rules and laws. Each license holder must operate the license holder's respective licensed program as a distinct program and within the capacity, age, and ratio distributions of each license.

Subd. 3. **Variances.** The commissioner may grant variances to this section to allow a primary provider of care, a not-for-profit organization, a church or religious organization, an employer, or a community collaborative to be licensed to provide child care under subdivision 1, paragraph (a), clauses (4) and (5), if the license holder meets the other requirements of the statute.

Sec. 17. Minnesota Statutes 2020, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 and background studies for family child care under chapter 245C; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06; or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and child foster care, dual licensure of child and adult foster care, and adult foster care and family child care;

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

(5) variances regarding disqualified individuals except that, before the implementation of NETStudy 2.0, county agencies may issue variances under section 245C.30 regarding disqualified individuals when the county is responsible for conducting a consolidated reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and

(b), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment;

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours;

(7) variances to requirements relating to chemical use problems of a license holder or a household member of a license holder; and

(8) variances to section 245A.53 for a time-limited period. If the commissioner grants a variance under this clause, the license holder must provide notice of the variance to all parents and guardians of the children in care.

Except as provided in section ~~245A.14, subdivision 4, paragraph (e)~~ 245A.141, subdivision 1, paragraph (a), clause (4), a county agency must not grant a license holder a variance to exceed the maximum allowable family child care license capacity of ~~14~~ 16 children.

(b) A county agency that has been designated by the commissioner to issue family child care variances must:

(1) publish the county agency's policies and criteria for issuing variances on the county's public website and update the policies as necessary; and

(2) annually distribute the county agency's policies and criteria for issuing variances to all family child care license holders in the county.

(c) Before the implementation of NETStudy 2.0, county agencies must report information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.

(d) For family child care programs, the commissioner shall require a county agency to conduct one unannounced licensing review at least annually.

(e) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(f) A license issued under this section may be issued for up to two years.

(g) During implementation of chapter 245D, the commissioner shall consider:

(1) the role of counties in quality assurance;

(2) the duties of county licensing staff; and

(3) the possible use of joint powers agreements, according to section 471.59, with counties through which some licensing duties under chapter 245D may be delegated by the commissioner to the counties.

Any consideration related to this paragraph must meet all of the requirements of the corrective action plan ordered by the federal Centers for Medicare and Medicaid Services.

(h) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, for family child foster care programs providing out-of-home respite, as identified in section 245D.03, subdivision 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and private agencies.

(i) A county agency shall report to the commissioner, in a manner prescribed by the commissioner, the following information for a licensed family child care program:

(1) the results of each licensing review completed, including the date of the review, and any licensing correction order issued;

(2) any death, serious injury, or determination of substantiated maltreatment; and

(3) any fires that require the service of a fire department within 48 hours of the fire. The information under this clause must also be reported to the state fire marshal within two business days of receiving notice from a licensed family child care provider.

(j) A county agency must forward all communications from the Department of Human Services about family child care to family child care providers in the county. Additional comments by the county agency may be included if labeled as county agency comments.

Sec. 18. Minnesota Statutes 2020, section 245A.16, is amended by adding a subdivision to read:

Subd. 9. **Licensed family foster settings.** (a) Before recommending to grant a license, deny a license under section 245A.05, or revoke a license under section 245A.07 for nondisqualifying background study information received under section 245C.05, subdivision 4, paragraph (a), clause (3), for a licensed family foster setting, a county agency or private agency that has been designated or licensed by the commissioner must review the following:

(1) the type of offenses;

(2) the number of offenses;

(3) the nature of the offenses;

(4) the age of the individual at the time of the offenses;

(5) the length of time that has elapsed since the last offense;

(6) the relationship of the offenses and the capacity to care for a child;

(7) evidence of rehabilitation;

(8) information or knowledge from community members regarding the individual's capacity to provide foster care;

(9) any available information regarding child maltreatment reports or child in need of protection or services petitions, or related cases, in which the individual has been involved or implicated, and documentation that the individual has remedied issues or conditions identified in child protection or court records that are relevant to safely caring for a child;

(10) a statement from the study subject;

(11) a statement from the license holder; and

(12) other aggravating and mitigating factors.

(b) For purposes of this section, "evidence of rehabilitation" includes but is not limited to the following:

(1) maintaining a safe and stable residence;

(2) continuous, regular, or stable employment;

(3) successful participation in an education or job training program;

(4) positive involvement with the community or extended family;

(5) compliance with the terms and conditions of probation or parole following the individual's most recent conviction;

(6) if the individual has had a substance use disorder, successful completion of a substance use disorder assessment, substance use disorder treatment, and recommended continuing care, if applicable, demonstrated abstinence from controlled substances, as defined in section 152.01, subdivision 4, or the establishment of a sober network;

(7) if the individual has had a mental illness or documented mental health issues, demonstrated completion of a mental health evaluation, participation in therapy or other recommended mental health treatment, or appropriate medication management, if applicable;

(8) if the individual's offense or conduct involved domestic violence, demonstrated completion of a domestic violence or anger management program, and the absence of any

orders for protection or harassment restraining orders against the individual since the previous offense or conduct;

(9) written letters of support from individuals of good repute, including but not limited to employers, members of the clergy, probation or parole officers, volunteer supervisors, or social services workers;

(10) demonstrated remorse for convictions or conduct, or demonstrated positive behavior changes; and

(11) absence of convictions or arrests since the previous offense or conduct, including any convictions that were expunged or pardoned.

(c) An applicant for a family foster setting license must sign all releases of information requested by the county or private licensing agency.

(d) When licensing a relative for a family foster setting, the commissioner shall also consider the importance of maintaining the child's relationship with relatives as an additional significant factor in determining whether an application will be denied.

(e) When recommending that the commissioner deny or revoke a license, the county or private licensing agency must send a summary of the review completed according to paragraph (a), on a form developed by the commissioner, to the commissioner and include any recommendation for licensing action.

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

Sec. 19. Minnesota Statutes 2020, section 245A.50, subdivision 1a, is amended to read:

Subd. 1a. **Definitions and general provisions.** For the purposes of this section, the following terms have the meanings given:

(1) "second adult caregiver" means an adult who cares for children in the licensed program along with the license holder for a cumulative total of more than 500 hours annually;

(2) "helper" means a minor, ages 13 to 17, who assists in caring for children; ~~and~~

(3) "substitute" means an adult who assumes responsibility for a license holder for a cumulative total of not more than 500 hours annually; and

(4) "adult assistant" means an adult who assists in caring for children exclusively under the direct supervision of the license holder. An adult assistant may not serve as a second adult caregiver and has the same training requirements as helpers.

An adult, except for an adult assistant, who cares for children in the licensed program along with the license holder for a cumulative total of not more than 500 hours annually has the same training requirements as a substitute.

Sec. 20. Minnesota Statutes 2020, section 245A.50, subdivision 7, is amended to read:

Subd. 7. **Training requirements for family and group family child care.** (a) For purposes of family and group family child care, the license holder and each second adult caregiver must complete 16 hours of ongoing training each year. Repeat of topical training requirements in subdivisions 2 to 8 shall count toward the annual 16-hour training requirement. Additional ongoing training subjects to meet the annual 16-hour training requirement must be selected from the following areas:

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

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

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

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

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

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

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

(b) A provider who is approved as a trainer through the Develop data system may count up to two hours of training instruction toward the annual 16-hour training requirement in paragraph (a). The provider may only count training instruction hours for the first instance

in which they deliver a particular content-specific training during each licensing year. Hours counted as training instruction must be approved through the Develop data system with attendance verified on the trainer's individual learning record.

Sec. 21. Minnesota Statutes 2020, section 245C.03, is amended by adding a subdivision to read:

Subd. 14. **First-time applicants for educator licenses with the Professional Educator Licensing and Standards Board.** The Professional Educator Licensing and Standards Board shall make all eligibility determinations for background studies conducted under this section for the Professional Educator Licensing and Standards Board. The commissioner may conduct a background study of all first-time applicants for educator licenses pursuant to section 122A.18, subdivision 8. The background study of all first-time applicants for educator licenses must include a review of information from the Bureau of Criminal Apprehension, including criminal history data as defined in section 13.87, and must also include a review of the national criminal records repository.

Sec. 22. Minnesota Statutes 2020, section 245C.03, is amended by adding a subdivision to read:

Subd. 15. **First-time applicants for administrator licenses with the Board of School Administrators.** The Board of School Administrators shall make all eligibility determinations for background studies conducted under this section for the Board of School Administrators. The commissioner may conduct a background study of all first-time applicants for administrator licenses pursuant to section 122A.18, subdivision 8. The background study of all first-time applicants for administrator licenses must include a review of information from the Bureau of Criminal Apprehension, including criminal history data as defined in section 13.87, and must also include a review of the national criminal records repository.

Sec. 23. Minnesota Statutes 2020, section 245C.03, is amended by adding a subdivision to read:

Subd. 16. **Occupations regulated by MNsure.** (a) The commissioner shall conduct a background study of any individual required under section 62V.05 to have a background study completed under this chapter. The commissioner shall conduct a background study only based on Minnesota criminal records of:

(1) each navigator;

(2) each in-person assister; and

(3) each certified application counselor.

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

(c) The commissioner shall review information that the commissioner receives to determine if the study subject has potentially disqualifying offenses. The commissioner shall send a letter to the subject indicating any of the subject's potential disqualifications as well as any relevant records. The commissioner shall send a copy of the letter indicating any of the subject's potential disqualifications to the MNsure board.

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

Sec. 24. Minnesota Statutes 2020, section 245C.05, subdivision 2c, is amended to read:

Subd. 2c. **Privacy notice to background study subject.** (a) Prior to initiating each background study, the entity initiating the study must provide the commissioner's privacy notice to the background study subject required under section 13.04, subdivision 2. The notice must be available through the commissioner's electronic NETStudy and NETStudy 2.0 systems and shall include the information in paragraphs (b) and (c).

(b) The background study subject shall be informed that any previous background studies that received a set-aside will be reviewed, and without further contact with the background study subject, the commissioner may notify the agency that initiated the subsequent background study:

(1) that the individual has a disqualification that has been set aside for the program or agency that initiated the study;

(2) the reason for the disqualification; and

(3) that information about the decision to set aside the disqualification will be available to the license holder upon request without the consent of the background study subject.

(c) The background study subject must also be informed that:

(1) the subject's fingerprints collected for purposes of completing the background study under this chapter must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or by the commissioner. The Federal Bureau of Investigation will

~~only retain fingerprints of subjects with a criminal history~~ not retain background study subjects' fingerprints;

(2) effective upon implementation of NETStudy 2.0, the subject's photographic image will be retained by the commissioner, and if the subject has provided the subject's Social Security number for purposes of the background study, the photographic image will be available to prospective employers and agencies initiating background studies under this chapter to verify the identity of the subject of the background study;

(3) the commissioner's authorized fingerprint collection vendor shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized fingerprint collection vendor shall retain no more than the subject's name and the date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities;

(4) the commissioner shall provide the subject notice, as required in section 245C.17, subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

(5) the subject may request in writing a report listing the entities that initiated a background study on the individual as provided in section 245C.17, subdivision 1, paragraph (b);

(6) the subject may request in writing that information used to complete the individual's background study in NETStudy 2.0 be destroyed if the requirements of section 245C.051, paragraph (a), are met; and

(7) notwithstanding clause (6), the commissioner shall destroy:

(i) the subject's photograph after a period of two years when the requirements of section 245C.051, paragraph (c), are met; and

(ii) any data collected on a subject under this chapter after a period of two years following the individual's death as provided in section 245C.051, paragraph (d).

Sec. 25. Minnesota Statutes 2020, section 245C.05, subdivision 2d, is amended to read:

Subd. 2d. **Fingerprint data notification.** The commissioner of human services shall notify all background study subjects under this chapter that the Department of Human Services, Department of Public Safety, and the Bureau of Criminal Apprehension do not retain fingerprint data after a background study is completed, and that the Federal Bureau

of Investigation ~~only retains the fingerprints of subjects who have a criminal history~~ does not retain background study subjects' fingerprints.

Sec. 26. Minnesota Statutes 2020, section 245C.05, subdivision 4, is amended to read:

Subd. 4. **Electronic transmission.** (a) For background studies conducted by the Department of Human Services, the commissioner shall implement a secure system for the electronic transmission of:

(1) background study information to the commissioner;

(2) background study results to the license holder;

(3) background study results to counties for background studies conducted by the commissioner for child foster care, including a summary of nondisqualifying results, except as prohibited by law; and

(4) background study results to county agencies for background studies conducted by the commissioner for adult foster care and family adult day services and, upon implementation of NETStudy 2.0, family child care and legal nonlicensed child care authorized under chapter 119B.

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as NETStudy or NETStudy 2.0 to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

(d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under this subdivision.

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

Sec. 27. Minnesota Statutes 2020, section 245C.08, subdivision 3, is amended to read:

Subd. 3. **Arrest and investigative information.** (a) For any background study completed under this section, if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual, the commissioner also may review arrest and investigative information from:

(1) the Bureau of Criminal Apprehension;

(2) the commissioners of health and human services;

(3) a county attorney;

(4) a county sheriff;

(5) a county agency;

(6) a local chief of police;

(7) other states;

(8) the courts;

(9) the Federal Bureau of Investigation;

(10) the National Criminal Records Repository; and

(11) criminal records from other states.

(b) Except when specifically required by law, the commissioner is not required to conduct more than one review of a subject's records from the Federal Bureau of Investigation if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the entity that initiated the background study.

(c) If the commissioner conducts a national criminal history record check when required by law and uses the information from the national criminal history record check to make a disqualification determination, the data obtained is private data and cannot be shared with ~~county agencies,~~ private agencies~~,~~ or prospective employers of the background study subject.

(d) If the commissioner conducts a national criminal history record check when required by law and uses the information from the national criminal history record check to make a disqualification determination, the license holder or entity that submitted the study is not required to obtain a copy of the background study subject's disqualification letter under section 245C.17, subdivision 3.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 28. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 18. **Occupations regulated by MNsure.** The commissioner shall set fees to recover the cost of background studies and criminal background checks initiated by MNsure under sections 62V.05 and 245C.03. The fee amount shall be established through interagency agreement between the commissioner and the board of MNsure or its designee. The fees

collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks.

Sec. 29. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 19. **Professional Educators Licensing Standards Board.** The commissioner shall recover the cost of background studies initiated by the Professional Educators Licensing Standards Board through a fee of no more than $51 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Sec. 30. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 20. **Board of School Administrators.** The commissioner shall recover the cost of background studies initiated by the Board of School Administrators through a fee of no more than $51 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Sec. 31. Minnesota Statutes 2020, section 245C.14, subdivision 1, is amended to read:

Subdivision 1. **Disqualification from direct contact.** (a) The commissioner shall disqualify an individual who is the subject of a background study from any position allowing direct contact with persons receiving services from the license holder or entity identified in section 245C.03, upon receipt of information showing, or when a background study completed under this chapter shows any of the following:

(1) a conviction of, admission to, or Alford plea to one or more crimes listed in section 245C.15, regardless of whether the conviction or admission is a felony, gross misdemeanor, or misdemeanor level crime;

(2) a preponderance of the evidence indicates the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, regardless of whether the preponderance of the evidence is for a felony, gross misdemeanor, or misdemeanor level crime; or

(3) an investigation results in an administrative determination listed under section 245C.15, subdivision 4, paragraph (b).

(b) No individual who is disqualified following a background study under section 245C.03, subdivisions 1 and 2, may be retained in a position involving direct contact with persons served by a program or entity identified in section 245C.03, unless the commissioner has provided written notice under section 245C.17 stating that:

(1) the individual may remain in direct contact during the period in which the individual may request reconsideration as provided in section 245C.21, subdivision 2;

(2) the commissioner has set aside the individual's disqualification for that program or entity identified in section 245C.03, as provided in section 245C.22, subdivision 4; or

(3) the license holder has been granted a variance for the disqualified individual under section 245C.30.

(c) Notwithstanding paragraph (a), for the purposes of a background study affiliated with a licensed family foster setting, the commissioner shall disqualify an individual who is the subject of a background study from any position allowing direct contact with persons receiving services from the license holder or entity identified in section 245C.03, upon receipt of information showing or when a background study completed under this chapter shows reason for disqualification under section 245C.15, subdivision 4a.

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

Sec. 32. Minnesota Statutes 2020, section 245C.15, is amended by adding a subdivision to read:

Subd. 4a. **Licensed family foster setting disqualifications.** (a) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting, regardless of how much time has passed, an individual is disqualified under section 245C.14 if the individual committed an act that resulted in a felony-level conviction for sections: 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.2112 (criminal vehicular homicide); 609.221 (assault in the first degree); 609.223, subdivision 2 (assault in the third degree, past pattern of child abuse); 609.223, subdivision 3 (assault in the third degree, victim under four); a felony offense under sections 609.2242 and 609.2243 (domestic assault, spousal abuse, child abuse or neglect, or a crime against children); 609.2247 (domestic assault by strangulation); 609.2325 (criminal abuse of a vulnerable adult resulting in the death of a vulnerable adult); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.255 (false imprisonment); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second

degree); 609.2663 (murder of an unborn child in the third degree); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.322, subdivision 1 (solicitation, inducement, and promotion of prostitution; sex trafficking in the first degree); 609.324, subdivision 1 (other prohibited acts; engaging in, hiring, or agreeing to hire minor to engage in prostitution); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory conduct); 609.352 (solicitation of children to engage in sexual conduct); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.561 (arson in the first degree); 609.582, subdivision 1 (burglary in the first degree); 609.746 (interference with privacy); 617.23 (indecent exposure); 617.246 (use of minors in sexual performance prohibited); or 617.247 (possession of pictorial representations of minors).

(b) Notwithstanding subdivisions 1 to 4, for the purposes of a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14, regardless of how much time has passed, if the individual:

(1) committed an action under paragraph (d) that resulted in death or involved sexual abuse, as defined in section 260E.03, subdivision 20;

(2) committed an act that resulted in a gross misdemeanor-level conviction for section 609.3451 (criminal sexual conduct in the fifth degree);

(3) committed an act against or involving a minor that resulted in a felony-level conviction for: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree); or 609.224 (assault in the fifth degree); or

(4) committed an act that resulted in a misdemeanor or gross misdemeanor-level conviction for section 617.293 (dissemination and display of harmful materials to minors).

(c) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14 if less than 20 years have passed since the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or if the individual consented to a termination of parental rights under section 260C.301, subdivision 1, paragraph (a), to settle a petition to

involuntarily terminate parental rights. An individual is disqualified under section 245C.14 if less than 20 years have passed since the termination of the individual's parental rights in any other state or country, where the conditions for the individual's termination of parental rights are substantially similar to the conditions in section 260C.301, subdivision 1, paragraph (b).

(d) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14 if less than five years have passed since a felony-level violation for sections: 152.021 (controlled substance crime in the first degree); 152.022 (controlled substance crime in the second degree); 152.023 (controlled substance crime in the third degree); 152.024 (controlled substance crime in the fourth degree); 152.025 (controlled substance crime in the fifth degree); 152.0261 (importing controlled substances across state borders); 152.0262, subdivision 1, paragraph (b) (possession of substance with intent to manufacture methamphetamine); 152.027, subdivision 6, paragraph (c) (sale or possession of synthetic cannabinoids); 152.096 (conspiracies prohibited); 152.097 (simulated controlled substances); 152.136 (anhydrous ammonia; prohibited conduct; criminal penalties; civil liabilities); 152.137 (methamphetamine-related crimes involving children or vulnerable adults); 169A.24 (felony first-degree driving while impaired); 243.166 (violation of predatory offender registration requirements); 609.2113 (criminal vehicular operation; bodily harm); 609.2114 (criminal vehicular operation; unborn child); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult not resulting in the death of a vulnerable adult); 609.233 (criminal neglect); 609.235 (use of drugs to injure or facilitate a crime); 609.24 (simple robbery); 609.322, subdivision 1a (solicitation, inducement, and promotion of prostitution; sex trafficking in the second degree); 609.498, subdivision 1 (tampering with a witness in the first degree); 609.498, subdivision 1b (aggravated first-degree witness tampering); 609.562 (arson in the second degree); 609.563 (arson in the third degree); 609.582, subdivision 2 (burglary in the second degree); 609.66 (felony dangerous weapons); 609.687 (adulteration); 609.713 (terroristic threats); 609.749, subdivision 3, 4, or 5 (felony-level harassment or stalking); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); or 624.713 (certain people not to possess firearms).

(e) Notwithstanding subdivisions 1 to 4, except as provided in paragraph (a), for a background study affiliated with a licensed family child foster care license, an individual is disqualified under section 245C.14 if less than five years have passed since:

(1) a felony-level violation for an act not against or involving a minor that constitutes: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third

degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the fifth degree);

(2) a violation of an order for protection under section 518B.01, subdivision 14;

(3) a determination or disposition of the individual's failure to make required reports under section 260E.06 or 626.557, subdivision 3, for incidents in which the final disposition under chapter 260E or section 626.557 was substantiated maltreatment and the maltreatment was recurring or serious;

(4) a determination or disposition of the individual's substantiated serious or recurring maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under chapter 260E or section 626.557 and meet the definition of serious maltreatment or recurring maltreatment;

(5) a gross misdemeanor-level violation for sections: 609.224, subdivision 2 (assault in the fifth degree); 609.2242 and 609.2243 (domestic assault); 609.233 (criminal neglect); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.746 (interference with privacy); 609.749 (stalking); or 617.23 (indecent exposure); or

(6) committing an act against or involving a minor that resulted in a misdemeanor-level violation of section 609.224, subdivision 1 (assault in the fifth degree).

(f) For purposes of this subdivision, the disqualification begins from:

(1) the date of the alleged violation, if the individual was not convicted;

(2) the date of conviction, if the individual was convicted of the violation but not committed to the custody of the commissioner of corrections; or

(3) the date of release from prison, if the individual was convicted of the violation and committed to the custody of the commissioner of corrections.

Notwithstanding clause (3), if the individual is subsequently reincarcerated for a violation of the individual's supervised release, the disqualification begins from the date of release from the subsequent incarceration.

(g) An individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota Statutes, permanently disqualifies the individual under section 245C.14. An individual is disqualified under section 245C.14 if less than five years have passed since the individual's

aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (d) and (e).

(h) An individual's offense in any other state or country, where the elements of the offense are substantially similar to any of the offenses listed in paragraphs (a) and (b), permanently disqualifies the individual under section 245C.14. An individual is disqualified under section 245C.14 if less than five years have passed since an offense in any other state or country, the elements of which are substantially similar to the elements of any offense listed in paragraphs (d) and (e).

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

Sec. 33. Minnesota Statutes 2020, section 245C.24, subdivision 2, is amended to read:

Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in paragraphs (b) to ~~(e)~~ (f), the commissioner may not set aside the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 1.

(b) For an individual in the chemical dependency or corrections field who was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose disqualification was set aside prior to July 1, 2005, the commissioner must consider granting a variance pursuant to section 245C.30 for the license holder for a program dealing primarily with adults. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the license holder that was subject to the prior set-aside decision addressing the individual's quality of care to children or vulnerable adults and the circumstances of the individual's departure from that service.

(c) If an individual who requires a background study for nonemergency medical transportation services under section 245C.03, subdivision 12, was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and if more than 40 years have passed since the discharge of the sentence imposed, the commissioner may consider granting a set-aside pursuant to section 245C.22. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the employer. This paragraph does not apply to a person disqualified based on a violation of sections 243.166; 609.185 to 609.205; 609.25; 609.342 to 609.3453; 609.352; 617.23, subdivision 2, clause (1), or 3, clause (1); 617.246; or 617.247.

(d) When a licensed foster care provider adopts an individual who had received foster care services from the provider for over six months, and the adopted individual is required to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30 to permit the adopted individual with a permanent disqualification to remain affiliated with the license holder under the conditions of the variance when the variance is recommended by the county of responsibility for each of the remaining individuals in placement in the home and the licensing agency for the home.

(e) For an individual 18 years of age or older affiliated with a licensed family foster setting, the commissioner must not set aside or grant a variance for the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 4a, paragraphs (a) and (b).

(f) In connection with a family foster setting license, the commissioner may grant a variance to the disqualification for an individual who is under 18 years of age at the time the background study is submitted.

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

Sec. 34. Minnesota Statutes 2020, section 245C.24, subdivision 3, is amended to read:

Subd. 3. **Ten-year bar to set aside disqualification.** (a) The commissioner may not set aside the disqualification of an individual in connection with a license to provide family child care for children~~, foster care for children in the provider's home,~~ or foster care or day care services for adults in the provider's home if: (1) less than ten years has passed since the discharge of the sentence imposed, if any, for the offense; or (2) when disqualified based on a preponderance of evidence determination under section 245C.14, subdivision 1, paragraph (a), clause (2), or an admission under section 245C.14, subdivision 1, paragraph (a), clause (1), and less than ten years has passed since the individual committed the act or admitted to committing the act, whichever is later; and (3) the individual has committed a violation of any of the following offenses: sections 609.165 (felon ineligible to possess firearm); criminal vehicular homicide or criminal vehicular operation causing death under 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (aiding suicide or aiding attempted suicide); felony violations under 609.223 or 609.2231 (assault in the third or fourth degree); 609.229 (crimes committed for benefit of a gang); 609.713 (terroristic threats); 609.235 (use of drugs to injure or to facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.562 (arson in the second degree); 609.71 (riot);

609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a witness); burglary in the first or second degree under 609.582 (burglary); 609.66 (dangerous weapon); 609.665 (spring guns); 609.67 (machine guns and short-barreled shotguns); 609.749, subdivision 2 (gross misdemeanor harassment); 152.021 or 152.022 (controlled substance crime in the first or second degree); 152.023, subdivision 1, clause (3) or (4) or subdivision 2, clause (4) (controlled substance crime in the third degree); 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree); 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report); 609.265 (abduction); 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree); 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree); 609.268 (injury or death of an unborn child in the commission of a crime); repeat offenses under 617.23 (indecent exposure); 617.293 (disseminating or displaying harmful material to minors); a felony-level conviction involving alcohol or drug use, a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts); a gross misdemeanor offense under 609.378 (neglect or endangerment of a child); a gross misdemeanor offense under 609.377 (malicious punishment of a child); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or 624.713 (certain persons not to possess firearms); or Minnesota Statutes 2012, section 609.21.

(b) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a) as each of these offenses is defined in Minnesota Statutes.

(c) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraph (a).

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

Sec. 35. Minnesota Statutes 2020, section 245C.24, subdivision 4, is amended to read:

Subd. 4. **Seven-year bar to set aside disqualification.** The commissioner may not set aside the disqualification of an individual in connection with a license to provide family

child care for children~~, foster care for children in the provider's home,~~ or foster care or day care services for adults in the provider's home if within seven years preceding the study:

(1) the individual committed an act that constitutes maltreatment of a child under sections 260E.24, subdivisions 1, 2, and 3, and 260E.30, subdivisions 1, 2, and 4, and the maltreatment resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence; or

(2) the individual was determined under section 626.557 to be the perpetrator of a substantiated incident of maltreatment of a vulnerable adult that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence.

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

Sec. 36. Minnesota Statutes 2020, section 245C.24, is amended by adding a subdivision to read:

Subd. 6. **Five-year bar to set aside disqualification; family foster setting.** (a) The commissioner shall not set aside or grant a variance for the disqualification of an individual 18 years of age or older in connection with a foster family setting license if within five years preceding the study the individual is convicted of a felony in section 245C.15, subdivision 4a, paragraph (d).

(b) In connection with a foster family setting license, the commissioner may set aside or grant a variance to the disqualification for an individual who is under 18 years of age at the time the background study is submitted.

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

Sec. 37. Minnesota Statutes 2020, section 245E.07, subdivision 1, is amended to read:

Subdivision 1. **Grounds for and methods of monetary recovery.** (a) The department may obtain monetary recovery from a provider who has been improperly paid by the child care assistance program, regardless of whether the error was intentional ~~or county error~~. Overpayments designated solely as agency error, and not the result of acts or omissions on the part of a provider or recipient, must not be established or collected. The department does not need to establish a pattern as a precondition of monetary recovery of erroneous or false billing claims, duplicate billing claims, or billing claims based on false statements or financial misconduct.

(b) The department shall obtain monetary recovery from providers by the following means:

(1) permitting voluntary repayment of money, either in lump-sum payment or installment payments;

(2) using any legal collection process;

(3) deducting or withholding program payments; or

(4) utilizing the means set forth in chapter 16D.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 38. Minnesota Statutes 2020, section 260C.215, subdivision 4, is amended to read:

Subd. 4. **Duties of commissioner.** The commissioner of human services shall:

(1) provide practice guidance to responsible social services agencies and licensed child-placing agencies that reflect federal and state laws and policy direction on placement of children;

(2) develop criteria for determining whether a prospective adoptive or foster family has the ability to understand and validate the child's cultural background;

(3) provide a standardized training curriculum for adoption and foster care workers and administrators who work with children. Training must address the following objectives:

(i) developing and maintaining sensitivity to all cultures;

(ii) assessing values and their cultural implications;

(iii) making individualized placement decisions that advance the best interests of a particular child under section 260C.212, subdivision 2; and

(iv) issues related to cross-cultural placement;

(4) provide a training curriculum for all prospective adoptive and foster families that prepares them to care for the needs of adoptive and foster children taking into consideration the needs of children outlined in section 260C.212, subdivision 2, paragraph (b), and, as necessary, preparation is continued after placement of the child and includes the knowledge and skills related to reasonable and prudent parenting standards for the participation of the child in age or developmentally appropriate activities, according to section 260C.212, subdivision 14;

(5) develop and provide to responsible social services agencies and licensed child-placing agencies a home study format to assess the capacities and needs of prospective adoptive and foster families. The format must address problem-solving skills; parenting skills; evaluate the degree to which the prospective family has the ability to understand and validate the child's cultural background, and other issues needed to provide sufficient information for agencies to make an individualized placement decision consistent with section 260C.212, subdivision 2. For a study of a prospective foster parent, the format must also address the capacity of the prospective foster parent to provide a safe, healthy, smoke-free home environment. If a prospective adoptive parent has also been a foster parent, any update necessary to a home study for the purpose of adoption may be completed by the licensing authority responsible for the foster parent's license. If a prospective adoptive parent with an approved adoptive home study also applies for a foster care license, the license application may be made with the same agency which provided the adoptive home study; ~~and~~

(6) consult with representatives reflecting diverse populations from the councils established under sections 3.922 and 15.0145, and other state, local, and community organizations~~.~~; and

(7) establish family foster setting licensing guidelines for county agencies and private agencies designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04. Guidelines that the commissioner establishes under this paragraph shall be considered directives of the commissioner under section 245A.16.

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

Sec. 39. Minnesota Statutes 2020, section 466.03, subdivision 6d, is amended to read:

Subd. 6d. **Licensing of providers.** (a) A claim against a municipality based on the failure of a provider to meet the standards needed for a license to operate a day care facility under chapter 245A for children, unless the municipality had actual knowledge of a failure to meet licensing standards that resulted in a dangerous condition that foreseeably threatened the plaintiff. A municipality shall be immune from liability for a claim arising out of a provider's use of a swimming pool located at a family day care or group family day care home under section 245A.14, subdivision ~~10~~ 11, unless the municipality had actual knowledge of a provider's failure to meet the licensing standards under section 245A.14, subdivision ~~10~~ 11, paragraph (a), clauses (1) to (3), that resulted in a dangerous condition that foreseeably threatened the plaintiff.

(b) For purposes of paragraph (a), the fact that a licensing variance had been granted for a day care facility for children under chapter 245A shall not constitute actual knowledge

by the municipality that granted the variance of a failure to meet licensing standards that resulted in a dangerous condition that foreseeably threatened the plaintiff.

Sec. 40. Laws 2020, First Special Session chapter 7, section 1, as amended by Laws 2020, Third Special Session chapter 1, section 3, is amended by adding a subdivision to read:

Subd. 5. **Waiver extension; 180-day transition period.** When the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, the modification in CV23: modifying certain background study requirements, issued by the commissioner of human services pursuant to Executive Orders 20-11 and 20-12, and including any amendments to the modification issued before the peacetime emergency expires, shall remain in effect for no more than 180 days.

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

Sec. 41. Laws 2020, First Special Session chapter 7, section 1, subdivision 3, is amended to read:

Subd. 3. **Waivers and modifications; 60-day transition period.** When the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, all waivers or modifications issued by the commissioner of human services in response to the COVID-19 outbreak that have not been extended as provided in subdivisions 1, 2, ~~and~~ 4, and 5 of this section may remain in effect for no more than 60 days, only for purposes of transitioning affected programs back to operating without the waivers or modifications in place.

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

Sec. 42. **COVID-19 PUBLIC HEALTH SUPPORT FUNDS FOR CHILD CARE PROGRAMS.**

Subdivision 1. **Public health support funds.** (a) The commissioner of human services shall distribute COVID-19 public health support funds to eligible child care programs to support the higher costs to operate safely as defined by state and federal public health guidance, including but not limited to efforts to create smaller and consistent child groupings, screening procedures, quarantine periods, cleaning and sanitation, additional sick leave, substitute teachers, supports for distance learning and incentive pay, and other public health measures that prevent transmission of COVID-19 and protect families and staff.

(b) The commissioner shall distribute monthly base grant awards under subdivision 4 for a distribution period beginning June 2021 through May 2023. Any funds remaining as

of June 1, 2023, may be distributed as monthly base grant awards in the same amount distributed for May 2023 until either September 30, 2023, or until the funds expire, whichever is sooner.

Subd. 2. **Eligible programs.** (a) The following programs are eligible to receive public health support funds under this section:

(1) family and group family day care homes licensed under Minnesota Rules, chapter 9502;

(2) child care centers licensed under Minnesota Rules, chapter 9503;

(3) certified license-exempt child care centers under Minnesota Statutes, chapter 245H; and

(4) Tribally licensed child care programs.

(b) Programs must not be:

(1) the subject of a finding of fraud;

(2) prohibited from receiving public funds under Minnesota Statutes, section 245.095; or

(3) under revocation, suspension, temporary immediate suspension, or decertification, regardless of whether the action is under appeal.

(c) Public health support funds under this section must be made available to all eligible programs on a noncompetitive basis.

Subd. 3. **Requirements to receive public health support funds.** (a) To receive funds under this section, an eligible program must complete a monthly application for COVID-19 public health support funds, attesting and agreeing in writing that the program has been operating and serving children during each month's funding period. An applicant program must further attest and agree in writing that the program intends to remain operating and serving children through the remainder of each month's funding period. Exceptions to this operating requirement are:

(1) service disruptions that are necessary due to public health guidance to protect the safety and health of children and child care programs issued by the Centers for Disease Control and Prevention, commissioner of health, commissioner of human services, or a local public health agency; and

(2) planned temporary closures for provider vacation and holidays for up to three weeks over the duration of the funding months beginning June 1, 2021, but not sequentially.

Temporary closures must be reported to the Department of Human Services using a form prescribed by the commissioner. For licensed and certified centers, only temporary closures of the entire program need to be reported; classroom closures or other operating adjustments do not need to be reported.

(b) Providers who close permanently for any reason are subject to recovery of funds for any period of time after program closure. Permanent closures must be reported to the Department of Human Services using a form prescribed by the commissioner.

(c) Notwithstanding paragraphs (a) and (b), if the commissioner determines that the temporary or permanent closure of one program is undertaken to ensure the continued availability of services to children by another program, the commissioner may issue the closed program's public health support funds to the program that has agreed to accept the children previously cared for by the closed program whether or not all the children choose to go to the remaining program and whether or not the remaining program is already receiving public health support funds.

(d) To receive funds under this section, an eligible program must:

(1) continue to comply with all other requirements listed in the application for 2021 COVID-19 public health support funds; and

(2) prioritize use of these funds during the monthly award periods, and must use the funds to cover costs incurred during the peacetime emergency declared by the governor relating to COVID-19. At least 72.5 percent of funds must be used for payroll salaries or employee benefits.

Subd. 4. **Maximum base payment to programs.** (a) An eligible family child care program may receive up to $1,200 in monthly public health support funds.

(b) An eligible licensed child care center may receive up to $8,500 in monthly public health support funds.

(c) An eligible certified child care center may receive up to $3,000 in monthly public health support funds.

(d) The commissioner of human services shall calculate monthly base payment amounts that are proportionate to the amount of funds available for a given funding period.

Sec. 43. **CHILD CARE FACILITY REVITALIZATION GRANT PROGRAM.**

Subdivision 1. **Child care facility revitalization grants.** (a) The commissioner of human services shall distribute child care facility revitalization grant funds to county human services

agencies for grant awards to eligible child care providers to be used to reopen a closed child care program facility or to maintain or improve an operating child care program facility. The commissioner shall distribute grant funds to counties on a per capita basis proportionate to the county's population.

(b) The commissioner shall develop a grant application form for use by counties that at least requires the applicant to submit a plan and proposed budget for reopening, repairing, or improving the child care program. The plan must include amounts and explanations of how grant funds will be used to maintain or improve an open child care program facility in compliance with the authorized uses of grant funds under subdivision 5.

(c) The commissioner shall make grant funds available to counties beginning August 1, 2021.

Subd. 2. **Eligible programs.** (a) The following programs are eligible to receive a child care facility revitalization grant under this section:

(1) family and group family day care homes licensed under Minnesota Rules, chapter 9502;

(2) child care centers licensed under Minnesota Rules, chapter 9503;

(3) certified license-exempt child care centers under Minnesota Statutes, chapter 245H; and

(4) Tribally licensed child care programs.

(b) Eligible programs must also be located outside the metropolitan area as defined in Minnesota Statutes, section 473.121, subdivision 2, and must not be:

(1) the subject of a finding of fraud;

(2) prohibited from receiving public funds under Minnesota Statutes, section 245.095; or

(3) under revocation, suspension, temporary immediate suspension, or decertification, regardless of whether the action is under appeal.

Subd. 3. **Requirements to receive a child care facility revitalization grant.** To receive funds under this section, an eligible program must complete the application developed by the commissioner and distributed to counties, attesting and agreeing in writing that the program intends to remain operating and serving children and that the program will pay back any grant award if the program permanently closes within one year of receiving the grant award. Providers who close permanently within one year for any reason are subject

to recovery of funds after program closure. Permanent closures must be reported to the Department of Human Services using a form prescribed by the commissioner.

Subd. 4. **Grant award amounts.** (a) An eligible child care program may receive up to $15,000 to reopen a closed family child care site.

(b) An eligible child care program may receive up to $100,000 to reopen a closed child care center site.

(c) An eligible child care program may receive up to $7,500 to repair or update an open and operating family child care program setting.

(d) An eligible child care program may receive up to $50,000 to repair or update an open and operating child care center.

Subd. 5. **Authorized uses of grant funds.** Eligible programs may use child care facility revitalization grant funds for:

(1) facility maintenance or improvements;

(2) personal protective equipment or cleaning and sanitation supplies and services;

(3) purchases or updates to equipment and supplies to respond to the COVID-19 public health emergency; or

(4) other goods and services necessary to maintain or resume child care services.

Sec. 44. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; FAMILY CHILD CARE TASK FORCE RECOMMENDATIONS IMPLEMENTATION PLAN.**

The commissioner of human services shall include individuals representing family child care providers in any group that develops a plan for implementing the recommendations of the Family Child Care Task Force.

Sec. 45. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; FAMILY CHILD CARE REGULATION MODERNIZATION.**

(a) The commissioner of human services shall contract with an experienced and independent organization or individual consultant to conduct the work outlined in this section. If practicable, the commissioner must contract with the National Association for Regulatory Administration.

(b) The consultant shall develop a proposal for a risk-based model for monitoring compliance with family child care licensing standards, grounded in national regulatory best

practices. Violations in the new model must be weighted to reflect the potential risk they pose to children's health and safety, and licensing sanctions must be tied to the potential risk. The proposed new model must protect the health and safety of children in family child care programs and be child-centered, family-friendly, and fair to providers. The proposal shall also include updates to family child care licensing standards.

(c) The consultant shall develop and implement a stakeholder engagement process that solicits input from parents, licensed family child care providers, county licensors, staff of the Department of Human Services, and experts in child development about licensing standards, tiers for violations of the standards based on the potential risk of harm that each violation poses, and licensing sanctions for each tier.

(d) The consultant shall solicit input from parents, licensed family child care providers, county licensors, and staff of the Department of Human Services about which family child care providers should be eligible for abbreviated inspections that predict compliance with other licensing standards for licensed family child care providers using key indicators previously identified by an empirically based statistical methodology developed by the National Association for Regulatory Administration and the Research Institute for Key Indicators.

(e) No later than February 1, 2024, the commissioner shall submit a report and proposed legislation required to implement the new licensing model and updated licensing standards to the chairs and ranking minority members of the legislative committees with jurisdiction over child care regulation.

Sec. 46. **WORKING GROUP; AFFORDABLE HIGH QUALITY CHILD CARE AND EARLY EDUCATION FOR ALL FAMILIES.**

Subdivision 1. **Goal.** It is the goal of the state of Minnesota for all families to have access to affordable high quality child care and early education, for children from birth up to age five, that enriches, nurtures, and supports children and their families. This goal will be achieved by:

(1) creating a system under which family costs for child care and early education are affordable;

(2) ensuring that a child's access to high quality child care and early education is not determined by the child's race, income, or zip code; and

(3) ensuring that Minnesota's early childhood educators are qualified, diverse, supported, and equitably compensated regardless of setting.

Subd. 2. **Working group; establishment.** (a) The commissioner of human services shall coordinate through the Minnesota Children's Cabinet to establish a working group that includes, but is not limited to members of the State Advisory Council on Early Childhood Care and Education. The group shall include early childhood care and education providers; parents; organizations that provide training and other supports to providers; business associations; children's advocates; and representatives from the Departments of Human Services, Health, and Education. The working group shall be convened as necessary to develop a plan to achieve the goal in subdivision 1 by January 1, 2031.

(b) The plan must incorporate strategies that:

(1) create a system under which family costs of child care and early education are affordable;

(2) ensure that a child's access to high quality child care and early education is not determined by the child's race, income, or zip code; and

(3) ensure that Minnesota has early childhood educators who are qualified, diverse, supported, and equitably compensated regardless of setting.

Subd. 3. **Required reports.** By July 1, 2022, the working group must submit to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over early childhood programs an interim report on the working group's preliminary findings and draft implementation plans relating to the plan required under subdivision 2. By February 1, 2023, the working group must submit to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over early childhood programs a final report on the working group's recommendations and implementation proposals relating to the plan required under subdivision 2.

Sec. 47. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; FAMILY CHILD CARE ONE-STOP ASSISTANCE NETWORK.**

By January 1, 2022, the commissioner of human services shall, in consultation with county agencies, providers, and other relevant stakeholders, develop a proposal to create, advertise, and implement a one-stop regional assistance network comprised of individuals who have experience starting a licensed family or group family day care or technical expertise regarding the applicable licensing statutes and procedures, in order to assist individuals with matters relating to starting or sustaining a licensed family or group family day care program. The proposal shall include an estimated timeline for implementation of the assistance network, an estimated budget of the cost of the assistance network, and any necessary

legislative proposals to implement the assistance network. The proposal shall also include a plan to raise awareness and distribute contact information for the assistance network to all licensed family or group family day care providers.

Sec. 48. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; FAMILY CHILD CARE LICENSE APPLICANT ORIENTATION TRAINING.**

By July 1, 2022, working with licensed family child care providers and county agencies, the commissioner of human services shall develop and implement orientation training for family child care license applicants to ensure that all family child care license applicants have the same critical baseline information about Minnesota Statutes, chapters 245A and 245C, and Minnesota Rules, chapter 9502.

Sec. 49. **FAMILY CHILD CARE TRAINING ADVISORY COMMITTEE.**

Subdivision 1. **Formation; duties.** (a) The Family Child Care Training Advisory Committee shall advise the commissioner of human services on the training requirements for licensed family and group family child care providers. Beginning January 1, 2022, the advisory committee shall meet at least twice per year. The advisory committee shall annually elect a chair from among its members who shall establish the agenda for each meeting. The commissioner or commissioner's designee shall attend all advisory committee meetings.

(b) The Family Child Care Training Advisory Committee shall advise and make recommendations to the commissioner of human services on:

(1) updates to the rules and statutes governing family child care training, including technical updates to facilitate providers' understanding of training requirements;

(2) modernization of family child care training requirements, including substantive changes to the training subject areas;

(3) difficulties facing family child care providers in completing training requirements, including proposed solutions to provider difficulties; and

(4) any other aspect of family child care training, as requested by:

(i) a committee member, who may request an item to be placed on the agenda for a future meeting. The request may be considered by the committee and voted upon. If the motion carries, the meeting agenda item may be developed for presentation to the committee;

(ii) a member of the public, who may approach the committee by letter or e-mail requesting that an item be placed on a future meeting agenda. The request may be considered

by the committee and voted upon. If the motion carries, the agenda item may be developed for presentation to the committee; or

(iii) the commissioner of human services or the commissioner's designee.

(c) The Family Child Care Training Advisory Committee shall expire December 1, 2025.

Subd. 2. **Advisory committee members.** (a) The Family Child Care Training Advisory Committee consists of:

(1) four members who are family child care providers from greater Minnesota, including one member appointed by the speaker of the house, one member appointed by the senate majority leader, one member appointed by the Minnesota Association of Child Care Professionals, and one member appointed by the Minnesota Child Care Provider Network;

(2) four members who are family child care providers from the metropolitan area as defined in Minnesota Statutes, section 473.121, subdivision 2, including one member appointed by the speaker of the house, one member appointed by the senate majority leader, one member appointed by the Minnesota Association of Child Care Professionals, and one member appointed by the Minnesota Child Care Provider Network; and

(3) up to seven members who have expertise in child development, instructional design, or training delivery, including up to two members appointed by the speaker of the house, up to two members appointed by the senate majority leader, one member appointed by the Minnesota Association of Child Care Professionals, one member appointed by the Minnesota Child Care Provider Network, and one member appointed by the Greater Minnesota Partnership.

(b) Advisory committee members shall not be employed by the Department of Human Services. Advisory committee members shall receive no compensation, except that public members of the advisory committee may be compensated as provided by Minnesota Statutes, section 15.059, subdivision 3.

(c) Advisory committee members must include representatives of diverse cultural communities.

(d) Advisory committee members shall serve two-year terms. Initial appointments to the advisory committee must be made by December 1, 2021. Subsequent appointments to the advisory committee must be made by December 1 of the year in which the member's term expires.

(e) The commissioner of human services must convene the first meeting of the advisory committee by March 1, 2022.

Subd. 3. **Commissioner report.** The commissioner of human services shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over child care on any recommendations from the Family Child Care Training Advisory Committee, including any draft legislation necessary to implement the recommendations.

Sec. 50. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; DHS FAMILY CHILD CARE FREQUENTLY ASKED QUESTIONS WEBSITE MODIFICATIONS.**

By January 1, 2022, the commissioner of human services shall expand the "frequently asked questions" website for family child care providers to include more answers to submitted questions and a function to search for answers to specific question topics.

Sec. 51. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; CHILD FOSTER CARE LICENSING GUIDELINES.**

By July 1, 2023, the commissioner of human services shall, in consultation with stakeholders with expertise in child protection and children's behavioral health, develop family foster setting licensing guidelines for county agencies and private agencies that perform licensing functions. Stakeholders include but are not limited to child advocates, representatives from community organizations, representatives of the state ethnic councils, the ombudsperson for families, family foster setting providers, youth who have experienced family foster setting placements, county child protection staff, and representatives of county and private licensing agencies.

Sec. 52. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; PARENT AWARE VALIDATION STUDY.**

The commissioner shall contract with an independent third-party evaluator to complete a validation study that evaluates whether the program's standards, indicators, and other measures are effectively measuring program quality and educational outcomes. The third-party evaluator shall report on the results of the study to the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over child care by February 1, 2024. The commissioner shall not update current Parent Aware standards and indicators until the validation study is complete.

Sec. 53. **LEGISLATIVE TASK FORCE; HUMAN SERVICES BACKGROUND STUDY ELIGIBILITY.**

Subdivision 1. **Creation; duties.** A legislative task force is created to review the statutes relating to human services background study eligibility and disqualifications, including but not limited to Minnesota Statutes, sections 245C.14 and 245C.15, in order to:

(1) evaluate the existing statutes' effectiveness in achieving their intended purposes, including by gathering and reviewing available background study disqualification data;

(2) identify the existing statutes' weaknesses, inefficiencies, unintended consequences, or other areas for improvement or modernization; and

(3) develop legislative proposals that improve or modernize the human services background study eligibility statutes, or otherwise address the issues identified in clauses (1) and (2).

Subd. 2. **Membership.** (a) The task force shall consist of 26 members, appointed as follows:

(1) two members representing licensing boards whose licensed providers are subject to the provisions in Minnesota Statutes, section 245C.03, one appointed by the speaker of the house of representatives, and one appointed by the senate majority leader;

(2) the commissioner of human services or a designee;

(3) the commissioner of health or a designee;

(4) two members representing county attorneys and law enforcement, one appointed by the speaker of the house of representatives, and one appointed by the senate majority leader;

(5) two members representing licensed service providers who are subject to the provisions in Minnesota Statutes, section 245C.15, one appointed by the speaker of the house of representatives, and one appointed by the senate majority leader;

(6) four members of the public, including two who have been subject to disqualification based on the provisions of Minnesota Statutes, section 245C.15, and two who have been subject to a set-aside based on the provisions of Minnesota Statutes, section 245C.15, with one from each category appointed by the speaker of the house of representatives, and one from each category appointed by the senate majority leader;

(7) one member appointed by the governor's Workforce Development Board;

(8) one member appointed by the One Minnesota Council on Diversity, Inclusion, and Equity;

(9) two members representing the Minnesota courts, one appointed by the speaker of the house of representatives, and one appointed by the senate majority leader;

(10) one member appointed jointly by Mid-Minnesota Legal Aid, Southern Minnesota Legal Services, and the Legal Rights Center;

(11) one member representing Tribal organizations, appointed by the Minnesota Indian Affairs Council;

(12) two members from the house of representatives, including one appointed by the speaker of the house of representatives and one appointed by the minority leader in the house of representatives;

(13) two members from the senate, including one appointed by the senate majority leader and one appointed by the senate minority leader;

(14) two members representing county human services agencies appointed by the Minnesota Association of County Social Service Administrators, including one appointed to represent the metropolitan area as defined in Minnesota Statutes, section 473.121, subdivision 2, and one appointed to represent the area outside of the metropolitan area; and

(15) two attorneys who have represented individuals that appealed a background study disqualification determination based on Minnesota Statutes, sections 245C.14 and 245C.15, one appointed by the speaker of the house of representatives, and one appointed by the senate majority leader.

(b) Appointments to the task force must be made by August 18, 2021.

Subd. 3. **Compensation.** Public members of the task force may be compensated as provided by Minnesota Statutes, section 15.059, subdivision 3.

Subd. 4. **Officers; meetings.** (a) The first meeting of the task force shall be cochaired by the task force member from the majority party of the house of representatives and the task force member from the majority party of the senate. The task force shall elect a chair and vice chair at the first meeting who shall preside at the remainder of the task force meetings. The task force may elect other officers as necessary.

(b) The task force shall meet at least monthly. The Legislative Coordinating Commission shall convene the first meeting by September 1, 2021.

(c) Meetings of the task force are subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.

Subd. 5. **Reports required.** The task force shall submit an interim written report by March 11, 2022, and a final report by December 16, 2022, to the chairs and ranking minority members of the committees in the house of representatives and the senate with jurisdiction over human services licensing. The reports shall explain the task force's findings and recommendations relating to each of the duties under subdivision 1, and include any draft legislation necessary to implement the recommendations.

Subd. 6. **Expiration.** The task force expires upon submission of the final report in subdivision 5 or December 20, 2022, whichever is later.

EFFECTIVE DATE. This section is effective the day following final enactment and expires December 31, 2022.

Sec. 54. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; REPORT ON PARTICIPATION IN EARLY CHILDHOOD PROGRAMS BY CHILDREN IN FOSTER CARE.**

Subdivision 1. **Reporting requirement.** (a) The commissioner of human services shall report on the participation in early care and education programs by children under age six who have experienced foster care, as defined in Minnesota Statutes, section 260C.007, subdivision 18, at any time during the reporting period.

(b) For purposes of this section, "early care and education program" means Early Head Start and Head Start under the federal Improving Head Start for School Readiness Act of 2007; special education programs under Minnesota Statutes, chapter 125A; early learning scholarships under Minnesota Statutes, section 124D.165; school readiness under Minnesota Statutes, sections 124D.15 and 124D.16; school readiness plus under Laws 2017, First Special Session chapter 5, article 8, section 9; voluntary prekindergarten under Minnesota Statutes, section 124D.151; child care assistance under Minnesota Statutes, chapter 119B; and other programs as determined by the commissioner.

Subd. 2. **Report content.** (a) The report shall provide counts and rates of participation by early care and education program and child's race, ethnicity, age, and county of residence. The report shall use the most current administrative data and include recommendations for collecting any data listed in this paragraph that is not currently available.

(b) The report shall include recommendations to:

(1) provide the data described in paragraph (a) on an annual basis as part of the report required under Minnesota Statutes, section 257.0725;

(2) facilitate children's continued participation in early care and education programs after reunification, adoption, or transfer of permanent legal and physical custody; and

(3) regularly report measures of early childhood well-being for children who have experienced foster care. "Measures of early childhood well-being" include developmental screening, school readiness assessments, well-child medical visits, and other indicators as determined by the commissioner, in consultation with the commissioners of health, education, and management and budget, county social service and public health agencies, and school districts.

(c) The report shall include an implementation plan to increase the rates of participation among children and their foster families in early care and education programs, including processes for referrals and follow-up. The plan shall be developed in collaboration with affected communities and families, incorporating their experiences and feedback. County social service and public health agencies and school districts shall also collaborate on the plan's development and implementation strategy.

(d) The report shall identify barriers to be addressed to ensure that early care and education programs are responsive to the cultural, logistical, and racial equity concerns and needs of children's foster families and families of origin, and the report shall identify methods to ensure the experiences and feedback from children's foster families and families of origin are included in the ongoing implementation of early care and education programs.

Subd. 3. **Submission to legislature.** By June 30, 2022, the commissioner shall submit an interim report, and by December 1, 2022, the commissioner shall submit the final report required under this section to the chairs and ranking minority members of the legislative committees with jurisdiction over human services, early childhood, and education.

Sec. 55. **CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATION; FAMILY CHILD CARE REGULATION MODERNIZATION PROJECT.**

The commissioner of human services shall allocate $1,170,000 in fiscal year 2022 from the amount that Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2201, for the child care and development block grant for the family child care regulation modernization project. This is a onetime allocation and remains available until June 30, 2024.

Sec. 56. **CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATION; AFFORDABLE HIGH QUALITY CHILD CARE AND EARLY EDUCATION FOR ALL FAMILIES WORKING GROUP.**

The commissioner of human services shall allocate up to $500,000 in fiscal year 2022 from the amount that Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2201, for the child care and development block grant for the affordable high quality child care and early education for all families working group. This is a onetime allocation and is available until June 30, 2023.

Sec. 57. **CHILD CARE STABILIZATION FUND ALLOCATION; CHILD CARE PROVIDER STARTUP GRANTS.**

(a) The commissioner of human services shall allocate $10,000,000 in fiscal year 2022 and $10,000,000 in fiscal year 2023 from the amount that Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2202, for the child care stabilization fund for grants to local communities to increase the supply of quality child care providers to support economic development. At least 60 percent of grant funds must go to communities located outside of the seven-county metropolitan area as defined under Minnesota Statutes, section 473.121, subdivision 2. Grant recipients must obtain a 50 percent nonstate match to grant funds in either cash or in-kind contributions. Grant funds available under this section must be used to implement projects to reduce the child care shortage in the state, including but not limited to funding for child care business start-ups or expansion, training, facility modifications or improvements required for licensing, and assistance with licensing and other regulatory requirements. In awarding grants, the commissioner must give priority to communities that have demonstrated a shortage of child care providers in the area. This is a onetime allocation.

(b) Within one year of receiving grant funds, grant recipients must report to the commissioner on the outcomes of the grant program, including but not limited to the number of new providers, the number of additional child care provider jobs created, the number of additional child care slots, and the amount of cash and in-kind local funds invested.

Sec. 58. **CHILD CARE STABILIZATION FUND ALLOCATION; CHILD CARE BUSINESS TRAINING PROGRAM.**

The commissioner of human services shall allocate $3,000,000 in fiscal year 2022 from the amount that Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2202, for the child care stabilization fund for a grant, through a competitive bidding

process, to a nonprofit organization with expertise in small business advising to operate a business training program for child care providers and to create materials that could be used, free of charge, for start-up, expansion, and operation of child care businesses statewide, with the goal of helping new and existing child care businesses in underserved areas of the state become profitable and sustainable. The commissioner shall report data on outcomes and recommendations for replication of this training program throughout Minnesota to the governor and the chairs and ranking minority members of the committees of the house of representatives and the senate with jurisdiction over child care by December 15, 2023. This is a onetime allocation and is available until June 30, 2023.

Sec. 59. **CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATION; CHILD CARE WORKFORCE DEVELOPMENT GRANTS.**

The commissioner of human services shall allocate $750,000 in fiscal year 2022 and $750,000 in fiscal year 2023 from the amount that Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2201, for the child care and development block grant for grants to nonprofit organizations to provide economically challenged individuals the jobs skills training, career counseling, and job placement assistance necessary to begin a career path in child care. By January 1, 2024, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over child care on the outcomes of the grant program, including the effects on the child care workforce. This is a onetime allocation.

Sec. 60. **CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATION; FAMILY CHILD CARE ONE-STOP ASSISTANCE NETWORK.**

The commissioner of human services shall allocate $4,000,000 in fiscal year 2023 and $4,000,000 in fiscal year 2024 from the amount that Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2201, for the family child care one-stop assistance network. This is a onetime allocation.

Sec. 61. **CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATION; FAMILY CHILD CARE LICENSE APPLICANT ORIENTATION TRAINING.**

The commissioner of human services shall allocate $1,000,000 in fiscal year 2023 and $1,000,000 in fiscal year 2024 from the amount that Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2201, for family child care license applicant orientation training. This is a onetime allocation.

Sec. 62. **CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATION; DHS FAMILY CHILD CARE FREQUENTLY ASKED QUESTIONS WEBSITE MODIFICATIONS.**

The commissioner of human services shall allocate $50,000 in fiscal year 2022 from the amount that Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2201, for the modifications to the family child care provider "frequently asked questions" website. This is a onetime allocation.

Sec. 63. **CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATION; JERRY RELPH FAMILY SUPPORTS AND IMPROVEMENT PLAN.**

The commissioner of human services shall allocate $4,500,000 in fiscal year 2022 and $4,500,000 in fiscal year 2023 from the amount that Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2201, for the child care and development block grant for grants to counties, beginning October 1, 2021, to coordinate a two-year, voluntary information sharing program between county agencies, child care providers, early childhood education providers, and parents of families who qualify for or are currently receiving child care assistance, to communicate the needs and circumstances of the participating families and children that prohibit, complicate, or otherwise limit access to or the effectiveness of the child care assistance program, and to evaluate the outcomes of other assistance programs for which the families are eligible. The information sharing program may include data sharing under Minnesota Statutes, section 13.32, subdivision 12. Grant award amounts shall be distributed annually and allocated to counties on a per capita basis, based on the number of children enrolled in the child care assistance program as of July 1 of each year in the county receiving grant funding. By February 1, 2023, and February 1, 2024, the commissioner of human services shall provide an interim and final report to the chairs and ranking minority members of the legislative committees with jurisdiction over the child care assistance program on the results of the project, including any recommendations for improvements to the child care assistance program to better meet the needs of participating families and children.

Sec. 64. **CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATION; TRANSFER FUNDS FOR EARLY LEARNING SCHOLARSHIPS.**

The commissioner of human services shall allocate $73,000,000 in fiscal year 2022 and $73,000,000 in fiscal year 2023 from the amount that Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2201, for the child care and development block

grant, to be transferred to the commissioner of education for the early learning scholarship program under Minnesota Statutes, section 124D.165. For purposes of expending federal resources, the commissioner of human services shall consult with the commissioner of education to ensure that the transferred resources are deployed to support prioritized groups of children, including but not limited to the groups identified in Minnesota Statutes, section 124D.165, while identifying and implementing any other oversight and reporting necessary to maintain compliance with the federal child care and development block grant accountability and data collection requirements in United States Code, title 42, section 9858i.

Sec. 65. **CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATION; BASIC SLIDING FEE CHILD CARE ASSISTANCE PROGRAM.**

The commissioner of human services shall allocate $14,574,000 in fiscal year 2022, $14,574,000 in fiscal year 2023, and $14,574,000 in fiscal year 2024 from the amount Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2201, for the child care and development block grant, for the basic sliding fee child care assistance program under Minnesota Statutes, section 119B.03. This is a onetime allocation.

Sec. 66. **CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATION; REETAIN GRANT PROGRAM.**

The commissioner of human services shall allocate $375,000 in fiscal year 2022 and $375,000 in fiscal year 2023 from the amount that Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2201, for the child care and development block grant, for REETAIN grants under Minnesota Statutes, section 119B.195. This is a onetime allocation.

Sec. 67. **CHILD CARE STABILIZATION FUND ALLOCATION; PUBLIC HEALTH SUPPORT FUNDS FOR CHILD CARE PROGRAMS.**

(a) The commissioner of human services shall allocate $252,000,000 in fiscal year 2022 from the amount that Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2202, for the child care stabilization fund for the public health support funds for child care programs in section 42. This is a onetime allocation and is available until September 30, 2023.

(b) Of the amount allocated under paragraph (a), $60,000,000 is for the three-month funding period from June to August 2021; $50,000,000 is for the three-month funding period

from September to November 2021; $40,000,000 is for the three-month funding period from December 2021 to February 2022; $30,000,000 is for the three-month funding period from March to May 2022; $25,000,000 is for the three-month funding period from June to August 2022; $20,000,000 is for the three-month funding period from September to November 2022; $15,000,000 is for the three-month funding period from December 2022 to February 2023; and $10,000,000 is for the three-month funding period from March to May 2023. The commissioner shall adjust grant award amounts in accordance with the amounts available for each three-month funding period.

(c) Of the amount allocated under paragraph (a), up to $2,000,000 is for administrative costs.

Sec. 68. **CHILD CARE STABILIZATION FUND ALLOCATION; CHILD CARE FACILITY REVITALIZATION GRANTS.**

The commissioner of human services shall allocate $50,000,000 in fiscal year 2022 from the amount that Minnesota received under the American Rescue Plan Act, Public Law 117-2, section 2202, for the child care stabilization fund for child care facility revitalization grants. Of this amount, up to $1,500,000 is for administrative costs. This is a onetime allocation and is available until September 30, 2023.

ARTICLE 8
MENTAL HEALTH UNIFORM SERVICE STANDARDS

Section 1. **[245I.01] PURPOSE AND CITATION.**

Subdivision 1. **Citation.** This chapter may be cited as the "Mental Health Uniform Service Standards Act."

Subd. 2. **Purpose.** In accordance with sections 245.461 and 245.487, the purpose of this chapter is to create a system of mental health care that is unified, accountable, and comprehensive, and to promote the recovery and resiliency of Minnesotans who have mental illnesses. The state's public policy is to support Minnesotans' access to quality outpatient and residential mental health services. Further, the state's public policy is to protect the health and safety, rights, and well-being of Minnesotans receiving mental health services.

Sec. 2. **[245I.011] APPLICABILITY.**

Subdivision 1. **License requirements.** A license holder under this chapter must comply with the requirements in chapters 245A, 245C, and 260E; section 626.557; and Minnesota Rules, chapter 9544.

Subd. 2. **Variances.** (a) The commissioner may grant a variance to an applicant, license holder, or certification holder as long as the variance does not affect the staff qualifications or the health or safety of any person in a licensed or certified program and the applicant, license holder, or certification holder meets the following conditions:

(1) an applicant, license holder, or certification holder must request the variance on a form approved by the commissioner and in a manner prescribed by the commissioner;

(2) the request for a variance must include the:

(i) reasons that the applicant, license holder, or certification holder cannot comply with a requirement as stated in the law; and

(ii) alternative equivalent measures that the applicant, license holder, or certification holder will follow to comply with the intent of the law; and

(3) the request for a variance must state the period of time when the variance is requested.

(b) The commissioner may grant a permanent variance when the conditions under which the applicant, license holder, or certification holder requested the variance do not affect the health or safety of any person whom the licensed or certified program serves, and when the conditions of the variance do not compromise the qualifications of staff who provide services to clients. A permanent variance expires when the conditions that warranted the variance change in any way. Any applicant, license holder, or certification holder must inform the commissioner of any changes to the conditions that warranted the permanent variance. If an applicant, license holder, or certification holder fails to advise the commissioner of changes to the conditions that warranted the variance, the commissioner must revoke the permanent variance and may impose other sanctions under sections 245A.06 and 245A.07.

(c) The commissioner's decision to grant or deny a variance request is final and not subject to appeal under the provisions of chapter 14.

Subd. 3. **Certification required.** (a) An individual, organization, or government entity that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause (19), and chooses to be identified as a certified mental health clinic must:

(1) be a mental health clinic that is certified under section 245I.20;

(2) comply with all of the responsibilities assigned to a license holder by this chapter except subdivision 1; and

(3) comply with all of the responsibilities assigned to a certification holder by chapter 245A.

(b) An individual, organization, or government entity described by this subdivision must obtain a criminal background study for each staff person or volunteer who provides direct contact services to clients.

Subd. 4. **License required.** An individual, organization, or government entity providing intensive residential treatment services or residential crisis stabilization to adults must be licensed under section 245I.23. An entity with an adult foster care license providing residential crisis stabilization is exempt from licensure under section 245I.23.

Subd. 5. **Programs certified under chapter 256B.** (a) An individual, organization, or government entity certified under the following sections must comply with all of the responsibilities assigned to a license holder under this chapter except subdivision 1:

(1) an assertive community treatment provider under section 256B.0622, subdivision 3a;

(2) an adult rehabilitative mental health services provider under section 256B.0623;

(3) a mobile crisis team under section 256B.0624;

(4) a children's therapeutic services and supports provider under section 256B.0943;

(5) an intensive treatment in foster care provider under section 256B.0946; and

(6) an intensive nonresidential rehabilitative mental health services provider under section 256B.0947.

(b) An individual, organization, or government entity certified under the sections listed in paragraph (a), clauses (1) to (6), must obtain a criminal background study for each staff person and volunteer providing direct contact services to a client.

Sec. 3. **[245I.02] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of this chapter, the terms in this section have the meanings given.

Subd. 2. **Approval.** "Approval" means the documented review of, opportunity to request changes to, and agreement with a treatment document. An individual may demonstrate approval with a written signature, secure electronic signature, or documented oral approval.

Subd. 3. **Behavioral sciences or related fields.** "Behavioral sciences or related fields" means an education from an accredited college or university in social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, nursing, and other similar fields approved by the commissioner.

Subd. 4. **Business day.** "Business day" means a weekday on which government offices are open for business. Business day does not include state or federal holidays, Saturdays, or Sundays.

Subd. 5. **Case manager.** "Case manager" means a client's case manager according to section 256B.0596; 256B.0621; 256B.0625, subdivision 20; 256B.092, subdivision 1a; 256B.0924; 256B.093, subdivision 3a; 256B.094; or 256B.49.

Subd. 6. **Certified rehabilitation specialist.** "Certified rehabilitation specialist" means a staff person who meets the qualifications of section 245I.04, subdivision 8.

Subd. 7. **Child.** "Child" means a client under the age of 18.

Subd. 8. **Client.** "Client" means a person who is seeking or receiving services regulated by this chapter. For the purpose of a client's consent to services, client includes a parent, guardian, or other individual legally authorized to consent on behalf of a client to services.

Subd. 9. **Clinical trainee.** "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

Subd. 10. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designee.

Subd. 11. **Co-occurring substance use disorder treatment.** "Co-occurring substance use disorder treatment" means the treatment of a person who has a co-occurring mental illness and substance use disorder. Co-occurring substance use disorder treatment is characterized by stage-wise comprehensive treatment, treatment goal setting, and flexibility for clients at each stage of treatment. Co-occurring substance use disorder treatment includes assessing and tracking each client's stage of change readiness and treatment using a treatment approach based on a client's stage of change, such as motivational interviewing when working with a client at an earlier stage of change readiness and a cognitive behavioral approach and relapse prevention to work with a client at a later stage of change; and facilitating a client's access to community supports.

Subd. 12. **Crisis plan.** "Crisis plan" means a plan to prevent and de-escalate a client's future crisis situation, with the goal of preventing future crises for the client and the client's

family and other natural supports. Crisis plan includes a crisis plan developed according to section 245.4871, subdivision 9a.

Subd. 13. **Critical incident.** "Critical incident" means an occurrence involving a client that requires a license holder to respond in a manner that is not part of the license holder's ordinary daily routine. Critical incident includes a client's suicide, attempted suicide, or homicide; a client's death; an injury to a client or other person that is life-threatening or requires medical treatment; a fire that requires a fire department's response; alleged maltreatment of a client; an assault of a client; an assault by a client; or other situation that requires a response by law enforcement, the fire department, an ambulance, or another emergency response provider.

Subd. 14. **Diagnostic assessment.** "Diagnostic assessment" means the evaluation and report of a client's potential diagnoses that a mental health professional or clinical trainee completes under section 245I.10, subdivisions 4 to 6.

Subd. 15. **Direct contact.** "Direct contact" has the meaning given in section 245C.02, subdivision 11.

Subd. 16. **Family and other natural supports.** "Family and other natural supports" means the people whom a client identifies as having a high degree of importance to the client. Family and other natural supports also means people that the client identifies as being important to the client's mental health treatment, regardless of whether the person is related to the client or lives in the same household as the client.

Subd. 17. **Functional assessment.** "Functional assessment" means the assessment of a client's current level of functioning relative to functioning that is appropriate for someone the client's age. For a client five years of age or younger, a functional assessment is the Early Childhood Service Intensity Instrument (ESCII). For a client six to 17 years of age, a functional assessment is the Child and Adolescent Service Intensity Instrument (CASII). For a client 18 years of age or older, a functional assessment is the functional assessment described in section 245I.10, subdivision 9.

Subd. 18. **Individual abuse prevention plan.** "Individual abuse prevention plan" means a plan according to section 245A.65, subdivision 2, paragraph (b), and section 626.557, subdivision 14.

Subd. 19. **Level of care assessment.** "Level of care assessment" means the level of care decision support tool appropriate to the client's age. For a client five years of age or younger, a level of care assessment is the Early Childhood Service Intensity Instrument (ESCII). For a client six to 17 years of age, a level of care assessment is the Child and Adolescent Service

Intensity Instrument (CASII). For a client 18 years of age or older, a level of care assessment is the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS).

Subd. 20. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

Subd. 21. **License holder.** "License holder" has the meaning given in section 245A.02, subdivision 9.

Subd. 22. **Licensed prescriber.** "Licensed prescriber" means an individual who is authorized to prescribe legend drugs under section 151.37.

Subd. 23. **Mental health behavioral aide.** "Mental health behavioral aide" means a staff person who is qualified under section 245I.04, subdivision 16.

Subd. 24. **Mental health certified family peer specialist.** "Mental health certified family peer specialist" means a staff person who is qualified under section 245I.04, subdivision 12.

Subd. 25. **Mental health certified peer specialist.** "Mental health certified peer specialist" means a staff person who is qualified under section 245I.04, subdivision 10.

Subd. 26. **Mental health practitioner.** "Mental health practitioner" means a staff person who is qualified under section 245I.04, subdivision 4.

Subd. 27. **Mental health professional.** "Mental health professional" means a staff person who is qualified under section 245I.04, subdivision 2.

Subd. 28. **Mental health rehabilitation worker.** "Mental health rehabilitation worker" means a staff person who is qualified under section 245I.04, subdivision 14.

Subd. 29. **Mental illness.** "Mental illness" means any of the conditions included in the most recent editions of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three or the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Subd. 30. **Organization.** "Organization" has the meaning given in section 245A.02, subdivision 10c.

Subd. 31. **Personnel file.** "Personnel file" means a set of records under section 245I.07, paragraph (a). Personnel files excludes information related to a person's employment that is not included in section 245I.07.

Subd. 32. **Registered nurse.** "Registered nurse" means a staff person who is qualified under section 148.171, subdivision 20.

Subd. 33. **Rehabilitative mental health services.** "Rehabilitative mental health services" means mental health services provided to an adult client that enable the client to develop and achieve psychiatric stability, social competencies, personal and emotional adjustment, independent living skills, family roles, and community skills when symptoms of mental illness has impaired any of the client's abilities in these areas.

Subd. 34. **Residential program.** "Residential program" has the meaning given in section 245A.02, subdivision 14.

Subd. 35. **Signature.** "Signature" means a written signature or an electronic signature defined in section 325L.02, paragraph (h).

Subd. 36. **Staff person.** "Staff person" means an individual who works under a license holder's direction or under a contract with a license holder. Staff person includes an intern, consultant, contractor, individual who works part-time, and an individual who does not provide direct contact services to clients. Staff person includes a volunteer who provides treatment services to a client or a volunteer whom the license holder regards as a staff person for the purpose of meeting staffing or service delivery requirements. A staff person must be 18 years of age or older.

Subd. 37. **Strengths.** "Strengths" means a person's inner characteristics, virtues, external relationships, activities, and connections to resources that contribute to a client's resilience and core competencies. A person can build on strengths to support recovery.

Subd. 38. **Trauma.** "Trauma" means an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma includes group traumatic experiences. Group traumatic experiences are emotional or psychological harm that a group experiences. Group traumatic experiences can be transmitted across generations within a community and are often associated with racial and ethnic population groups who suffer major intergenerational losses.

Subd. 39. **Treatment plan.** "Treatment plan" means services that a license holder formulates to respond to a client's needs and goals. A treatment plan includes individual treatment plans under section 245I.10, subdivisions 7 and 8; initial treatment plans under section 245I.23, subdivision 7; and crisis treatment plans under sections 245I.23, subdivision 8, and 256B.0624, subdivision 11.

Subd. 40. **Treatment supervision.** "Treatment supervision" means a mental health professional's or certified rehabilitation specialist's oversight, direction, and evaluation of a staff person providing services to a client according to section 245I.06.

Subd. 41. **Volunteer.** "Volunteer" means an individual who, under the direction of the license holder, provides services to or facilitates an activity for a client without compensation.

Sec. 4. **[245I.03] REQUIRED POLICIES AND PROCEDURES.**

Subdivision 1. **Generally.** A license holder must establish, enforce, and maintain policies and procedures to comply with the requirements of this chapter and chapters 245A, 245C, and 260E; sections 626.557 and 626.5572; and Minnesota Rules, chapter 9544. The license holder must make all policies and procedures available in writing to each staff person. The license holder must complete and document a review of policies and procedures every two years and update policies and procedures as necessary. Each policy and procedure must identify the date that it was initiated and the dates of all revisions. The license holder must clearly communicate any policy and procedural change to each staff person and provide necessary training to each staff person to implement any policy and procedural change.

Subd. 2. **Health and safety.** A license holder must have policies and procedures to ensure the health and safety of each staff person and client during the provision of services, including policies and procedures for services based in community settings.

Subd. 3. **Client rights.** A license holder must have policies and procedures to ensure that each staff person complies with the client rights and protections requirements in section 245I.12.

Subd. 4. **Behavioral emergencies.** (a) A license holder must have procedures that each staff person follows when responding to a client who exhibits behavior that threatens the immediate safety of the client or others. A license holder's behavioral emergency procedures must incorporate person-centered planning and trauma-informed care.

(b) A license holder's behavioral emergency procedures must include:

(1) a plan designed to prevent the client from inflicting self-harm and harming others;

(2) contact information for emergency resources that a staff person must use when the license holder's behavioral emergency procedures are unsuccessful in controlling a client's behavior;

(3) the types of behavioral emergency procedures that a staff person may use;

(4) the specific circumstances under which the program may use behavioral emergency procedures; and

(5) the staff persons whom the license holder authorizes to implement behavioral emergency procedures.

(c) The license holder's behavioral emergency procedures must not include secluding or restraining a client except as allowed under section 245.8261.

(d) Staff persons must not use behavioral emergency procedures to enforce program rules or for the convenience of staff persons. Behavioral emergency procedures must not be part of any client's treatment plan. A staff person may not use behavioral emergency procedures except in response to a client's current behavior that threatens the immediate safety of the client or others.

Subd. 5. **Health services and medications.** If a license holder is licensed as a residential program, stores or administers client medications, or observes clients self-administer medications, the license holder must ensure that a staff person who is a registered nurse or licensed prescriber reviews and approves of the license holder's policies and procedures to comply with the health services and medications requirements in section 245I.11, the training requirements in section 245I.05, subdivision 6, and the documentation requirements in section 245I.08, subdivision 5.

Subd. 6. **Reporting maltreatment.** A license holder must have policies and procedures for reporting a staff person's suspected maltreatment, abuse, or neglect of a client according to chapter 260E and section 626.557.

Subd. 7. **Critical incidents.** If a license holder is licensed as a residential program, the license holder must have policies and procedures for reporting and maintaining records of critical incidents according to section 245I.13.

Subd. 8. **Personnel.** A license holder must have personnel policies and procedures that:

(1) include a chart or description of the organizational structure of the program that indicates positions and lines of authority;

(2) ensure that it will not adversely affect a staff person's retention, promotion, job assignment, or pay when a staff person communicates in good faith with the Department of Human Services, the Office of Ombudsman for Mental Health and Developmental Disabilities, the Department of Health, a health-related licensing board, a law enforcement agency, or a local agency investigating a complaint regarding a client's rights, health, or safety;

(3) prohibit a staff person from having sexual contact with a client in violation of chapter 604, sections 609.344 or 609.345;

(4) prohibit a staff person from neglecting, abusing, or maltreating a client as described in chapter 260E and sections 626.557 and 626.5572;

(5) include the drug and alcohol policy described in section 245A.04, subdivision 1, paragraph (c);

(6) describe the process for disciplinary action, suspension, or dismissal of a staff person for violating a policy provision described in clauses (3) to (5);

(7) describe the license holder's response to a staff person who violates other program policies or who has a behavioral problem that interferes with providing treatment services to clients; and

(8) describe each staff person's position that includes the staff person's responsibilities, authority to execute the responsibilities, and qualifications for the position.

Subd. 9. **Volunteers.** A license holder must have policies and procedures for using volunteers, including when a license holder must submit a background study for a volunteer, and the specific tasks that a volunteer may perform.

Subd. 10. **Data privacy.** (a) A license holder must have policies and procedures that comply with all applicable state and federal law. A license holder's use of electronic record keeping or electronic signatures does not alter a license holder's obligations to comply with applicable state and federal law.

(b) A license holder must have policies and procedures for a staff person to promptly document a client's revocation of consent to disclose the client's health record. The license holder must verify that the license holder has permission to disclose a client's health record before releasing any client data.

Sec. 5. **[245I.04] PROVIDER QUALIFICATIONS AND SCOPE OF PRACTICE.**

Subdivision 1. **Tribal providers.** For purposes of this section, a Tribal entity may credential an individual according to section 256B.02, subdivision 7, paragraphs (b) and (c).

Subd. 2. **Mental health professional qualifications.** The following individuals may provide services to a client as a mental health professional:

(1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a: (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and

mental health nursing by a national certification organization; or (ii) nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization;

(2) a licensed independent clinical social worker as defined in section 148E.050, subdivision 5;

(3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;

(4) a physician licensed under chapter 147 if the physician is: (i) certified by the American Board of Psychiatry and Neurology; (ii) certified by the American Osteopathic Board of Neurology and Psychiatry; or (iii) eligible for board certification in psychiatry;

(5) a marriage and family therapist licensed under sections 148B.29 to 148B.392; or

(6) a licensed professional clinical counselor licensed under section 148B.5301.

Subd. 3. **Mental health professional scope of practice.** A mental health professional must maintain a valid license with the mental health professional's governing health-related licensing board and must only provide services to a client within the scope of practice determined by the applicable health-related licensing board.

Subd. 4. **Mental health practitioner qualifications.** (a) An individual who is qualified in at least one of the ways described in paragraph (b) to (d) may serve as a mental health practitioner.

(b) An individual is qualified as a mental health practitioner through relevant coursework if the individual completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:

(1) has at least 2,000 hours of experience providing services to individuals with:

(i) a mental illness or a substance use disorder; or

(ii) a traumatic brain injury or a developmental disability, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to a client;

(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the individual's clients belong, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to a client;

(3) is working in a day treatment program under section 256B.0671, subdivision 3, or 256B.0943; or

(4) has completed a practicum or internship that (i) required direct interaction with adult clients or child clients, and (ii) was focused on behavioral sciences or related fields.

(c) An individual is qualified as a mental health practitioner through work experience if the individual:

(1) has at least 4,000 hours of experience in the delivery of services to individuals with:

(i) a mental illness or a substance use disorder; or

(ii) a traumatic brain injury or a developmental disability, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to clients; or

(2) receives treatment supervision at least once per week until meeting the requirement in clause (1) of 4,000 hours of experience and has at least 2,000 hours of experience providing services to individuals with:

(i) a mental illness or a substance use disorder; or

(ii) a traumatic brain injury or a developmental disability, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to clients.

(d) An individual is qualified as a mental health practitioner if the individual has a master's or other graduate degree in behavioral sciences or related fields.

Subd. 5. **Mental health practitioner scope of practice.** (a) A mental health practitioner under the treatment supervision of a mental health professional or certified rehabilitation specialist may provide an adult client with client education, rehabilitative mental health services, functional assessments, level of care assessments, and treatment plans. A mental health practitioner under the treatment supervision of a mental health professional may provide skill-building services to a child client and complete treatment plans for a child client.

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

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

Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who: (1) is enrolled in an accredited graduate program of study to prepare the staff person for

independent licensure as a mental health professional and who is participating in a practicum or internship with the license holder through the individual's graduate program; or (2) has completed an accredited graduate program of study to prepare the staff person for independent licensure as a mental health professional and who is in compliance with the requirements of the applicable health-related licensing board, including requirements for supervised practice.

(b) A clinical trainee is responsible for notifying and applying to a health-related licensing board to ensure that the trainee meets the requirements of the health-related licensing board. As permitted by a health-related licensing board, treatment supervision under this chapter may be integrated into a plan to meet the supervisory requirements of the health-related licensing board but does not supersede those requirements.

Subd. 7. **Clinical trainee scope of practice.** (a) A clinical trainee under the treatment supervision of a mental health professional may provide a client with psychotherapy, client education, rehabilitative mental health services, diagnostic assessments, functional assessments, level of care assessments, and treatment plans.

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

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

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

Subd. 8. **Certified rehabilitation specialist qualifications.** A certified rehabilitation specialist must have:

(1) a master's degree from an accredited college or university in behavioral sciences or related fields;

(2) at least 4,000 hours of post-master's supervised experience providing mental health services to clients; and

(3) a valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner.

Subd. 9. **Certified rehabilitation specialist scope of practice.** (a) A certified rehabilitation specialist may provide an adult client with client education, rehabilitative

mental health services, functional assessments, level of care assessments, and treatment plans.

(b) A certified rehabilitation specialist may provide treatment supervision to a mental health certified peer specialist, mental health practitioner, and mental health rehabilitation worker.

Subd. 10. **Mental health certified peer specialist qualifications.** A mental health certified peer specialist must:

(1) have been diagnosed with a mental illness;

(2) be a current or former mental health services client; and

(3) have a valid certification as a mental health certified peer specialist under section 256B.0615.

Subd. 11. **Mental health certified peer specialist scope of practice.** A mental health certified peer specialist under the treatment supervision of a mental health professional or certified rehabilitation specialist must:

(1) provide individualized peer support to each client;

(2) promote a client's recovery goals, self-sufficiency, self-advocacy, and development of natural supports; and

(3) support a client's maintenance of skills that the client has learned from other services.

Subd. 12. **Mental health certified family peer specialist qualifications.** A mental health certified family peer specialist must:

(1) have raised or be currently raising a child with a mental illness;

(2) have experience navigating the children's mental health system; and

(3) have a valid certification as a mental health certified family peer specialist under section 256B.0616.

Subd. 13. **Mental health certified family peer specialist scope of practice.** A mental health certified family peer specialist under the treatment supervision of a mental health professional must provide services to increase the child's ability to function in the child's home, school, and community. The mental health certified family peer specialist must:

(1) provide family peer support to build on a client's family's strengths and help the family achieve desired outcomes;

(2) provide nonadversarial advocacy to a child client and the child's family that encourages partnership and promotes the child's positive change and growth;

(3) support families in advocating for culturally appropriate services for a child in each treatment setting;

(4) promote resiliency, self-advocacy, and development of natural supports;

(5) support maintenance of skills learned from other services;

(6) establish and lead parent support groups;

(7) assist parents in developing coping and problem-solving skills; and

(8) educate parents about mental illnesses and community resources, including resources that connect parents with similar experiences to one another.

Subd. 14. **Mental health rehabilitation worker qualifications.** (a) A mental health rehabilitation worker must:

(1) have a high school diploma or equivalent; and

(2) meet one of the following qualification requirements:

(i) be fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

(ii) have an associate of arts degree;

(iii) have two years of full-time postsecondary education or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields;

(iv) be a registered nurse;

(v) have, within the previous ten years, three years of personal life experience with mental illness;

(vi) have, within the previous ten years, three years of life experience as a primary caregiver to an adult with a mental illness, traumatic brain injury, substance use disorder, or developmental disability; or

(vii) have, within the previous ten years, 2,000 hours of work experience providing health and human services to individuals.

(b) A mental health rehabilitation worker who is scheduled as an overnight staff person and works alone is exempt from the additional qualification requirements in paragraph (a), clause (2).

Subd. 15. **Mental health rehabilitation worker scope of practice.** A mental health rehabilitation worker under the treatment supervision of a mental health professional or certified rehabilitation specialist may provide rehabilitative mental health services to an adult client according to the client's treatment plan.

Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health behavioral aide must have: (1) a high school diploma or equivalent; or (2) two years of experience as a primary caregiver to a child with mental illness within the previous ten years.

(b) A level 2 mental health behavioral aide must: (1) have an associate or bachelor's degree; or (2) be certified by a program under section 256B.0943, subdivision 8a.

Subd. 17. **Mental health behavioral aide scope of practice.** While under the treatment supervision of a mental health professional, a mental health behavioral aide may practice psychosocial skills with a child client according to the child's treatment plan and individual behavior plan that a mental health professional, clinical trainee, or mental health practitioner has previously taught to the child.

Sec. 6. **[245I.05] TRAINING REQUIRED.**

Subdivision 1. **Training plan.** A license holder must develop a training plan to ensure that staff persons receive ongoing training according to this section. The training plan must include:

(1) a formal process to evaluate the training needs of each staff person. An annual performance evaluation of a staff person satisfies this requirement;

(2) a description of how the license holder conducts ongoing training of each staff person, including whether ongoing training is based on a staff person's hire date or a specified annual cycle determined by the program;

(3) a description of how the license holder verifies and documents each staff person's previous training experience. A license holder may consider a staff person to have met a training requirement in subdivision 3, paragraph (d) or (e), if the staff person has received equivalent postsecondary education in the previous four years or training experience in the previous two years; and

(4) a description of how the license holder determines when a staff person needs additional training, including when the license holder will provide additional training.

Subd. 2. **Documentation of training.** (a) The license holder must provide training to each staff person according to the training plan and must document that the license holder provided the training to each staff person. The license holder must document the following information for each staff person's training:

(1) the topics of the training;

(2) the name of the trainee;

(3) the name and credentials of the trainer;

(4) the license holder's method of evaluating the trainee's competency upon completion of training;

(5) the date of the training; and

(6) the length of training in hours and minutes.

(b) Documentation of a staff person's continuing education credit accepted by the governing health-related licensing board is sufficient to document training for purposes of this subdivision.

Subd. 3. **Initial training.** (a) A staff person must receive training about:

(1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and

(2) the maltreatment of minor reporting requirements and definitions in chapter 260E within 72 hours of first providing direct contact services to a client.

(b) Before providing direct contact services to a client, a staff person must receive training about:

(1) client rights and protections under section 245I.12;

(2) the Minnesota Health Records Act, including client confidentiality, family engagement under section 144.294, and client privacy;

(3) emergency procedures that the staff person must follow when responding to a fire, inclement weather, a report of a missing person, and a behavioral or medical emergency;

(4) specific activities and job functions for which the staff person is responsible, including the license holder's program policies and procedures applicable to the staff person's position;

(5) professional boundaries that the staff person must maintain; and

(6) specific needs of each client to whom the staff person will be providing direct contact services, including each client's developmental status, cognitive functioning, physical and mental abilities.

(c) Before providing direct contact services to a client, a mental health rehabilitation worker, mental health behavioral aide, or mental health practitioner qualified under section 245I.04, subdivision 4, must receive 30 hours of training about:

(1) mental illnesses;

(2) client recovery and resiliency;

(3) mental health de-escalation techniques;

(4) co-occurring mental illness and substance use disorders; and

(5) psychotropic medications and medication side effects.

(d) Within 90 days of first providing direct contact services to an adult client, a clinical trainee, mental health practitioner, mental health certified peer specialist, or mental health rehabilitation worker must receive training about:

(1) trauma-informed care and secondary trauma;

(2) person-centered individual treatment plans, including seeking partnerships with family and other natural supports;

(3) co-occurring substance use disorders; and

(4) culturally responsive treatment practices.

(e) Within 90 days of first providing direct contact services to a child client, a clinical trainee, mental health practitioner, mental health certified family peer specialist, mental health certified peer specialist, or mental health behavioral aide must receive training about the topics in clauses (1) to (5). This training must address the developmental characteristics of each child served by the license holder and address the needs of each child in the context of the child's family, support system, and culture. Training topics must include:

(1) trauma-informed care and secondary trauma, including adverse childhood experiences (ACEs);

(2) family-centered treatment plan development, including seeking partnership with a child client's family and other natural supports;

(3) mental illness and co-occurring substance use disorders in family systems;

(4) culturally responsive treatment practices; and

(5) child development, including cognitive functioning, and physical and mental abilities.

(f) For a mental health behavioral aide, the training under paragraph (e) must include parent team training using a curriculum approved by the commissioner.

Subd. 4. **Ongoing training.** (a) A license holder must ensure that staff persons who provide direct contact services to clients receive annual training about the topics in subdivision 3, paragraphs (a) and (b), clauses (1) to (3).

(b) A license holder must ensure that each staff person who is qualified under section 245I.04 who is not a mental health professional receives 30 hours of training every two years. The training topics must be based on the program's needs and the staff person's areas of competency.

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

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

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

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

Sec. 7. **[245I.06] TREATMENT SUPERVISION.**

Subdivision 1. **Generally.** (a) A license holder must ensure that a mental health professional or certified rehabilitation specialist provides treatment supervision to each staff person who provides services to a client and who is not a mental health professional or certified rehabilitation specialist. When providing treatment supervision, a treatment supervisor must follow a staff person's written treatment supervision plan.

(b) Treatment supervision must focus on each client's treatment needs and the ability of the staff person under treatment supervision to provide services to each client, including the following topics related to the staff person's current caseload:

(1) a review and evaluation of the interventions that the staff person delivers to each client;

(2) instruction on alternative strategies if a client is not achieving treatment goals;

(3) a review and evaluation of each client's assessments, treatment plans, and progress notes for accuracy and appropriateness;

(4) instruction on the cultural norms or values of the clients and communities that the license holder serves and the impact that a client's culture has on providing treatment;

(5) evaluation of and feedback regarding a direct service staff person's areas of competency; and

(6) coaching, teaching, and practicing skills with a staff person.

(c) A treatment supervisor must provide treatment supervision to a staff person using methods that allow for immediate feedback, including in-person, telephone, and interactive video supervision.

(d) A treatment supervisor's responsibility for a staff person receiving treatment supervision is limited to the services provided by the associated license holder. If a staff person receiving treatment supervision is employed by multiple license holders, each license holder is responsible for providing treatment supervision related to the treatment of the license holder's clients.

Subd. 2. **Treatment supervision planning.** (a) A treatment supervisor and the staff person supervised by the treatment supervisor must develop a written treatment supervision plan. The license holder must ensure that a new staff person's treatment supervision plan is completed and implemented by a treatment supervisor and the new staff person within 30 days of the new staff person's first day of employment. The license holder must review and update each staff person's treatment supervision plan annually.

(b) Each staff person's treatment supervision plan must include:

(1) the name and qualifications of the staff person receiving treatment supervision;

(2) the names and licensures of the treatment supervisors who are supervising the staff person;

(3) how frequently the treatment supervisors must provide treatment supervision to the staff person; and

(4) the staff person's authorized scope of practice, including a description of the client population that the staff person serves, and a description of the treatment methods and modalities that the staff person may use to provide services to clients.

Subd. 3. **Treatment supervision and direct observation of mental health rehabilitation workers and mental health behavioral aides.** (a) A mental health behavioral aide or a mental health rehabilitation worker must receive direct observation from a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner while the mental health behavioral aide or mental health rehabilitation worker provides treatment services to clients, no less than twice per month for the first six months of employment and once per month thereafter. The staff person performing the direct observation must approve of the progress note for the observed treatment service.

(b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work must at a minimum consist of:

(1) monthly individual supervision; and

(2) direct observation twice per month.

Sec. 8. **[245I.07] PERSONNEL FILES.**

(a) For each staff person, a license holder must maintain a personnel file that includes:

(1) verification of the staff person's qualifications required for the position including training, education, practicum or internship agreement, licensure, and any other required qualifications;

(2) documentation related to the staff person's background study;

(3) the hiring date of the staff person;

(4) a description of the staff person's job responsibilities with the license holder;

(5) the date that the staff person's specific duties and responsibilities became effective, including the date that the staff person began having direct contact with clients;

(6) documentation of the staff person's training as required by section 245I.05, subdivision 2;

(7) a verification copy of license renewals that the staff person completed during the staff person's employment;

(8) annual job performance evaluations; and

(9) if applicable, the staff person's alleged and substantiated violations of the license holder's policies under section 245I.03, subdivision 8, clauses (3) to (7), and the license holder's response.

(b) The license holder must ensure that all personnel files are readily accessible for the commissioner's review. The license holder is not required to keep personnel files in a single location.

Sec. 9. **[245I.08] DOCUMENTATION STANDARDS.**

Subdivision 1. **Generally.** A license holder must ensure that all documentation required by this chapter complies with this section.

Subd. 2. **Documentation standards.** A license holder must ensure that all documentation required by this chapter:

(1) is legible;

(2) identifies the applicable client and staff person on each page; and

(3) is signed and dated by the staff persons who provided services to the client or completed the documentation, including the staff persons' credentials.

Subd. 3. **Documenting approval.** A license holder must ensure that all diagnostic assessments, functional assessments, level of care assessments, and treatment plans completed by a clinical trainee or mental health practitioner contain documentation of approval by a treatment supervisor within five business days of initial completion by the staff person under treatment supervision.

Subd. 4. **Progress notes.** A license holder must use a progress note to document each occurrence of a mental health service that a staff person provides to a client. A progress note must include the following:

(1) the type of service;

(2) the date of service;

(3) the start and stop time of the service unless the license holder is licensed as a residential program;

(4) the location of the service;

(5) the scope of the service, including: (i) the targeted goal and objective; (ii) the intervention that the staff person provided to the client and the methods that the staff person used; (iii) the client's response to the intervention; (iv) the staff person's plan to take future actions, including changes in treatment that the staff person will implement if the intervention was ineffective; and (v) the service modality;

(6) the signature, printed name, and credentials of the staff person who provided the service to the client;

(7) the mental health provider travel documentation required by section 256B.0625, if applicable; and

(8) significant observations by the staff person, if applicable, including: (i) the client's current risk factors; (ii) emergency interventions by staff persons; (iii) consultations with or referrals to other professionals, family, or significant others; and (iv) changes in the client's mental or physical symptoms.

Subd. 5. **Medication administration record.** If a license holder administers or observes a client self-administer medications, the license holder must maintain a medication administration record for each client that contains the following, as applicable:

(1) the client's date of birth;

(2) the client's allergies;

(3) all medication orders for the client, including client-specific orders for over-the-counter medications and approved condition-specific protocols;

(4) the name of each ordered medication, date of each medication's expiration, each medication's dosage frequency, method of administration, and time;

(5) the licensed prescriber's name and telephone number;

(6) the date of initiation;

(7) the signature, printed name, and credentials of the staff person who administered the medication or observed the client self-administer the medication; and

(8) the reason that the license holder did not administer the client's prescribed medication or observe the client self-administer the client's prescribed medication.

Sec. 10. **[245I.09] CLIENT FILES.**

Subdivision 1. **Generally.** (a) A license holder must maintain a file for each client that contains the client's current and accurate records. The license holder must store each client

file on the premises where the license holder provides or coordinates services for the client. The license holder must ensure that all client files are readily accessible for the commissioner's review. The license holder is not required to keep client files in a single location.

(b) The license holder must protect client records against loss, tampering, or unauthorized disclosure of confidential client data according to the Minnesota Government Data Practices Act, chapter 13; the privacy provisions of the Minnesota health care programs provider agreement; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191; and the Minnesota Health Records Act, sections 144.291 to 144.298.

Subd. 2. **Record retention.** A license holder must retain client records of a discharged client for a minimum of five years from the date of the client's discharge. A license holder who ceases to provide treatment services to a client must retain the client's records for a minimum of five years from the date that the license holder stopped providing services to the client and must notify the commissioner of the location of the client records and the name of the individual responsible for storing and maintaining the client records.

Subd. 3. **Contents.** A license holder must retain a clear and complete record of the information that the license holder receives regarding a client, and of the services that the license holder provides to the client. If applicable, each client's file must include the following information:

(1) the client's screenings, assessments, and testing;

(2) the client's treatment plans and reviews of the client's treatment plan;

(3) the client's individual abuse prevention plans;

(4) the client's health care directive under section 145C.01, subdivision 5a, and the client's emergency contacts;

(5) the client's crisis plans;

(6) the client's consents for releases of information and documentation of the client's releases of information;

(7) the client's significant medical and health-related information;

(8) a record of each communication that a staff person has with the client's other mental health providers and persons interested in the client, including the client's case manager, family members, primary caregiver, legal representatives, court representatives, representatives from the correctional system, or school administration;

(9) written information by the client that the client requests to include in the client's file; and

(10) the date of the client's discharge from the license holder's program, the reason that the license holder discontinued services for the client, and the client's discharge summaries.

Sec. 11. **[245I.10] ASSESSMENT AND TREATMENT PLANNING.**

Subdivision 1. **Definitions.** (a) "Diagnostic formulation" means a written analysis and explanation of a client's clinical assessment to develop a hypothesis about the cause and nature of a client's presenting problems and to identify the most suitable approach for treating the client.

(b) "Responsivity factors" means the factors other than the diagnostic formulation that may modify a client's treatment needs. This includes a client's learning style, abilities, cognitive functioning, cultural background, and personal circumstances. When documenting a client's responsivity factors a mental health professional or clinical trainee must include an analysis of how a client's strengths are reflected in the license holder's plan to deliver services to the client.

Subd. 2. **Generally.** (a) A license holder must use a client's diagnostic assessment or crisis assessment to determine a client's eligibility for mental health services, except as provided in this section.

(b) Prior to completing a client's initial diagnostic assessment, a license holder may provide a client with the following services:

(1) an explanation of findings;

(2) neuropsychological testing, neuropsychological assessment, and psychological testing;

(3) any combination of psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed three sessions;

(4) crisis assessment services according to section 256B.0624; and

(5) ten days of intensive residential treatment services according to the assessment and treatment planning standards in section 245.23, subdivision 7.

(c) Based on the client's needs that a crisis assessment identifies under section 256B.0624, a license holder may provide a client with the following services:

(1) crisis intervention and stabilization services under section 245I.23 or 256B.0624; and

(2) any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization.

(d) Based on the client's needs in the client's brief diagnostic assessment, a license holder may provide a client with any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization for any new client or for an existing client who the license holder projects will need fewer than ten sessions during the next 12 months.

(e) Based on the client's needs that a hospital's medical history and presentation examination identifies, a license holder may provide a client with:

(1) any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization for any new client or for an existing client who the license holder projects will need fewer than ten sessions during the next 12 months; and

(2) up to five days of day treatment services or partial hospitalization.

(f) A license holder must complete a new standard diagnostic assessment of a client:

(1) when the client requires services of a greater number or intensity than the services that paragraphs (b) to (e) describe;

(2) at least annually following the client's initial diagnostic assessment if the client needs additional mental health services and the client does not meet the criteria for a brief assessment;

(3) when the client's mental health condition has changed markedly since the client's most recent diagnostic assessment; or

(4) when the client's current mental health condition does not meet the criteria of the client's current diagnosis.

(g) For an existing client, the license holder must ensure that a new standard diagnostic assessment includes a written update containing all significant new or changed information about the client, and an update regarding what information has not significantly changed,

including a discussion with the client about changes in the client's life situation, functioning, presenting problems, and progress with achieving treatment goals since the client's last diagnostic assessment was completed.

Subd. 3. **Continuity of services.** (a) For any client with a diagnostic assessment completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before the effective date of this section, the diagnostic assessment is valid for authorizing the client's treatment and billing for one calendar year after the date that the assessment was completed.

(b) For any client with an individual treatment plan completed under section 256B.0622, 256B.0623, 256B.0943, 256B.0946, or 256B.0947 or Minnesota Rules, parts 9505.0370 to 9505.0372, the client's treatment plan is valid for authorizing treatment and billing until the treatment plan's expiration date.

(c) This subdivision expires July 1, 2023.

Subd. 4. **Diagnostic assessment.** A client's diagnostic assessment must: (1) identify at least one mental health diagnosis for which the client meets the diagnostic criteria and recommend mental health services to develop the client's mental health services and treatment plan; or (2) include a finding that the client does not meet the criteria for a mental health disorder.

Subd. 5. **Brief diagnostic assessment; required elements.** (a) Only a mental health professional or clinical trainee may complete a brief diagnostic assessment of a client. A license holder may only use a brief diagnostic assessment for a client who is six years of age or older.

(b) When conducting a brief diagnostic assessment of a client, the assessor must complete a face-to-face interview with the client and a written evaluation of the client. The assessor must gather and document initial components of the client's standard diagnostic assessment, including the client's:

(1) age;

(2) description of symptoms, including the reason for the client's referral;

(3) history of mental health treatment;

(4) cultural influences on the client; and

(5) mental status examination.

(c) Based on the initial components of the assessment, the assessor must develop a provisional diagnostic formulation about the client. The assessor may use the client's

provisional diagnostic formulation to address the client's immediate needs and presenting problems.

(d) A mental health professional or clinical trainee may use treatment sessions with the client authorized by a brief diagnostic assessment to gather additional information about the client to complete the client's standard diagnostic assessment if the number of sessions will exceed the coverage limits in subdivision 2.

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a client and a written evaluation of the client. The assessor must complete a client's standard diagnostic assessment within the client's cultural context.

(b) When completing a standard diagnostic assessment of a client, the assessor must gather and document information about the client's current life situation, including the following information:

(1) the client's age;

(2) the client's current living situation, including the client's housing status and household members;

(3) the status of the client's basic needs;

(4) the client's education level and employment status;

(5) the client's current medications;

(6) any immediate risks to the client's health and safety;

(7) the client's perceptions of the client's condition;

(8) the client's description of the client's symptoms, including the reason for the client's referral;

(9) the client's history of mental health treatment; and

(10) cultural influences on the client.

(c) If the assessor cannot obtain the information that this subdivision requires without retraumatizing the client or harming the client's willingness to engage in treatment, the assessor must identify which topics will require further assessment during the course of the client's treatment. The assessor must gather and document information related to the following topics:

(1) the client's relationship with the client's family and other significant personal relationships, including the client's evaluation of the quality of each relationship;

(2) the client's strengths and resources, including the extent and quality of the client's social networks;

(3) important developmental incidents in the client's life;

(4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

(5) the client's history of or exposure to alcohol and drug usage and treatment; and

(6) the client's health history and the client's family health history, including the client's physical, chemical, and mental health history.

(d) When completing a standard diagnostic assessment of a client, an assessor must use a recognized diagnostic framework.

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

(2) When completing a standard diagnostic assessment of a client who is six years of age or older, the assessor must use the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(3) When completing a standard diagnostic assessment of a client who is five years of age or younger, an assessor must administer the Early Childhood Service Intensity Instrument (ECSII) to the client and include the results in the client's assessment.

(4) When completing a standard diagnostic assessment of a client who is six to 17 years of age, an assessor must administer the Child and Adolescent Service Intensity Instrument (CASII) to the client and include the results in the client's assessment.

(5) When completing a standard diagnostic assessment of a client who is 18 years of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association to screen and assess the client for a substance use disorder.

(e) When completing a standard diagnostic assessment of a client, the assessor must include and document the following components of the assessment:

(1) the client's mental status examination;

(2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client information that supports the assessor's findings after applying a recognized diagnostic framework from paragraph (d); and any differential diagnosis of the client;

(3) an explanation of: (i) how the assessor diagnosed the client using the information from the client's interview, assessment, psychological testing, and collateral information about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths; and (v) the client's responsivity factors.

(f) When completing a standard diagnostic assessment of a client, the assessor must consult the client and the client's family about which services that the client and the family prefer to treat the client. The assessor must make referrals for the client as to services required by law.

Subd. 7. **Individual treatment plan.** A license holder must follow each client's written individual treatment plan when providing services to the client with the following exceptions:

(1) services that do not require that a license holder completes a standard diagnostic assessment of a client before providing services to the client;

(2) when developing a service plan; and

(3) when a client re-engages in services under subdivision 8, paragraph (b).

Subd. 8. **Individual treatment plan; required elements.** (a) After completing a client's diagnostic assessment and before providing services to the client, the license holder must complete the client's individual treatment plan. The license holder must:

(1) base the client's individual treatment plan on the client's diagnostic assessment and baseline measurements;

(2) for a child client, use a child-centered, family-driven, and culturally appropriate planning process that allows the child's parents and guardians to observe and participate in the child's individual and family treatment services, assessments, and treatment planning;

(3) for an adult client, use a person-centered, culturally appropriate planning process that allows the client's family and other natural supports to observe and participate in the client's treatment services, assessments, and treatment planning;

(4) identify the client's treatment goals, measureable treatment objectives, a schedule for accomplishing the client's treatment goals and objectives, a treatment strategy, and the

individuals responsible for providing treatment services and supports to the client. The license holder must have a treatment strategy to engage the client in treatment if the client:

(i) has a history of not engaging in treatment; and

(ii) is ordered by a court to participate in treatment services or to take neuroleptic medications;

(5) identify the participants involved in the client's treatment planning. The client must be a participant in the client's treatment planning. If applicable, the license holder must document the reasons that the license holder did not involve the client's family or other natural supports in the client's treatment planning;

(6) review the client's individual treatment plan every 180 days and update the client's individual treatment plan with the client's treatment progress, new treatment objectives and goals or, if the client has not made treatment progress, changes in the license holder's approach to treatment; and

(7) ensure that the client approves of the client's individual treatment plan unless a court orders the client's treatment plan under chapter 253B.

(b) If the client disagrees with the client's treatment plan, the license holder must document in the client file the reasons why the client does not agree with the treatment plan. If the license holder cannot obtain the client's approval of the treatment plan, a mental health professional must make efforts to obtain approval from a person who is authorized to consent on the client's behalf within 30 days after the client's previous individual treatment plan expired. A license holder may not deny a client service during this time period solely because the license holder could not obtain the client's approval of the client's individual treatment plan. A license holder may continue to bill for the client's otherwise eligible services when the client re-engages in services.

Subd. 9. **Functional assessment; required elements.** When a license holder is completing a functional assessment for an adult client, the license holder must:

(1) complete a functional assessment of the client after completing the client's diagnostic assessment;

(2) use a collaborative process that allows the client and the client's family and other natural supports, the client's referral sources, and the client's providers to provide information about how the client's symptoms of mental illness impact the client's functioning;

(3) if applicable, document the reasons that the license holder did not contact the client's family and other natural supports;

(4) assess and document how the client's symptoms of mental illness impact the client's functioning in the following areas:

(i) the client's mental health symptoms;

(ii) the client's mental health service needs;

(iii) the client's substance use;

(iv) the client's vocational and educational functioning;

(v) the client's social functioning, including the use of leisure time;

(vi) the client's interpersonal functioning, including relationships with the client's family and other natural supports;

(vii) the client's ability to provide self-care and live independently;

(viii) the client's medical and dental health;

(ix) the client's financial assistance needs; and

(x) the client's housing and transportation needs;

(5) include a narrative summarizing the client's strengths, resources, and all areas of functional impairment;

(6) complete the client's functional assessment before the client's initial individual treatment plan unless a service specifies otherwise; and

(7) update the client's functional assessment with the client's current functioning whenever there is a significant change in the client's functioning or at least every 180 days, unless a service specifies otherwise.

Sec. 12. **[245I.11] HEALTH SERVICES AND MEDICATIONS.**

Subdivision 1. **Generally.** If a license holder is licensed as a residential program, stores or administers client medications, or observes clients self-administer medications, the license holder must ensure that a staff person who is a registered nurse or licensed prescriber is responsible for overseeing storage and administration of client medications and observing as a client self-administers medications, including training according to section 245I.05, subdivision 6, and documenting the occurrence according to section 245I.08, subdivision 5.

Subd. 2. **Health services.** If a license holder is licensed as a residential program, the license holder must:

(1) ensure that a client is screened for health issues within 72 hours of the client's admission;

(2) monitor the physical health needs of each client on an ongoing basis;

(3) offer referrals to clients and coordinate each client's care with psychiatric and medical services;

(4) identify circumstances in which a staff person must notify a registered nurse or licensed prescriber of any of a client's health concerns and the process for providing notification of client health concerns; and

(5) identify the circumstances in which the license holder must obtain medical care for a client and the process for obtaining medical care for a client.

Subd. 3. **Storing and accounting for medications.** (a) If a license holder stores client medications, the license holder must:

(1) store client medications in original containers in a locked location;

(2) store refrigerated client medications in special trays or containers that are separate from food;

(3) store client medications marked "for external use only" in a compartment that is separate from other client medications;

(4) store Schedule II to IV drugs listed in section 152.02, subdivisions 3 to 5, in a compartment that is locked separately from other medications;

(5) ensure that only authorized staff persons have access to stored client medications;

(6) follow a documentation procedure on each shift to account for all scheduled drugs; and

(7) record each incident when a staff person accepts a supply of client medications and destroy discontinued, outdated, or deteriorated client medications.

(b) If a license holder is licensed as a residential program, the license holder must allow clients who self-administer medications to keep a private medication supply. The license holder must ensure that the client stores all private medication in a locked container in the client's private living area, unless the private medication supply poses a health and safety risk to any clients. A client must not maintain a private medication supply of a prescription medication without a written medication order from a licensed prescriber and a prescription label that includes the client's name.

Subd. 4. **Medication orders.** (a) If a license holder stores, prescribes, or administers medications or observes a client self-administer medications, the license holder must:

(1) ensure that a licensed prescriber writes all orders to accept, administer, or discontinue client medications;

(2) accept nonwritten orders to administer client medications in emergency circumstances only;

(3) establish a timeline and process for obtaining a written order with the licensed prescriber's signature when the license holder accepts a nonwritten order to administer client medications;

(4) obtain prescription medication renewals from a licensed prescriber for each client every 90 days for psychotropic medications and annually for all other medications; and

(5) maintain the client's right to privacy and dignity.

(b) If a license holder employs a licensed prescriber, the license holder must inform the client about potential medication effects and side effects and obtain and document the client's informed consent before the licensed prescriber prescribes a medication.

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

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

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

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

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

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

Sec. 13. **[245I.12] CLIENT RIGHTS AND PROTECTIONS.**

Subdivision 1. **Client rights.** A license holder must ensure that all clients have the following rights:

(1) the rights listed in the health care bill of rights in section 144.651;

(2) the right to be free from discrimination based on age, race, color, creed, religion, national origin, gender, marital status, disability, sexual orientation, and status with regard to public assistance. The license holder must follow all applicable state and federal laws including the Minnesota Human Rights Act, chapter 363A; and

(3) the right to be informed prior to a photograph or audio or video recording being made of the client. The client has the right to refuse to allow any recording or photograph of the client that is not for the purposes of identification or supervision by the license holder.

Subd. 2. **Restrictions to client rights.** If the license holder restricts a client's right, the license holder must document in the client file a mental health professional's approval of the restriction and the reasons for the restriction.

Subd. 3. **Notice of rights.** The license holder must give a copy of the client's rights according to this section to each client on the day of the client's admission. The license holder must document that the license holder gave a copy of the client's rights to each client on the day of the client's admission according to this section. The license holder must post a copy of the client rights in an area visible or accessible to all clients. The license holder must include the client rights in Minnesota Rules, chapter 9544, for applicable clients.

Subd. 4. **Client property.** (a) The license holder must meet the requirements of section 245A.04, subdivision 13.

(b) If the license holder is unable to obtain a client's signature acknowledging the receipt or disbursement of the client's funds or property required by section 245A.04, subdivision 13, paragraph (c), clause (1), two staff persons must sign documentation acknowledging that the staff persons witnessed the client's receipt or disbursement of the client's funds or property.

(c) The license holder must return all of the client's funds and other property to the client except for the following items:

(1) illicit drugs, drug paraphernalia, and drug containers that are subject to forfeiture under section 609.5316. The license holder must give illicit drugs, drug paraphernalia, and drug containers to a local law enforcement agency or destroy the items; and

(2) weapons, explosives, and other property that may cause serious harm to the client or others. The license holder may give a client's weapons and explosives to a local law enforcement agency. The license holder must notify the client that a local law enforcement agency has the client's property and that the client has the right to reclaim the property if the client has a legal right to possess the item.

(d) If a client leaves the license holder's program but abandons the client's funds or property, the license holder must retain and store the client's funds or property, including medications, for a minimum of 30 days after the client's discharge from the program.

Subd. 5. **Client grievances.** (a) The license holder must have a grievance procedure that:

(1) describes to clients how the license holder will meet the requirements in this subdivision; and

(2) contains the current public contact information of the Department of Human Services, Licensing Division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Department of Health, Office of Health Facilities Complaints; and all applicable health-related licensing boards.

(b) On the day of each client's admission, the license holder must explain the grievance procedure to the client.

(c) The license holder must:

(1) post the grievance procedure in a place visible to clients and provide a copy of the grievance procedure upon request;

(2) allow clients, former clients, and their authorized representatives to submit a grievance to the license holder;

(3) within three business days of receiving a client's grievance, acknowledge in writing that the license holder received the client's grievance. If applicable, the license holder must include a notice of the client's separate appeal rights for a managed care organization's reduction, termination, or denial of a covered service;

(4) within 15 business days of receiving a client's grievance, provide a written final response to the client's grievance containing the license holder's official response to the grievance; and

(5) allow the client to bring a grievance to the person with the highest level of authority in the program.

Sec. 14. **[245I.13] CRITICAL INCIDENTS.**

If a license holder is licensed as a residential program, the license holder must report all critical incidents to the commissioner within ten days of learning of the incident on a form approved by the commissioner. The license holder must keep a record of critical incidents in a central location that is readily accessible to the commissioner for review upon the commissioner's request for a minimum of two licensing periods.

Sec. 15. **[245I.20] MENTAL HEALTH CLINIC.**

Subdivision 1. **Purpose.** Certified mental health clinics provide clinical services for the treatment of mental illnesses with a treatment team that reflects multiple disciplines and areas of expertise.

Subd. 2. **Definitions.** (a) "Clinical services" means services provided to a client to diagnose, describe, predict, and explain the client's status relative to a condition or problem as described in the: (1) current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or (2) current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three. Where necessary, clinical services includes services to treat a client to reduce the client's impairment due to the client's condition. Clinical services also includes individual treatment planning, case review, record-keeping required for a client's treatment, and treatment supervision. For the purposes of this section, clinical services excludes services delivered to a client under a separate license and services listed under section 245I.011, subdivision 5.

(b) "Competent" means having professional education, training, continuing education, consultation, supervision, experience, or a combination thereof necessary to demonstrate sufficient knowledge of and proficiency in a specific clinical service.

(c) "Discipline" means a branch of professional knowledge or skill acquired through a specific course of study, training, and supervised practice. Discipline is usually documented by a specific educational degree, licensure, or certification of proficiency. Examples of the

mental health disciplines include but are not limited to psychiatry, psychology, clinical social work, marriage and family therapy, clinical counseling, and psychiatric nursing.

(d) "Treatment team" means the mental health professionals, mental health practitioners, and clinical trainees who provide clinical services to clients.

Subd. 3. **Organizational structure.** (a) A mental health clinic location must be an entire facility or a clearly identified unit within a facility that is administratively and clinically separate from the rest of the facility. The mental health clinic location may provide services other than clinical services to clients, including medical services, substance use disorder services, social services, training, and education.

(b) The certification holder must notify the commissioner of all mental health clinic locations. If there is more than one mental health clinic location, the certification holder must designate one location as the main location and all of the other locations as satellite locations. The main location as a unit and the clinic as a whole must comply with the minimum staffing standards in subdivision 4.

(c) The certification holder must ensure that each satellite location:

(1) adheres to the same policies and procedures as the main location;

(2) provides treatment team members with face-to-face or telephone access to a mental health professional for the purposes of supervision whenever the satellite location is open. The certification holder must maintain a schedule of the mental health professionals who will be available and the contact information for each available mental health professional. The schedule must be current and readily available to treatment team members; and

(3) enables clients to access all of the mental health clinic's clinical services and treatment team members, as needed.

Subd. 4. **Minimum staffing standards.** (a) A certification holder's treatment team must consist of at least four mental health professionals. At least two of the mental health professionals must be employed by or under contract with the mental health clinic for a minimum of 35 hours per week each. Each of the two mental health professionals must specialize in a different mental health discipline.

(b) The treatment team must include:

(1) a physician qualified as a mental health professional according to section 245I.04, subdivision 2, clause (4), or a nurse qualified as a mental health professional according to section 245I.04, subdivision 2, clause (1); and

(2) a psychologist qualified as a mental health professional according to section 245I.04, subdivision 2, clause (3).

(c) The staff persons fulfilling the requirement in paragraph (b) must provide clinical services at least:

(1) eight hours every two weeks if the mental health clinic has over 25.0 full-time equivalent treatment team members;

(2) eight hours each month if the mental health clinic has 15.1 to 25.0 full-time equivalent treatment team members;

(3) four hours each month if the mental health clinic has 5.1 to 15.0 full-time equivalent treatment team members; or

(4) two hours each month if the mental health clinic has 2.0 to 5.0 full-time equivalent treatment team members or only provides in-home services to clients.

(d) The certification holder must maintain a record that demonstrates compliance with this subdivision.

Subd. 5. **Treatment supervision specified.** (a) A mental health professional must remain responsible for each client's case. The certification holder must document the name of the mental health professional responsible for each case and the dates that the mental health professional is responsible for the client's case from beginning date to end date. The certification holder must assign each client's case for assessment, diagnosis, and treatment services to a treatment team member who is competent in the assigned clinical service, the recommended treatment strategy, and in treating the client's characteristics.

(b) Treatment supervision of mental health practitioners and clinical trainees required by section 245I.06 must include case reviews as described in this paragraph. Every two months, a mental health professional must complete a case review of each client assigned to the mental health professional when the client is receiving clinical services from a mental health practitioner or clinical trainee. The case review must include a consultation process that thoroughly examines the client's condition and treatment, including: (1) a review of the client's reason for seeking treatment, diagnoses and assessments, and the individual treatment plan; (2) a review of the appropriateness, duration, and outcome of treatment provided to the client; and (3) treatment recommendations.

Subd. 6. **Additional policy and procedure requirements.** (a) In addition to the policies and procedures required by section 245I.03, the certification holder must establish, enforce, and maintain the policies and procedures required by this subdivision.

(b) The certification holder must have a clinical evaluation procedure to identify and document each treatment team member's areas of competence.

(c) The certification holder must have policies and procedures for client intake and case assignment that:

(1) outline the client intake process;

(2) describe how the mental health clinic determines the appropriateness of accepting a client into treatment by reviewing the client's condition and need for treatment, the clinical services that the mental health clinic offers to clients, and other available resources; and

(3) contain a process for assigning a client's case to a mental health professional who is responsible for the client's case and other treatment team members.

Subd. 7. **Referrals.** If necessary treatment for a client or treatment desired by a client is not available at the mental health clinic, the certification holder must facilitate appropriate referrals for the client. When making a referral for a client, the treatment team member must document a discussion with the client that includes: (1) the reason for the client's referral; (2) potential treatment resources for the client; and (3) the client's response to receiving a referral.

Subd. 8. **Emergency service.** For the certification holder's telephone numbers that clients regularly access, the certification holder must include the contact information for the area's mental health crisis services as part of the certification holder's message when a live operator is not available to answer clients' calls.

Subd. 9. **Quality assurance and improvement plan.** (a) At a minimum, a certification holder must develop a written quality assurance and improvement plan that includes a plan for:

(1) encouraging ongoing consultation among members of the treatment team;

(2) obtaining and evaluating feedback about services from clients, family and other natural supports, referral sources, and staff persons;

(3) measuring and evaluating client outcomes;

(4) reviewing client suicide deaths and suicide attempts;

(5) examining the quality of clinical service delivery to clients; and

(6) self-monitoring of compliance with this chapter.

(b) At least annually, the certification holder must review, evaluate, and update the quality assurance and improvement plan. The review must: (1) include documentation of the actions that the certification holder will take as a result of information obtained from monitoring activities in the plan; and (2) establish goals for improved service delivery to clients for the next year.

Subd. 10. **Application procedures.** (a) The applicant for certification must submit any documents that the commissioner requires on forms approved by the commissioner.

(b) Upon submitting an application for certification, an applicant must pay the application fee required by section 245A.10, subdivision 3.

(c) The commissioner must act on an application within 90 working days of receiving a completed application.

(d) When the commissioner receives an application for initial certification that is incomplete because the applicant failed to submit required documents or is deficient because the submitted documents do not meet certification requirements, the commissioner must provide the applicant with written notice that the application is incomplete or deficient. In the notice, the commissioner must identify the particular documents that are missing or deficient and give the applicant 45 days to submit a second application that is complete. An applicant's failure to submit a complete application within 45 days after receiving notice from the commissioner is a basis for certification denial.

(e) The commissioner must give notice of a denial to an applicant when the commissioner has made the decision to deny the certification application. In the notice of denial, the commissioner must state the reasons for the denial in plain language. The commissioner must send or deliver the notice of denial to an applicant by certified mail or personal service. In the notice of denial, the commissioner must state the reasons that the commissioner denied the application and must inform the applicant of the applicant's right to request a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an applicant delivers an appeal by personal service, the commissioner must receive the appeal within 20 calendar days after the applicant received the notice of denial.

Subd. 11. **Commissioner's right of access.** (a) When the commissioner is exercising the powers conferred to the commissioner by this chapter, if the mental health clinic is in

operation and the information is relevant to the commissioner's inspection or investigation, the certification holder must provide the commissioner access to:

(1) the physical facility and grounds where the program is located;

(2) documentation and records, including electronically maintained records;

(3) clients served by the mental health clinic;

(4) staff persons of the mental health clinic; and

(5) personnel records of current and former staff of the mental health clinic.

(b) The certification holder must provide the commissioner with access to the facility and grounds, documentation and records, clients, and staff without prior notice and as often as the commissioner considers necessary if the commissioner is investigating alleged maltreatment or a violation of a law or rule, or conducting an inspection. When conducting an inspection, the commissioner may request and must receive assistance from other state, county, and municipal governmental agencies and departments. The applicant or certification holder must allow the commissioner, at the commissioner's expense, to photocopy, photograph, and make audio and video recordings during an inspection.

Subd. 12. **Monitoring and inspections.** (a) The commissioner may conduct a certification review of the certified mental health clinic every two years to determine the certification holder's compliance with applicable rules and statutes.

(b) The commissioner must offer the certification holder a choice of dates for an announced certification review. A certification review must occur during the clinic's normal working hours.

(c) The commissioner must make the results of certification reviews and investigations publicly available on the department's website.

Subd. 13. **Correction orders.** (a) If the applicant or certification holder fails to comply with a law or rule, the commissioner may issue a correction order. The correction order must state:

(1) the condition that constitutes a violation of the law or rule;

(2) the specific law or rule that the applicant or certification holder has violated; and

(3) the time that the applicant or certification holder is allowed to correct each violation.

(b) If the applicant or certification holder believes that the commissioner's correction order is erroneous, the applicant or certification holder may ask the commissioner to

reconsider the part of the correction order that is allegedly erroneous. An applicant or certification holder must make a request for reconsideration in writing. The request must be postmarked and sent to the commissioner within 20 calendar days after the applicant or certification holder received the correction order; and the request must:

(1) specify the part of the correction order that is allegedly erroneous;

(2) explain why the specified part is erroneous; and

(3) include documentation to support the allegation of error.

(c) A request for reconsideration does not stay any provision or requirement of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal.

(d) If the commissioner finds that the applicant or certification holder failed to correct the violation specified in the correction order, the commissioner may decertify the certified mental health clinic according to subdivision 14.

(e) Nothing in this subdivision prohibits the commissioner from decertifying a mental health clinic according to subdivision 14.

Subd. 14. **Decertification.** (a) The commissioner may decertify a mental health clinic if a certification holder:

(1) failed to comply with an applicable law or rule; or

(2) knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for certification, during an investigation, or regarding compliance with applicable laws or rules.

(b) When considering decertification of a mental health clinic, the commissioner must consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of clients.

(c) If the commissioner decertifies a mental health clinic, the order of decertification must inform the certification holder of the right to have a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The certification holder may appeal the decertification. The certification holder must appeal a decertification in writing and send or deliver the appeal to the commissioner by certified mail or personal service. If the certification holder mails the appeal, the appeal must be postmarked and sent to the commissioner within ten calendar days after the certification holder receives the order of decertification. If the certification holder delivers an appeal by personal service, the

commissioner must receive the appeal within ten calendar days after the certification holder received the order. If a certification holder submits a timely appeal of an order of decertification, the certification holder may continue to operate the program until the commissioner issues a final order on the decertification.

(d) If the commissioner decertifies a mental health clinic pursuant to paragraph (a), clause (1), based on a determination that the mental health clinic was responsible for maltreatment, and if the certification holder appeals the decertification according to paragraph (c), and appeals the maltreatment determination under section 260E.33, the final decertification determination is stayed until the commissioner issues a final decision regarding the maltreatment appeal.

Subd. 15. **Transfer prohibited.** A certification issued under this section is only valid for the premises and the individual, organization, or government entity identified by the commissioner on the certification. A certification is not transferable or assignable.

Subd. 16. **Notifications required and noncompliance.** (a) A certification holder must notify the commissioner, in a manner prescribed by the commissioner, and obtain the commissioner's approval before making any change to the name of the certification holder or the location of the mental health clinic.

(b) Changes in mental health clinic organization, staffing, treatment, or quality assurance procedures that affect the ability of the certification holder to comply with the minimum standards of this section must be reported in writing by the certification holder to the commissioner within 15 days of the occurrence. Review of the change must be conducted by the commissioner. A certification holder with changes resulting in noncompliance in minimum standards must receive written notice and may have up to 180 days to correct the areas of noncompliance before being decertified. Interim procedures to resolve the noncompliance on a temporary basis must be developed and submitted in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. Not reporting an occurrence of a change that results in noncompliance within 15 days, failure to develop an approved interim procedure within 30 days of the determination of the noncompliance, or nonresolution of the noncompliance within 180 days will result in immediate decertification.

(c) The mental health clinic may be required to submit written information to the department to document that the mental health clinic has maintained compliance with this section and mental health clinic procedures.

Sec. 16. **[245I.23] INTENSIVE RESIDENTIAL TREATMENT SERVICES AND RESIDENTIAL CRISIS STABILIZATION.**

Subdivision 1. **Purpose.** (a) Intensive residential treatment services is a community-based medically monitored level of care for an adult client that uses established rehabilitative principles to promote a client's recovery and to develop and achieve psychiatric stability, personal and emotional adjustment, self-sufficiency, and other skills that help a client transition to a more independent setting.

(b) Residential crisis stabilization provides structure and support to an adult client in a community living environment when a client has experienced a mental health crisis and needs short-term services to ensure that the client can safely return to the client's home or precrisis living environment with additional services and supports identified in the client's crisis assessment.

Subd. 2. **Definitions.** (a) "Program location" means a set of rooms that are each physically self-contained and have defining walls extending from floor to ceiling. Program location includes bedrooms, living rooms or lounge areas, bathrooms, and connecting areas.

(b) "Treatment team" means a group of staff persons who provide intensive residential treatment services or residential crisis stabilization to clients. The treatment team includes mental health professionals, mental health practitioners, clinical trainees, certified rehabilitation specialists, mental health rehabilitation workers, and mental health certified peer specialists.

Subd. 3. **Treatment services description.** The license holder must describe in writing all treatment services that the license holder provides. The license holder must have the description readily available for the commissioner upon the commissioner's request.

Subd. 4. **Required intensive residential treatment services.** (a) On a daily basis, the license holder must follow a client's treatment plan to provide intensive residential treatment services to the client to improve the client's functioning.

(b) The license holder must offer and have the capacity to directly provide the following treatment services to each client:

(1) rehabilitative mental health services;

(2) crisis prevention planning to assist a client with:

(i) identifying and addressing patterns in the client's history and experience of the client's mental illness; and

(ii) developing crisis prevention strategies that include de-escalation strategies that have been effective for the client in the past;

(3) health services and administering medication;

(4) co-occurring substance use disorder treatment;

(5) engaging the client's family and other natural supports in the client's treatment and educating the client's family and other natural supports to strengthen the client's social and family relationships; and

(6) making referrals for the client to other service providers in the community and supporting the client's transition from intensive residential treatment services to another setting.

(c) The license holder must include Illness Management and Recovery (IMR), Enhanced Illness Management and Recovery (E-IMR), or other similar interventions in the license holder's programming as approved by the commissioner.

Subd. 5. **Required residential crisis stabilization services.** (a) On a daily basis, the license holder must follow a client's individual crisis treatment plan to provide services to the client in residential crisis stabilization to improve the client's functioning.

(b) The license holder must offer and have the capacity to directly provide the following treatment services to the client:

(1) crisis stabilization services as described in section 256B.0624, subdivision 7;

(2) rehabilitative mental health services;

(3) health services and administering the client's medications; and

(4) making referrals for the client to other service providers in the community and supporting the client's transition from residential crisis stabilization to another setting.

Subd. 6. **Optional treatment services.** (a) If the license holder offers additional treatment services to a client, the treatment service must be:

(1) approved by the commissioner; and

(2)(i) a mental health evidence-based practice that the federal Department of Health and Human Services Substance Abuse and Mental Health Service Administration has adopted;

(ii) a nationally recognized mental health service that substantial research has validated as effective in helping individuals with serious mental illness achieve treatment goals; or

(iii) developed under state-sponsored research of publicly funded mental health programs and validated to be effective for individuals, families, and communities.

(b) Before providing an optional treatment service to a client, the license holder must provide adequate training to a staff person about providing the optional treatment service to a client.

Subd. 7. **Intensive residential treatment services assessment and treatment planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate and document the client's immediate needs, including the client's:

(1) health and safety, including the client's need for crisis assistance;

(2) responsibilities for children, family and other natural supports, and employers; and

(3) housing and legal issues.

(b) Within 24 hours of the client's admission, the license holder must complete an initial treatment plan for the client. The license holder must:

(1) base the client's initial treatment plan on the client's referral information and an assessment of the client's immediate needs;

(2) consider crisis assistance strategies that have been effective for the client in the past;

(3) identify the client's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the client engage in treatment;

(4) identify the participants involved in the client's treatment planning. The client must be a participant; and

(5) ensure that a treatment supervisor approves of the client's initial treatment plan if a mental health practitioner or clinical trainee completes the client's treatment plan, notwithstanding section 245I.08, subdivision 3.

(c) According to section 245A.65, subdivision 2, paragraph (b), the license holder must complete an individual abuse prevention plan as part of a client's initial treatment plan.

(d) Within five days of the client's admission and again within 60 days after the client's admission, the license holder must complete a level of care assessment of the client. If the license holder determines that a client does not need a medically monitored level of service, a treatment supervisor must document how the client's admission to and continued services in intensive residential treatment services are medically necessary for the client.

(e) Within ten days of a client's admission, the license holder must complete or review and update the client's standard diagnostic assessment.

(f) Within ten days of a client's admission, the license holder must complete the client's individual treatment plan, notwithstanding section 245I.10, subdivision 8. Within 40 days after the client's admission and again within 70 days after the client's admission, the license holder must update the client's individual treatment plan. The license holder must focus the client's treatment planning on preparing the client for a successful transition from intensive residential treatment services to another setting. In addition to the required elements of an individual treatment plan under section 245I.10, subdivision 8, the license holder must identify the following information in the client's individual treatment plan: (1) the client's referrals and resources for the client's health and safety; and (2) the staff persons who are responsible for following up with the client's referrals and resources. If the client does not receive a referral or resource that the client needs, the license holder must document the reason that the license holder did not make the referral or did not connect the client to a particular resource. The license holder is responsible for determining whether additional follow-up is required on behalf of the client.

(g) Within 30 days of the client's admission, the license holder must complete a functional assessment of the client. Within 60 days after the client's admission, the license holder must update the client's functional assessment to include any changes in the client's functioning and symptoms.

(h) For a client with a current substance use disorder diagnosis and for a client whose substance use disorder screening in the client's standard diagnostic assessment indicates the possibility that the client has a substance use disorder, the license holder must complete a written assessment of the client's substance use within 30 days of the client's admission. In the substance use assessment, the license holder must: (1) evaluate the client's history of substance use, relapses, and hospitalizations related to substance use; (2) assess the effects of the client's substance use on the client's relationships including with family member and others; (3) identify financial problems, health issues, housing instability, and unemployment; (4) assess the client's legal problems, past and pending incarceration, violence, and victimization; and (5) evaluate the client's suicide attempts, noncompliance with taking prescribed medications, and noncompliance with psychosocial treatment.

(i) On a weekly basis, a mental health professional or certified rehabilitation specialist must review each client's treatment plan and individual abuse prevention plan. The license holder must document in the client's file each weekly review of the client's treatment plan and individual abuse prevention plan.

Subd. 8. **Residential crisis stabilization assessment and treatment planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate the client and document the client's immediate needs, including the client's:

(1) health and safety, including the client's need for crisis assistance;

(2) responsibilities for children, family and other natural supports, and employers; and

(3) housing and legal issues.

(b) Within 24 hours of a client's admission, the license holder must complete a crisis treatment plan for the client under section 256B.0624, subdivision 11. The license holder must base the client's crisis treatment plan on the client's referral information and an assessment of the client's immediate needs.

(c) Section 245A.65, subdivision 2, paragraph (b), requires the license holder to complete an individual abuse prevention plan for a client as part of the client's crisis treatment plan.

Subd. 9. **Key staff positions.** (a) The license holder must have a staff person assigned to each of the following key staff positions at all times:

(1) a program director who qualifies as a mental health practitioner. The license holder must designate the program director as responsible for all aspects of the operation of the program and the program's compliance with all applicable requirements. The program director must know and understand the implications of this chapter; chapters 245A, 245C, and 260E; sections 626.557 and 626.5572; Minnesota Rules, chapter 9544; and all other applicable requirements. The license holder must document in the program director's personnel file how the program director demonstrates knowledge of these requirements. The program director may also serve as the treatment director of the program, if qualified;

(2) a treatment director who qualifies as a mental health professional. The treatment director must be responsible for overseeing treatment services for clients and the treatment supervision of all staff persons; and

(3) a registered nurse who qualifies as a mental health practitioner. The registered nurse must:

(i) work at the program location a minimum of eight hours per week;

(ii) provide monitoring and supervision of staff persons as defined in section 148.171, subdivisions 8a and 23;

(iii) be responsible for the review and approval of health service and medication policies and procedures under section 245I.03, subdivision 5; and

(iv) oversee the license holder's provision of health services to clients, medication storage, and medication administration to clients.

(b) Within five business days of a change in a key staff position, the license holder must notify the commissioner of the staffing change. The license holder must notify the commissioner of the staffing change on a form approved by the commissioner and include the name of the staff person now assigned to the key staff position and the staff person's qualifications.

Subd. 10. **Minimum treatment team staffing levels and ratios.** (a) The license holder must maintain a treatment team staffing level sufficient to:

(1) provide continuous daily coverage of all shifts;

(2) follow each client's treatment plan and meet each client's needs as identified in the client's treatment plan;

(3) implement program requirements; and

(4) safely monitor and guide the activities of each client, taking into account the client's level of behavioral and psychiatric stability, cultural needs, and vulnerabilities.

(b) The license holder must ensure that treatment team members:

(1) remain awake during all work hours; and

(2) are available to monitor and guide the activities of each client whenever clients are present in the program.

(c) On each shift, the license holder must maintain a treatment team staffing ratio of at least one treatment team member to nine clients. If the license holder is serving nine or fewer clients, at least one treatment team member on the day shift must be a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner. If the license holder is serving more than nine clients, at least one of the treatment team members working during both the day and evening shifts must be a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.

(d) If the license holder provides residential crisis stabilization to clients and is serving at least one client in residential crisis stabilization and more than four clients in residential crisis stabilization and intensive residential treatment services, the license holder must maintain a treatment team staffing ratio on each shift of at least two treatment team members during the client's first 48 hours in residential crisis stabilization.

Subd. 11. **Shift exchange.** A license holder must ensure that treatment team members working on different shifts exchange information about a client as necessary to effectively care for the client and to follow and update a client's treatment plan and individual abuse prevention plan.

Subd. 12. **Daily documentation.** (a) For each day that a client is present in the program, the license holder must provide a daily summary in the client's file that includes observations about the client's behavior and symptoms, including any critical incidents in which the client was involved.

(b) For each day that a client is not present in the program, the license holder must document the reason for a client's absence in the client's file.

Subd. 13. **Access to a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.** Treatment team members must have access in person or by telephone to a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner within 30 minutes. The license holder must maintain a schedule of mental health professionals, clinical trainees, certified rehabilitation specialists, or mental health practitioners who will be available and contact information to reach them. The license holder must keep the schedule current and make the schedule readily available to treatment team members.

Subd. 14. **Weekly team meetings.** (a) The license holder must hold weekly team meetings and ancillary meetings according to this subdivision.

(b) A mental health professional or certified rehabilitation specialist must hold at least one team meeting each calendar week and be physically present at the team meeting. All treatment team members, including treatment team members who work on a part-time or intermittent basis, must participate in a minimum of one team meeting during each calendar week when the treatment team member is working for the license holder. The license holder must document all weekly team meetings, including the names of meeting attendees.

(c) If a treatment team member cannot participate in a weekly team meeting, the treatment team member must participate in an ancillary meeting. A mental health professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner who participated in the most recent weekly team meeting may lead the ancillary meeting. During the ancillary meeting, the treatment team member leading the ancillary meeting must review the information that was shared at the most recent weekly team meeting, including revisions to client treatment plans and other information that the treatment supervisors exchanged

with treatment team members. The license holder must document all ancillary meetings, including the names of meeting attendees.

Subd. 15. **Intensive residential treatment services admission criteria.** (a) An eligible client for intensive residential treatment services is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a mental illness;

(3) because of a mental illness, has a substantial disability and functional impairment in three or more areas listed in section 245I.10, subdivision 9, clause (4), that markedly reduce the individual's self-sufficiency;

(4) has one or more of the following: a history of recurring or prolonged inpatient hospitalizations during the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services with poor outcomes for the individual; and

(5) in the written opinion of a mental health professional, needs mental health services that available community-based services cannot provide, or is likely to experience a mental health crisis or require a more restrictive setting if the individual does not receive intensive rehabilitative mental health services.

(b) The license holder must not limit or restrict intensive residential treatment services to a client based solely on:

(1) the client's substance use;

(2) the county in which the client resides; or

(3) whether the client elects to receive other services for which the client may be eligible, including case management services.

(c) This subdivision does not prohibit the license holder from restricting admissions of individuals who present an imminent risk of harm or danger to themselves or others.

Subd. 16. **Residential crisis stabilization services admission criteria.** An eligible client for residential crisis stabilization is an individual who is age 18 or older and meets the eligibility criteria in section 256B.0624, subdivision 3.

Subd. 17. **Admissions referrals and determinations.** (a) The license holder must identify the information that the license holder needs to make a determination about a person's admission referral.

(b) The license holder must:

(1) always be available to receive referral information about a person seeking admission to the license holder's program;

(2) respond to the referral source within eight hours of receiving a referral and, within eight hours, communicate with the referral source about what information the license holder needs to make a determination concerning the person's admission;

(3) consider the license holder's staffing ratio and the areas of treatment team members' competency when determining whether the license holder is able to meet the needs of a person seeking admission; and

(4) determine whether to admit a person within 72 hours of receiving all necessary information from the referral source.

Subd. 18. **Discharge standards.** (a) When a license holder discharges a client from a program, the license holder must categorize the discharge as a successful discharge, program-initiated discharge, or non-program-initiated discharge according to the criteria in this subdivision. The license holder must meet the standards associated with the type of discharge according to this subdivision.

(b) To successfully discharge a client from a program, the license holder must ensure that the following criteria are met:

(1) the client must substantially meet the client's documented treatment plan goals and objectives;

(2) the client must complete discharge planning with the treatment team; and

(3) the client and treatment team must arrange for the client to receive continuing care at a less intensive level of care after discharge.

(c) Prior to successfully discharging a client from a program, the license holder must complete the client's discharge summary and provide the client with a copy of the client's discharge summary in plain language that includes:

(1) a brief review of the client's problems and strengths during the period that the license holder provided services to the client;

(2) the client's response to the client's treatment plan;

(3) the goals and objectives that the license holder recommends that the client addresses during the first three months following the client's discharge from the program;

(4) the recommended actions, supports, and services that will assist the client with a successful transition from the program to another setting;

(5) the client's crisis plan; and

(6) the client's forwarding address and telephone number.

(d) For a non-program-initiated discharge of a client from a program, the following criteria must be met:

(1)(i) the client has withdrawn the client's consent for treatment; (ii) the license holder has determined that the client has the capacity to make an informed decision; and (iii) the client does not meet the criteria for an emergency hold under section 253B.051, subdivision 2;

(2) the client has left the program against staff person advice;

(3) an entity with legal authority to remove the client has decided to remove the client from the program; or

(4) a source of payment for the services is no longer available.

(e) Within ten days of a non-program-initiated discharge of a client from a program, the license holder must complete the client's discharge summary in plain language that includes:

(1) the reasons for the client's discharge;

(2) a description of attempts by staff persons to enable the client to continue treatment or to consent to treatment; and

(3) recommended actions, supports, and services that will assist the client with a successful transition from the program to another setting.

(f) For a program-initiated discharge of a client from a program, the following criteria must be met:

(1) the client is competent but has not participated in treatment or has not followed the program rules and regulations and the client has not participated to such a degree that the program's level of care is ineffective or unsafe for the client, despite multiple, documented attempts that the license holder has made to address the client's lack of participation in treatment;

(2) the client has not made progress toward the client's treatment goals and objectives despite the license holder's persistent efforts to engage the client in treatment, and the license holder has no reasonable expectation that the client will make progress at the program's

level of care nor does the client require the program's level of care to maintain the current level of functioning;

(3) a court order or the client's legal status requires the client to participate in the program but the client has left the program against staff person advice; or

(4) the client meets criteria for a more intensive level of care and a more intensive level of care is available to the client.

(g) Prior to a program-initiated discharge of a client from a program, the license holder must consult the client, the client's family and other natural supports, and the client's case manager, if applicable, to review the issues involved in the program's decision to discharge the client from the program. During the discharge review process, which must not exceed five working days, the license holder must determine whether the license holder, treatment team, and any interested persons can develop additional strategies to resolve the issues leading to the client's discharge and to permit the client to have an opportunity to continue receiving services from the license holder. The license holder may temporarily remove a client from the program facility during the five-day discharge review period. The license holder must document the client's discharge review in the client's file.

(h) Prior to a program-initiated discharge of a client from the program, the license holder must complete the client's discharge summary and provide the client with a copy of the discharge summary in plain language that includes:

(1) the reasons for the client's discharge;

(2) the alternatives to discharge that the license holder considered or attempted to implement;

(3) the names of each individual who is involved in the decision to discharge the client and a description of each individual's involvement; and

(4) recommended actions, supports, and services that will assist the client with a successful transition from the program to another setting.

Subd. 19. **Program facility.** (a) The license holder must be licensed or certified as a board and lodging facility, supervised living facility, or a boarding care home by the Department of Health.

(b) The license holder must have a capacity of five to 16 beds and the program must not be declared as an institution for mental disease.

(c) The license holder must furnish each program location to meet the psychological, emotional, and developmental needs of clients.

(d) The license holder must provide one living room or lounge area per program location. There must be space available to provide services according to each client's treatment plan, such as an area for learning recreation time skills and areas for learning independent living skills, such as laundering clothes and preparing meals.

(e) The license holder must ensure that each program location allows each client to have privacy. Each client must have privacy during assessment interviews and counseling sessions. Each client must have a space designated for the client to see outside visitors at the program facility.

Subd. 20. **Physical separation of services.** If the license holder offers services to individuals who are not receiving intensive residential treatment services or residential stabilization at the program location, the license holder must inform the commissioner and submit a plan for approval to the commissioner about how and when the license holder will provide services. The license holder must only provide services to clients who are not receiving intensive residential treatment services or residential crisis stabilization in an area that is physically separated from the area in which the license holder provides clients with intensive residential treatment services or residential crisis stabilization.

Subd. 21. **Dividing staff time between locations.** A license holder must obtain approval from the commissioner prior to providing intensive residential treatment services or residential crisis stabilization to clients in more than one program location under one license and dividing one staff person's time between program locations during the same work period.

Subd. 22. **Additional policy and procedure requirements.** (a) In addition to the policies and procedures in section 245I.03, the license holder must establish, enforce, and maintain the policies and procedures in this subdivision.

(b) The license holder must have policies and procedures for receiving referrals and making admissions determinations about referred persons under subdivisions 14 to 16.

(c) The license holder must have policies and procedures for discharging clients under subdivision 17. In the policies and procedures, the license holder must identify the staff persons who are authorized to discharge clients from the program.

Subd. 23. **Quality assurance and improvement plan.** (a) A license holder must develop a written quality assurance and improvement plan that includes a plan to:

(1) encourage ongoing consultation between members of the treatment team;

(2) obtain and evaluate feedback about services from clients, family and other natural supports, referral sources, and staff persons;

(3) measure and evaluate client outcomes in the program;

(4) review critical incidents in the program;

(5) examine the quality of clinical services in the program; and

(6) self-monitor the license holder's compliance with this chapter.

(b) At least annually, the license holder must review, evaluate, and update the license holder's quality assurance and improvement plan. The license holder's review must:

(1) document the actions that the license holder will take in response to the information that the license holder obtains from the monitoring activities in the plan; and

(2) establish goals for improving the license holder's services to clients during the next year.

Subd. 24. **Application.** When an applicant requests licensure to provide intensive residential treatment services, residential crisis stabilization, or both to clients, the applicant must submit, on forms that the commissioner provides, any documents that the commissioner requires.

Sec. 17. **[256B.0671] COVERED MENTAL HEALTH SERVICES.**

Subdivision 1. **Definitions.** (a) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(b) "Mental health practitioner" means a staff person who is qualified under section 245I.04, subdivision 4.

(c) "Mental health professional" means a staff person who is qualified under section 245I.04, subdivision 2.

Subd. 2. **Generally.** (a) An individual, organization, or government entity providing mental health services to a client under this section must obtain a criminal background study of each staff person or volunteer who is providing direct contact services to a client.

(b) An individual, organization, or government entity providing mental health services to a client under this section must comply with all responsibilities that chapter 245I assigns to a license holder, except section 245I.011, subdivision 1, unless all of the individual's, organization's, or government entity's treatment staff are qualified as mental health professionals.

(c) An individual, organization, or government entity providing mental health services to a client under this section must comply with the following requirements if all of the license holder's treatment staff are qualified as mental health professionals:

(1) provider qualifications and scopes of practice under section 245I.04;

(2) maintaining and updating personnel files under section 245I.07;

(3) documenting under section 245I.08;

(4) maintaining and updating client files under section 245I.09;

(5) completing client assessments and treatment planning under section 245I.10;

(6) providing clients with health services and medications under section 245I.11; and

(7) respecting and enforcing client rights under section 245I.12.

Subd. 3. **Adult day treatment services.** (a) Subject to federal approval, medical assistance covers adult day treatment (ADT) services that are provided under contract with the county board. Adult day treatment payment is subject to the conditions in paragraphs (b) to (e). The provider must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments, protocols, and forms approved by the commissioner.

(b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve the effects of mental illness on a client to enable the client to benefit from a lower level of care and to live and function more independently in the community. Adult day treatment services must be provided to a client to stabilize the client's mental health and to improve the client's independent living and socialization skills. Adult day treatment must consist of at least one hour of group psychotherapy and must include group time focused on rehabilitative interventions or other therapeutic services that a multidisciplinary team provides to each client. Adult day treatment services are not a part of inpatient or residential treatment services. The following providers may apply to become adult day treatment providers:

(1) a hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 256B.0625, subdivision 5; or

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475.

(c) An adult day treatment (ADT) services provider must:

(1) ensure that the commissioner has approved of the organization as an adult day treatment provider organization;

(2) ensure that a multidisciplinary team provides ADT services to a group of clients. A mental health professional must supervise each multidisciplinary staff person who provides ADT services;

(3) make ADT services available to the client at least two days a week for at least three consecutive hours per day. ADT services may be longer than three hours per day, but medical assistance may not reimburse a provider for more than 15 hours per week;

(4) provide ADT services to each client that includes group psychotherapy by a mental health professional or clinical trainee and daily rehabilitative interventions by a mental health professional, clinical trainee, or mental health practitioner; and

(5) include ADT services in the client's individual treatment plan, when appropriate. The adult day treatment provider must:

(i) complete a functional assessment of each client under section 245I.10, subdivision 9;

(ii) notwithstanding section 245I.10, subdivision 8, review the client's progress and update the individual treatment plan at least every 90 days until the client is discharged from the program; and

(iii) include a discharge plan for the client in the client's individual treatment plan.

(d) To be eligible for adult day treatment, a client must:

(1) be 18 years of age or older;

(2) not reside in a nursing facility, hospital, institute of mental disease, or state-operated treatment center unless the client has an active discharge plan that indicates a move to an independent living setting within 180 days;

(3) have the capacity to engage in rehabilitative programming, skills activities, and psychotherapy in the structured, therapeutic setting of an adult day treatment program and demonstrate measurable improvements in functioning resulting from participation in the adult day treatment program;

(4) have a level of care assessment under section 245I.02, subdivision 19, recommending that the client participate in services with the level of intensity and duration of an adult day treatment program; and

(5) have the recommendation of a mental health professional for adult day treatment services. The mental health professional must find that adult day treatment services are medically necessary for the client.

(e) Medical assistance does not cover the following services as adult day treatment services:

(1) services that are primarily recreational or that are provided in a setting that is not under medical supervision, including sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) social or educational services that do not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultations with other providers or service agency staff persons about the care or progress of a client;

(4) prevention or education programs that are provided to the community;

(5) day treatment for clients with a primary diagnosis of a substance use disorder;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours per day; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Subd. 4. **Explanation of findings.** (a) Subject to federal approval, medical assistance covers an explanation of findings that a mental health professional or clinical trainee provides when the provider has obtained the authorization from the client or the client's representative to release the information.

(b) A mental health professional or clinical trainee provides an explanation of findings to assist the client or related parties in understanding the results of the client's testing or diagnostic assessment and the client's mental illness, and provides professional insight that the client or related parties need to carry out a client's treatment plan. Related parties may include the client's family and other natural supports and other service providers working with the client.

(c) An explanation of findings is not paid for separately when a mental health professional or clinical trainee explains the results of psychological testing or a diagnostic assessment to the client or the client's representative as part of the client's psychological testing or a diagnostic assessment.

Subd. 5. **Family psychoeducation services.** (a) Subject to federal approval, medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a mental health professional or a clinical trainee who has determined it medically necessary to involve family members in the child's care.

(b) "Family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Subd. 6. **Dialectical behavior therapy.** (a) Subject to federal approval, medical assistance covers intensive mental health outpatient treatment for dialectical behavior therapy for adults. A dialectical behavior therapy provider must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments and protocols that are approved by the commissioner.

(b) "Dialectical behavior therapy" means an evidence-based treatment approach that a mental health professional or clinical trainee provides to a client or a group of clients in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program involves: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

(c) To be eligible for dialectical behavior therapy, a client must:

(1) be 18 years of age or older;

(2) have mental health needs that available community-based services cannot meet or that the client must receive concurrently with other community-based services;

(3) have either:

(i) a diagnosis of borderline personality disorder; or

(ii) multiple mental health diagnoses, exhibit behaviors characterized by impulsivity or intentional self-harm, and be at significant risk of death, morbidity, disability, or severe dysfunction in multiple areas of the client's life;

(4) be cognitively capable of participating in dialectical behavior therapy as an intensive therapy program and be able and willing to follow program policies and rules to ensure the safety of the client and others; and

(5) be at significant risk of one or more of the following if the client does not receive dialectical behavior therapy:

(i) having a mental health crisis;

(ii) requiring a more restrictive setting such as hospitalization;

(iii) decompensating; or

(iv) engaging in intentional self-harm behavior.

(d) Individual dialectical behavior therapy combines individualized rehabilitative and psychotherapeutic interventions to treat a client's suicidal and other dysfunctional behaviors and to reinforce a client's use of adaptive skillful behaviors. A mental health professional or clinical trainee must provide individual dialectical behavior therapy to a client. A mental health professional or clinical trainee providing dialectical behavior therapy to a client must:

(1) identify, prioritize, and sequence the client's behavioral targets;

(2) treat the client's behavioral targets;

(3) assist the client in applying dialectical behavior therapy skills to the client's natural environment through telephone coaching outside of treatment sessions;

(4) measure the client's progress toward dialectical behavior therapy targets;

(5) help the client manage mental health crises and life-threatening behaviors; and

(6) help the client learn and apply effective behaviors when working with other treatment providers.

(e) Group skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group setting to reduce the client's suicidal and other dysfunctional coping behaviors and restore function. Group skills training must teach the client adaptive skills in the following areas: (1) mindfulness; (2) interpersonal effectiveness; (3) emotional regulation; and (4) distress tolerance.

(f) Group skills training must be provided by two mental health professionals or by a mental health professional co-facilitating with a clinical trainee or a mental health practitioner. Individual skills training must be provided by a mental health professional, a clinical trainee, or a mental health practitioner.

(g) Before a program provides dialectical behavior therapy to a client, the commissioner must certify the program as a dialectical behavior therapy provider. To qualify for certification as a dialectical behavior therapy provider, a provider must:

(1) allow the commissioner to inspect the provider's program;

(2) provide evidence to the commissioner that the program's policies, procedures, and practices meet the requirements of this subdivision and chapter 245I;

(3) be enrolled as a MHCP provider; and

(4) have a manual that outlines the program's policies, procedures, and practices that meet the requirements of this subdivision.

Subd. 7. **Mental health clinical care consultation.** (a) Subject to federal approval, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a mental health professional or a clinical trainee.

(b) "Clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the treatment supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings and to direct and coordinate clinical service components provided to the client and family.

Subd. 8. **Neuropsychological assessment.** (a) Subject to federal approval, medical assistance covers a client's neuropsychological assessment.

(b) Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist. A neuropsychological assessment must include a face-to-face interview with the client, interpretation of the test results, and preparation and completion of a report.

(c) A client is eligible for a neuropsychological assessment if the client meets at least one of the following criteria:

(1) the client has a known or strongly suspected brain disorder based on the client's medical history or the client's prior neurological evaluation, including a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorder, significant exposure to neurotoxins, central nervous system infection, metabolic

or toxic encephalopathy, fetal alcohol syndrome, or congenital malformation of the brain; or

(2) the client has cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology or suspected neuropsychological impairment in addition to functional psychopathology. The client's symptoms may include:

(i) having a poor memory or impaired problem solving;

(ii) experiencing change in mental status evidenced by lethargy, confusion, or disorientation;

(iii) experiencing a deteriorating level of functioning;

(iv) displaying a marked change in behavior or personality;

(v) in a child or an adolescent, having significant delays in acquiring academic skill or poor attention relative to peers;

(vi) in a child or an adolescent, having reached a significant plateau in expected development of cognitive, social, emotional, or physical functioning relative to peers; and

(vii) in a child or an adolescent, significant inability to develop expected knowledge, skills, or abilities to adapt to new or changing cognitive, social, emotional, or physical demands.

(d) The neuropsychological assessment must be completed by a neuropsychologist who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program and:

(i) completed an internship or its equivalent in a clinically relevant area of professional psychology;

(ii) completed the equivalent of two full-time years of experience and specialized training, at least one of which is at the postdoctoral level, supervised by a clinical neuropsychologist in the study and practice of clinical neuropsychology and related neurosciences; and

(iii) holds a current license to practice psychology independently according to sections 144.88 to 144.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in clause (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessments prior to December 31, 2010.

Subd. 9. **Neuropsychological testing.** (a) Subject to federal approval, medical assistance covers neuropsychological testing for clients.

(b) "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn, and recall information and use problem solving and judgment.

(c) Medical assistance covers neuropsychological testing of a client when the client:

(1) has a significant mental status change that is not a result of a metabolic disorder and that has failed to respond to treatment;

(2) is a child or adolescent with a significant plateau in expected development of cognitive, social, emotional, or physical function relative to peers;

(3) is a child or adolescent with a significant inability to develop expected knowledge, skills, or abilities to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) has a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(i) traumatic brain injury;

(ii) stroke;

(iii) brain tumor;

(iv) substance use disorder;

(v) cerebral anoxic or hypoxic episode;

(vi) central nervous system infection or other infectious disease;

(vii) neoplasms or vascular injury of the central nervous system;

(viii) neurodegenerative disorders;

(ix) demyelinating disease;

(x) extrapyramidal disease;

(xi) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(xii) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders, including lupus, erythematosus, or celiac disease;

(xiii) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, including phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(xiv) severe or prolonged nutrition or malabsorption syndromes; or

(xv) a condition presenting in a manner difficult for a clinician to distinguish between the neurocognitive effects of a neurogenic syndrome, including dementia or encephalopathy; and a major depressive disorder when adequate treatment for major depressive disorder has not improved the client's neurocognitive functioning; or another disorder, including autism, selective mutism, anxiety disorder, or reactive attachment disorder.

(d) Neuropsychological testing must be administered or clinically supervised by a qualified neuropsychologist under subdivision 8, paragraph (c).

(e) Medical assistance does not cover neuropsychological testing of a client when the testing is:

(1) primarily for educational purposes;

(2) primarily for vocational counseling or training;

(3) for personnel or employment testing;

(4) a routine battery of psychological tests given to the client at the client's inpatient admission or during a client's continued inpatient stay; or

(5) for legal or forensic purposes.

Subd. 10. **Psychological testing.** (a) Subject to federal approval, medical assistance covers psychological testing of a client.

(b) "Psychological testing" means the use of tests or other psychometric instruments to determine the status of a client's mental, intellectual, and emotional functioning.

(c) The psychological testing must:

(1) be administered or supervised by a licensed psychologist qualified under section 245I.04, subdivision 2, clause (3), who is competent in the area of psychological testing; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a clinical trainee in psychology under the treatment supervision of a licensed psychologist under section 245I.06.

(d) A licensed psychologist must supervise the administration, scoring, and interpretation of a client's psychological tests when a clinical psychology trainee, technician, psychometrist, or psychological assistant or a computer-assisted psychological testing program completes the psychological testing of the client. The report resulting from the psychological testing must be signed by the licensed psychologist who conducts the face-to-face interview with the client. The licensed psychologist or a staff person who is under treatment supervision must place the client's psychological testing report in the client's record and release one copy of the report to the client and additional copies to individuals authorized by the client to receive the report.

Subd. 11. **Psychotherapy.** (a) Subject to federal approval, medical assistance covers psychotherapy for a client.

(b) "Psychotherapy" means treatment of a client with mental illness that applies to the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client. Medical assistance covers psychotherapy if a mental health professional or a clinical trainee provides psychotherapy to a client.

(c) "Individual psychotherapy" means psychotherapy that a mental health professional or clinical trainee designs for a client.

(d) "Family psychotherapy" means psychotherapy that a mental health professional or clinical trainee designs for a client and one or more of the client's family members or primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance for medical assistance to cover family psychotherapy. For purposes of this paragraph, "primary caregiver whose participation is necessary to accomplish the client's treatment goals" excludes shift or facility staff persons who work at the client's residence. Medical assistance payments for family psychotherapy are limited to face-to-face sessions during which the client is present throughout the session, unless the mental health professional or clinical trainee believes that the client's exclusion from the family

psychotherapy session is necessary to meet the goals of the client's individual treatment plan. If the client is excluded from a family psychotherapy session, a mental health professional or clinical trainee must document the reason for the client's exclusion and the length of time that the client is excluded. The mental health professional must also document any reason that a member of the client's family is excluded from a psychotherapy session.

(e) Group psychotherapy is appropriate for a client who, because of the nature of the client's emotional, behavioral, or social dysfunctions, can benefit from treatment in a group setting. For a group of three to eight clients, at least one mental health professional or clinical trainee must provide psychotherapy to the group. For a group of nine to 12 clients, a team of at least two mental health professionals or two clinical trainees or one mental health professional and one clinical trainee must provide psychotherapy to the group. Medical assistance will cover group psychotherapy for a group of no more than 12 persons.

(f) A multiple-family group psychotherapy session is eligible for medical assistance if a mental health professional or clinical trainee designs the psychotherapy session for at least two but not more than five families. A mental health professional or clinical trainee must design multiple-family group psychotherapy sessions to meet the treatment needs of each client. If the client is excluded from a psychotherapy session, the mental health professional or clinical trainee must document the reason for the client's exclusion and the length of time that the client was excluded. The mental health professional or clinical trainee must document any reason that a member of the client's family was excluded from a psychotherapy session.

Subd. 12. **Partial hospitalization.** (a) Subject to federal approval, medical assistance covers a client's partial hospitalization.

(b) "Partial hospitalization" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x(ff), that a multidisciplinary staff person provides in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services to a client.

(c) Partial hospitalization is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness who meets the criteria for an inpatient hospital admission under Minnesota Rules, part 9505.0520, subpart 1, and who has family and community resources that support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services for a client that a multidisciplinary staff person provides to a client to treat the client's mental illness.

Subd. 13. **Diagnostic assessments.** Subject to federal approval, medical assistance covers a client's diagnostic assessments that a mental health professional or clinical trainee completes under section 245I.10.

Sec. 18. **DIRECTION TO COMMISSIONER; SINGLE COMPREHENSIVE LICENSE STRUCTURE.**

The commissioner of human services, in consultation with stakeholders including counties, tribes, managed care organizations, provider organizations, advocacy groups, and clients and clients' families, shall develop recommendations to develop a single comprehensive licensing structure for mental health service programs, including outpatient and residential services for adults and children. The recommendations must prioritize program integrity, the welfare of clients and clients' families, improved integration of mental health and substance use disorder services, and the reduction of administrative burden on providers.

Sec. 19. **EFFECTIVE DATE.**

This article is effective upon federal approval or July 1, 2022, whichever is later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 9
CRISIS RESPONSE SERVICES

Section 1. Minnesota Statutes 2020, section 245.469, subdivision 1, is amended to read:

Subdivision 1. **Availability of emergency services.** ~~By July 1, 1988,~~ (a) County boards must provide or contract for enough emergency services within the county to meet the needs of adults, children, and families in the county who are experiencing an emotional crisis or mental illness. ~~Clients may be required to pay a fee according to section 245.481.~~ Emergency service providers must not delay the timely provision of emergency services to a client because of the unwillingness or inability of the client to pay for services. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of ~~adults with mental illness or emotional crises~~ each client;

(2) minimize further deterioration of ~~adults with mental illness or emotional crises~~ each client;

(3) help ~~adults with mental illness or emotional crises~~ each client to obtain ongoing care and treatment; ~~and~~

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs~~.~~; and

(5) provide support, psychoeducation, and referrals to each client's family members, service providers, and other third parties on behalf of the client in need of emergency services.

(b) If a county provides engagement services under section 253B.041, the county's emergency service providers must refer clients to engagement services when the client meets the criteria for engagement services.

Sec. 2. Minnesota Statutes 2020, section 245.469, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to adults with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, ~~a~~ a clinical trainee, or mental health practitioner~~, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional~~.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional, clinical trainee, or mental health practitioner ~~after January 1, 1991,~~ if the county documents that:

(1) mental health professionals, clinical trainees, or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives ~~clinical~~ treatment supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services ~~reviewed by the state advisory council on mental health and then~~ approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services ~~reviewed by the state advisory council on mental health and then~~ approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Sec. 3. Minnesota Statutes 2020, section 245.4879, subdivision 1, is amended to read:

Subdivision 1. **Availability of emergency services.** County boards must provide or contract for ~~enough~~ mental health emergency services ~~within the county to meet the needs of children, and children's families when clinically appropriate, in the county who are experiencing an emotional crisis or emotional disturbance. The county board shall ensure that parents, providers, and county residents are informed about when and how to access emergency mental health services for children. A child or the child's parent may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the parent to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:~~ according to section 245.469.

~~(1) promote the safety and emotional stability of children with emotional disturbances or emotional crises;~~

~~(2) minimize further deterioration of the child with emotional disturbance or emotional crisis;~~

~~(3) help each child with an emotional disturbance or emotional crisis to obtain ongoing care and treatment; and~~

~~(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs.~~

Sec. 4. Minnesota Statutes 2020, section 256B.0624, is amended to read:

256B.0624 ~~ADULT~~ CRISIS RESPONSE SERVICES COVERED.

Subdivision 1. **Scope.** ~~Medical assistance covers adult mental health crisis response services as defined in subdivision 2, paragraphs (c) to (e),~~ (a) Subject to federal approval, ~~if provided to a recipient as defined in subdivision 3 and provided by a qualified provider entity as defined in this section and by a qualified individual provider working within the provider's scope of practice and as defined in this subdivision and identified in the recipient's individual crisis treatment plan as defined in subdivision 11 and if determined to be medically necessary~~ medical assistance covers medically necessary crisis response services when the services are provided according to the standards in this section.

(b) Subject to federal approval, medical assistance covers medically necessary residential crisis stabilization for adults when the services are provided by an entity licensed under and meeting the standards in section 245I.23 or an entity with an adult foster care license meeting the standards in this section.

(c) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments and protocols approved by the commissioner.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

~~(a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization.~~

~~(b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with section 62Q.55.~~

~~A mental health crisis or emergency is determined for medical assistance service reimbursement by a physician, a mental health professional, or crisis mental health practitioner with input from the recipient whenever possible.~~

(a) "Certified rehabilitation specialist" means a staff person who is qualified under section 245I.04, subdivision 8.

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

(c) "~~Mental health~~ Crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or ~~mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation. It includes, when feasible, assessing whether the person might be willing to voluntarily accept treatment, determining whether the person has an advance directive, and obtaining information and history from involved family members or caretakers~~ a qualified member of a crisis team, as described in subdivision 6a.

(d) "~~Mental health mobile~~ Crisis intervention ~~services~~" means face-to-face, short-term intensive mental health services initiated during a mental health crisis ~~or mental health emergency~~ to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning. ~~The services, including screening and treatment plan recommendations, must be culturally and linguistically appropriate.~~

~~(1) This service is provided on site by a mobile crisis intervention team outside of an inpatient hospital setting. Mental health mobile crisis intervention services must be available 24 hours a day, seven days a week.~~

~~(2) The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances.~~

~~(3) The mobile crisis intervention team must be available to meet promptly face-to-face with a person in mental health crisis or emergency in a community setting or hospital emergency room.~~

~~(4) The intervention must consist of a mental health crisis assessment and a crisis treatment plan.~~

~~(5) The team must be available to individuals who are experiencing a co-occurring substance use disorder, who do not need the level of care provided in a detoxification facility.~~

~~(6) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient, including engagement in treatment planning and family psychoeducation.~~

(e) "Crisis screening" means a screening of a client's potential mental health crisis situation under subdivision 6.

~~(e)~~ (f) "~~Mental health~~ Crisis stabilization ~~services~~" means individualized mental health services provided to a recipient ~~following crisis intervention services~~ which are designed to restore the recipient to the recipient's prior functional level. ~~Mental health~~ Crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, ~~or~~ a short-term supervised, licensed residential program, or an emergency department. ~~Mental health crisis stabilization does not include partial hospitalization or day treatment. Mental health~~ Crisis stabilization services includes family psychoeducation.

(g) "Crisis team" means the staff of a provider entity who are supervised and prepared to provide mobile crisis services to a client in a potential mental health crisis situation.

(h) "Mental health certified family peer specialist" means a staff person who is qualified under section 245I.04, subdivision 12.

(i) "Mental health certified peer specialist" means a staff person who is qualified under section 245I.04, subdivision 10.

(j) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without the provision of crisis response services, would likely result in significantly reducing the recipient's levels of functioning in primary activities of daily living, in an emergency situation under section 62Q.55, or in the placement of the recipient in a more restrictive setting, including but not limited to inpatient hospitalization.

(k) "Mental health practitioner" means a staff person who is qualified under section 245I.04, subdivision 4.

(l) "Mental health professional" means a staff person who is qualified under section 245I.04, subdivision 2.

(m) "Mental health rehabilitation worker" means a staff person who is qualified under section 245I.04, subdivision 14.

(n) "Mobile crisis services" means screening, assessment, intervention, and community-based stabilization, excluding residential crisis stabilization, that is provided to a recipient.

Subd. 3. **Eligibility.** ~~An eligible recipient is an individual who:~~

~~(1) is age 18 or older;~~

~~(2) is screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed; and~~

~~(3) is assessed as experiencing a mental health crisis or emergency, and mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.~~

(a) A recipient is eligible for crisis assessment services when the recipient has screened positive for a potential mental health crisis during a crisis screening.

(b) A recipient is eligible for crisis intervention services and crisis stabilization services when the recipient has been assessed during a crisis assessment to be experiencing a mental health crisis.

Subd. 4. **Provider entity standards.** (a) A ~~provider entity is an entity that meets the standards listed in paragraph (c) and~~ mobile crisis provider must be:

(1) ~~is~~ a county board operated entity; ~~or~~

(2) an Indian health services facility or facility owned and operated by a tribe or Tribal organization operating under United States Code, title 325, section 450f; or

~~(2) is~~ (3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

(b) A mobile crisis provider must meet the following standards:

(1) ensure that crisis screenings, crisis assessments, and crisis intervention services are available to a recipient 24 hours a day, seven days a week;

(2) be able to respond to a call for services in a designated service area or according to a written agreement with the local mental health authority for an adjacent area;

(3) have at least one mental health professional on staff at all times and at least one additional staff member capable of leading a crisis response in the community; and

(4) provide the commissioner with information about the number of requests for service, the number of people that the provider serves face-to-face, outcomes, and the protocols that the provider uses when deciding when to respond in the community.

~~(b)~~ (c) A provider entity that provides crisis stabilization services in a residential setting under subdivision 7 is not required to meet the requirements of ~~paragraph~~ paragraphs (a)~~, clauses (1) and (2)~~ and (b), but must meet all other requirements of this subdivision.

~~(c) The adult mental health~~ (d) A crisis ~~response~~ services provider ~~entity~~ must have the capacity to meet and carry out the standards in section 245I.011, subdivision 5, and the following standards:

(1) ~~has the capacity to recruit, hire, and manage and train mental health professionals, practitioners, and rehabilitation workers~~ ensures that staff persons provide support for a recipient's family and natural supports, by enabling the recipient's family and natural supports to observe and participate in the recipient's treatment, assessments, and planning services;

(2) has adequate administrative ability to ensure availability of services;

~~(3) is able to ensure adequate preservice and in-service training;~~

~~(4)~~ (3) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;

~~(5)~~ (4) is able to ensure that staff are ~~capable of~~ implementing culturally specific treatment identified in the ~~individual~~ crisis treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;

~~(6)~~ (5) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient or family member during the service partnership between the recipient and providers;

~~(7)~~ (6) is able to ensure that ~~mental health professionals and mental health practitioners~~ staff have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;

~~(8)~~ (7) is able to coordinate these services with county emergency services, community hospitals, ambulance, transportation services, social services, law enforcement, engagement services, and mental health crisis services through regularly scheduled interagency meetings;

~~(9) is able to ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;~~

~~(10)~~ (8) is able to ensure that services are coordinated with other ~~mental~~ behavioral health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the ~~adult~~ recipient or parent or guardian. Services must also be coordinated with the recipient's case manager if the ~~adult~~ recipient is receiving case management services;

~~(11)~~ (9) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486 and 245.487 to 245.4879;

~~(12) is able to submit information as required by the state;~~

~~(13) maintains staff training and personnel files;~~

(10) is able to coordinate detoxification services for the recipient according to Minnesota Rules, parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F;

~~(14)~~ (11) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction; and

~~(15) is able to keep records as required by applicable laws;~~

~~(16) is able to comply with all applicable laws and statutes;~~

~~(17)~~ (12) is an enrolled medical assistance provider~~; and~~.

~~(18) develops and maintains written policies and procedures regarding service provision and administration of the provider entity, including safety of staff and recipients in high-risk situations.~~

Subd. 4a. **Alternative provider standards.** If a county or tribe demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services according to the standards in subdivision 4, paragraph ~~(c), clause (9)~~ (b), the commissioner may approve ~~a crisis response provider based on~~ an alternative plan proposed by a county or ~~group of counties~~ tribe. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of mobile crisis services;

(2) provide mobile crisis services outside of the usual nine-to-five office hours and on weekends and holidays; and

(3) comply with standards for emergency mental health services in section 245.469.

Subd. 5. **~~Mobile~~ Crisis assessment and intervention staff qualifications.** ~~For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two people with at least one member providing on-site crisis intervention services when needed.~~ (a) Qualified individual staff of a qualified provider entity must provide crisis assessment and intervention services to a recipient. A staff member providing crisis assessment and intervention services to a recipient must be qualified as a:

(1) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health certified peer specialist.

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

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

(d) Team members must be experienced in ~~mental health~~ crisis assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources. ~~The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.~~

Subd. 6. **Crisis ~~assessment and mobile intervention treatment planning~~ screening.** (a) ~~Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted.~~ The crisis screening may use the resources of ~~crisis assistance and~~ emergency services as defined in ~~sections 245.462, subdivision 6, and~~ section 245.469,

subdivisions 1 and 2. The crisis screening must gather information, determine whether a mental health crisis situation exists, identify parties involved, and determine an appropriate response.

(b) When conducting the crisis screening of a recipient, a provider must:

(1) employ evidence-based practices to reduce the recipient's risk of suicide and self-injurious behavior;

(2) work with the recipient to establish a plan and time frame for responding to the recipient's mental health crisis, including responding to the recipient's immediate need for support by telephone or text message until the provider can respond to the recipient face-to-face;

(3) document significant factors in determining whether the recipient is experiencing a mental health crisis, including prior requests for crisis services, a recipient's recent presentation at an emergency department, known calls to 911 or law enforcement, or information from third parties with knowledge of a recipient's history or current needs;

(4) accept calls from interested third parties and consider the additional needs or potential mental health crises that the third parties may be experiencing;

(5) provide psychoeducation, including means reduction, to relevant third parties including family members or other persons living with the recipient; and

(6) consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(c) For the purposes of this section, the following situations indicate a positive screen for a potential mental health crisis and the provider must prioritize providing a face-to-face crisis assessment of the recipient, unless a provider documents specific evidence to show why this was not possible, including insufficient staffing resources, concerns for staff or recipient safety, or other clinical factors:

(1) the recipient presents at an emergency department or urgent care setting and the health care team at that location requested crisis services; or

(2) a peace officer requested crisis services for a recipient who is potentially subject to transportation under section 253B.051.

(d) A provider is not required to have direct contact with the recipient to determine that the recipient is experiencing a potential mental health crisis. A mobile crisis provider may

gather relevant information about the recipient from a third party to establish the recipient's need for services and potential safety factors.

Subd. 6a. **Crisis assessment.** ~~(b)~~ (a) If a ~~crisis exists~~ recipient screens positive for potential mental health crisis, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which ~~emergency~~ services are needed and, as time permits, the recipient's current life situation, health information, including current medications, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, current functioning, and the recipient's preferences as communicated directly by the recipient, or as communicated in a health care directive as described in chapters 145C and 253B, the crisis treatment plan described under ~~paragraph (d)~~ subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

(b) A provider must conduct a crisis assessment at the recipient's location whenever possible.

(c) Whenever possible, the assessor must attempt to include input from the recipient and the recipient's family and other natural supports to assess whether a crisis exists.

(d) A crisis assessment includes: (1) determining (i) whether the recipient is willing to voluntarily engage in treatment, or (ii) whether the recipient has an advance directive, and (2) gathering the recipient's information and history from involved family or other natural supports.

(e) A crisis assessment must include coordinated response with other health care providers if the assessment indicates that a recipient needs detoxification, withdrawal management, or medical stabilization in addition to crisis response services. If the recipient does not need an acute level of care, a team must serve an otherwise eligible recipient who has a co-occurring substance use disorder.

(f) If, after completing a crisis assessment of a recipient, a provider refers a recipient to an intensive setting, including an emergency department, inpatient hospitalization, or residential crisis stabilization, one of the crisis team members who completed or conferred about the recipient's crisis assessment must immediately contact the referral entity and consult with the triage nurse or other staff responsible for intake at the referral entity. During the consultation, the crisis team member must convey key findings or concerns that led to the recipient's referral. Following the immediate consultation, the provider must also send written documentation upon completion. The provider must document if these releases occurred with authorization by the recipient, the recipient's legal guardian, or as allowed by section 144.293, subdivision 5.

Subd. 6b. **Crisis intervention services.** ~~(c)~~ (a) If the crisis assessment determines mobile crisis intervention services are needed, the crisis intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the crisis assessment, crisis treatment plan, and actions taken and needed. At least one of the team members must be ~~on site~~ providing face-to-face crisis intervention services. If providing ~~on-site~~ crisis intervention services, a clinical trainee or mental health practitioner must seek ~~clinical~~ treatment supervision as required in subdivision 9.

(b) If a provider delivers crisis intervention services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

~~(d)~~ (c) The mobile crisis intervention team must develop ~~an initial, brief~~ a crisis treatment plan ~~as soon as appropriate but no later than 24 hours after the initial face-to-face intervention~~ according to subdivision 11. ~~The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.~~

~~(e)~~ (d) The mobile crisis intervention team must document which ~~short-term goals~~ crisis treatment plan goals and objectives have been met and when no further crisis intervention services are required.

~~(f)~~ (e) If the recipient's mental health crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

~~(g)~~ (f) If the recipient's mental health crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis ~~stabilization~~ treatment plan must be developed ~~which~~ that meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; ~~and~~

(3) crisis stabilization services must be delivered according to the crisis treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis ~~stabilization~~ treatment plan, ~~supportive counseling,~~ skills training, and collaboration with other service providers in the community~~.~~; and

(4) if a provider delivers crisis stabilization services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

~~(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.~~

~~(c)~~ (b) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization ~~services~~, the residential staff must include, for at least eight hours per day, at least one ~~individual who meets the qualifications in subdivision 8, paragraph (a), clause (1) or (2)~~ mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.

~~(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.~~

Subd. 8. **~~Adult~~ Crisis stabilization staff qualifications.** (a) ~~Adult~~ Mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. ~~Individual provider staff must have the following qualifications~~ A staff member providing crisis stabilization services to a recipient must be qualified as a:

(1) ~~be a~~ mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~;

(2) ~~be a~~ certified rehabilitation specialist;

(3) clinical trainee;

(4) mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional~~;

(5) mental health certified family peer specialist;

~~(3) be a~~ (6) mental health certified peer specialist ~~under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional~~; or

~~(4) be a~~ (7) mental health rehabilitation worker ~~who meets the criteria in section 256B.0623, subdivision 5, paragraph (a), clause (4); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional~~.

(b) ~~Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.~~ The 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce a recipient's risk of suicide and self-injurious behavior.

Subd. 9. **Supervision.** Clinical trainees and mental health practitioners may provide crisis assessment and ~~mobile~~ crisis intervention services if the following ~~clinical~~ treatment supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity~~, who is an employee or under contract with the provider entity,~~ must be immediately available by phone or in person for ~~clinical~~ treatment supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a clinical trainee or mental health practitioner provides ~~on-site service~~ crisis assessment or crisis intervention services; and

(4) the mental health professional must:

(i) review and approve, as defined in section 245I.02, subdivision 2, of the tentative crisis assessment and crisis treatment plan within 24 hours of first providing services to the recipient, notwithstanding section 245I.08, subdivision 3; and

(ii) document the consultation~~; and~~ required in clause (3).

~~(iii) sign the crisis assessment and treatment plan within the next business day;~~

~~(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and~~

~~(6) the on-site observation must be documented in the recipient's record and signed by the mental health professional.~~

~~Subd. 10.~~ **~~Recipient file.~~** ~~Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:~~

~~(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;~~

~~(2) signed release forms;~~

~~(3) recipient health information and current medications;~~

~~(4) emergency contacts for the recipient;~~

~~(5) case records which document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;~~

~~(6) required clinical supervision by mental health professionals;~~

~~(7) summary of the recipient's case reviews by staff;~~

~~(8) any written information by the recipient that the recipient wants in the file; and~~

~~(9) an advance directive, if there is one available.~~

~~Documentation in the file must comply with all requirements of the commissioner.~~

Subd. 11. **Crisis treatment plan.** ~~The individual crisis stabilization treatment plan must include, at a minimum:~~

~~(1) a list of problems identified in the assessment;~~

~~(2) a list of the recipient's strengths and resources;~~

~~(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;~~

~~(4) specific objectives directed toward the achievement of each one of the goals;~~

~~(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;~~

~~(6) planned frequency and type of services initiated;~~

~~(7) a crisis response action plan if a crisis should occur;~~

~~(8) clear progress notes on outcome of goals;~~

~~(9) a written plan must be completed within 24 hours of beginning services with the recipient; and~~

~~(10) a treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.~~

(a) Within 24 hours of the recipient's admission, the provider entity must complete the recipient's crisis treatment plan. The provider entity must:

(1) base the recipient's crisis treatment plan on the recipient's crisis assessment;

(2) consider crisis assistance strategies that have been effective for the recipient in the past;

(3) for a child recipient, use a child-centered, family-driven, and culturally appropriate planning process that allows the recipient's parents and guardians to observe or participate in the recipient's individual and family treatment services, assessment, and treatment planning;

(4) for an adult recipient, use a person-centered, culturally appropriate planning process that allows the recipient's family and other natural supports to observe or participate in treatment services, assessment, and treatment planning;

(5) identify the participants involved in the recipient's treatment planning. The recipient, if possible, must be a participant;

(6) identify the recipient's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the recipient engage in treatment;

(7) include documentation of referral to and scheduling of services, including specific providers where applicable;

(8) ensure that the recipient or the recipient's legal guardian approves under section 245I.02, subdivision 2, of the recipient's crisis treatment plan unless a court orders the recipient's treatment plan under chapter 253B. If the recipient or the recipient's legal guardian disagrees with the crisis treatment plan, the license holder must document in the client file the reasons why the recipient disagrees with the crisis treatment plan; and

(9) ensure that a treatment supervisor approves under section 245I.02, subdivision 2, of the recipient's treatment plan within 24 hours of the recipient's admission if a mental health practitioner or clinical trainee completes the crisis treatment plan, notwithstanding section 245I.08, subdivision 3.

(b) The provider entity must provide the recipient and the recipient's legal guardian with a copy of the recipient's crisis treatment plan.

Subd. 12. **Excluded services.** The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) recipient transportation costs may be covered under other medical assistance provisions, but transportation services are not an adult mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide adult mental health crisis response services;

(5) services performed by volunteers;

(6) direct billing of time spent "on call" when not delivering services to a recipient;

(7) provider service time included in case management reimbursement. When a provider is eligible to provide more than one type of medical assistance service, the recipient must have a choice of provider for each service, unless otherwise provided for by law;

(8) outreach services to potential recipients; ~~and~~

(9) a mental health service that is not medically necessary~~.~~;

(10) services that a residential treatment center licensed under Minnesota Rules, chapter 2960, provides to a client;

(11) partial hospitalization or day treatment; and

(12) a crisis assessment that a residential provider completes when a daily rate is paid for the recipient's crisis stabilization.

Sec. 5. **EFFECTIVE DATE.**

This article is effective upon federal approval or July 1, 2022, whichever is later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 10
UNIFORM SERVICE STANDARDS; CONFORMING CHANGES

Section 1. Minnesota Statutes 2020, section 62A.152, subdivision 3, is amended to read:

Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber contracts that provide benefits for mental or nervous disorder treatments in a hospital must provide direct reimbursement for those services if performed by a mental health professional~~,~~ ~~as defined in sections 245.462, subdivision 18, clauses (1) to (5); and 245.4871, subdivision 27, clauses (1) to (5)~~ qualified according to section 245I.04, subdivision 2, to the extent that the services and treatment are within the scope of mental health professional licensure.

This subdivision is intended to provide payment of benefits for mental or nervous disorder treatments performed by a licensed mental health professional in a hospital and is not intended to change or add benefits for those services provided in policies or contracts to which this subdivision applies.

Sec. 2. Minnesota Statutes 2020, section 62A.3094, subdivision 1, is amended to read:

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

(b) "Autism spectrum disorders" means the conditions as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(c) "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing and preventative services. Medically necessary care must be consistent with generally accepted practice parameters as determined by physicians and licensed psychologists who typically manage patients who have autism spectrum disorders.

(d) "Mental health professional" means a mental health professional ~~as defined in section 245.4871, subdivision 27~~ who is qualified according to section 245I.04, subdivision 2, clause (1), (2), (3), (4), or (6), who has training and expertise in autism spectrum disorder and child development.

Sec. 3. Minnesota Statutes 2020, section 62Q.096, is amended to read:

62Q.096 CREDENTIALING OF PROVIDERS.

If a health plan company has initially credentialed, as providers in its provider network, individual providers employed by or under contract with an entity that:

(1) is authorized to bill under section 256B.0625, subdivision 5;

(2) ~~meets the requirements of Minnesota Rules, parts 9520.0750 to 9520.0870~~ is a mental health clinic certified under section 245I.20;

(3) is designated an essential community provider under section 62Q.19; and

(4) is under contract with the health plan company to provide mental health services,

the health plan company must continue to credential at least the same number of providers from that entity, as long as those providers meet the health plan company's credentialing standards.

A health plan company shall not refuse to credential these providers on the grounds that their provider network has a sufficient number of providers of that type.

Sec. 4. Minnesota Statutes 2020, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under chapter 245G or 245I, or Minnesota Rules, parts 9530.6510 to 9530.6590.

Sec. 5. Minnesota Statutes 2020, section 144D.01, subdivision 4, is amended to read:

Subd. 4. **Housing with services establishment or establishment.** (a) "Housing with services establishment" or "establishment" means:

(1) an establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment; or

(2) an establishment that registers under section 144D.025.

(b) Housing with services establishment does not include:

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

(2) a hospital, certified boarding care home, or supervised living facility licensed under sections 144.50 to 144.56;

(3) a board and lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D ~~or~~, 245G, or 245I;

(4) a board and lodging establishment which serves as a shelter for battered women or other similar purpose;

(5) a family adult foster care home licensed by the Department of Human Services;

(6) private homes in which the residents are related by kinship, law, or affinity with the providers of services;

(7) residential settings for persons with developmental disabilities in which the services are licensed under chapter 245D;

(8) a home-sharing arrangement such as when an elderly or disabled person or single-parent family makes lodging in a private residence available to another person in exchange for services or rent, or both;

(9) a duly organized condominium, cooperative, common interest community, or owners' association of the foregoing where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(10) services for persons with developmental disabilities that are provided under a license under chapter 245D; or

(11) a temporary family health care dwelling as defined in sections 394.307 and 462.3593.

Sec. 6. Minnesota Statutes 2020, section 144G.08, subdivision 7, as amended by Laws 2020, Seventh Special Session chapter 1, article 6, section 5, is amended to read:

Subd. 7. **Assisted living facility.** "Assisted living facility" means a facility that provides sleeping accommodations and assisted living services to one or more adults. Assisted living facility includes assisted living facility with dementia care, and does not include:

(1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361;

(2) a nursing home licensed under chapter 144A;

(3) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56;

(4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D ~~or~~, 245G, or 245I;

(5) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D;

(6) a private home in which the residents are related by kinship, law, or affinity with the provider of services;

(7) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593;

(9) a setting offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing;

(10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services;

(11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q;

(12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56;

(13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011;

(14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b); or

(15) any establishment that exclusively or primarily serves as a shelter or temporary shelter for victims of domestic or any other form of violence.

Sec. 7. Minnesota Statutes 2020, section 148B.5301, subdivision 2, is amended to read:

Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed 4,000 hours of post-master's degree supervised professional practice in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders in both children and adults. The supervised practice shall be conducted according to the requirements in paragraphs (b) to (e).

(b) The supervision must have been received under a contract that defines clinical practice and supervision from a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~ who is qualified according to section 245I.04, subdivision 2, or by a board-approved supervisor, who has at least two years of postlicensure experience in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders. All supervisors must meet the supervisor requirements in Minnesota Rules, part 2150.5010.

(c) The supervision must be obtained at the rate of two hours of supervision per 40 hours of professional practice. The supervision must be evenly distributed over the course of the supervised professional practice. At least 75 percent of the required supervision hours must be received in person. The remaining 25 percent of the required hours may be received by telephone or by audio or audiovisual electronic device. At least 50 percent of the required hours of supervision must be received on an individual basis. The remaining 50 percent may be received in a group setting.

(d) The supervised practice must include at least 1,800 hours of clinical client contact.

(e) The supervised practice must be clinical practice. Supervision includes the observation by the supervisor of the successful application of professional counseling knowledge, skills, and values in the differential diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders.

Sec. 8. Minnesota Statutes 2020, section 148E.120, subdivision 2, is amended to read:

Subd. 2. **Alternate supervisors.** (a) The board may approve an alternate supervisor as determined in this subdivision. The board shall approve up to 25 percent of the required supervision hours by a ~~licensed~~ mental health professional who is competent and qualified to provide supervision according to the mental health professional's respective licensing board, as established by section ~~245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

(b) The board shall approve up to 100 percent of the required supervision hours by an alternate supervisor if the board determines that:

(1) there are five or fewer supervisors in the county where the licensee practices social work who meet the applicable licensure requirements in subdivision 1;

(2) the supervisor is an unlicensed social worker who is employed in, and provides the supervision in, a setting exempt from licensure by section 148E.065, and who has qualifications equivalent to the applicable requirements specified in sections 148E.100 to 148E.115;

(3) the supervisor is a social worker engaged in authorized social work practice in Iowa, Manitoba, North Dakota, Ontario, South Dakota, or Wisconsin, and has the qualifications equivalent to the applicable requirements in sections 148E.100 to 148E.115; or

(4) the applicant or licensee is engaged in nonclinical authorized social work practice outside of Minnesota and the supervisor meets the qualifications equivalent to the applicable requirements in sections 148E.100 to 148E.115, or the supervisor is an equivalent mental health professional, as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency; or

(5) the applicant or licensee is engaged in clinical authorized social work practice outside of Minnesota and the supervisor meets qualifications equivalent to the applicable requirements in section 148E.115, or the supervisor is an equivalent mental health professional as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency.

(c) In order for the board to consider an alternate supervisor under this section, the licensee must:

(1) request in the supervision plan and verification submitted according to section 148E.125 that an alternate supervisor conduct the supervision; and

(2) describe the proposed supervision and the name and qualifications of the proposed alternate supervisor. The board may audit the information provided to determine compliance with the requirements of this section.

Sec. 9. Minnesota Statutes 2020, section 148F.11, subdivision 1, is amended to read:

Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes, but is not limited to: licensed physicians; registered nurses; licensed practical nurses; licensed psychologists and licensed psychological practitioners; members of the clergy provided such services are provided within the scope of regular ministries; American Indian medicine men and women; licensed attorneys; probation officers; licensed marriage and family therapists; licensed social workers; social workers employed by city, county, or state agencies; licensed professional counselors; licensed professional clinical counselors; licensed school counselors; registered occupational therapists or occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders (UMICAD) certified counselors when providing services to Native American people; city, county, or state employees when providing assessments or case management under Minnesota Rules, chapter 9530; and individuals defined in section 256B.0623, subdivision 5, paragraph (a), clauses (1) ~~and (2)~~ to (6), providing ~~integrated dual diagnosis~~ co-occurring substance use disorder treatment in adult mental health rehabilitative programs certified or licensed by the Department of Human Services under section 245I.23, 256B.0622, or 256B.0623.

(b) Nothing in this chapter prohibits technicians and resident managers in programs licensed by the Department of Human Services from discharging their duties as provided in Minnesota Rules, chapter 9530.

(c) Any person who is exempt from licensure under this section must not use a title incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug counselor" or otherwise hold himself or herself out to the public by any title or description stating or implying that he or she is engaged in the practice of alcohol and drug counseling, or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice

of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the use of one of the titles in paragraph (a).

Sec. 10. Minnesota Statutes 2020, section 245.462, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** The definitions in this section apply to sections 245.461 to ~~245.486~~ 245.4863.

Sec. 11. Minnesota Statutes 2020, section 245.462, subdivision 6, is amended to read:

Subd. 6. **Community support services program.** "Community support services program" means services, other than inpatient or residential treatment services, provided or coordinated by an identified program and staff under the ~~clinical~~ treatment supervision of a mental health professional designed to help adults with serious and persistent mental illness to function and remain in the community. A community support services program includes:

(1) client outreach,

(2) medication monitoring,

(3) assistance in independent living skills,

(4) development of employability and work-related opportunities,

(5) crisis assistance,

(6) psychosocial rehabilitation,

(7) help in applying for government benefits, and

(8) housing support services.

The community support services program must be coordinated with the case management services specified in section 245.4711.

Sec. 12. Minnesota Statutes 2020, section 245.462, subdivision 8, is amended to read:

Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means ~~a structured program of treatment and care provided to an adult in or by: (1) a hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (2) a community mental health center under section 245.62; or (3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least two days~~

~~a week by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as part of the treatment process. The services are aimed at stabilizing the adult's mental health status, providing mental health services, and developing and improving the adult's independent living and socialization skills. The goal of day treatment is to reduce or relieve mental illness and to enable the adult to live in the community. Day treatment services are not a part of inpatient or residential treatment services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. The commissioner may limit medical assistance reimbursement for day treatment to 15 hours per week per person~~ the treatment services described by section 256B.0671, subdivision 3.

Sec. 13. Minnesota Statutes 2020, section 245.462, subdivision 9, is amended to read:

Subd. 9. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update~~ section 245I.10, subdivisions 4 to 6.

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~

~~(2) description of symptoms, including reason for referral;~~

~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~

~~(5) mental status examination.~~

~~(c) On the basis of the initial components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

~~(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3), unit (a), a brief diagnostic assessment may be used for a client's family who requires a language interpreter to participate in the assessment.~~

Sec. 14. Minnesota Statutes 2020, section 245.462, subdivision 14, is amended to read:

Subd. 14. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan of intervention, treatment, and services for an adult with mental illness that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsible for providing treatment to the adult with mental illness~~ the formulation of planned services that are responsive to the needs and goals of a client. An individual treatment plan must be completed according to section 245I.10, subdivisions 7 and 8.

Sec. 15. Minnesota Statutes 2020, section 245.462, subdivision 16, is amended to read:

Subd. 16. **Mental health funds.** "Mental health funds" are funds expended under sections 245.73 and 256E.12, federal mental health block grant funds, and funds expended under section 256D.06 to facilities licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670.

Sec. 16. Minnesota Statutes 2020, section 245.462, subdivision 17, is amended to read:

Subd. 17. **Mental health practitioner.** ~~(a)~~ "Mental health practitioner" means a staff person ~~providing services to adults with mental illness or children with emotional disturbance who is qualified in at least one of the ways described in paragraphs (b) to (g). A mental~~

~~health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults~~ qualified according to section 245I.04, subdivision 4.

~~(b) For purposes of this subdivision, a practitioner is qualified through relevant coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:~~

~~(1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects;~~

~~(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to adults with mental illness or children with emotional disturbance, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;~~

~~(3) is working in a day treatment program under section 245.4712, subdivision 2; or~~

~~(4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(c) For purposes of this subdivision, a practitioner is qualified through work experience if the person:~~

~~(1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; or~~

~~(2) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, emotional disturbance, or substance use disorder, and receives clinical supervision as required by applicable statutes and rules from a mental health professional~~

~~at least once a week until the requirement of 4,000 hours of supervised experience is met; or~~

~~(ii) traumatic brain injury or developmental disabilities; completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; and receives clinical supervision as required by applicable statutes and rules at least once a week from a mental health professional until the requirement of 4,000 hours of supervised experience is met.~~

~~(d) For purposes of this subdivision, a practitioner is qualified through a graduate student internship if the practitioner is a graduate student in behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training.~~

~~(e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's degree if the practitioner:~~

~~(1) holds a master's or other graduate degree in behavioral sciences or related fields; or~~

~~(2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical care if the practitioner meets the definition of vendor of medical care in section 256B.02, subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.~~

~~(g) For purposes of medical assistance coverage of diagnostic assessments, explanations of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health practitioner working as a clinical trainee means that the practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of direct practice, treatment team collaboration, continued professional learning, and job management. The practitioner must also:~~

~~(1) comply with requirements for licensure or board certification as a mental health professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or~~

~~(2) be a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.~~

~~(h) For purposes of this subdivision, "behavioral sciences or related fields" has the meaning given in section 256B.0623, subdivision 5, paragraph (d).~~

~~(i) Notwithstanding the licensing requirements established by a health-related licensing board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other statute or rule.~~

Sec. 17. Minnesota Statutes 2020, section 245.462, subdivision 18, is amended to read:

Subd. 18. **Mental health professional.** "Mental health professional" means a staff person ~~providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:~~ who is qualified according to section 245I.04, subdivision 2.

~~(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285; and:~~

~~(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization; or~~

~~(ii) who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(2) in clinical social work: a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(3) in psychology: an individual licensed by the Board of Psychology under sections 148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;~~

~~(4) in psychiatry: a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

~~(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; or~~

~~(7) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.~~

Sec. 18. Minnesota Statutes 2020, section 245.462, subdivision 21, is amended to read:

Subd. 21. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the ~~clinical~~ treatment supervision of a mental health professional to adults with mental illness who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 19. Minnesota Statutes 2020, section 245.462, subdivision 23, is amended to read:

Subd. 23. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the ~~clinical~~ treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for adults with mental illness under chapter 245I, Minnesota Rules, parts 9520.0500 to 9520.0670, or other rules adopted by the commissioner.

Sec. 20. Minnesota Statutes 2020, section 245.462, is amended by adding a subdivision to read:

Subd. 27. **Treatment supervision.** "Treatment supervision" means the treatment supervision described by section 245I.06.

Sec. 21. Minnesota Statutes 2020, section 245.4661, subdivision 5, is amended to read:

Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with the exception of the placement of a Minnesota specialty treatment facility as defined in paragraph (c), must be developed under the direction of the county board, or multiple county boards acting jointly, as the local mental health authority. The planning process for each pilot shall include, but not be limited to, mental health consumers, families, advocates, local mental health advisory councils, local and state providers, representatives of state and local public employee bargaining units, and the department of human services. As part of the planning process, the county board or boards shall designate a managing entity responsible for receipt of funds and management of the pilot project.

(b) For Minnesota specialty treatment facilities, the commissioner shall issue a request for proposal for regions in which a need has been identified for services.

(c) For purposes of this section, "Minnesota specialty treatment facility" is defined as an intensive residential treatment service licensed under ~~section 256B.0622, subdivision 2, paragraph (b)~~ chapter 245I.

Sec. 22. Minnesota Statutes 2020, section 245.4662, subdivision 1, is amended to read:

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

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

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

(d) "Intensive residential treatment services" has the meaning given in section 256B.0622~~, subdivision 2~~.

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

Sec. 23. Minnesota Statutes 2020, section 245.467, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~All providers of residential, acute care hospital inpatient, and regional treatment centers must complete a diagnostic assessment for each of their clients within five days of admission. Providers of day treatment services must complete a~~

~~diagnostic assessment within five days after the adult's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within three years preceding admission, only an adult diagnostic assessment update is necessary. An "adult diagnostic assessment update" means a written summary by a mental health professional of the adult's current mental health status and service needs and includes a face-to-face interview with the adult. If the adult's mental health status has changed markedly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.~~ Providers of services governed by this section must complete a diagnostic assessment according to the standards of section 245I.10, subdivisions 4 to 6.

Sec. 24. Minnesota Statutes 2020, section 245.467, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment services, residential treatment, acute care hospital inpatient treatment, and all regional treatment centers must develop an individual treatment plan for each of their adult clients. The individual treatment plan must be based on a diagnostic assessment. To the extent possible, the adult client shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment and acute care hospital inpatient treatment, and all regional treatment centers must develop the individual treatment plan within ten days of client intake and must review the individual treatment plan every 90 days after intake. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Outpatient and day treatment services providers must review the individual treatment plan every 90 days after intake.~~ Providers of services governed by this section must complete an individual treatment plan according to the standards of section 245I.10, subdivisions 7 and 8.

Sec. 25. Minnesota Statutes 2020, section 245.470, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of adults with mental illness residing in the county. Services may be provided directly by the county

through county-operated ~~mental health centers or~~ mental health clinics ~~approved by the commissioner under section 245.69, subdivision 2~~ meeting the standards of chapter 245I; by contract with privately operated ~~mental health centers or~~ mental health clinics ~~approved by the commissioner under section 245.69, subdivision 2~~ meeting the standards of chapter 245I; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a ~~licensed~~ mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~. Clients may be required to pay a fee according to section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating an adult's mental health needs through therapy;

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

(7) preventing placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the client can best be served outside the county.

Sec. 26. Minnesota Statutes 2020, section 245.4712, subdivision 2, is amended to read:

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be developed as a part of the community support services available to adults with serious and persistent mental illness residing in the county. Adults may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client need;

(4) coordinate with or be offered in conjunction with a local education agency's special education program; and

(5) operate on a continuous basis throughout the year.

(b) ~~For purposes of complying with medical assistance requirements, an adult day treatment program must comply with the method of clinical supervision specified in Minnesota Rules, part 9505.0371, subpart 4. The clinical supervision must be performed by a qualified supervisor who satisfies the requirements of Minnesota Rules, part 9505.0371, subpart 5.~~ An adult day treatment program must comply with medical assistance requirements in section 256B.0671, subdivision 3.

~~A day treatment program must demonstrate compliance with this clinical supervision requirement by the commissioner's review and approval of the program according to Minnesota Rules, part 9505.0372, subpart 8.~~

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

(1) an alternative plan of care exists through the county's community support services for clients who would otherwise need day treatment services;

(2) day treatment, if included, would be duplicative of other components of the community support services; and

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

Sec. 27. Minnesota Statutes 2020, section 245.472, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** Providers of residential services must be licensed under chapter 245I or applicable rules adopted by the commissioner ~~and must be clinically supervised by a mental health professional. Persons employed in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, in the capacity of program director as of July 1, 1987, in accordance with Minnesota Rules, parts 9520.0500 to 9520.0670, may be allowed to continue providing clinical supervision within a facility, provided they continue to be employed as a program director in a facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670~~. Residential services must be provided under treatment supervision.

Sec. 28. Minnesota Statutes 2020, section 245.4863, is amended to read:

245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.

(a) The commissioner shall require individuals who perform chemical dependency assessments to screen clients for co-occurring mental health disorders, and staff who perform

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

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

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

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

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

(4) a mental health professional~~, as defined in Minnesota Rules, part 9505.0370, subpart 18,~~ who is competent to perform diagnostic assessments of co-occurring disorders is performing a diagnostic assessment ~~that meets the requirements in Minnesota Rules, part 9533.0090, subpart 5,~~ to identify whether the client may have co-occurring mental health and chemical dependency disorders. If an individual is identified to have co-occurring mental health and substance use disorders, the assessing mental health professional must document what actions will be taken to address the client's co-occurring disorders.

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

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

Sec. 29. Minnesota Statutes 2020, section 245.4871, subdivision 9a, is amended to read:

Subd. 9a. **Crisis ~~assistance~~ planning.** "Crisis ~~assistance~~ planning" means ~~assistance to the child, the child's family, and all providers of services to the child to: recognize factors precipitating a mental health crisis, identify behaviors related to the crisis, and be informed of available resources to resolve the crisis. Crisis assistance requires the development of a plan which addresses prevention and intervention strategies to be used in a potential crisis. Other interventions include: (1) arranging for admission to acute care hospital inpatient treatment~~ the development of a written plan to assist a child and the child's family in

preventing and addressing a potential crisis and is distinct from mobile crisis services defined in section 256B.0624. The plan must address prevention, deescalation, and intervention strategies to be used in a crisis. The plan identifies factors that might precipitate a crisis, behaviors or symptoms related to the emergence of a crisis, and the resources available to resolve a crisis. The plan must address the following potential needs: (1) acute care; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis. When appropriate for the child's needs, the plan must include strategies to reduce the child's risk of suicide and self-injurious behavior. Crisis ~~assistance~~ planning does not include services designed to secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.

Sec. 30. Minnesota Statutes 2020, section 245.4871, subdivision 10, is amended to read:

Subd. 10. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to a child in:

(1) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 245.62;

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475; ~~or~~

(4) an entity that operates a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract with an entity that is under contract with a county board~~.~~; or

(5) a program certified under section 256B.0943.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum two-hour time block by a multidisciplinary staff under the ~~clinical~~ treatment supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as an extension of the treatment process. The services are aimed at stabilizing the child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. Day treatment services are not a part of inpatient hospital or residential treatment services.

A day treatment service must be available to a child up to 15 hours a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

Sec. 31. Minnesota Statutes 2020, section 245.4871, subdivision 11a, is amended to read:

Subd. 11a. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update~~ section 245I.10, subdivisions 4 to 6.

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~

~~(2) description of symptoms, including reason for referral;~~

~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~

~~(5) mental status examination.~~

~~(c) On the basis of the brief components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family~~

~~psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

Sec. 32. Minnesota Statutes 2020, section 245.4871, subdivision 17, is amended to read:

Subd. 17. **Family community support services.** "Family community support services" means services provided under the ~~clinical~~ treatment supervision of a mental health professional and designed to help each child with severe emotional disturbance to function and remain with the child's family in the community. Family community support services do not include acute care hospital inpatient treatment, residential treatment services, or regional treatment center services. Family community support services include:

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

(2) medication monitoring where necessary;

(3) assistance in developing independent living skills;

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

(5) assistance with leisure and recreational activities;

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

(7) professional home-based family treatment;

(8) foster care with therapeutic supports;

(9) day treatment;

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

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

Sec. 33. Minnesota Statutes 2020, section 245.4871, subdivision 21, is amended to read:

Subd. 21. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan of intervention, treatment, and services for a child with an emotional disturbance that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. An individual treatment plan for a child must be developed in conjunction with the family unless clinically inappropriate. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment to the child~~

~~with an emotional disturbance~~ the formulation of planned services that are responsive to the needs and goals of a client. An individual treatment plan must be completed according to section 245I.10, subdivisions 7 and 8.

Sec. 34. Minnesota Statutes 2020, section 245.4871, subdivision 26, is amended to read:

Subd. 26. **Mental health practitioner.** "Mental health practitioner" ~~has the meaning given in section 245.462, subdivision 17~~ means a staff person who is qualified according to section 245I.04, subdivision 4.

Sec. 35. Minnesota Statutes 2020, section 245.4871, subdivision 27, is amended to read:

Subd. 27. **Mental health professional.** "Mental health professional" means a staff person ~~providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:~~ who is qualified according to section 245I.04, subdivision 2.

~~(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;~~

~~(3) in psychology, the mental health professional must be an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;~~

~~(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry or an osteopathic physician licensed under chapter 147~~

~~and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

~~(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances;~~

~~(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or~~

~~(7) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.~~

Sec. 36. Minnesota Statutes 2020, section 245.4871, subdivision 29, is amended to read:

Subd. 29. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the ~~clinical~~ treatment supervision of a mental health professional to children with emotional disturbances who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 37. Minnesota Statutes 2020, section 245.4871, subdivision 31, is amended to read:

Subd. 31. **Professional home-based family treatment.** "Professional home-based family treatment" means intensive mental health services provided to children because of an emotional disturbance (1) who are at risk of out-of-home placement; (2) who are in out-of-home placement; or (3) who are returning from out-of-home placement. Services are provided to the child and the child's family primarily in the child's home environment. Services may also be provided in the child's school, child care setting, or other community setting appropriate to the child. Services must be provided on an individual family basis, must be child-oriented and family-oriented, and must be designed using information from diagnostic and functional assessments to meet the specific mental health needs of the child and the child's family. Examples of services are: (1) individual therapy; (2) family therapy; (3) client outreach; (4) assistance in developing individual living skills; (5) assistance in

developing parenting skills necessary to address the needs of the child; (6) assistance with leisure and recreational services; (7) crisis ~~assistance~~ planning, including crisis respite care and arranging for crisis placement; and (8) assistance in locating respite and child care. Services must be coordinated with other services provided to the child and family.

Sec. 38. Minnesota Statutes 2020, section 245.4871, subdivision 32, is amended to read:

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

Sec. 39. Minnesota Statutes 2020, section 245.4871, subdivision 34, is amended to read:

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

Sec. 40. Minnesota Statutes 2020, section 245.4871, is amended by adding a subdivision to read:

Subd. 36. **Treatment supervision.** "Treatment supervision" means the treatment supervision described by section 245I.06.

Sec. 41. Minnesota Statutes 2020, section 245.4876, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~All residential treatment facilities and acute care hospital inpatient treatment facilities that provide mental health services for children must complete a diagnostic assessment for each of their child clients within five working days of admission. Providers of day treatment services for children must complete a diagnostic assessment within five days after the child's second visit or 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within 180 days preceding admission, only updating is necessary. "Updating" means a written summary by a mental health professional of the child's current mental health status~~

~~and service needs. If the child's mental health status has changed markedly since the child's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.~~ Providers of services governed by this section shall complete a diagnostic assessment according to the standards of section 245I.10, subdivisions 4 to 6.

Sec. 42. Minnesota Statutes 2020, section 245.4876, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment services, professional home-based family treatment, residential treatment, and acute care hospital inpatient treatment, and all regional treatment centers that provide mental health services for children must develop an individual treatment plan for each child client. The individual treatment plan must be based on a diagnostic assessment. To the extent appropriate, the child and the child's family shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment, professional home-based family treatment, and acute care hospital inpatient treatment, and regional treatment centers must develop the individual treatment plan within ten working days of client intake or admission and must review the individual treatment plan every 90 days after intake, except that the administrative review of the treatment plan of a child placed in a residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Providers of outpatient and day treatment services must review the individual treatment plan every 90 days after intake.~~ Providers of services governed by this section shall complete an individual treatment plan according to the standards of section 245I.10, subdivisions 7 and 8.

Sec. 43. Minnesota Statutes 2020, section 245.488, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of each child with emotional disturbance residing in the county and the child's family. Services may be provided directly by the county through county-operated ~~mental health centers or~~ mental

health clinics ~~approved by the commissioner under section 245.69, subdivision 2~~ meeting the standards of chapter 245I; by contract with privately operated ~~mental health centers or~~ mental health clinics ~~approved by the commissioner under section 245.69, subdivision 2~~ meeting the standards of chapter 245I; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a ~~licensed~~ mental health professional ~~as defined in section 245.4871, subdivision 27, clauses (1) to (6)~~. A child or a child's parent may be required to pay a fee based in accordance with section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

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

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

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

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

Sec. 44. Minnesota Statutes 2020, section 245.4901, subdivision 2, is amended to read:

Subd. 2. **Eligible applicants.** An eligible applicant for school-linked mental health grants is an entity that is:

(1) a mental health clinic certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a tribe or tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943; or

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals qualified according to section ~~245I.16~~ 245I.04, subdivision 2, or two alcohol and drug counselors licensed or exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families.

Sec. 45. Minnesota Statutes 2020, section 245.62, subdivision 2, is amended to read:

Subd. 2. **Definition.** A community mental health center is a private nonprofit corporation or public agency approved under the ~~rules promulgated by the commissioner pursuant to subdivision 4~~ standards of section 256B.0625, subdivision 5.

Sec. 46. Minnesota Statutes 2020, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification process for certified community behavioral health clinics (CCBHCs). Entities that choose to be CCBHCs must:

(1) comply with the CCBHC criteria published by the United States Department of Health and Human Services;

(2) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors, and staff who are culturally and linguistically trained to meet the needs of the population the clinic serves;

(3) ensure that clinic services are available and accessible to individuals and families of all ages and genders and that crisis management services are available 24 hours per day;

(4) establish fees for clinic services for individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to an individual's inability to pay for services;

(5) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

(6) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services;

peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans;

(7) provide coordination of care across settings and providers to ensure seamless transitions for individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be ~~certified as~~ mental health clinics ~~under section 245.69, subdivision 2~~ meeting the standards of chapter 245I;

(9) ~~comply with standards relating to mental health services in Minnesota Rules, parts 9505.0370 to 9505.0372~~ be a co-occurring disorder specialist;

(10) be licensed to provide substance use disorder treatment under chapter 245G;

(11) be certified to provide children's therapeutic services and supports under section 256B.0943;

(12) be certified to provide adult rehabilitative mental health services under section 256B.0623;

(13) be enrolled to provide mental health crisis response services under ~~sections~~ section 256B.0624 ~~and 256B.0944~~;

(14) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

(15) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926;

(16) provide services that comply with the evidence-based practices described in paragraph (e); and

(17) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer services are provided.

(b) If an entity is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has a current contract with another entity that has the required authority to provide that service and that meets federal CCBHC criteria as a designated collaborating organization, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under section 256B.0625, subdivision 5m, for those services without a county contract or county approval. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state.

At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

(f) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

Sec. 47. Minnesota Statutes 2020, section 245A.04, subdivision 5, is amended to read:

Subd. 5. **Commissioner's right of access.** (a) When the commissioner is exercising the powers conferred by this chapter, ~~sections 245.69 and~~ section 626.557, and chapter 260E, the commissioner must be given access to:

(1) the physical plant and grounds where the program is provided;

(2) documents and records, including records maintained in electronic format;

(3) persons served by the program; and

(4) staff and personnel records of current and former staff whenever the program is in operation and the information is relevant to inspections or investigations conducted by the commissioner. Upon request, the license holder must provide the commissioner verification of documentation of staff work experience, training, or educational requirements.

The commissioner must be given access without prior notice and as often as the commissioner considers necessary if the commissioner is investigating alleged maltreatment, conducting a licensing inspection, or investigating an alleged violation of applicable laws or rules. In conducting inspections, the commissioner may request and shall receive assistance from other state, county, and municipal governmental agencies and departments. The applicant or license holder shall allow the commissioner to photocopy, photograph, and make audio and video tape recordings during the inspection of the program at the commissioner's expense. The commissioner shall obtain a court order or the consent of the subject of the records or the parents or legal guardian of the subject before photocopying hospital medical records.

(b) Persons served by the program have the right to refuse to consent to be interviewed, photographed, or audio or videotaped. Failure or refusal of an applicant or license holder to fully comply with this subdivision is reasonable cause for the commissioner to deny the application or immediately suspend or revoke the license.

Sec. 48. Minnesota Statutes 2020, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600
125 to 149 persons	$700
150 to 174 persons	$800
175 to 199 persons	$900
200 to 224 persons	$1,000
225 or more persons	$1,100

(b)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee based on revenues derived from the provision of services that would require licensure under chapter 245D during the calendar year immediately preceding the year in which the license fee is paid, according to the following schedule:

License Holder Annual Revenue	License Fee
less than or equal to $10,000	$200
greater than $10,000 but less than or equal to $25,000	$300
greater than $25,000 but less than or equal to $50,000	$400
greater than $50,000 but less than or equal to $100,000	$500
greater than $100,000 but less than or equal to $150,000	$600
greater than $150,000 but less than or equal to $200,000	$800
greater than $200,000 but less than or equal to $250,000	$1,000
greater than $250,000 but less than or equal to $300,000	$1,200
greater than $300,000 but less than or equal to $350,000	$1,400

greater than $350,000 but less than or equal to $400,000	$1,600
greater than $400,000 but less than or equal to $450,000	$1,800
greater than $450,000 but less than or equal to $500,000	$2,000
greater than $500,000 but less than or equal to $600,000	$2,250
greater than $600,000 but less than or equal to $700,000	$2,500
greater than $700,000 but less than or equal to $800,000	$2,750
greater than $800,000 but less than or equal to $900,000	$3,000
greater than $900,000 but less than or equal to $1,000,000	$3,250
greater than $1,000,000 but less than or equal to $1,250,000	$3,500
greater than $1,250,000 but less than or equal to $1,500,000	$3,750
greater than $1,500,000 but less than or equal to $1,750,000	$4,000
greater than $1,750,000 but less than or equal to $2,000,000	$4,250
greater than $2,000,000 but less than or equal to $2,500,000	$4,500
greater than $2,500,000 but less than or equal to $3,000,000	$4,750
greater than $3,000,000 but less than or equal to $3,500,000	$5,000
greater than $3,500,000 but less than or equal to $4,000,000	$5,500
greater than $4,000,000 but less than or equal to $4,500,000	$6,000
greater than $4,500,000 but less than or equal to $5,000,000	$6,500
greater than $5,000,000 but less than or equal to $7,500,000	$7,000
greater than $7,500,000 but less than or equal to $10,000,000	$8,500
greater than $10,000,000 but less than or equal to $12,500,000	$10,000
greater than $12,500,000 but less than or equal to $15,000,000	$14,000
greater than $15,000,000	$18,000

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(5) Notwithstanding clause (1), a license holder providing services under one or more licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license holder for all licenses held under chapter 245B for calendar year 2013. For calendar year 2017 and thereafter, the license holder shall pay an annual license fee according to clause (1).

(c) A chemical dependency treatment program licensed under chapter 245G, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

(d) A chemical dependency program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

(e) Except for child foster care, a residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

(f) A residential facility licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

(g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(h) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of $1,500.

(i) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

(j) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900
75 to 99 persons	$1,100
100 or more persons	$1,300

(k) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(l) A ~~mental health center or~~ mental health clinic ~~requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870~~ certified under section 245I.20~~,~~ shall pay ~~a~~ an annual nonrefundable certification fee of $1,550 ~~per year~~. If the ~~mental health center or~~ mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

Sec. 49. Minnesota Statutes 2020, section 245A.65, subdivision 2, is amended to read:

Subd. 2. **Abuse prevention plans.** All license holders shall establish and enforce ongoing written program abuse prevention plans and individual abuse prevention plans as required under section 626.557, subdivision 14.

(a) The scope of the program abuse prevention plan is limited to the population, physical plant, and environment within the control of the license holder and the location where licensed services are provided. In addition to the requirements in section 626.557, subdivision 14, the program abuse prevention plan shall meet the requirements in clauses (1) to (5).

(1) The assessment of the population shall include an evaluation of the following factors: age, gender, mental functioning, physical and emotional health or behavior of the client; the need for specialized programs of care for clients; the need for training of staff to meet identified individual needs; and the knowledge a license holder may have regarding previous abuse that is relevant to minimizing risk of abuse for clients.

(2) The assessment of the physical plant where the licensed services are provided shall include an evaluation of the following factors: the condition and design of the building as it relates to the safety of the clients; and the existence of areas in the building which are difficult to supervise.

(3) The assessment of the environment for each facility and for each site when living arrangements are provided by the agency shall include an evaluation of the following factors: the location of the program in a particular neighborhood or community; the type of grounds and terrain surrounding the building; the type of internal programming; and the program's staffing patterns.

(4) The license holder shall provide an orientation to the program abuse prevention plan for clients receiving services. If applicable, the client's legal representative must be notified

of the orientation. The license holder shall provide this orientation for each new person within 24 hours of admission, or for persons who would benefit more from a later orientation, the orientation may take place within 72 hours.

(5) The license holder's governing body or the governing body's delegated representative shall review the plan at least annually using the assessment factors in the plan and any substantiated maltreatment findings that occurred since the last review. The governing body or the governing body's delegated representative shall revise the plan, if necessary, to reflect the review results.

(6) A copy of the program abuse prevention plan shall be posted in a prominent location in the program and be available upon request to mandated reporters, persons receiving services, and legal representatives.

(b) In addition to the requirements in section 626.557, subdivision 14, the individual abuse prevention plan shall meet the requirements in clauses (1) and (2).

(1) The plan shall include a statement of measures that will be taken to minimize the risk of abuse to the vulnerable adult when the individual assessment required in section 626.557, subdivision 14, paragraph (b), indicates the need for measures in addition to the specific measures identified in the program abuse prevention plan. The measures shall include the specific actions the program will take to minimize the risk of abuse within the scope of the licensed services, and will identify referrals made when the vulnerable adult is susceptible to abuse outside the scope or control of the licensed services. When the assessment indicates that the vulnerable adult does not need specific risk reduction measures in addition to those identified in the program abuse prevention plan, the individual abuse prevention plan shall document this determination.

(2) An individual abuse prevention plan shall be developed for each new person as part of the initial individual program plan or service plan required under the applicable licensing rule or statute. The review and evaluation of the individual abuse prevention plan shall be done as part of the review of the program plan ~~or~~, service plan, or treatment plan. The person receiving services shall participate in the development of the individual abuse prevention plan to the full extent of the person's abilities. If applicable, the person's legal representative shall be given the opportunity to participate with or for the person in the development of the plan. The interdisciplinary team shall document the review of all abuse prevention plans at least annually, using the individual assessment and any reports of abuse relating to the person. The plan shall be revised to reflect the results of this review.

Sec. 50. Minnesota Statutes 2020, section 245D.02, subdivision 20, is amended to read:

Subd. 20. **Mental health crisis intervention team.** "Mental health crisis intervention team" means a mental health crisis response provider as identified in section 256B.0624~~, subdivision 2, paragraph (d), for adults, and in section 256B.0944, subdivision 1, paragraph (d), for children~~.

Sec. 51. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

(3) care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) medication-assisted therapy services that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(9) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according

to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(12) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the

commissioner, to serve clients with the specific disabilities that the program is designed to serve;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are ~~licensed~~ mental health professionals~~, as defined in section 245.462, subdivision 18, clauses (1) to (6)~~ qualified according to section 245I.04, subdivision 2, or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and ~~licensed~~ mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a ~~licensed~~ mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video. The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

Sec. 52. Minnesota Statutes 2020, section 256B.0615, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist services, as established in subdivision 2, subject to federal approval, if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and are provided by a mental health certified peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 10.

Sec. 53. Minnesota Statutes 2020, section 256B.0615, subdivision 5, is amended to read:

Subd. 5. **Certified peer specialist training and certification.** The commissioner of human services shall develop a training and certification process for certified peer specialists~~,~~ ~~who must be at least 21 years of age~~. The candidates must have had a primary diagnosis of mental illness, be a current or former consumer of mental health services, and must demonstrate leadership and advocacy skills and a strong dedication to recovery. The training curriculum must teach participating consumers specific skills relevant to providing peer support to other consumers. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to peer support counseling.

Sec. 54. Minnesota Statutes 2020, section 256B.0616, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services, as established in subdivision 2, subject to federal approval, if provided

to recipients who have an emotional disturbance or severe emotional disturbance under chapter 245, and are provided by a mental health certified family peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 12. A family peer specialist cannot provide services to the peer specialist's family.

Sec. 55. Minnesota Statutes 2020, section 256B.0616, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** Family peer support services may be ~~located in~~ provided to recipients of inpatient hospitalization, partial hospitalization, residential treatment, intensive treatment in foster care, day treatment, children's therapeutic services and supports, or crisis services.

Sec. 56. Minnesota Statutes 2020, section 256B.0616, subdivision 5, is amended to read:

Subd. 5. **Certified family peer specialist training and certification.** The commissioner shall develop a training and certification process for certified family peer specialists ~~who must be at least 21 years of age~~. The candidates must have raised or be currently raising a child with a mental illness, have had experience navigating the children's mental health system, and must demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach participating family peer specialists specific skills relevant to providing peer support to other parents. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support counseling.

Sec. 57. Minnesota Statutes 2020, section 256B.0622, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically necessary, assertive community treatment ~~for clients as defined in subdivision 2a and intensive residential treatment services for clients as defined in subdivision 3,~~ when the services are provided by an entity certified under and meeting the standards in this section.

(b) Subject to federal approval, medical assistance covers medically necessary, intensive residential treatment services when the services are provided by an entity licensed under and meeting the standards in section 245I.23.

(c) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Sec. 58. Minnesota Statutes 2020, section 256B.0622, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "ACT team" means the group of interdisciplinary mental health staff who work as a team to provide assertive community treatment.

(c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per day, seven days per week, in a community-based setting.

(d) "Individual treatment plan" means ~~the document that results from a person-centered planning process of determining real-life outcomes with clients and developing strategies to achieve those outcomes~~ a plan described by section 245I.10, subdivisions 7 and 8.

~~(e) "Assertive engagement" means the use of collaborative strategies to engage clients to receive services.~~

~~(f) "Benefits and finance support" means assisting clients in capably managing financial affairs. Services include, but are not limited to, assisting clients in applying for benefits; assisting with redetermination of benefits; providing financial crisis management; teaching and supporting budgeting skills and asset development; and coordinating with a client's representative payee, if applicable.~~

~~(g) "Co-occurring disorder treatment" means the treatment of co-occurring mental illness and substance use disorders and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment. Services include, but are not limited to, assessing and tracking clients' stages of change readiness and treatment; applying the appropriate treatment based on stages of change, such as outreach and motivational interviewing techniques to work with clients in earlier stages of change readiness and cognitive behavioral approaches and relapse prevention to work with clients in later stages of change; and facilitating access to community supports.~~

~~(h)~~ (e) "Crisis assessment and intervention" means mental health crisis response services as defined in section 256B.0624, subdivision 2~~, paragraphs (c) to (e)~~.

~~(i) "Employment services" means assisting clients to work at jobs of their choosing. Services must follow the principles of the individual placement and support (IPS) employment model, including focusing on competitive employment; emphasizing individual~~

~~client preferences and strengths; ensuring employment services are integrated with mental health services; conducting rapid job searches and systematic job development according to client preferences and choices; providing benefits counseling; and offering all services in an individualized and time-unlimited manner. Services shall also include educating clients about opportunities and benefits of work and school and assisting the client in learning job skills, navigating the work place, and managing work relationships.~~

~~(j) "Family psychoeducation and support" means services provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include, but are not limited to, individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent.~~

~~(k) "Housing access support" means assisting clients to find, obtain, retain, and move to safe and adequate housing of their choice. Housing access support includes, but is not limited to, locating housing options with a focus on integrated independent settings; applying for housing subsidies, programs, or resources; assisting the client in developing relationships with local landlords; providing tenancy support and advocacy for the individual's tenancy rights at the client's home; and assisting with relocation.~~

~~(l)~~ (f) "Individual treatment team" means a minimum of three members of the ACT team who are responsible for consistently carrying out most of a client's assertive community treatment services.

~~(m) "Intensive residential treatment services treatment team" means all staff who provide intensive residential treatment services under this section to clients. At a minimum, this includes the clinical supervisor; mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision 5, paragraph (a), clause (4); and mental health certified peer specialists under section 256B.0615.~~

~~(n) "Intensive residential treatment services" means short-term, time-limited services provided in a residential setting to clients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes.~~

~~(o) "Medication assistance and support" means assisting clients in accessing medication, developing the ability to take medications with greater independence, and providing medication setup. This includes the prescription, administration, and order of medication by appropriate medical staff.~~

~~(p) "Medication education" means educating clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications.~~

~~(q) "Overnight staff" means a member of the intensive residential treatment services team who is responsible during hours when clients are typically asleep.~~

~~(r) "Mental health certified peer specialist services" has the meaning given in section 256B.0615.~~

~~(s) "Physical health services" means any service or treatment to meet the physical health needs of the client to support the client's mental health recovery. Services include, but are not limited to, education on primary health issues, including wellness education; medication administration and monitoring; providing and coordinating medical screening and follow-up; scheduling routine and acute medical and dental care visits; tobacco cessation strategies; assisting clients in attending appointments; communicating with other providers; and integrating all physical and mental health treatment.~~

~~(t)~~ (g) "Primary team member" means the person who leads and coordinates the activities of the individual treatment team and is the individual treatment team member who has primary responsibility for establishing and maintaining a therapeutic relationship with the client on a continuing basis.

~~(u) "Rehabilitative mental health services" means mental health services that are rehabilitative and enable the client to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness.~~

~~(v) "Symptom management" means supporting clients in identifying and targeting the symptoms and occurrence patterns of their mental illness and developing strategies to reduce the impact of those symptoms.~~

~~(w) "Therapeutic interventions" means empirically supported techniques to address specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms. Interventions include empirically supported psychotherapies including, but not limited to, cognitive behavioral therapy, exposure therapy, acceptance and commitment therapy, interpersonal therapy, and motivational interviewing.~~

~~(x) "Wellness self-management and prevention" means a combination of approaches to working with the client to build and apply skills related to recovery, and to support the client in participating in leisure and recreational activities, civic participation, and meaningful structure.~~

(h) "Certified rehabilitation specialist" means a staff person who is qualified according to section 245I.04, subdivision 8.

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

(j) "Mental health certified peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 10.

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

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

(m) "Mental health rehabilitation worker" means a staff person who is qualified according to section 245I.04, subdivision 14.

Sec. 59. Minnesota Statutes 2020, section 256B.0622, subdivision 3a, is amended to read:

Subd. 3a. **Provider certification and contract requirements for assertive community treatment.** (a) The assertive community treatment provider must:

(1) have a contract with the host county to provide assertive community treatment services; and

(2) have each ACT team be certified by the state following the certification process and procedures developed by the commissioner. The certification process determines whether the ACT team meets the standards for assertive community treatment under this section ~~as~~

~~well as~~, the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum program fidelity standards as measured by a nationally recognized fidelity tool approved by the commissioner. Recertification must occur at least every three years.

(b) An ACT team certified under this subdivision must meet the following standards:

(1) have capacity to recruit, hire, manage, and train required ACT team members;

(2) have adequate administrative ability to ensure availability of services;

~~(3) ensure adequate preservice and ongoing training for staff;~~

~~(4) ensure that staff is capable of implementing culturally specific services that are culturally responsive and appropriate as determined by the client's culture, beliefs, values, and language as identified in the individual treatment plan;~~

~~(5)~~ (3) ensure flexibility in service delivery to respond to the changing and intermittent care needs of a client as identified by the client and the individual treatment plan;

~~(6) develop and maintain client files, individual treatment plans, and contact charting;~~

~~(7) develop and maintain staff training and personnel files;~~

~~(8) submit information as required by the state;~~

~~(9)~~ (4) keep all necessary records required by law;

~~(10) comply with all applicable laws;~~

~~(11)~~ (5) be an enrolled Medicaid provider; and

~~(12)~~ (6) establish and maintain a quality assurance plan to determine specific service outcomes and the client's satisfaction with services~~; and~~.

~~(13) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.~~

(c) The commissioner may intervene at any time and decertify an ACT team with cause. The commissioner shall establish a process for decertification of an ACT team and shall require corrective action, medical assistance repayment, or decertification of an ACT team that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process. The decertification is subject to appeal to the state.

Sec. 60. Minnesota Statutes 2020, section 256B.0622, subdivision 4, is amended to read:

Subd. 4. **Provider entity licensure and contract requirements for intensive residential treatment services.** ~~(a) The intensive residential treatment services provider entity must:~~

~~(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;~~

~~(2) not exceed 16 beds per site; and~~

~~(3) comply with the additional standards in this section.~~

~~(b)~~ (a) The commissioner shall develop procedures for counties and providers to submit other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

~~(c)~~ (b) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

~~(d)~~ (c) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and tribal authority that serves as a local mental health authority in the proposed service area. The statement of need must specify if the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within 60 days of the receipt of the request, the commissioner shall determine the need for the program based on the documentation submitted by the provider entity.

Sec. 61. Minnesota Statutes 2020, section 256B.0622, subdivision 7, is amended to read:

Subd. 7. **Assertive community treatment service standards.** (a) ACT teams must offer and have the capacity to directly provide the following services:

(1) assertive engagement using collaborative strategies to encourage clients to receive services;

(2) benefits and finance support that assists clients to capably manage financial affairs. Services include but are not limited to assisting clients in applying for benefits, assisting with redetermination of benefits, providing financial crisis management, teaching and supporting budgeting skills and asset development, and coordinating with a client's representative payee, if applicable;

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

(4) crisis assessment and intervention;

(5) employment services that assist clients to work at jobs of the clients' choosing. Services must follow the principles of the individual placement and support employment model, including focusing on competitive employment, emphasizing individual client preferences and strengths, ensuring employment services are integrated with mental health services, conducting rapid job searches and systematic job development according to client preferences and choices, providing benefits counseling, and offering all services in an individualized and time-unlimited manner. Services must also include educating clients about opportunities and benefits of work and school and assisting the client in learning job skills, navigating the workplace, workplace accommodations, and managing work relationships;

(6) family psychoeducation and support provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include but are not limited to individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent;

(7) housing access support that assists clients to find, obtain, retain, and move to safe and adequate housing of their choice. Housing access support includes but is not limited to locating housing options with a focus on integrated independent settings; applying for housing subsidies, programs, or resources; assisting the client in developing relationships with local landlords; providing tenancy support and advocacy for the individual's tenancy rights at the client's home; and assisting with relocation;

(8) medication assistance and support that assists clients in accessing medication, developing the ability to take medications with greater independence, and providing

medication setup. Medication assistance and support includes assisting the client with the prescription, administration, and ordering of medication by appropriate medical staff;

(9) medication education that educates clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications;

(10) mental health certified peer specialists services according to section 256B.0615;

(11) physical health services to meet the physical health needs of the client to support the client's mental health recovery. Services include but are not limited to education on primary health and wellness issues, medication administration and monitoring, providing and coordinating medical screening and follow-up, scheduling routine and acute medical and dental care visits, tobacco cessation strategies, assisting clients in attending appointments, communicating with other providers, and integrating all physical and mental health treatment;

(12) rehabilitative mental health services as defined in section 245I.02, subdivision 33;

(13) symptom management that supports clients in identifying and targeting the symptoms and occurrence patterns of their mental illness and developing strategies to reduce the impact of those symptoms;

(14) therapeutic interventions to address specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms. Interventions include empirically supported psychotherapies including but not limited to cognitive behavioral therapy, exposure therapy, acceptance and commitment therapy, interpersonal therapy, and motivational interviewing;

(15) wellness self-management and prevention that includes a combination of approaches to working with the client to build and apply skills related to recovery, and to support the client in participating in leisure and recreational activities, civic participation, and meaningful structure; and

(16) other services based on client needs as identified in a client's assertive community treatment individual treatment plan.

(b) ACT teams must ensure the provision of all services necessary to meet a client's needs as identified in the client's individual treatment plan.

Sec. 62. Minnesota Statutes 2020, section 256B.0622, subdivision 7a, is amended to read:

Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

(i) shall be a ~~licensed~~ mental health professional ~~who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role but must obtain full licensure within 24 months of assuming the role of team leader;

(ii) must be an active member of the ACT team and provide some direct services to clients;

(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team, providing ~~clinical oversight~~ treatment supervision of services in conjunction with the psychiatrist or psychiatric care provider, and supervising team members to ensure delivery of best and ethical practices; and

(iv) must be available to provide overall ~~clinical oversight~~ treatment supervision to the ACT team after regular business hours and on weekends and holidays. The team leader may delegate this duty to another qualified member of the ACT team;

(2) the psychiatric care provider:

(i) must be a ~~licensed psychiatrist certified by the American Board of Psychiatry and Neurology or eligible for board certification or certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~ mental health professional permitted to prescribe psychiatric medications as part of the mental health professional's scope of practice. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness;

(ii) shall collaborate with the team leader in sharing overall clinical responsibility for screening and admitting clients; monitoring clients' treatment and team member service delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects, and health-related conditions; actively collaborating with nurses; and helping provide ~~clinical~~ treatment supervision to the team;

(iii) shall fulfill the following functions for assertive community treatment clients: provide assessment and treatment of clients' symptoms and response to medications, including side effects; provide brief therapy to clients; provide diagnostic and medication education to clients, with medication decisions based on shared decision making; monitor clients' nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and community visits;

(iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized for mental health treatment and shall communicate directly with the client's inpatient psychiatric care providers to ensure continuity of care;

(v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per 50 clients. Part-time psychiatric care providers shall have designated hours to work on the team, with sufficient blocks of time on consistent days to carry out the provider's clinical, supervisory, and administrative responsibilities. No more than two psychiatric care providers may share this role;

(vi) may not provide specific roles and responsibilities by telemedicine unless approved by the commissioner; and

(vii) shall provide psychiatric backup to the program after regular business hours and on weekends and holidays. The psychiatric care provider may delegate this duty to another qualified psychiatric provider;

(3) the nursing staff:

(i) shall consist of one to three registered nurses or advanced practice registered nurses, of whom at least one has a minimum of one-year experience working with adults with serious mental illness and a working knowledge of psychiatric medications. No more than two individuals can share a full-time equivalent position;

(ii) are responsible for managing medication, administering and documenting medication treatment, and managing a secure medication room; and

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

(i) shall be a full-time equivalent co-occurring disorder specialist who has received specific training on co-occurring disorders that is consistent with national evidence-based practices. The training must include practical knowledge of common substances and how they affect mental illnesses, the ability to assess substance use disorders and the client's stage of treatment, motivational interviewing, and skills necessary to provide counseling to clients at all different stages of change and treatment. The co-occurring disorder specialist

may also be an individual who is a licensed alcohol and drug counselor as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience, and other requirements in section 245G.11, subdivision 5. No more than two co-occurring disorder specialists may occupy this role; and

(ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients. The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT team members on co-occurring disorders;

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services to individuals with mental illness. An individual who does not meet these qualifications may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

(ii) shall provide or facilitate the provision of vocational services to clients. The vocational specialist serves as a consultant and educator to fellow ACT team members on these services; and

(iii) ~~should~~ must not refer individuals to receive any type of vocational services or linkage by providers outside of the ACT team;

(6) the mental health certified peer specialist:

(i) shall be a full-time equivalent ~~mental health certified peer specialist as defined in section 256B.0615~~. No more than two individuals can share this position. The mental health certified peer specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of clients. This requirement may be waived due to workforce shortages upon approval of the commissioner;

(ii) must provide coaching, mentoring, and consultation to the clients to promote recovery, self-advocacy, and self-direction, promote wellness management strategies, and assist clients in developing advance directives; and

(iii) must model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience, provide consultation to team members, promote a culture where the clients' points of view and preferences are recognized, understood, respected, and integrated into treatment, and serve in a manner equivalent to other team members;

(7) the program administrative assistant shall be a full-time office-based program administrative assistant position assigned to solely work with the ACT team, providing a range of supports to the team, clients, and families; and

(8) additional staff:

(i) shall be based on team size. Additional treatment team staff may include ~~licensed~~ mental health professionals ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A~~; clinical trainees; certified rehabilitation specialists; mental health practitioners ~~as defined in section 245.462, subdivision 17; a mental health practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C~~; or mental health rehabilitation workers ~~as defined in section 256B.0623, subdivision 5, paragraph (a), clause (4)~~. These individuals shall have the knowledge, skills, and abilities required by the population served to carry out rehabilitation and support functions; and

(ii) shall be selected based on specific program needs or the population served.

(b) Each ACT team must clearly document schedules for all ACT team members.

(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.

(d) Members of the ACT team must have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of rehabilitation services. Each staff member shall be proficient in their respective discipline and be able to work collaboratively as a member of a multidisciplinary team to deliver the majority of the treatment, rehabilitation, and support services clients require to fully benefit from receiving assertive community treatment.

(e) Each ACT team member must fulfill training requirements established by the commissioner.

Sec. 63. Minnesota Statutes 2020, section 256B.0622, subdivision 7b, is amended to read:

Subd. 7b. **Assertive community treatment program size and opportunities.** (a) Each ACT team shall maintain an annual average caseload that does not exceed 100 clients. Staff-to-client ratios shall be based on team size as follows:

(1) a small ACT team must:

(i) employ at least six but no more than seven full-time treatment team staff, excluding the program assistant and the psychiatric care provider;

(ii) serve an annual average maximum of no more than 50 clients;

(iii) ensure at least one full-time equivalent position for every eight clients served;

(iv) schedule ACT team staff for at least eight-hour shift coverage on weekdays and on-call duty to provide crisis services and deliver services after hours when staff are not working;

(v) provide crisis services during business hours if the small ACT team does not have sufficient staff numbers to operate an after-hours on-call system. During all other hours, the ACT team may arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider;

(vi) adjust schedules and provide staff to carry out the needed service activities in the evenings or on weekend days or holidays, when necessary;

(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team's psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must be arranged and a mechanism of timely communication and coordination established in writing; and

(viii) be composed of, at minimum, one full-time team leader, at least 16 hours each week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time equivalent nursing, one full-time ~~substance abuse~~ co-occurring disorder specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least one additional full-time ACT team member who has mental health professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner status; and

(2) a midsize ACT team shall:

(i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry time for 51 clients, with an additional two hours for every six clients added to the team, 1.5 to two full-time equivalent nursing staff, one full-time ~~substance abuse~~ co-occurring disorder

specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT members, with at least one dedicated full-time staff member with mental health professional status. Remaining team members may have mental health professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner status;

(ii) employ seven or more treatment team full-time equivalents, excluding the program assistant and the psychiatric care provider;

(iii) serve an annual average maximum caseload of 51 to 74 clients;

(iv) ensure at least one full-time equivalent position for every nine clients served;

(v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays and six- to eight-hour shift coverage on weekends and holidays. In addition to these minimum specifications, staff are regularly scheduled to provide the necessary services on a client-by-client basis in the evenings and on weekends and holidays;

(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working;

(vii) have the authority to arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider; and

(viii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must be arranged and a mechanism of timely communication and coordination established in writing;

(3) a large ACT team must:

(i) be composed of, at minimum, one full-time team leader, at least 32 hours each week per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff, one full-time ~~substance abuse~~ co-occurring disorder specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least two additional full-time equivalent ACT team members, with at least one dedicated full-time staff member with mental health professional status.

Remaining team members may have mental health professional or mental health practitioner status;

(ii) employ nine or more treatment team full-time equivalents, excluding the program assistant and psychiatric care provider;

(iii) serve an annual average maximum caseload of 75 to 100 clients;

(iv) ensure at least one full-time equivalent position for every nine individuals served;

(v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the second shift providing services at least 12 hours per day weekdays. For weekends and holidays, the team must operate and schedule ACT team staff to work one eight-hour shift, with a minimum of two staff each weekend day and every holiday;

(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working; and

(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team psychiatric care provider during all hours is not feasible, alternative psychiatric backup must be arranged and a mechanism of timely communication and coordination established in writing.

(b) An ACT team of any size may have a staff-to-client ratio that is lower than the requirements described in paragraph (a) upon approval by the commissioner, but may not exceed a one-to-ten staff-to-client ratio.

Sec. 64. Minnesota Statutes 2020, section 256B.0622, subdivision 7d, is amended to read:

Subd. 7d. **Assertive community treatment assessment and individual treatment plan.** (a) An initial assessment~~, including a diagnostic assessment that meets the requirements of Minnesota Rules, part 9505.0372, subpart 1, and a 30-day treatment plan~~ shall be completed the day of the client's admission to assertive community treatment by the ACT team leader or the psychiatric care provider, with participation by designated ACT team members and the client. The initial assessment must include obtaining or completing a standard diagnostic assessment according to section 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader, psychiatric care provider, or other mental health professional designated by the team leader or psychiatric care provider, must update the client's diagnostic assessment at least annually.

(b) ~~An initial~~ A functional assessment must be completed ~~within ten days of intake and updated every six months for assertive community treatment, or prior to discharge from the service, whichever comes first~~ according to section 245I.10, subdivision 9.

~~(c) Within 30 days of the client's assertive community treatment admission, the ACT team shall complete an in-depth assessment of the domains listed under section 245.462, subdivision 11a.~~

~~(d)~~ Each part of the ~~in-depth~~ functional assessment areas shall be completed by each respective team specialist or an ACT team member with skill and knowledge in the area being assessed. ~~The assessments are based upon all available information, including that from client interview family and identified natural supports, and written summaries from other agencies, including police, courts, county social service agencies, outpatient facilities, and inpatient facilities, where applicable.~~

~~(e)~~ (c) Between 30 and 45 days after the client's admission to assertive community treatment, the entire ACT team must hold a comprehensive case conference, where all team members, including the psychiatric provider, present information discovered from the completed ~~in-depth~~ assessments and provide treatment recommendations. The conference must serve as the basis for the first ~~six-month~~ individual treatment plan, which must be written by the primary team member.

~~(f)~~ (d) The client's psychiatric care provider, primary team member, and individual treatment team members shall assume responsibility for preparing the written narrative of the results from the psychiatric and social functioning history timeline and the comprehensive assessment.

~~(g)~~ (e) The primary team member and individual treatment team members shall be assigned by the team leader in collaboration with the psychiatric care provider by the time of the first treatment planning meeting or 30 days after admission, whichever occurs first.

~~(h)~~ (f) Individual treatment plans must be developed through the following treatment planning process:

(1) The individual treatment plan shall be developed in collaboration with the client and the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT team shall evaluate, together with each client, the client's needs, strengths, and preferences and develop the individual treatment plan collaboratively. The ACT team shall make every effort to ensure that the client and the client's family and natural supports, with the client's consent, are in attendance at the treatment planning meeting, are involved in ongoing

meetings related to treatment, and have the necessary supports to fully participate. The client's participation in the development of the individual treatment plan shall be documented.

(2) The client and the ACT team shall work together to formulate and prioritize the issues, set goals, research approaches and interventions, and establish the plan. The plan is individually tailored so that the treatment, rehabilitation, and support approaches and interventions achieve optimum symptom reduction, help fulfill the personal needs and aspirations of the client, take into account the cultural beliefs and realities of the individual, and improve all the aspects of psychosocial functioning that are important to the client. The process supports strengths, rehabilitation, and recovery.

(3) Each client's individual treatment plan shall identify service needs, strengths and capacities, and barriers, and set specific and measurable short- and long-term goals for each service need. The individual treatment plan must clearly specify the approaches and interventions necessary for the client to achieve the individual goals, when the interventions shall happen, and identify which ACT team member shall carry out the approaches and interventions.

(4) The primary team member and the individual treatment team, together with the client and the client's family and natural supports with the client's consent, are responsible for reviewing and rewriting the treatment goals and individual treatment plan whenever there is a major decision point in the client's course of treatment or at least every six months.

(5) The primary team member shall prepare a summary that thoroughly describes in writing the client's and the individual treatment team's evaluation of the client's progress and goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last individual treatment plan. The client's most recent diagnostic assessment must be included with the treatment plan summary.

(6) The individual treatment plan and review must be ~~signed~~ approved or acknowledged by the client, the primary team member, the team leader, the psychiatric care provider, and all individual treatment team members. A copy of the ~~signed~~ approved individual treatment plan ~~is~~ must be made available to the client.

Sec. 65. Minnesota Statutes 2020, section 256B.0623, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers medically necessary adult rehabilitative mental health services ~~as defined in subdivision 2, subject to federal approval, if provided to recipients as defined in subdivision 3 and provided by a qualified provider entity meeting the standards in this section and by a qualified individual~~

~~provider working within the provider's scope of practice and identified in the recipient's individual treatment plan as defined in section 245.462, subdivision 14, and if determined to be medically necessary according to section 62Q.53~~ when the services are provided by an entity meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Sec. 66. Minnesota Statutes 2020, section 256B.0623, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means ~~mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services~~ the services described in section 245I.02, subdivision 33.

~~(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.~~

~~(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.~~

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program ~~under Minnesota Rules, chapter 9505~~, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Sec. 67. Minnesota Statutes 2020, section 256B.0623, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section ~~245.462, subdivision 11a~~ 245I.10, subdivision 9, clause (4), so that self-sufficiency is markedly reduced; and

(4) has had a recent standard diagnostic assessment ~~or an adult diagnostic assessment update~~ by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

Sec. 68. Minnesota Statutes 2020, section 256B.0623, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the state following the certification process and procedures developed by the commissioner.

(b) The certification process is a determination as to whether the entity meets the standards in this ~~subdivision~~ section and chapter 245I, as required in section 245I.011, subdivision 5. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) A noncounty provider entity must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate its services with the other services available in that county. A county-operated entity must obtain this additional certification from any other county in which it will provide services.

(d) State-level recertification must occur at least every three years.

(e) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(f) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train ~~mental health professionals, mental health practitioners, and mental health rehabilitation workers~~ qualified staff;

(2) have adequate administrative ability to ensure availability of services;

~~(3) ensure adequate preservice and inservice and ongoing training for staff;~~

~~(4)~~ (3) ensure that ~~mental health professionals, mental health practitioners, and mental health rehabilitation workers~~ staff are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

~~(5) ensure that staff is capable of implementing culturally specific services that are culturally competent and appropriate as determined by the recipient's culture, beliefs, values, and language as identified in the individual treatment plan;~~

~~(6)~~ (4) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

~~(7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan;~~

~~(8)~~ (5) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

~~(9)~~ (6) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

~~(10) develop and maintain recipient files, individual treatment plans, and contact charting;~~

~~(11) develop and maintain staff training and personnel files;~~

~~(12) submit information as required by the state;~~

~~(13) establish and maintain a quality assurance plan to evaluate the outcome of services provided;~~

~~(14)~~ (7) keep all necessary records required by law;

~~(15)~~ (8) deliver services as required by section 245.461;

~~(16) comply with all applicable laws;~~

~~(17)~~ (9) be an enrolled Medicaid provider; and

~~(18)~~ (10) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services~~; and~~.

~~(19) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.~~

Sec. 69. Minnesota Statutes 2020, section 256B.0623, subdivision 5, is amended to read:

Subd. 5. **Qualifications of provider staff.** ~~(a)~~ Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified ~~under one of the following criteria~~ as:

(1) a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending receipt of adult mental health rehabilitative services, the definition of mental health professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (7), and who holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner~~ who is qualified according to section 245I.04, subdivision 2;

(2) a certified rehabilitation specialist who is qualified according to section 245I.04, subdivision 8;

(3) a clinical trainee who is qualified according to section 245I.04, subdivision 6;

(4) a mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional~~ qualified according to section 245I.04, subdivision 4;

~~(3)~~ (5) a mental health certified peer specialist ~~under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional~~ who is qualified according to section 245I.04, subdivision 10; or

~~(4)~~ (6) a mental health rehabilitation worker who is qualified according to section 245I.04, subdivision 14. ~~A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who:~~

~~(i) is at least 21 years of age;~~

~~(ii) has a high school diploma or equivalent;~~

~~(iii) has successfully completed 30 hours of training during the two years immediately prior to the date of hire, or before provision of direct services, in all of the following areas: recovery from mental illness, mental health de-escalation techniques, recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and~~

~~(iv) meets the qualifications in paragraph (b).~~

~~(b) In addition to the requirements in paragraph (a), a mental health rehabilitation worker must also meet the qualifications in clause (1), (2), or (3):~~

~~(1) has an associates of arts degree, two years of full-time postsecondary education, or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields; is a registered nurse; or within the previous ten years has:~~

~~(i) three years of personal life experience with serious mental illness;~~

~~(ii) three years of life experience as a primary caregiver to an adult with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability; or~~

~~(iii) 2,000 hours of supervised work experience in the delivery of mental health services to adults with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability;~~

~~(2)(i) is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;~~

~~(ii) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;~~

~~(iii) has 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;~~

~~(iv) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or mental health practitioner; and~~

~~(v) has 15 hours of additional continuing education on mental health topics during the first year of employment and 15 hours during every additional year of employment; or~~

~~(3) for providers of crisis residential services, intensive residential treatment services, partial hospitalization, and day treatment services:~~

~~(i) satisfies clause (2), items (ii) to (iv); and~~

~~(ii) has 40 hours of additional continuing education on mental health topics during the first year of employment.~~

~~(c) A mental health rehabilitation worker who solely acts and is scheduled as overnight staff is not required to comply with paragraph (a), clause (4), item (iv).~~

~~(d) For purposes of this subdivision, "behavioral sciences or related fields" means an education from an accredited college or university and includes but is not limited to social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, and other fields as approved by the commissioner.~~

Sec. 70. Minnesota Statutes 2020, section 256B.0623, subdivision 6, is amended to read:

Subd. 6. **Required ~~training and~~ supervision.** ~~(a) Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d).~~

~~(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).~~

~~(c) Clinical supervision may be provided by a full- or part-time qualified professional employed by or under contract with the provider entity. Clinical supervision may be provided~~

~~by interactive videoconferencing according to procedures developed by the commissioner. A mental health professional providing clinical supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:~~

~~(1) review the information in the recipient's file;~~

~~(2) review and approve initial and updates of individual treatment plans;~~

(a) A treatment supervisor providing treatment supervision required by section 245I.06 must:

~~(3)~~ (1) meet with ~~mental health rehabilitation workers and practitioners, individually or in small groups,~~ staff receiving treatment supervision at least monthly to discuss treatment topics of interest ~~to the workers and practitioners;~~

~~(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss~~ and treatment plans of recipients~~, and approve by signature and document in the recipient's file any resulting plan updates~~; and

~~(5)~~ (2) meet at least monthly with the directing clinical trainee or mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing clinical trainee or mental health practitioner~~; and~~.

~~(6) be available for urgent consultation as the individual recipient needs or the situation necessitates.~~

~~(d)~~ (b) An adult rehabilitative mental health services provider entity must have a treatment director who is a ~~mental health practitioner or~~ mental health professional clinical trainee, certified rehabilitation specialist, or mental health practitioner. The treatment director must ~~ensure the following~~:

(1) ~~while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by a mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works~~ ensure the direct observation of mental health rehabilitation workers required by section 245I.06, subdivision 3, is provided;

~~(2) the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;~~

~~(3) progress notes are reviewed from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the individual treatment plan and goals;~~

~~(4)~~ (2) ensure immediate availability by phone or in person for consultation by a mental health professional, certified rehabilitation specialist, clinical trainee, or a mental health practitioner to the mental health rehabilitation ~~services~~ worker during service provision;

~~(5) oversee the identification of changes in individual recipient treatment strategies, revise the plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;~~

~~(6)~~ (3) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;

~~(7)~~ (4) ensure that clinical trainees, mental health practitioners, and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers; and

~~(8)~~ (5) oversee the record of the results of ~~on-site~~ direct observation ~~and charting~~, progress note evaluation, and corrective actions taken to modify the work of the clinical trainees, mental health practitioners, and mental health rehabilitation workers.

~~(c)~~ (c) A clinical trainee or mental health practitioner who is providing treatment direction for a provider entity must receive treatment supervision at least monthly ~~from a mental health professional~~ to:

(1) identify and plan for general needs of the recipient population served;

(2) identify and plan to address provider entity program needs and effectiveness;

(3) identify and plan provider entity staff training and personnel needs and issues; and

(4) plan, implement, and evaluate provider entity quality improvement programs.

Sec. 71. Minnesota Statutes 2020, section 256B.0623, subdivision 9, is amended to read:

Subd. 9. **Functional assessment.** (a) Providers of adult rehabilitative mental health services must complete a written functional assessment ~~as defined in section 245.462, subdivision 11a~~ according to section 245I.10, subdivision 9, for each recipient. ~~The functional assessment must be completed within 30 days of intake, and reviewed and updated at least every six months after it is developed, unless there is a significant change in the functioning of the recipient. If there is a significant change in functioning, the assessment must be~~

~~updated. A single functional assessment can meet case management and adult rehabilitative mental health services requirements if agreed to by the recipient. Unless the recipient refuses, the recipient must have significant participation in the development of the functional assessment.~~

(b) When a provider of adult rehabilitative mental health services completes a written functional assessment, the provider must also complete a level of care assessment as defined in section 245I.02, subdivision 19, for the recipient.

Sec. 72. Minnesota Statutes 2020, section 256B.0623, subdivision 12, is amended to read:

Subd. 12. **Additional requirements.** (a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.

(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community. Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or section 245I.23, or an acute care hospital.

(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and individual treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's individual treatment plan. No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

(d) Adult rehabilitative mental health services are appropriate if provided to enable a recipient to retain stability and functioning, when the recipient is at risk of significant functional decompensation or requiring more restrictive service settings without these services.

(e) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas including: interpersonal communication skills, community resource utilization and integration skills, crisis planning, relapse prevention skills, health care directives, budgeting

and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.

(f) Community intervention, including consultation with relatives, guardians, friends, employers, treatment providers, and other significant individuals, is appropriate when directed exclusively to the treatment of the client.

Sec. 73. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week, except as provided in paragraph (f). Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6, a community paramedic as defined under section 144E.001, subdivision 5f, ~~or~~ a clinical trainee who is qualified according to section 245I.04, subdivision 6, a mental health practitioner ~~defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional~~ qualified according to section 245I.04, subdivision 4, and a community health worker who meets the criteria under subdivision 49, paragraph (a); "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

(f) The limit on coverage of three telemedicine services per enrollee per calendar week does not apply if:

(1) the telemedicine services provided by the licensed health care provider are for the treatment and control of tuberculosis; and

(2) the services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the commissioner of health.

Sec. 74. Minnesota Statutes 2020, section 256B.0625, subdivision 5, is amended to read:

Subd. 5. **Community mental health center services.** Medical assistance covers community mental health center services provided by a community mental health center that meets the requirements in paragraphs (a) to (j).

(a) The provider is ~~licensed under Minnesota Rules, parts 9520.0750 to 9520.0870~~ certified as a mental health clinic under section 245I.20.

(b) ~~The provider provides mental health services under the clinical supervision of a mental health professional who is licensed for independent practice at the doctoral level or by a board-certified psychiatrist or a psychiatrist who is eligible for board certification. Clinical supervision has the meaning given in Minnesota Rules, part 9505.0370, subpart 6.~~ In addition to the policies and procedures required by section 245I.03, the provider must establish, enforce, and maintain policies and procedures for the oversight of clinical services by a doctoral level psychologist or a board-certified or board-eligible psychiatrist. These policies and procedures must be developed with the involvement of a doctoral level psychologist and a board-certified or board-eligible psychiatrist. These policies and procedures must include:

(1) requirements for when to seek clinical consultation with a doctoral level psychologist or a board-certified or board-eligible psychiatrist;

(2) requirements for the involvement of a doctoral level psychologist or a board-certified or board-eligible psychiatrist in the direction of clinical services; and

(3) involvement of a doctoral level psychologist or a board-certified or board-eligible psychiatrist in quality improvement initiatives and review as part of a multidisciplinary care team.

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in section 245.481, and agree to serve within the limits of its capacity all individuals residing in its service delivery area.

(e) At a minimum, the provider must provide the following outpatient mental health services: a diagnostic assessment; explanation of findings; family, group, and individual psychotherapy, including crisis intervention psychotherapy services, ~~multiple family group psychotherapy,~~ psychological testing, and medication management. In addition, the provider must provide or be capable of providing upon request of the local mental health authority day treatment services, multiple family group psychotherapy, and professional home-based mental health services. The provider must have the capacity to provide such services to specialized populations such as the elderly, families with children, persons who are seriously and persistently mentally ill, and children who are seriously emotionally disturbed.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are ~~diagnosed with both~~ dually diagnosed with mental illness or emotional disturbance, and ~~chemical dependency~~ substance use disorder, and to individuals who are dually diagnosed with a mental illness or emotional disturbance and developmental disability.

(g) The provider must provide 24-hour emergency care services or demonstrate the capacity to assist recipients in need of such services to access such services on a 24-hour basis.

(h) The provider must have a contract with the local mental health authority to provide one or more of the services specified in paragraph (e).

(i) The provider must agree, upon request of the local mental health authority, to enter into a contract with the county to provide mental health services not reimbursable under the medical assistance program.

(j) The provider may not be enrolled with the medical assistance program as both a hospital and a community mental health center. The community mental health center's administrative, organizational, and financial structure must be separate and distinct from that of the hospital.

(k) The commissioner may require the provider to annually attest, on forms that the commissioner provides, to meeting the requirements in this subdivision.

EFFECTIVE DATE. Paragraphs (e), (f), and (k) are effective the day following final enactment.

Sec. 75. Minnesota Statutes 2020, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision

19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~; a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148E.010 and 148E.055, or a qualified designated coordinator under section 245D.081, subdivision 2. The qualified professional shall perform the duties required in section 256B.0659.

Sec. 76. Minnesota Statutes 2020, section 256B.0625, subdivision 28a, is amended to read:

Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers services performed by a licensed physician assistant if the service is otherwise covered under this chapter as a physician service and if the service is within the scope of practice of a licensed physician assistant as defined in section 147A.09.

(b) Licensed physician assistants, who are supervised by a physician certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, may bill for medication management and evaluation and management services provided to medical assistance enrollees in inpatient hospital settings, and in outpatient settings after the licensed physician assistant completes 2,000 hours of clinical experience in the evaluation and treatment of mental health, consistent with their authorized scope of practice, as defined in section 147A.09, with the exception of performing psychotherapy or diagnostic assessments or providing ~~clinical~~ treatment supervision.

Sec. 77. Minnesota Statutes 2020, section 256B.0625, subdivision 42, is amended to read:

Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part 9505.0175, subpart 28, the definition of a mental health professional ~~shall include a person who is~~ qualified ~~as specified in~~ according to section ~~245.462, subdivision 18, clauses (1) to (6); or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2, for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Sec. 78. Minnesota Statutes 2020, section 256B.0625, subdivision 48, is amended to read:

Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance covers consultation provided by a ~~psychiatrist, a psychologist, an advanced practice registered nurse certified in psychiatric mental health, a licensed independent clinical social worker,~~

~~as defined in section 245.462, subdivision 18, clause (2), or a licensed marriage and family therapist, as defined in section 245.462, subdivision 18, clause (5)~~ mental health professional qualified according to section 245I.04, subdivision 2, except a licensed professional clinical counselor licensed under section 148B.5301, via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Sec. 79. Minnesota Statutes 2020, section 256B.0625, subdivision 49, is amended to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has~~:~~

~~(1)~~ received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum~~; or~~.

~~(2) at least five years of supervised experience with an enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.~~

~~Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.~~

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5)~~, or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Sec. 80. Minnesota Statutes 2020, section 256B.0625, subdivision 56a, is amended to read:

Subd. 56a. **Officer-involved community-based care coordination.** (a) Medical assistance covers officer-involved community-based care coordination for an individual who:

(1) has screened positive for benefiting from treatment for a mental illness or substance use disorder using a tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in officer-involved community-based care coordination.

(b) Officer-involved community-based care coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) Officer-involved community-based care coordination must be provided by an individual who is an employee of or is under contract with a county, or is an employee of or under contract with an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility to provide officer-involved community-based care coordination and is qualified under one of the following criteria:

(1) a ~~licensed~~ mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~;

(2) a clinical trainee qualified according to section 245I.04, subdivision 6, working under the treatment supervision of a mental health professional according to section 245I.06;

(3) a mental health practitioner ~~as defined in section 245.462, subdivision 17~~ qualified according to section 245I.04, subdivision 4, working under the ~~clinical~~ treatment supervision of a mental health professional according to section 245I.06;

~~(3)~~ (4) a mental health certified peer specialist ~~under section 256B.0615~~ qualified according to section 245I.04, subdivision 10, working under the ~~clinical~~ treatment supervision of a mental health professional according to section 245I.06;

(4) an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5; or

(5) a recovery peer qualified under section 245G.11, subdivision 8, working under the supervision of an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of officer-involved community-based care coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure that services and payments provided under officer-involved community-based care coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for officer-involved community-based care coordination services shall be provided by the county providing the services, from sources other than federal funds or funds used to match other federal funds.

Sec. 81. Minnesota Statutes 2020, section 256B.0757, subdivision 4c, is amended to read:

Subd. 4c. **Behavioral health home services staff qualifications.** (a) A behavioral health home services provider must maintain staff with required professional qualifications appropriate to the setting.

(b) If behavioral health home services are offered in a mental health setting, the integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice Act, sections 148.171 to 148.285.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be a mental health professional ~~as defined in~~ who is qualified according to section ~~245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

(d) If behavioral health home services are offered in either a primary care setting or mental health setting, the systems navigator must be a mental health practitioner ~~as defined in~~ who is qualified according to section ~~245.462, subdivision 17~~ 245I.04, subdivision 4, or a community health worker as defined in section 256B.0625, subdivision 49.

(e) If behavioral health home services are offered in either a primary care setting or mental health setting, the qualified health home specialist must be one of the following:

(1) a mental health certified peer ~~support~~ specialist ~~as defined in~~ who is qualified according to section ~~256B.0615~~ 245I.04, subdivision 10;

(2) a mental health certified family peer ~~support~~ specialist ~~as defined in~~ who is qualified according to section ~~256B.0616~~ 245I.04, subdivision 12;

(3) a case management associate as defined in section 245.462, subdivision 4, paragraph (g), or 245.4871, subdivision 4, paragraph (j);

(4) a mental health rehabilitation worker ~~as defined in~~ who is qualified according to section ~~256B.0623, subdivision 5, clause (4)~~ 245I.04, subdivision 14;

(5) a community paramedic as defined in section 144E.28, subdivision 9;

(6) a peer recovery specialist as defined in section 245G.07, subdivision 1, clause (5); or

(7) a community health worker as defined in section 256B.0625, subdivision 49.

Sec. 82. Minnesota Statutes 2020, section 256B.0941, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, services are determined to be medically necessary according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for

one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) was referred for treatment in a psychiatric residential treatment facility by a ~~qualified~~ mental health professional ~~licensed as defined in~~ qualified according to section ~~245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

(b) The commissioner shall provide oversight and review the use of referrals for clients admitted to psychiatric residential treatment facilities to ensure that eligibility criteria, clinical services, and treatment planning reflect clinical, state, and federal standards for psychiatric residential treatment facility level of care. The commissioner shall coordinate the production of a statewide list of children and youth who meet the medical necessity criteria for psychiatric residential treatment facility level of care and who are awaiting admission. The commissioner and any recipient of the list shall not use the statewide list to direct admission of children and youth to specific facilities.

Sec. 83. Minnesota Statutes 2020, section 256B.0943, subdivision 1, is amended to read:

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

(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed emotional disturbance, as defined in section 245.4871, subdivision 15, or a diagnosed mental illness, as defined in section 245.462, subdivision 20. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

~~(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility~~

~~for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.~~

~~(c)~~ (b) "Clinical trainee" means a ~~mental health practitioner who meets the qualifications specified in Minnesota Rules, part 9505.0371, subpart 5, item C~~ staff person who is qualified according to section 245I.04, subdivision 6.

~~(d)~~ (c) "Crisis ~~assistance~~ planning" has the meaning given in section 245.4871, subdivision 9a. ~~Crisis assistance entails the development of a written plan to assist a child's family to contend with a potential crisis and is distinct from the immediate provision of crisis intervention services.~~

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

~~(f)~~ (e) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for three or more individuals and individual or group skills training provided by a ~~multidisciplinary~~ team, under the ~~clinical~~ treatment supervision of a mental health professional.

~~(g)~~ (f) "Standard diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0372, subpart 1~~ means the assessment described in 245I.10, subdivision 6.

~~(h)~~ (g) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered telemedicine services. Direct service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

~~(i)~~ (h) "Direction of mental health behavioral aide" means the activities of a mental health professional, clinical trainee, or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's ~~individualized~~ individual treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

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

~~(k)~~ (j) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or a clinical trainee or mental health practitioner~~,~~ under the ~~clinical~~ treatment supervision of a mental health professional, to guide the work of the mental health behavioral aide. The individual behavioral plan may be incorporated into the child's individual treatment plan so long as the behavioral plan is separately communicable to the mental health behavioral aide.

~~(l)~~ (k) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part 9505.0371, subpart 7~~ means the plan described in section 245I.10, subdivisions 7 and 8.

~~(m)~~ (l) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a ~~trained paraprofessional qualified as provided in subdivision 7, paragraph (b), clause (3)~~ mental health behavioral aide qualified according to section 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

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

(n) "Mental health practitioner" ~~has the meaning given in section 245.462, subdivision 17, except that a practitioner working in a day treatment setting may qualify as a mental health practitioner if the practitioner holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university, and: (1) has at least 2,000 hours of clinically supervised experience in the delivery of mental health services to clients with mental illness; (2) is fluent in the language, other than English, of the cultural group that makes up at least 50 percent of the practitioner's clients, completes 40 hours of training on the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once per week until meeting the required 2,000 hours of supervised experience; or (3) receives 40 hours of training on the delivery of services to clients with mental illness within six months of employment, and clinical supervision from a mental health professional at least once per week until meeting the required 2,000 hours of supervised experience~~ means a staff person who is qualified according to section 245I.04, subdivision 4.

(o) "Mental health professional" means ~~an individual as defined in Minnesota Rules, part 9505.0370, subpart 18~~ a staff person who is qualified according to section 245I.04, subdivision 2.

(p) "Mental health service plan development" includes:

(1) the development, review, and revision of a child's individual treatment plan, ~~as provided in Minnesota Rules, part 9505.0371, subpart 7,~~ including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) administering and reporting the standardized outcome ~~measurement instruments, determined and updated by the commissioner~~ measurements in section 245I.10, subdivision 6, paragraph (d), clauses (3) and (4), and other standardized outcome measurements approved by the commissioner, as periodically needed to evaluate the effectiveness of treatment ~~for children receiving clinical services and reporting outcome measures, as required by the commissioner~~.

(q) "Mental illness," for persons at least age 18 but under age 21, has the meaning given in section 245.462, subdivision 20, paragraph (a).

(r) "Psychotherapy" means the treatment ~~of mental or emotional disorders or maladjustment by psychological means. Psychotherapy may be provided in many modalities in accordance with Minnesota Rules, part 9505.0372, subpart 6, including patient and/or family psychotherapy; family psychotherapy; psychotherapy for crisis; group psychotherapy; or multiple-family psychotherapy. Beginning with the American Medical Association's Current Procedural Terminology, standard edition, 2014, the procedure "individual psychotherapy" is replaced with "patient and/or family psychotherapy," a substantive change that permits the therapist to work with the client's family without the client present to obtain information about the client or to explain the client's treatment plan to the family. Psychotherapy is appropriate for crisis response when a child has become dysregulated or experienced new trauma since the diagnostic assessment was completed and needs psychotherapy to address issues not currently included in the child's individual treatment plan~~ described in section 256B.0671, subdivision 11.

(s) "Rehabilitative services" or "psychiatric rehabilitation services" means ~~a series or multidisciplinary combination of psychiatric and psychosocial~~ interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with,

counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement. ~~Continuing progress toward goals is expected, and rehabilitative potential ceases when successive improvement is not observable over a period of time.~~

(t) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

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

Sec. 84. Minnesota Statutes 2020, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports ~~as defined in this section that~~ when the services are provided by an eligible provider entity certified under ~~subdivision 4 provides to a client eligible under subdivision 3~~ and meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) The service components of children's therapeutic services and supports are:

(1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional, clinical trainee, or mental health practitioner;

(3) crisis ~~assistance~~ planning;

(4) mental health behavioral aide services;

(5) direction of a mental health behavioral aide;

(6) mental health service plan development; and

(7) children's day treatment.

Sec. 85. Minnesota Statutes 2020, section 256B.0943, subdivision 3, is amended to read:

Subd. 3. **Determination of client eligibility.** (a) A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a standard diagnostic assessment by a mental health professional or a ~~mental health practitioner who meets the requirements of a clinical trainee as defined in Minnesota Rules, part 9505.0371, subpart 5, item C,~~ clinical trainee that is performed within one year before the initial start of service. The standard diagnostic assessment must ~~meet the requirements for a standard or extended diagnostic assessment as defined in Minnesota Rules, part 9505.0372, subpart 1, items B and C, and~~:

~~(1) include current diagnoses, including any differential diagnosis, in accordance with all criteria for a complete diagnosis and diagnostic profile as specified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, or, for children under age five, as specified in the current edition of the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood;~~

~~(2)~~ (1) determine whether a child under age 18 has a diagnosis of emotional disturbance or, if the person is between the ages of 18 and 21, whether the person has a mental illness;

~~(3)~~ (2) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals; and

~~(4)~~ (3) be used in the development of the ~~individualized~~ individual treatment plan~~; and~~.

~~(5) be completed annually until age 18. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means an adult diagnostic update as defined in Minnesota Rules, part 9505.0371, subpart 2, item E.~~

(b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to five days of day treatment under this section based on a hospital's medical history and presentation examination of the client.

Sec. 86. Minnesota Statutes 2020, section 256B.0943, subdivision 4, is amended to read:

Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial provider entity application and certification process and recertification process to determine

whether a provider entity has an administrative and clinical infrastructure that meets the requirements in subdivisions 5 and 6. A provider entity must be certified for the three core rehabilitation services of psychotherapy, skills training, and crisis ~~assistance~~ planning. The commissioner shall recertify a provider entity at least every three years. The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process.

(b) For purposes of this section, a provider entity must meet the standards in this section and chapter 245I, as required in section 245I.011, subdivision 5, and be:

(1) an Indian health services facility or a facility owned and operated by a tribe or tribal organization operating as a 638 facility under Public Law 93-638 certified by the state;

(2) a county-operated entity certified by the state; or

(3) a noncounty entity certified by the state.

Sec. 87. Minnesota Statutes 2020, section 256B.0943, subdivision 5, is amended to read:

Subd. 5. **Provider entity administrative infrastructure requirements.** (a) ~~To be an eligible provider entity under this section, a provider entity must have an administrative infrastructure that establishes authority and accountability for decision making and oversight of functions, including finance, personnel, system management, clinical practice, and individual treatment outcomes measurement.~~ An eligible provider entity shall demonstrate the availability, by means of employment or contract, of at least one backup mental health professional in the event of the primary mental health professional's absence. ~~The provider must have written policies and procedures that it reviews and updates every three years and distributes to staff initially and upon each subsequent update.~~

(b) ~~The administrative infrastructure written~~ In addition to the policies and procedures required by section 245I.03, the policies and procedures must include:

~~(1) personnel procedures, including a process for: (i) recruiting, hiring, training, and retention of culturally and linguistically competent providers; (ii) conducting a criminal background check on all direct service providers and volunteers; (iii) investigating, reporting, and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting on violations of data privacy policies that are compliant with federal and state laws; (v) utilizing volunteers, including screening applicants, training and supervising volunteers,~~

~~and providing liability coverage for volunteers; and (vi) documenting that each mental health professional, mental health practitioner, or mental health behavioral aide meets the applicable provider qualification criteria, training criteria under subdivision 8, and clinical supervision or direction of a mental health behavioral aide requirements under subdivision 6;~~

~~(2)~~ (1) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws; and

~~(3)~~ (2) a client-specific treatment outcomes measurement system, including baseline measures, to measure a client's progress toward achieving mental health rehabilitation goals. ~~Effective July 1, 2017, to be eligible for medical assistance payment, a provider entity must report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner; and~~

~~(4) a process to establish and maintain individual client records. The client's records must include:~~

~~(i) the client's personal information;~~

~~(ii) forms applicable to data privacy;~~

~~(iii) the client's diagnostic assessment, updates, results of tests, individual treatment plan, and individual behavior plan, if necessary;~~

~~(iv) documentation of service delivery as specified under subdivision 6;~~

~~(v) telephone contacts;~~

~~(vi) discharge plan; and~~

~~(vii) if applicable, insurance information.~~

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

Sec. 88. Minnesota Statutes 2020, section 256B.0943, subdivision 5a, is amended to read:

Subd. 5a. **Background studies.** The requirements for background studies under ~~this~~ section 245I.011, subdivision 4, paragraph (d), may be met by a children's therapeutic services and supports services agency through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 7, and 245C.10, subdivision 8.

Sec. 89. Minnesota Statutes 2020, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, ~~individualized~~ individual treatment plans, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review, and update as necessary, the clinical policies and procedures every three years, must distribute the policies and procedures to staff initially and upon each subsequent update, and must train staff accordingly.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for meeting the requirements in this subdivision:

(1) providing or obtaining a client's standard diagnostic assessment, including a standard diagnostic assessment ~~performed by an outside or independent clinician, that identifies acute and chronic clinical disorders, co-occurring medical conditions, and sources of psychological and environmental problems, including baselines, and a functional assessment. The functional assessment component must clearly summarize the client's individual strengths and needs.~~ When required components of the standard diagnostic assessment~~, such as baseline measures,~~ are not provided in an outside or independent assessment or ~~when baseline measures~~ cannot be attained ~~in a one-session standard diagnostic assessment~~ immediately, the provider entity must determine the missing information within 30 days and amend the child's standard diagnostic assessment or incorporate the ~~baselines~~ information into the child's individual treatment plan;

(2) developing an individual treatment plan ~~that:~~;

~~(i) is based on the information in the client's diagnostic assessment and baselines;~~

~~(ii) identified goals and objectives of treatment, treatment strategy, schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;~~

~~(iii) is developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;~~

~~(iv) is developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessment, and treatment planning;~~

~~(v) is reviewed at least once every 90 days and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment; and~~

~~(vi) is signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;~~

(3) developing an individual behavior plan that documents ~~treatment strategies~~ and describes interventions to be provided by the mental health behavioral aide. The individual behavior plan must include:

(i) detailed instructions on the ~~treatment strategies to be provided~~ psychosocial skills to be practiced;

(ii) time allocated to each ~~treatment strategy~~ intervention;

(iii) methods of documenting the child's behavior;

(iv) methods of monitoring the child's progress in reaching objectives; and

(v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) providing ~~clinical~~ treatment supervision plans for ~~mental health practitioners and mental health behavioral aides. A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. The clinical supervisor also shall document supervisee-specific supervision in the supervisee's personnel file. Clinical~~ staff according to section 245I.06. Treatment supervision does not include the authority to make or terminate court-ordered placements of the child. A ~~clinical~~ treatment supervisor must be available for urgent consultation as required by the individual client's needs or the situation~~. Clinical supervision may occur individually or in a small group to discuss treatment and review progress toward goals. The focus of clinical supervision must be the client's treatment needs and progress and the mental health practitioner's or behavioral aide's ability to provide services~~;

(4a) meeting day treatment program conditions in items (i) ~~to (iii)~~ and (ii):

(i) the ~~clinical~~ treatment supervisor must be present and available on the premises more than 50 percent of the time in a provider's standard working week during which the supervisee is providing a mental health service; and

~~(ii) the diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan must be made by or reviewed, approved, and signed by the clinical supervisor; and~~

~~(iii)~~ (ii) every 30 days, the ~~clinical~~ treatment supervisor must review and sign the record indicating the supervisor has reviewed the client's care for all activities in the preceding 30-day period;

(4b) meeting the ~~clinical~~ treatment supervision standards in items (i) ~~to (iv)~~ and (ii) for all other services provided under CTSS:

~~(i) medical assistance shall reimburse for services provided by a mental health practitioner who is delivering services that fall within the scope of the practitioner's practice and who is supervised by a mental health professional who accepts full professional responsibility;~~

~~(ii) medical assistance shall reimburse for services provided by a mental health behavioral aide who is delivering services that fall within the scope of the aide's practice and who is supervised by a mental health professional who accepts full professional responsibility and has an approved plan for clinical supervision of the behavioral aide. Plans must be developed in accordance with supervision standards defined in Minnesota Rules, part 9505.0371, subpart 4, items A to D;~~

~~(iii)~~ (i) the mental health professional is required to be present at the site of service delivery for observation as clinically appropriate when the clinical trainee, mental health practitioner, or mental health behavioral aide is providing CTSS services; and

~~(iv)~~ (ii) when conducted, the on-site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the ~~clinical~~ treatment supervisor must be employed by the provider entity or other provider certified to provide mental health behavioral aide services to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The ~~mental health professional or mental health practitioner~~ staff giving direction must begin with the goals on the ~~individualized~~ individual treatment plan, and instruct the mental health behavioral aide on how to implement therapeutic activities and interventions that will lead to goal attainment. The ~~professional or practitioner~~ staff giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client

and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain or demonstrate the activities the aide is doing with the client and the activities' relationship to treatment goals. Direction is more didactic than is supervision and requires the ~~professional or practitioner~~ staff providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the ~~individualized~~ individual treatment plan and the ~~individualized~~ individual behavior plan. When providing direction, the ~~professional or practitioner~~ staff must:

(i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the ~~professional or practitioner~~ staff must approve and sign the progress notes;

(ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(iii) demonstrate family-friendly behaviors that support healthy collaboration among the child, the child's family, and providers as treatment is planned and implemented;

(iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; ~~and~~

(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide; and

(vi) ensure the immediate accessibility of a mental health professional, clinical trainee, or mental health practitioner to the behavioral aide during service delivery;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met each of the goals and objectives in the treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. ~~Revision of the individual treatment plan does not require a new diagnostic assessment unless the client's mental health status has changed markedly. The updated treatment plan must be signed by the clinical supervisor and by the client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.~~

Sec. 90. Minnesota Statutes 2020, section 256B.0943, subdivision 7, is amended to read:

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as a:

(1) ~~a~~ mental health professional ~~as defined in subdivision 1, paragraph (o);~~ ~~or~~

(2) ~~a~~ clinical trainee;

(3) mental health practitioner ~~or clinical trainee. The mental health practitioner or clinical trainee must work under the clinical supervision of a mental health professional~~; ~~or~~

(4) mental health certified family peer specialist; or

~~(3) a~~ (5) mental health behavioral aide ~~working under the clinical supervision of a mental health professional to implement the rehabilitative mental health services previously introduced by a mental health professional or practitioner and identified in the client's individual treatment plan and individual behavior plan.~~

~~(A) A level I mental health behavioral aide must:~~

~~(i) be at least 18 years old;~~

~~(ii) have a high school diploma or commissioner of education-selected high school equivalency certification or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and~~

~~(iii) meet preservice and continuing education requirements under subdivision 8.~~

~~(B) A level II mental health behavioral aide must:~~

~~(i) be at least 18 years old;~~

~~(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents or complete a certificate program established under subdivision 8a; and~~

~~(iii) meet preservice and continuing education requirements in subdivision 8.~~

(c) A day treatment ~~multidisciplinary~~ team must include at least one mental health professional or clinical trainee and one mental health practitioner.

Sec. 91. Minnesota Statutes 2020, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) ~~each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs.~~ the provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a ~~multidisciplinary~~ team under the ~~clinical~~ treatment supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available year-round at least three to five days per week, two or three hours per day, unless the normal five-day school week is shortened by a holiday, weather-related cancellation, or other districtwide reduction in a school week. A child transitioning into or out of day treatment must receive a minimum treatment of one day a week for a two-hour time block. The two-hour time block must include at least one hour of patient and/or family or group psychotherapy. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally

required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) To be eligible for medical assistance payment, a provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) ~~patient and/or family, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0372, subpart 6.~~ psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it. When a provider delivering other services to a child under this section deems it not medically necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider entity must document the medical reasons why psychotherapy is not necessary. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training ~~must be provided by a mental health professional or a mental health practitioner who is delivering services that fall within the scope of the provider's practice and is supervised by a mental health professional who accepts full professional responsibility for the training. Skills training~~ is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) the mental health professional delivering or supervising the delivery of skills training must document any underlying psychiatric condition and must document how skills training is being used in conjunction with psychotherapy to address the underlying condition;

(iv) skills training delivered to the child's family must teach skills needed by parents to enhance the child's skill development, to help the child utilize daily life skills taught by a mental health professional, clinical trainee, or mental health practitioner, and to develop or maintain a home environment that supports the child's progressive use of skills;

(v) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(A) one mental health professional ~~or one~~, clinical trainee, or mental health practitioner ~~under supervision of a licensed mental health professional~~ must work with a group of three to eight clients; or

(B) any combination of two mental health professionals, ~~two~~ clinical trainees, or mental health practitioners ~~under supervision of a licensed mental health professional, or one mental health professional or clinical trainee and one mental health practitioner~~ must work with a group of nine to 12 clients;

(vi) a mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client; and

(vii) for group skills training, when a skills group that meets the minimum group size requirement temporarily falls below the minimum group size because of a group member's temporary absence, the provider may conduct the session for the group members in attendance;

(3) crisis ~~assistance~~ planning to a child and family must include development of a written plan that anticipates the particular factors specific to the child that may precipitate a psychiatric crisis for the child in the near future. The written plan must document actions that the family should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for direct intervention and support services to the child and the child's family. Crisis ~~assistance~~ planning must include preparing resources designed to address abrupt or substantial changes in the functioning of the child or the child's family when sudden change in behavior or a loss of usual coping mechanisms is observed, or the child begins to present a danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan and individual behavior plan, ~~which are performed minimally by a paraprofessional qualified according to subdivision 7, paragraph (b), clause (3),~~ and which are designed to improve the functioning of the child in the progressive use of developmentally appropriate psychosocial skills. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (t), as previously taught by a mental health professional, clinical trainee, or mental health practitioner including:

(i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions so that the child progressively recognizes and responds to the cues independently;

(ii) performing as a practice partner or role-play partner;

(iii) reinforcing the child's accomplishments;

(iv) generalizing skill-building activities in the child's multiple natural settings;

(v) assigning further practice activities; and

(vi) intervening as necessary to redirect the child's target behavior and to de-escalate behavior that puts the child or other person at risk of injury.

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with an emotional disturbance or a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must implement treatment strategies in the individual treatment plan and the individual behavior plan as developed by the mental health professional, clinical trainee, or mental health practitioner providing direction for the mental health behavioral aide. The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies; and

~~(5) direction of a mental health behavioral aide must include the following:~~

~~(i) ongoing face-to-face observation of the mental health behavioral aide delivering services to a child by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and~~

~~(ii) immediate accessibility of the mental health professional, clinical trainee, or mental health practitioner to the mental health behavioral aide during service provision;~~

~~(6)~~ (5) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to ~~review, revise, and sign~~ approve the individual treatment plan. ~~Notwithstanding Minnesota Rules, part 9505.0371, subpart 7,~~ Medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If

upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development~~; and~~.

~~(7) to be eligible for payment, a diagnostic assessment must be complete with regard to all required components, including multiple assessment appointments required for an extended diagnostic assessment and the written report. Dates of the multiple assessment appointments must be noted in the client's clinical record.~~

Sec. 92. Minnesota Statutes 2020, section 256B.0943, subdivision 11, is amended to read:

Subd. 11. **Documentation and billing.** ~~(a)~~ A provider entity must document the services it provides under this section. The provider entity must ensure that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. Billing for covered service components under subdivision 2, paragraph (b), must not include anything other than direct service time.

~~(b) An individual mental health provider must promptly document the following in a client's record after providing services to the client:~~

~~(1) each occurrence of the client's mental health service, including the date, type, start and stop times, scope of the service as described in the child's individual treatment plan, and outcome of the service compared to baselines and objectives;~~

~~(2) the name, dated signature, and credentials of the person who delivered the service;~~

~~(3) contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools. The provider must document the name and date of each contact;~~

~~(4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative, if applicable;~~

~~(5) required clinical supervision directly related to the identified client's services and needs, as appropriate, with co-signatures of the supervisor and supervisee; and~~

~~(6) the date when services are discontinued and reasons for discontinuation of services.~~

Sec. 93. Minnesota Statutes 2020, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) ~~Effective May 23, 2013, and~~ Subject to federal approval, medical assistance covers medically necessary intensive

treatment services ~~described under paragraph (b) that~~ when the services are provided by a provider entity ~~eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the regulations established by a federally recognized Minnesota tribe~~ certified under and meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) Intensive treatment services to children with mental illness residing in foster family settings that comprise specific required service components provided in clauses (1) to (5) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~;

(2) crisis ~~assistance provided according to standards for children's therapeutic services and supports in section 256B.0943~~ planning;

(3) individual, family, and group psychoeducation services~~, defined in subdivision 1a, paragraph (q),~~ provided by a mental health professional or a clinical trainee;

(4) clinical care consultation~~, as defined in subdivision 1a, and~~ provided by a mental health professional or a clinical trainee; and

(5) service delivery payment requirements as provided under subdivision 4.

Sec. 94. Minnesota Statutes 2020, section 256B.0946, subdivision 1a, is amended to read:

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

(a) "Clinical care consultation" means communication from a treating clinician to other providers working with the same client to inform, inquire, and instruct regarding the client's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, including but not limited to the client's school, social services, day care, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the client and family.

~~(b) "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for~~

~~the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.~~

~~(c) "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.~~

~~(d)~~ (b) "Clinical trainee" ~~has the meaning given in Minnesota Rules, part 9505.0371, subpart 5, item C;~~ means a staff person who is qualified according to section 245I.04, subdivision 6.

~~(e)~~ (c) "Crisis ~~assistance~~ planning" has the meaning given in section 245.4871, subdivision 9a~~, including the development of a plan that addresses prevention and intervention strategies to be used in a potential crisis, but does not include actual crisis intervention~~.

~~(f)~~ (d) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences~~, as defined in Minnesota Rules, part 9505.0370, subpart 9,~~ into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

~~(g)~~ (e) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

~~(h)~~ (f) "Standard diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 11~~ means the assessment described in section 245I.10, subdivision 6.

~~(i)~~ (g) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

~~(j)~~ (h) "Foster care" has the meaning given in section 260C.007, subdivision 18.

~~(k)~~ (i) "Foster family setting" means the foster home in which the license holder resides.

~~(l)~~ (j) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 15~~ means the plan described in section 245I.10, subdivisions 7 and 8.

~~(m) "Mental health practitioner" has the meaning given in section 245.462, subdivision 17, and a mental health practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C.~~

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

~~(n)~~ (l) "Mental health professional" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 18~~ means a staff person who is qualified according to section 245I.04, subdivision 2.

~~(o)~~ (m) "Mental illness" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 20~~ section 245I.02, subdivision 29.

~~(p)~~ (n) "Parent" has the meaning given in section 260C.007, subdivision 25.

~~(q)~~ (o) "Psychoeducation services" means information or demonstration provided to an individual, family, or group to explain, educate, and support the individual, family, or group in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

~~(r)~~ (p) "Psychotherapy" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 27~~ means the treatment described in section 256B.0671, subdivision 11.

~~(s)~~ (q) "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

(r) "Trauma" has the meaning given in section 245I.02, subdivision 38.

(s) "Treatment supervision" means the supervision described under section 245I.06.

Sec. 95. Minnesota Statutes 2020, section 256B.0946, subdivision 2, is amended to read:

Subd. 2. **Determination of client eligibility.** An eligible recipient is an individual, from birth through age 20, who is currently placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the regulations established by a federally recognized Minnesota tribe, and has received: (1) a

standard diagnostic assessment ~~and an evaluation of level of care needed, as defined in paragraphs (a) and (b).~~ within 180 days before the start of service that documents that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments; and (2) a level of care assessment as defined in section 245I.02, subdivision 19, that demonstrates that the individual requires intensive intervention without 24-hour medical monitoring, and a functional assessment as defined in section 245I.02, subdivision 17. The level of care assessment and the functional assessment must include information gathered from the placing county, tribe, or case manager.

~~(a) The diagnostic assessment must:~~

~~(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be conducted by a mental health professional or a clinical trainee;~~

~~(2) determine whether or not a child meets the criteria for mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20;~~

~~(3) document that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments;~~

~~(4) be performed within 180 days before the start of service; and~~

~~(5) be completed as either a standard or extended diagnostic assessment annually to determine continued eligibility for the service.~~

~~(b) The evaluation of level of care must be conducted by the placing county, tribe, or case manager in conjunction with the diagnostic assessment as described by Minnesota Rules, part 9505.0372, subpart 1, item B, using a validated tool approved by the commissioner of human services and not subject to the rulemaking process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates that the child requires intensive intervention without 24-hour medical monitoring. The commissioner shall update the list of approved level of care tools annually and publish on the department's website.~~

Sec. 96. Minnesota Statutes 2020, section 256B.0946, subdivision 3, is amended to read:

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive children's mental health services in a foster family setting must be certified by the state and have a service provision contract with a county board or a reservation tribal council and must be able to demonstrate the ability to provide all of the services required in this section and meet the standards in chapter 245I, as required in section 245I.011, subdivision 5.

(b) For purposes of this section, a provider agency must be:

(1) a county-operated entity certified by the state;

(2) an Indian Health Services facility operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

(3) a noncounty entity.

(c) Certified providers that do not meet the service delivery standards required in this section shall be subject to a decertification process.

(d) For the purposes of this section, all services delivered to a client must be provided by a mental health professional or a clinical trainee.

Sec. 97. Minnesota Statutes 2020, section 256B.0946, subdivision 4, is amended to read:

Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under this section, a provider must develop and practice written policies and procedures for intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply with the following requirements in paragraphs (b) to ~~(n)~~ (l).

~~(b) A qualified clinical supervisor, as defined in and performing in compliance with Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and provision of services described in this section.~~

~~(c) Each client receiving treatment services must receive an extended diagnostic assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30 days of enrollment in this service unless the client has a previous extended diagnostic assessment that the client, parent, and mental health professional agree still accurately describes the client's current mental health functioning.~~

~~(d)~~ (b) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received. This information must be reviewed and incorporated into the standard diagnostic assessment and team consultation and treatment planning review process.

~~(e)~~ (c) Each client receiving treatment must be assessed for a trauma history, and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

(d) The level of care assessment as defined in section 245I.02, subdivision 19, and functional assessment as defined in section 245I.02, subdivision 17, must be updated at least every 90 days or prior to discharge from the service, whichever comes first.

~~(f)~~ (e) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and ~~signed~~ approved every 90 days using the team consultation and treatment planning process~~, as defined in subdivision 1a, paragraph (s)~~.

~~(g)~~ (f) Clinical care consultation~~, as defined in subdivision 1a, paragraph (a),~~ must be provided in accordance with the client's individual treatment plan.

~~(h)~~ (g) Each client must have a crisis ~~assistance~~ plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.

~~(i)~~ (h) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week, unless reduced units of service are specified on the treatment plan as part of transition or on a discharge plan to another service or level of care. ~~Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.~~

~~(j)~~ (i) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

~~(k)~~ (j) Treatment must be developmentally and culturally appropriate for the client.

~~(l)~~ (k) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects.

~~(m)~~ (l) Parents, siblings, foster parents, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

~~(n)~~ (m) Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

Sec. 98. Minnesota Statutes 2020, section 256B.0946, subdivision 6, is amended to read:

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

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

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

(6) crisis response services under section ~~256B.0944~~ 256B.0624; ~~and~~

(7) transportation~~.~~; and

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

(b) Children receiving intensive treatment in foster care services are not eligible for medical assistance reimbursement for the following services while receiving intensive treatment in foster care:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section ~~256B.0625, subdivision 35b~~ 256B.0943;

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

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) room and board costs as defined in section 256I.03, subdivision 6.

Sec. 99. Minnesota Statutes 2020, section 256B.0947, subdivision 1, is amended to read:

Subdivision 1. **Scope.** ~~Effective November 1, 2011, and~~ Subject to federal approval, medical assistance covers medically necessary, intensive nonresidential rehabilitative mental health services ~~as defined in subdivision 2, for recipients as defined in subdivision 3,~~ when the services are provided by an entity meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Sec. 100. Minnesota Statutes 2020, section 256B.0947, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, as adapted for youth, and are directed to recipients ~~ages 16, 17, 18, 19, or 20 with a serious mental illness or co-occurring mental illness and substance abuse addiction~~ who require intensive services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

(b) "Co-occurring mental illness and substance ~~abuse addiction~~ use disorder" means a dual diagnosis of at least one form of mental illness and at least one substance use disorder. Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine use.

(c) "Standard diagnostic assessment" ~~has the meaning given to it in Minnesota Rules, part 9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota Rules, part 9505.0372, subpart 1, and for this section must incorporate a determination of the youth's necessary level of care using a standardized functional assessment instrument approved and periodically updated by the commissioner~~ means the assessment described in section 245I.10, subdivision 6.

~~(d) "Education specialist" means an individual with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities.~~

~~(e) "Housing access support" means an ancillary activity to help an individual find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.~~

~~(f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring mental illness and substance use disorders by a team of cross-trained clinicians within the same program, and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment.~~

~~(g)~~ (d) "Medication education services" means services provided individually or in groups, which focus on:

(1) educating the client and client's family or significant nonfamilial supporters about mental illness and symptoms;

(2) the role and effects of medications in treating symptoms of mental illness; and

(3) the side effects of medications.

Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses with certification in psychiatric and mental health care.

~~(h) "Peer specialist" means an employed team member who is a mental health certified peer specialist according to section 256B.0615 and also a former children's mental health consumer who:~~

~~(1) provides direct services to clients including social, emotional, and instrumental support and outreach;~~

~~(2) assists younger peers to identify and achieve specific life goals;~~

~~(3) works directly with clients to promote the client's self-determination, personal responsibility, and empowerment;~~

~~(4) assists youth with mental illness to regain control over their lives and their developmental process in order to move effectively into adulthood;~~

~~(5) provides training and education to other team members, consumer advocacy organizations, and clients on resiliency and peer support; and~~

~~(6) meets the following criteria:~~

~~(i) is at least 22 years of age;~~

~~(ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20, or co-occurring mental illness and substance abuse addiction;~~

~~(iii) is a former consumer of child and adolescent mental health services, or a former or current consumer of adult mental health services for a period of at least two years;~~

~~(iv) has at least a high school diploma or equivalent;~~

~~(v) has successfully completed training requirements determined and periodically updated by the commissioner;~~

~~(vi) is willing to disclose the individual's own mental health history to team members and clients; and~~

~~(vii) must be free of substance use problems for at least one year.~~

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

~~(i)~~ (f) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.

~~(j)~~ (g) "Substance use disorders" means one or more of the disorders defined in the diagnostic and statistical manual of mental disorders, current edition.

~~(k)~~ (h) "Transition services" means:

(1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the client to establish provider relationships;

(2) providing the client with knowledge and skills needed posttransition;

(3) establishing communication between sending and receiving entities;

(4) supporting a client's request for service authorization and enrollment; and

(5) establishing and enforcing procedures and schedules.

A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.

~~(l)~~ (i) "Treatment team" means all staff who provide services to recipients under this section.

~~(m)~~ (j) "Family peer specialist" means a staff person who is qualified under section 256B.0616.

Sec. 101. Minnesota Statutes 2020, section 256B.0947, subdivision 3, is amended to read:

Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

(1) is age 16, 17, 18, 19, or 20; and

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance ~~abuse addiction~~ use disorder, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a ~~level-of-care determination, using an instrument approved by the commissioner~~ level of care assessment as defined in section 245I.02, subdivision 19, that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers;

(4) has received a functional assessment as defined in section 245I.02, subdivision 17, that indicates functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system within the next two years; and

(5) has had a recent standard diagnostic assessment~~, as provided in Minnesota Rules, part 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A,~~ that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

Sec. 102. Minnesota Statutes 2020, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** ~~(a) Subject to federal approval, medical assistance covers all medically necessary intensive nonresidential rehabilitative mental health services and supports, as defined in this section, under a single daily rate per client. Services and supports must be delivered by an eligible provider under subdivision 5 to an eligible client under subdivision 3.~~

~~(b)~~ (a) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities are covered by ~~the~~ a single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

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

(3) crisis ~~assistance~~ planning as defined in section 245.4871, subdivision 9a~~, which includes recognition of factors precipitating a mental health crisis, identification of behaviors related to the crisis, and the development of a plan to address prevention, intervention, and follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental health crisis; crisis assistance does not mean crisis response services or crisis intervention services provided in section 256B.0944~~;

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

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

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

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

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

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

(10) coordination with, or performance of, crisis intervention and stabilization services as defined in section ~~256B.0944~~ 256B.0624;

~~(11) assessment of a client's treatment progress and effectiveness of services using standardized outcome measures published by the commissioner;~~

~~(12)~~ (11) transition services ~~as defined in this section~~;

~~(13) integrated dual disorders treatment as defined in this section~~ (12) co-occurring substance use disorder treatment as defined in section 245I.02, subdivision 11; and

~~(14)~~ (13) housing access support that assists clients to find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

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

~~(1)~~ client access to crisis intervention services, as defined in section ~~256B.0944~~ 256B.0624, and available 24 hours per day and seven days per week~~;~~.

~~(2) completion of an extended diagnostic assessment, as defined in Minnesota Rules, part 9505.0372, subpart 1, item C; and~~

~~(3) determination of the client's needed level of care using an instrument approved and periodically updated by the commissioner.~~

Sec. 103. Minnesota Statutes 2020, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must ~~be provided by a provider entity as provided in subdivision 4~~ meet the standards in this section and chapter 245I as required in section 245I.011, subdivision 5.

(b) The treatment team for intensive nonresidential rehabilitative mental health services comprises both permanently employed core team members and client-specific team members as follows:

(1) ~~The core treatment team is an entity that operates under the direction of an independently licensed mental health professional, who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility for clients.~~ Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must minimally include~~, but is not limited to~~:

(i) ~~an independently licensed~~ a mental health professional~~, qualified under Minnesota Rules, part 9505.0371, subpart 5, item A,~~ who serves as team leader to provide administrative direction and ~~clinical~~ treatment supervision to the team;

(ii) an advanced-practice registered nurse with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist, either of which must be credentialed to prescribe medications;

(iii) a licensed alcohol and drug counselor who is also trained in mental health interventions; and

(iv) a mental health certified peer specialist ~~as defined in subdivision 2, paragraph (h)~~ who is qualified according to section 245I.04, subdivision 10, and is also a former children's mental health consumer.

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a clinical trainee qualified according to section 245I.04, subdivision 6;

(vi) a mental health practitioner~~, as defined in section 245.4871, subdivision 26~~ qualified according to section 245I.04, subdivision 4;

~~(vi)~~ (vii) a case management service provider, as defined in section 245.4871, subdivision 4;

~~(vii)~~ (viii) a housing access specialist; and

~~(viii)~~ (ix) a family peer specialist as defined in subdivision 2, paragraph (m).

(3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc members not employed by the team who consult on a specific client and who must accept overall clinical direction from the treatment team for the duration of the client's placement with the treatment team and must be paid by the provider agency at the rate for a typical session by that provider with that client or at a rate negotiated with the client-specific member. Client-specific treatment team members may include:

(i) the mental health professional treating the client prior to placement with the treatment team;

(ii) the client's current substance ~~abuse~~ use counselor, if applicable;

(iii) a lead member of the client's individualized education program team or school-based mental health provider, if applicable;

(iv) a representative from the client's health care home or primary care clinic, as needed to ensure integration of medical and behavioral health care;

(v) the client's probation officer or other juvenile justice representative, if applicable; and

(vi) the client's current vocational or employment counselor, if applicable.

(c) The ~~clinical~~ treatment supervisor shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team shall meet with the ~~clinical~~ treatment supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting must include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the individual client's treatment record.

(d) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

(e) The treatment team shall serve no more than 80 clients at any one time. Should local demand exceed the team's capacity, an additional team must be established rather than exceed this limit.

(f) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner, clinical trainee, or mental health professional. The provider shall have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(g) The intensive nonresidential rehabilitative mental health services provider shall participate in evaluation of the assertive community treatment for youth (Youth ACT) model as conducted by the commissioner, including the collection and reporting of data and the reporting of performance measures as specified by contract with the commissioner.

(h) A regional treatment team may serve multiple counties.

Sec. 104. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team must use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) Services must be age-appropriate and meet the specific needs of the client.

(d) The ~~initial functional assessment must be completed within ten days of intake and~~ level of care assessment as defined in section 245I.02, subdivision 19, and functional assessment as defined in section 245I.02, subdivision 17, must be updated at least every ~~six months~~ 90 days or prior to discharge from the service, whichever comes first.

(e) An individual treatment plan must be completed for each client, according to section 245I.10, subdivisions 7 and 8, and, additionally, must:

~~(1) be based on the information in the client's diagnostic assessment and baselines;~~

~~(2) identify goals and objectives of treatment, a treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;~~

~~(3) be developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;~~

~~(4) be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessments, and treatment planning;~~

~~(5) be reviewed at least once every six months and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment;~~

~~(6) be signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;~~

~~(7)~~ (1) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan;

~~(8)~~ (2) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment;

(ii) develop a schedule for accomplishing substance use disorder treatment goals and objectives; and

(iii) identify the individuals responsible for providing substance use disorder treatment services and supports;

~~(ii) be reviewed at least once every 90 days and revised, if necessary;~~

~~(9) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and~~

~~(10)~~ (3) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services~~.~~; and

(4) notwithstanding section 245I.10, subdivision 8, be reviewed at least every 90 days and revised to document treatment progress or, if progress is not documented, to document changes in treatment.

(f) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(g) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(h) The treatment team shall provide interventions to promote positive interpersonal relationships.

Sec. 105. Minnesota Statutes 2020, section 256B.0947, subdivision 7, is amended to read:

Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this section must be based on one daily encounter rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services, supports, and ancillary activities under this section, staff travel time to provide rehabilitative services under this section, and crisis response services under section ~~256B.0944~~ 256B.0624.

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

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

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

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

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

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

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

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

Sec. 106. Minnesota Statutes 2020, section 256B.0949, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this subdivision.

(b) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide EIDBI services and that has the legal responsibility to ensure that its employees or contractors carry out the responsibilities defined in this section. Agency includes a licensed individual professional who practices independently and acts as an agency.

(c) "Autism spectrum disorder or a related condition" or "ASD or a related condition" means either autism spectrum disorder (ASD) as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found to be closely related to ASD, as identified under the current version of the DSM, and meets all of the following criteria:

(1) is severe and chronic;

(2) results in impairment of adaptive behavior and function similar to that of a person with ASD;

(3) requires treatment or services similar to those required for a person with ASD; and

(4) results in substantial functional limitations in three core developmental deficits of ASD: social or interpersonal interaction; functional communication, including nonverbal or social communication; and restrictive or repetitive behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits or a high level of support in one or more of the following domains:

(i) behavioral challenges and self-regulation;

(ii) cognition;

(iii) learning and play;

(iv) self-care; or

(v) safety.

(d) "Person" means a person under 21 years of age.

(e) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including individual treatment planning, staff supervision, individual treatment plan progress monitoring, and treatment review for each person. Clinical supervision is provided by a qualified supervising professional (QSP) who takes full professional responsibility for the service provided by each supervisee.

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

(g) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive evaluation of a person to determine medical necessity for EIDBI services based on the requirements in subdivision 5.

(h) "Department" means the Department of Human Services, unless otherwise specified.

(i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI benefit" means a variety of individualized, intensive treatment modalities approved and published by the commissioner that are based in behavioral and developmental science consistent with best practices on effectiveness.

(j) "Generalizable goals" means results or gains that are observed during a variety of activities over time with different people, such as providers, family members, other adults, and people, and in different environments including, but not limited to, clinics, homes, schools, and the community.

(k) "Incident" means when any of the following occur:

(1) an illness, accident, or injury that requires first aid treatment;

(2) a bump or blow to the head; or

(3) an unusual or unexpected event that jeopardizes the safety of a person or staff, including a person leaving the agency unattended.

(l) "Individual treatment plan" or "ITP" means the person-centered, individualized written plan of care that integrates and coordinates person and family information from the CMDE

for a person who meets medical necessity for the EIDBI benefit. An individual treatment plan must meet the standards in subdivision 6.

(m) "Legal representative" means the parent of a child who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about service for a person. For the purpose of this subdivision, "other representative with legal authority to make decisions" includes a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(n) "Mental health professional" ~~has the meaning given in~~ means a staff person who is qualified according to section ~~245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

(o) "Person-centered" means a service that both responds to the identified needs, interests, values, preferences, and desired outcomes of the person or the person's legal representative and respects the person's history, dignity, and cultural background and allows inclusion and participation in the person's community.

(p) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or level III treatment provider.

Sec. 107. Minnesota Statutes 2020, section 256B.0949, subdivision 4, is amended to read:

Subd. 4. **Diagnosis.** (a) A diagnosis of ASD or a related condition must:

(1) be based upon current DSM criteria including direct observations of the person and information from the person's legal representative or primary caregivers;

(2) be completed by either (i) a licensed physician or advanced practice registered nurse or (ii) a mental health professional; and

(3) meet the requirements of ~~Minnesota Rules, part 9505.0372, subpart 1, items B and C~~ a standard diagnostic assessment according to section 245I.10, subdivision 6.

(b) Additional assessment information may be considered to complete a diagnostic assessment including specialized tests administered through special education evaluations and licensed school personnel, and from professionals licensed in the fields of medicine, speech and language, psychology, occupational therapy, and physical therapy. A diagnostic assessment may include treatment recommendations.

Sec. 108. Minnesota Statutes 2020, section 256B.0949, subdivision 5a, is amended to read:

Subd. 5a. **Comprehensive multidisciplinary evaluation provider qualification.** A CMDE provider must:

(1) be a licensed physician, advanced practice registered nurse, a mental health professional, or a ~~mental health practitioner who meets the requirements of a~~ clinical trainee ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~ who is qualified according to section 245I.04, subdivision 6;

(2) have at least 2,000 hours of clinical experience in the evaluation and treatment of people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in the following content areas: ASD or a related condition diagnosis, ASD or a related condition treatment strategies, and child development; and

(3) be able to diagnose, evaluate, or provide treatment within the provider's scope of practice and professional license.

Sec. 109. Minnesota Statutes 2020, section 256B.25, subdivision 3, is amended to read:

Subd. 3. **Payment exceptions.** The limitation in subdivision 2 shall not apply to:

(1) payment of Minnesota supplemental assistance funds to recipients who reside in facilities which are involved in litigation contesting their designation as an institution for treatment of mental disease;

(2) payment or grants to a boarding care home or supervised living facility licensed by the Department of Human Services under Minnesota Rules, parts 2960.0130 to 2960.0220 ~~or~~, 2960.0580 to 2960.0700, or 9520.0500 to 9520.0670, or under chapter 245G or 245I, or payment to recipients who reside in these facilities;

(3) payments or grants to a boarding care home or supervised living facility which are ineligible for certification under United States Code, title 42, sections 1396-1396p;

(4) payments or grants otherwise specifically authorized by statute or rule.

Sec. 110. Minnesota Statutes 2020, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall

be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

~~(c) The commissioner shall establish three levels of payment for mental health diagnostic assessment, based on three levels of complexity. The aggregate payment under the tiered rates must not exceed the projected aggregate payments for mental health diagnostic assessment under the previous single rate. The new rate structure is effective January 1, 2011, or upon federal approval, whichever is later.~~

~~(d)~~ (c) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

~~(e)~~ (d) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

Sec. 111. Minnesota Statutes 2020, section 256B.763, is amended to read:

256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.

(a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

(2) community mental health centers under section 256B.0625, subdivision 5; and

(3) mental health clinics ~~and centers~~ certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20, or hospital outpatient psychiatric departments that are designated as essential community providers under section 62Q.19.

(b) This increase applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

(c) This increase does not apply to rates that are governed by section 256B.0625, subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

(d) The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in paragraphs (a), (e), and (f). The prepaid health plan must pass this rate increase to the providers identified in paragraphs (a), (e), (f), and (g).

(e) Payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007, for:

(1) medication education services provided on or after January 1, 2008, by adult rehabilitative mental health services providers certified under section 256B.0623; and

(2) mental health behavioral aide services provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943 and not already included in paragraph (a), payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007.

(g) Payment rates shall be increased by 2.3 percent over the rates in effect on December 31, 2007, for individual and family skills training provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(h) For services described in paragraphs (b), (e), and (g) and rendered on or after July 1, 2017, payment rates for mental health clinics ~~and centers~~ certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20, that are not designated as essential community providers under section 62Q.19 shall be equal to payment rates for mental health clinics ~~and centers~~ certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20,

that are designated as essential community providers under section 62Q.19. In order to receive increased payment rates under this paragraph, a provider must demonstrate a commitment to serve low-income and underserved populations by:

(1) charging for services on a sliding-fee schedule based on current poverty income guidelines; and

(2) not restricting access or services because of a client's financial limitation.

Sec. 112. Minnesota Statutes 2020, section 256P.01, subdivision 6a, is amended to read:

Subd. 6a. **Qualified professional.** (a) For illness, injury, or incapacity, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse, physical therapist, occupational therapist, or licensed chiropractor, according to their scope of practice.

(b) For developmental disability, learning disability, and intelligence testing, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse, licensed independent clinical social worker, licensed psychologist, certified school psychologist, or certified psychometrist working under the supervision of a licensed psychologist.

(c) For mental health, a "qualified professional" means a licensed physician, advanced practice registered nurse, or qualified mental health professional under section ~~245.462, subdivision 18, clauses (1) to (6)~~ 245I.04, subdivision 2.

(d) For substance use disorder, a "qualified professional" means a licensed physician, a qualified mental health professional under section 245.462, subdivision 18, clauses (1) to (6), or an individual as defined in section 245G.11, subdivision 3, 4, or 5.

Sec. 113. Minnesota Statutes 2020, section 295.50, subdivision 9b, is amended to read:

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

(1) bed and board;

(2) nursing services and other related services;

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

(4) medical social services;

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

(6) other diagnostic or therapeutic items or services;

(7) medical or surgical services;

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

(9) emergency services.

(b) "Patient services" does not include:

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

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

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

(4) services provided under the following programs: day treatment services as defined in section 245.462, subdivision 8; assertive community treatment as described in section 256B.0622; adult rehabilitative mental health services as described in section 256B.0623; ~~adult~~ crisis response services as described in section 256B.0624; and children's therapeutic services and supports as described in section 256B.0943; ~~and children's mental health crisis response services as described in section 256B.0944;~~

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

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

(7) hospice care services;

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

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

(10) services provided to the following: supervised living facilities for persons with developmental disabilities licensed under Minnesota Rules, parts 4665.0100 to 4665.9900;

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

Sec. 114. Minnesota Statutes 2020, section 325F.721, subdivision 1, is amended to read:

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

(b) "Covered setting" means an unlicensed setting providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, supportive services. For the purposes of this section, covered setting does not mean:

(1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361;

(2) a nursing home licensed under chapter 144A;

(3) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56;

(4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D ~~or~~, 245G, or 245I;

(5) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D;

(6) private homes in which the residents are related by kinship, law, or affinity with the providers of services;

(7) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(8) temporary family health care dwellings as defined in sections 394.307 and 462.3593;

(9) settings offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing;

(10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services;

(11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q;

(12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56;

(13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011; or

(14) an assisted living facility licensed under chapter 144G.

(c) "'I'm okay' check services" means providing a service to, by any means, check on the safety of a resident.

(d) "Resident" means a person entering into written contract for housing and services with a covered setting.

(e) "Supportive services" means:

(1) assistance with laundry, shopping, and household chores;

(2) housekeeping services;

(3) provision of meals or assistance with meals or food preparation;

(4) help with arranging, or arranging transportation to, medical, social, recreational, personal, or social services appointments; or

(5) provision of social or recreational services.

Arranging for services does not include making referrals or contacting a service provider in an emergency.

Sec. 115. **REPEALER.**

(a) Minnesota Statutes 2020, sections 245.462, subdivision 4a; 245.4879, subdivision 2; 245.62, subdivisions 3 and 4; 245.69, subdivision 2; 256B.0615, subdivision 2; 256B.0616, subdivision 2; 256B.0622, subdivisions 3 and 5a; 256B.0623, subdivisions 7, 8, 10, and 11; 256B.0625, subdivisions 5l, 35a, 35b, 61, 62, and 65; 256B.0943, subdivisions 8 and 10; 256B.0944; and 256B.0946, subdivision 5, are repealed.

(b) Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020; 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090; 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160; 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; 9520.0230; 9520.0750; 9520.0760; 9520.0770; 9520.0780; 9520.0790; 9520.0800; 9520.0810; 9520.0820; 9520.0830; 9520.0840; 9520.0850; 9520.0860; and 9520.0870, are repealed.

Sec. 116. **EFFECTIVE DATE.**

This article is effective upon federal approval or July 1, 2022, whichever is later, unless otherwise noted. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 11
FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2019, First Special Session chapter 9, article 14, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2021" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2021.

	APPROPRIATIONS Available for the Year Ending June 30 2021
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	
Subdivision 1. **Total Appropriation**	**$ (816,996,000)**

	Appropriations by Fund	
	2021	
General	(745,266,000)	
Health Care Access	(36,893,000)	
Federal TANF	(34,837,000)	

Subd. 2. **Forecasted Programs**

(a) **Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP)**

	Appropriations by Fund	
	2021	
General	59,004,000	
Federal TANF	(34,843,000)	

(b) **MFIP Child Care Assistance** (54,158,000)

(c) **General Assistance** 3,925,000

(d) **Minnesota Supplemental Aid** 3,849,000

(e) **Housing Support** 3,022,000

(f) **Northstar Care for Children** (8,639,000)

(g) **MinnesotaCare** (36,893,000)

This appropriation is from the health care access fund.

(h) **Medical Assistance**

	Appropriations by Fund	
	2021	
General	(694,938,000)	
Health Care Access	-0-	

(i) **Alternative Care** 247,000

(j) **Consolidated Chemical Dependency Treatment Fund (CCDTF) Entitlement** (57,578,000)

Subd. 3. **Technical Activities** 6,000

This appropriation is from the federal TANF fund.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 12

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2022" and "2023" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2022, or June 30, 2023, respectively. "The first year" is fiscal year 2022. "The second year" is fiscal year 2023. "The biennium" is fiscal years 2022 and 2023.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2022	**2023**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	**$**	**9,045,462,000**	**$** **9,534,697,000**

Appropriations by Fund

	2022	2023
General	7,884,210,000	8,405,243,000
State Government Special Revenue	4,299,000	4,299,000
Health Care Access	867,157,000	847,957,000
Federal TANF	285,340,000	272,842,000
Lottery Prize	1,896,000	1,896,000
Opiate Epidemic Response	2,560,000	2,560,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **TANF Maintenance of Effort**

(a) **Nonfederal Expenditures.** The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF/MOE requirements, the commissioner may report as TANF/MOE expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) **Nonfederal Expenditures; Reporting.** For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) **Limitation; Exceptions.** The commissioner must not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

(d) **Supplemental Expenditures.** For the purposes of paragraph (c), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(e) **Reduction of Appropriations; Exception.** The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(f) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(g) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for information systems projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner of management

and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

(h) **Federal SNAP Education and Training Grants.** Federal funds available during fiscal years 2022 and 2023 for Supplemental Nutrition Assistance Program Education and Training and SNAP Quality Control Performance Bonus grants are appropriated to the commissioner of human services for the purposes allowable under the terms of the federal award. This paragraph is effective the day following final enactment.

Subd. 3. **Central Office; Operations**

	Appropriations by Fund	
General	158,297,000	155,788,000
State Government Special Revenue	4,174,000	4,174,000
Health Care Access	16,966,000	16,966,000
Federal TANF	100,000	100,000

(a) **Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Background Studies.** $2,074,000 in fiscal year 2022 is from the general fund to provide a credit to providers who paid for emergency background studies in NETStudy 2.0. This is a onetime appropriation.

(c) **Base Level Adjustment.** The general fund base is $155,603,000 in fiscal year 2024 and $155,636,000 in fiscal year 2025.

Subd. 4. **Central Office; Children and Families**

	Appropriations by Fund	
General	17,684,000	18,189,000
Federal TANF	2,582,000	2,582,000

(a) **Indian Child Welfare Training.** $1,012,000 in fiscal year 2022 and $993,000 in fiscal year 2023 are from the general fund for establishment and operation of the Tribal Training and Certification Partnership at the University of Minnesota, Duluth campus, to provide training, establish federal Indian Child Welfare Act and Minnesota Indian Family Preservation Act training requirements for county child welfare workers, and develop Indigenous child welfare training for American Indian Tribes. The general fund base for this appropriation is $1,053,000 in fiscal year 2024 and $1,053,000 in fiscal year 2025.

(b) **Report on Participation in Early Childhood Programs by Children in Foster Care.** $200,000 in fiscal year 2022 and $90,000 in fiscal year 2023 are from the general fund for the interim and final reports on participation in early childhood programs by children in foster care. This is a onetime appropriation.

(c) **Ombudsperson for Child Care Providers.** $242,000 in fiscal year 2022 and $242,000 in fiscal year 2023 are from the general fund for the ombudsperson for child care providers under Minnesota Statutes, section 119B.27.

(d) **Parent Aware Validation Study.** $204,000 in fiscal year 2022 and $476,000 in fiscal year 2023 are from the general fund to contract with an independent third-party evaluator to conduct a validation study of the Parent Aware program. The base for this appropriation is $255,000 in fiscal year 2024 and $0 in fiscal year 2025.

(e) **Base Level Adjustment.** The general fund base is $18,168,000 in fiscal year 2024 and $17,913,000 in fiscal year 2025.

Subd. 5. **Central Office; Health Care**

Appropriations by Fund		
General	21,304,000	21,035,000
Health Care Access	28,168,000	28,168,000

Base Level Adjustment. The general fund base is $21,218,000 in fiscal year 2024 and $21,066,000 in fiscal year 2025.

Subd. 6. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	19,793,000	19,101,000
State Government Special Revenue	125,000	125,000

Base Level Adjustment. The general fund base is $19,161,000 in fiscal year 2024 and $19,174,000 in fiscal year 2025.

Subd. 7. **Central Office; Community Supports**

	Appropriations by Fund	
General	35,223,000	34,409,000
Lottery Prize	163,000	163,000
Opioid Epidemic Response	60,000	60,000

(a) **Substance Use Disorder Provider Reduction in Regulatory Requirements.** $125,000 in fiscal year 2022 and $75,000 in fiscal year 2023 are from the general fund for a contract with a vendor to develop statewide system improvements to minimize regulatory paperwork for substance use disorder programs. This is a onetime appropriation.

(b) **Substance Use Disorder Provider Payment Modifications.** $200,000 in fiscal year 2022 is from the general fund for a contract for a qualified vendor to conduct rate modeling and develop frameworks for all substance use disorder treatment rates. This is a onetime appropriation.

(c) **Substance Use Disorder Technical Assistance Centers.** $250,000 in fiscal year 2022 and $250,000 in fiscal year 2023 are from the general fund for one or more technical assistance centers for substance use disorder treatment providers.

(d) **Study on Sober Housing Program.** $77,000 in fiscal year 2022 and $13,000 in fiscal year 2023 are from the general fund to conduct a sober housing program study. This is a onetime appropriation.

(e) **Intensive Rehabilitation Mental Health Services Modifications.** $80,000 in fiscal year 2022 and $160,000 in fiscal year 2023 are from the general fund for a contract with a third party to provide specialized age-based training to intensive rehabilitation mental health treatment teams.

(f) **Base Level Adjustment.** The general fund base is $33,942,000 in fiscal year 2024 and $33,866,000 in fiscal year 2025. The opiate epidemic response fund base is $60,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 8. **Forecasted Programs; MFIP/DWP**

	Appropriations by Fund	
General	91,476,000	88,251,000
Federal TANF	102,003,000	94,776,000

Subd. 9. **Forecasted Programs; MFIP Child Care Assistance**	103,201,000	110,219,000
Subd. 10. **Forecasted Programs; General Assistance**	53,600,000	52,819,000

(a) **General Assistance Standard.** The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

(b) **Emergency General Assistance Limit.** The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2022 and $6,729,812 in fiscal year 2023. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

Subd. 11. **Forecasted Programs; Minnesota Supplemental Aid**	51,801,000	52,515,000
Subd. 12. **Forecasted Programs; Housing Support**	186,127,000	196,171,000
Subd. 13. **Forecasted Programs; Northstar Care for Children**	107,034,000	121,246,000
Subd. 14. **Forecasted Programs; MinnesotaCare**	207,380,000	187,159,000

This appropriation is from the health care access fund.

Subd. 15. **Forecasted Programs; Medical Assistance**

Appropriations by Fund		
General	6,098,351,000	6,572,616,000
Health Care Access	611,178,000	612,099,000

(a) **Behavioral Health Services.** $1,000,000 in fiscal year 2022 and $1,000,000 in fiscal year 2023 are from the general fund for behavioral health services provided by hospitals identified under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (a), clause (4). The increase in payments shall be made by increasing the adjustment under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (e), clause (2).

(b) **Retainer Payments for Home and Community-Based Service Providers.** $61,070,000 in fiscal year 2022 is from the

general fund for retainer payments for home and community-based service providers. This is a onetime appropriation and is available until June 30, 2023.

(c) **Personal Care Assistance Service Rate Increase.** $18,688,000 in fiscal year 2022 and $57,460,000 in fiscal year 2023 are from the general fund for the personal care assistance service rate increases described in this act. The general fund base for this appropriation is $60,899,000 in fiscal year 2024 and $63,766,000 in fiscal year 2025.

(d) **Home Care Service Rate Increase.** $4,800,000 in fiscal year 2022 and $4,926,000 in fiscal year 2023 are from the general fund for home care service rate increases described in this act. The general fund base for this appropriation is $5,064,000 in fiscal year 2024 and $5,210,000 in fiscal year 2025.

(e) **Elderly Waiver Rate Increase.** $6,057,000 in fiscal year 2022 and $6,136,000 in fiscal year 2023 are from the general fund for elderly waiver service rate increases described in this act. The general fund base for this appropriation is $6,707,000 in fiscal year 2024 and $7,357,000 in fiscal year 2025.

Subd. 16. **Forecasted Programs; Alternative Care** 45,487,000 45,185,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 17. **Forecasted Programs; Behavioral Health Fund** 96,205,000 120,389,000

Subd. 18. **Grant Programs; Support Services Grants**

	Appropriations by Fund	
General	8,715,000	8,715,000
Federal TANF	101,311,000	96,984,000

MFIP Consolidated Fund. $5,000,000 in fiscal year 2022 and $673,000 in fiscal year 2023 are from the federal TANF fund for the MFIP consolidated fund under Minnesota Statutes, section 256J.626. The federal TANF fund base for this appropriation is $5,000,000 in fiscal year 2024 and $5,000,000 in fiscal year 2025.

Base Level Adjustment. The federal TANF fund base is $101,311,000 in fiscal year 2024 and $101,311,000 in fiscal year 2025.

Subd. 19. **Grant Programs; Basic Sliding Fee Child Care Assistance Grants** 53,367,000 53,385,000

Base Level Adjustment. The general fund base is $53,389,000 in fiscal year 2024 and $53,389,000 in fiscal year 2025.

Subd. 20. **Grant Programs; Child Care Development Grants** 1,737,000 1,737,000

Subd. 21. **Grant Programs; Child Support Enforcement Grants** 50,000 50,000

Subd. 22. **Grant Programs; Children's Services Grants**

	Appropriations by Fund	
General	52,503,000	52,218,000
Federal TANF	140,000	140,000

(a) **Title IV-E Adoption Assistance.** (1) The commissioner shall allocate funds from the Title IV-E reimbursement to the state from the Fostering Connections to Success and Increasing Adoptions Act for adoptive, foster,

and kinship families as required in Minnesota Statutes, section 256N.261.

(2) Additional federal reimbursement to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for Title IV-E adoption assistance is for postadoption, foster care, adoption, and kinship services, including a parent-to-parent support network.

(b) **Initial Implementation of Court-Appointed Counsel in Child Protection Proceedings.** $520,000 in fiscal year 2022 and $520,000 in fiscal year 2023 are from the general fund for county costs related to court-appointed counsel in child protection proceedings pursuant to Minnesota Statutes, section 260C.163, subdivision 3. The commissioner shall distribute funds to counties that do not currently provide court-appointed counsel to all parents, guardians, or custodians who qualify for court-appointed counsel at emergency protective care hearings for reimbursement of costs related to providing this counsel.

Subd. 23. **Grant Programs; Children and Community Service Grants**	63,251,000	63,856,000

(a) **Family First Prevention Services Act Implementation.** $2,000,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 are from the general fund for grants to lead agencies for reduced Title IV-E federal reimbursement for room and board costs.

(b) **Additional Funding for Community Action Programs.** $1,000,000 in fiscal year 2022 and $1,000,000 in fiscal year 2023 are

from the general fund for community action programs.

Subd. 24. **Grant Programs; Children and Economic Support Grants** 22,990,000 22,740,000

(a) **Minnesota Food Assistance Program.** Unexpended funds for the Minnesota food assistance program for fiscal year 2022 do not cancel but are available in fiscal year 2023.

(b) **Grant to Minnesota Association for Volunteer Administration.** $250,000 in fiscal year 2022 is from the general fund for a grant to the Minnesota Association for Volunteer Administration to administer needs-based volunteerism subgrants. This is a onetime appropriation and is available until June 30, 2023.

Subd. 25. **Grant Programs; Health Care Grants**

Appropriations by Fund		
General	3,711,000	3,711,000
Health Care Access	3,465,000	3,465,000

Subd. 26. **Grant Programs; Other Long-Term Care Grants** 1,925,000 1,925,000

Subd. 27. **Grant Programs; Aging and Adult Services Grants** 32,995,000 32,995,000

Customized Living Quality Improvements Grants. $500,000 in fiscal year 2022 and $500,000 in fiscal year 2023 are from the general fund for customized living quality improvement grants under Minnesota Statutes, section 256.479.

Subd. 28. **Grant Programs; Deaf and Hard-of-Hearing Grants** 2,886,000 2,886,000

Subd. 29. **Grant Programs; Disabilities Grants** 23,291,000 22,903,000

(a) **Parent-to-Parent Peer Support.** $125,000 in fiscal year 2022 and $125,000 in fiscal year 2023 are from the general fund for a grant to an alliance member of Parent to Parent USA to support the alliance member's parent-to-parent peer support program for families of children with a disability or special health care need.

(b) **Self-Advocacy Grants.** (1) $143,000 in fiscal year 2022 and $143,000 in fiscal year 2023 are from the general fund for a grant under Minnesota Statutes, section 256.477, subdivision 1.

(2) $105,000 in fiscal year 2022 and $105,000 in fiscal year 2023 are from the general fund for subgrants under Minnesota Statutes, section 256.477, subdivision 2.

(c) **Minnesota Inclusion Initiative Grants.** $150,000 in fiscal year 2022 and $150,000 in fiscal year 2023 are from the general fund for grants under Minnesota Statutes, section 256.4772.

(d) **Grants to Expand Access to Child Care for Children with Disabilities.** $250,000 in fiscal year 2022 and $250,000 in fiscal year 2023 are from the general fund for grants to expand access to child care for children with disabilities. The commissioner may use up to seven percent of the appropriation for administration and technical assistance. This is a onetime appropriation.

(e) **Parenting with a Disability Pilot Project.** $250,000 in fiscal year 2022 and $250,000 in fiscal year 2023 are from the general fund for

the parenting with a disability pilot project. This is a onetime appropriation.

(f) **Base Level Adjustment.** The general fund base is $22,403,000 in fiscal year 2024 and $22,403,000 in fiscal year 2025.

Subd. 30. **Grant Programs; Housing Support Grants** 11,364,000 10,364,000

Integrated Community-Based Housing Pilot Project. $1,000,000 in fiscal year 2022 is from the general fund for competitive grants to nonprofits for the initial phase of the integrated community-based housing pilot project. The commissioner shall award competitive grants for the planning, design, construction, acquisition, and rehabilitation of permanent supportive housing that provides integrated community-based settings for people with disabilities and elderly individuals seeking to remain in their communities. This is a onetime appropriation and is available until June 30, 2023.

Subd. 31. **Grant Programs; Adult Mental Health Grants**

Appropriations by Fund		
General	83,323,000	83,324,000
Opiate Epidemic Response	2,000,000	2,000,000

Base Level Adjustment. The opiate epidemic response fund base is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 32. **Grant Programs; Child Mental Health Grants** 25,726,000 25,726,000

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

	Appropriations by Fund		
General	2,636,000	2,636,000	
Lottery Prize	1,733,000	1,733,000	
Opiate Epidemic Response	500,000	500,000	

(a) **Support Grants Problem Gambling Services.** The general fund base includes $2,508,000 in fiscal year 2022 and $1,508,000 in fiscal year 2023 for a grant to the state affiliate recognized by the National Council on Problem Gambling for problem gambling assessments; nonresidential and residential treatment of problem gambling and gambling disorder; training for gambling treatment providers and other behavioral health services providers; and research projects that evaluate awareness, prevention, education, treatment service, and recovery supports related to problem gambling and gambling disorder.

(b) **Base Level Adjustment.** The opiate epidemic response fund base is $500,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 34. **Direct Care and Treatment - Generally**

Transfer Authority. Money appropriated to budget activities under this subdivision and subdivisions 35 to 38 may be transferred between budget activities and between years of the biennium with the approval of the commissioner of management and budget.

Subd. 35. **Direct Care and Treatment - Mental Health and Substance Abuse**	129,197,000	129,197,000

Transfer Authority. Money appropriated to support the continued operations of the Community Addiction Recovery Enterprise

(C.A.R.E.) program may be transferred to the enterprise fund for C.A.R.E.

Subd. 36. **Direct Care and Treatment - Community-Based Services** 17,176,000 17,176,000

Transfer Authority. Money appropriated to support the continued operations of the Minnesota State Operated Community Services (MSOCS) program may be transferred to the enterprise fund for MSOCS.

Subd. 37. **Direct Care and Treatment - Forensic Services** 115,644,000 115,644,000

Subd. 38. **Direct Care and Treatment - Sex Offender Program** 96,285,000 96,285,000

Transfer Authority. Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

Subd. 39. **Direct Care and Treatment - Operations** 49,855,000 49,837,000

Plan to Address Effects on Community of Certain State-Operated Services. $18,000 in fiscal year 2022 is from the general fund to develop a plan to ameliorate the effects of repeated incidents occurring at Minnesota state-operated community services programs. This is a onetime appropriation.

Subd. 40. **Technical Activities** 79,204,000 78,260,000

This appropriation is from the federal TANF fund.

Base Level Adjustment. The federal TANF fund base is $71,493,000 in fiscal year 2024 and $71,493,000 in fiscal year 2025.

Sec. 3. **COMMISSIONER OF HEALTH** **$** **263,000** **216,000**

The general fund base for this appropriation is $229,000 in fiscal year 2024 and $229,000 in fiscal year 2025.

Sec. 4. **COUNCIL ON DISABILITY** **$ 1,022,000 $ 1,038,000**

Sec. 5. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,487,000 $ 2,536,000**

Department of Psychiatry Monitoring.

$100,000 in fiscal year 2022 and $100,000 in fiscal year 2023 are for monitoring the Department of Psychiatry at the University of Minnesota.

Sec. 6. **OMBUDSPERSONS FOR FAMILIES** **$ 733,000 $ 744,000**

Sec. 7. **LEGISLATIVE COORDINATING COMMISSION** **$ 132,000 $ 76,000**

Legislative Task Force on Human Services Background Study Disqualifications.

$132,000 in fiscal year 2022 and $76,000 in fiscal year 2023 are from the general fund for the Legislative Task Force on Human Services Background Study Eligibility. This is a onetime appropriation.

Sec. 8. **SUPREME COURT** **$ 30,000 $ -0-**

Sec. 9. **RETURN OF PAYMENTS FOR JENSEN SETTLEMENT COSTS.**

If the state receives funds disbursed from the United States District Court for the District of Minnesota registry related to Jensen v. Minnesota Department of Human Services, Civ. No. 09-1775 (DWF/BRT), then the commissioner shall deposit the disbursed funds, estimated to be $613,000, into an account in the general fund, and the balance of the account is appropriated to the commissioner of human services for the disability services system reform efforts of the Disability Services Division. The commissioner of human services shall allocate all of these funds to the operating budget of the Disability Services Division. By January 1, 2023, the commissioner of human services shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services on the uses of the funds appropriated under this section.

EFFECTIVE DATE. This section is effective retroactively from December 6, 2020.

Sec. 10. **APPROPRIATION; REFINANCING AND CANCELLATION OF EMERGENCY CHILD CARE GRANTS.**

$26,623,000 in fiscal year 2020 is appropriated from the federal coronavirus relief fund to the commissioner of human services to replace $26,623,000 of the general fund appropriation in Laws 2020, chapter 71, article 1, section 2, subdivision 9. $26,623,000 of the appropriation in Laws 2020, chapter 71, article 1, section 2, subdivision 9, is canceled to the general fund. This is a onetime appropriation.

EFFECTIVE DATE. This section is effective retroactively from March 29, 2020.

Sec. 11. **ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGE FOR HOME AND COMMUNITY-BASED SERVICES; DEPOSIT.**

Beginning April 1, 2021, the commissioner of management and budget shall deposit in the health care access fund all amounts, estimated to be $478,017,000, attributable to the enhanced federal medical assistance percentage for home and community-based services authorized in section 9817 of the federal American Rescue Plan Act, Public Law 117-2.

EFFECTIVE DATE. This section is effective retroactively from April 1, 2021.

Sec. 12. **ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGE FOR HOME AND COMMUNITY-BASED SERVICES; TRANSFERS.**

(a) The commissioner of management and budget shall transfer $76,643,000 in fiscal year 2022, $47,883,000 in fiscal year 2023, $50,749,000 in fiscal year 2024, and $53,069,000 in fiscal year 2025, from the health care access fund to the general fund to meet the maintenance of effort requirement under section 9817 of the federal American Rescue Plan Act, Public Law 117-2.

(b) The commissioner of management and budget shall transfer $249,673,000 in fiscal year 2022 from the health care access fund to the general fund to meet the maintenance of effort requirement under section 9817 of the federal American Rescue Plan Act, Public Law 117-2. This is section expires on June 30, 2025.

Sec. 13. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances

for the biennium ending June 30, 2023, within fiscal years among the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid program, group residential housing program, the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services as the commissioner considers necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance quarterly about transfers made under this section.

Sec. 14. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioner of human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 15. **APPROPRIATION ENACTED MORE THAN ONCE.**

If an appropriation in this act is enacted more than once in the 2021 legislative session, the appropriation must be given effect only once.

Sec. 16. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2023, unless a different expiration date is explicit.

Sec. 17. **EFFECTIVE DATE.**

This article is effective July 1, 2021, unless a different effective date is specified.

245.462 DEFINITIONS.

Subd. 4a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional cosigning individual treatment plans and by entries in the client's record regarding supervisory activities.

245.4871 DEFINITIONS.

Subd. 32a. **Responsible social services agency.** "Responsible social services agency" is defined in section 260C.007, subdivision 27a.

245.4879 EMERGENCY SERVICES.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to the child with an emotional disturbance provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) When emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

245.62 COMMUNITY MENTAL HEALTH CENTER.

Subd. 3. **Clinical supervisor.** All community mental health center services shall be provided under the clinical supervision of a licensed psychologist licensed under sections 148.88 to 148.98, or a physician who is board certified or eligible for board certification in psychiatry, and who is licensed under section 147.02.

Subd. 4. **Rules.** The commissioner shall promulgate rules to establish standards for the designation of an agency as a community mental health center. These standards shall include, but are not limited to:

(1) provision of mental health services in the prevention, identification, treatment and aftercare of emotional disorders, chronic and acute mental illness, developmental disabilities, and alcohol and drug abuse and dependency, including the services listed in section 245.61 except detoxification services;

(2) establishment of a community mental health center board pursuant to section 245.66; and

(3) approval pursuant to section 245.69, subdivision 2.

245.69 ADDITIONAL DUTIES OF COMMISSIONER.

Subd. 2. **Approval of centers and clinics.** The commissioner of human services has the authority to approve or disapprove public and private mental health centers and public and private mental health clinics for the purposes of section 62A.152, subdivision 2. For the purposes of this subdivision the commissioner shall promulgate rules in accordance with sections 14.001 to 14.69. The rules shall require each applicant to pay a fee to cover costs of processing applications and determining compliance with the rules and this subdivision. The commissioner may contract with any state agency, individual, corporation or association to which the commissioner shall delegate all but final approval and disapproval authority to determine compliance or noncompliance.

(a) Each approved mental health center and each approved mental health clinic shall have a multidisciplinary team of professional staff persons as required by rule. A mental health center or mental health clinic may provide the staffing required by rule by means of written contracts with professional persons or with other health care providers. Any personnel qualifications developed by rule shall be consistent with any personnel standards developed pursuant to chapter 214.

(b) Each approved mental health clinic and each approved mental health center shall establish a written treatment plan for each outpatient for whom services are reimbursable through insurance or public assistance. The treatment plan shall be developed in accordance with the rules and shall include a patient history, treatment goals, a statement of diagnosis and a treatment strategy. The clinic or center shall provide access to hospital admission as a bed patient as needed by any outpatient. The clinic or center shall ensure ongoing consultation among and availability of all members of the multidisciplinary team.

(c) As part of the required consultation, members of the multidisciplinary team shall meet at least twice monthly to conduct case reviews, peer consultations, treatment plan development and in-depth case discussion. Written minutes of these meetings shall be kept at the clinic or center for three years.

(d) Each approved center or clinic shall establish mechanisms for quality assurance and submit documentation concerning the mechanisms to the commissioner as required by rule, including:

(1) continuing education of each professional staff person;

(2) an ongoing internal utilization and peer review plan and procedures;

(3) mechanisms of staff supervision; and

(4) procedures for review by the commissioner or a delegate.

(e) The commissioner shall disapprove an applicant, or withdraw approval of a clinic or center, which the commissioner finds does not comply with the requirements of the rules or this subdivision. A clinic or center which is disapproved or whose approval is withdrawn is entitled to a contested case hearing and judicial review pursuant to sections 14.01 to 14.69.

(f) Data on individuals collected by approved clinics and centers, including written minutes of team meetings, is private data on individuals within the welfare system as provided in chapter 13.

(g) Each center or clinic that is approved and in compliance with the commissioner's existing rule on July 1, 1980, is approved for purposes of section 62A.152, subdivision 2, until rules are promulgated to implement this section.

245.735 EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.

Subdivision 1. **Excellence in Mental Health demonstration project.** The commissioner shall develop and execute projects to reform the mental health system by participating in the Excellence in Mental Health demonstration project.

Subd. 2. **Federal proposal.** The commissioner shall develop and submit to the United States Department of Health and Human Services a proposal for the Excellence in Mental Health demonstration project. The proposal shall include any necessary state plan amendments, waivers, requests for new funding, realignment of existing funding, and other authority necessary to implement the projects specified in subdivision 3.

Subd. 4. **Public participation.** In developing and implementing CCBHCs under subdivision 3, the commissioner shall consult, collaborate, and partner with stakeholders, including but not limited to mental health providers, substance use disorder treatment providers, advocacy organizations, licensed mental health professionals, counties, tribes, hospitals, other health care providers, and Minnesota public health care program enrollees who receive mental health services and their families.

252.28 COMMISSIONER OF HUMAN SERVICES; DUTIES.

Subdivision 1. **Determinations; redeterminations.** In conjunction with the appropriate county boards, the commissioner of human services shall determine, and shall redetermine at least every four years, the need, anticipated growth or decline in need until the next anticipated redetermination, location, size, and program of public and private day training and habilitation services for persons with developmental disabilities. This subdivision does not apply to semi-independent living services and residential-based habilitation services provided to four or fewer persons at a single site funded as home and community-based services. A determination of need shall not be required for a change in ownership.

Subd. 5. **Appeals.** A county may appeal a determination of need, size, location, or program according to chapter 14. Notice of appeals must be provided to the commissioner within 30 days after the receipt of the commissioner's determination.

252A.02 DEFINITIONS.

Subd. 8. **Public conservator.** "Public conservator" means the commissioner of human services when exercising some, but not all the powers designated in section 252A.111.

Subd. 10. **Conservatee.** "Conservatee" means a person with a developmental disability for whom the court has appointed a public conservator.

252A.21 GENERAL PROVISIONS.

Subd. 3. **Terminology.** Whenever the term "guardian" is used in sections 252A.01 to 252A.21, it shall include "conservator," and the term "ward" shall include "conservatee" unless another intention clearly appears from the context.

256B.0615 MENTAL HEALTH CERTIFIED PEER SPECIALIST.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified peer specialist program model, which:

(1) provides nonclinical peer support counseling by certified peer specialists;

(2) provides a part of a wraparound continuum of services in conjunction with other community mental health services;

(3) is individualized to the consumer; and

(4) promotes socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

256B.0616 MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified family peer specialists program model which:

(1) provides nonclinical family peer support counseling, building on the strengths of families and helping them achieve desired outcomes;

(2) collaborates with others providing care or support to the family;

(3) provides nonadversarial advocacy;

(4) promotes the individual family culture in the treatment milieu;

(5) links parents to other parents in the community;

(6) offers support and encouragement;

(7) assists parents in developing coping mechanisms and problem-solving skills;

(8) promotes resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services;

(9) establishes and provides peer-led parent support groups; and

(10) increases the child's ability to function better within the child's home, school, and community by educating parents on community resources, assisting with problem solving, and educating parents on mental illnesses.

256B.0622 ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL TREATMENT SERVICES.

Subd. 3. **Eligibility for intensive residential treatment services.** An eligible client for intensive residential treatment services is an individual who:

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

(4) because of a mental illness, has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced;

(5) has one or more of the following: a history of recurring or prolonged inpatient hospitalizations in the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services yielding poor outcomes; and

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

Subd. 5a. **Standards for intensive residential rehabilitative mental health services.** (a) The standards in this subdivision apply to intensive residential mental health services.

(b) The provider of intensive residential treatment services must have sufficient staff to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the treatment plan and to safely supervise and direct the activities of clients, given the client's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education, when appropriate.

(c) At a minimum:

(1) staff must provide direction and supervision whenever clients are present in the facility;

(2) staff must remain awake during all work hours;

(3) there must be a staffing ratio of at least one to nine clients for each day and evening shift. If more than nine clients are present at the residential site, there must be a minimum of two staff during day and evening shifts, one of whom must be a mental health practitioner or mental health professional;

(4) if services are provided to clients who need the services of a medical professional, the provider shall ensure that these services are provided either by the provider's own medical staff or through referral to a medical professional; and

(5) the provider must ensure the timely availability of a licensed registered nurse, either directly employed or under contract, who is responsible for ensuring the effectiveness and safety of medication administration in the facility and assessing clients for medication side effects and drug interactions.

(d) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5, who are trained and supervised according to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, paragraph (a), clause (4), item (iv).

(e) The clinical supervisor must be an active member of the intensive residential services treatment team. The team must meet with the clinical supervisor at least weekly to discuss clients' progress and make rapid adjustments to meet clients' needs. The team meeting shall include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the client's treatment record.

(f) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(g) The initial functional assessment must be completed within ten days of intake and updated at least every 30 days, or prior to discharge from the service, whichever comes first.

(h) The initial individual treatment plan must be completed within 24 hours of admission. Within ten days of admission, the initial treatment plan must be refined and further developed, except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the client and updated at least monthly.

256B.0623 ADULT REHABILITATIVE MENTAL HEALTH SERVICES COVERED.

Subd. 7. **Personnel file.** The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff. Each file must contain:

(1) an annual performance review;

(2) a summary of on-site service observations and charting review;

(3) a criminal background check of all direct service staff;

(4) evidence of academic degree and qualifications;

(5) a copy of professional license;

(6) any job performance recognition and disciplinary actions;

(7) any individual staff written input into own personnel file;

(8) all clinical supervision provided; and

(9) documentation of compliance with continuing education requirements.

Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within three years preceding admission, an adult diagnostic assessment update must be completed. An update shall include a face-to-face interview with the recipient and a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required.

Subd. 10. **Individual treatment plan.** All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient. The provisions in clauses (1) and (2) apply:

(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake. The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

(2) The individual treatment plan must include:

(i) a list of problems identified in the assessment;

(ii) the recipient's strengths and resources;

(iii) concrete, measurable goals to be achieved, including time frames for achievement;

(iv) specific objectives directed toward the achievement of each one of the goals;

(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;

(vi) cultural considerations, resources, and needs of the recipient must be included;

(vii) planned frequency and type of services must be initiated; and

(viii) clear progress notes on outcome of goals.

(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).

Subd. 11. **Recipient file.** Providers of adult rehabilitative mental health services must maintain a file for each recipient that contains the following information:

(1) diagnostic assessment or verification of its location that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;

(2) functional assessments;

(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(4) recipient history;

(5) signed release forms;

(6) recipient health information and current medications;

(7) emergency contacts for the recipient;

(8) case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;

(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;

(10) summary of recipient case reviews by staff; and

(11) written information by the recipient that the recipient requests be included in the file.

256B.0625 COVERED SERVICES.

Subd. 5l. **Intensive mental health outpatient treatment.** Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy. The commissioner shall establish:

(1) certification procedures to ensure that providers of these services are qualified; and

(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

Subd. 35a. **Children's mental health crisis response services.** Medical assistance covers children's mental health crisis response services according to section 256B.0944.

Subd. 35b. **Children's therapeutic services and supports.** Medical assistance covers children's therapeutic services and supports according to section 256B.0943.

Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota

Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who has determined it medically necessary to involve family members in the child's care. For the purposes of this subdivision, "family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

Subd. 65. **Outpatient mental health services.** Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy according to Minnesota Rules, part 9505.0372, when the mental health services are performed by a mental health practitioner working as a clinical trainee according to section 245.462, subdivision 17, paragraph (g).

256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.

Subd. 8. **Required preservice and continuing education.** (a) A provider entity shall establish a plan to provide preservice and continuing education for staff. The plan must clearly describe the type of training necessary to maintain current skills and obtain new skills and that relates to the provider entity's goals and objectives for services offered.

(b) A provider that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of preservice training. The preservice training must include parent team training. The preservice training must include 15 hours of in-person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Curricula for parent team training must be approved in advance by the commissioner. Components of parent team training include:

(1) partnering with parents;

(2) fundamentals of family support;

(3) fundamentals of policy and decision making;

(4) defining equal partnership;

(5) complexities of the parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses;

(6) sibling impacts;

(7) support networks; and

(8) community resources.

(c) A provider entity that employs a mental health practitioner and a mental health behavioral aide to provide children's therapeutic services and supports under this section must require the mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. The continuing education must be related to serving the needs of a child with emotional disturbance in the child's home environment and the child's family.

(d) The provider entity must document the mental health practitioner's or mental health behavioral aide's annual completion of the required continuing education. The documentation must include the date, subject, and number of hours of the continuing education, and attendance records, as verified by the staff member's signature, job title, and the instructor's name. The provider entity

must keep documentation for each employee, including records of attendance at professional workshops and conferences, at a central location and in the employee's personnel file.

Subd. 10. **Service authorization.** Children's therapeutic services and supports are subject to authorization criteria and standards published by the commissioner according to section 256B.0625, subdivision 25.

256B.0944 CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.

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

(a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation that, but for the provision of crisis response services to the child, would likely result in significantly reduced levels of functioning in primary activities of daily living, an emergency situation, or the child's placement in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or crisis mental health practitioner determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests the child may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency. Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Mental health mobile services must be provided on site by a mobile crisis intervention team outside of an inpatient hospital setting.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

Subd. 2. **Medical assistance coverage.** Medical assistance covers medically necessary children's mental health crisis response services, subject to federal approval, if provided to an eligible recipient under subdivision 3, by a qualified provider entity under subdivision 4 or a qualified individual provider working within the provider's scope of practice, and identified in the recipient's individual crisis treatment plan under subdivision 8.

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is eligible for medical assistance;

(2) is under age 18 or between the ages of 18 and 21;

(3) is screened as possibly experiencing a mental health crisis or mental health emergency where a mental health crisis assessment is needed;

(4) is assessed as experiencing a mental health crisis or mental health emergency, and mental health mobile crisis intervention or mental health crisis stabilization services are determined to be medically necessary; and

(5) meets the criteria for emotional disturbance or mental illness.

Subd. 4. **Provider entity standards.** (a) A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:

(1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility;

(2) a county board-operated entity; or

(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.

(b) The children's mental health crisis response services provider entity must:

(1) ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(2) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;

(3) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4889; and

(4) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high-risk situations.

Subd. 4a. **Alternative provider standards.** If a provider entity demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services 24 hours a day, seven days a week, according to the standards in subdivision 4, paragraph (b), clause (1), the commissioner may approve a crisis response provider based on an alternative plan proposed by a provider entity. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of crisis services; and

(2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays.

Subd. 5. **Mobile crisis intervention staff qualifications.** (a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:

(1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph (o); or

(2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.

(b) The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including the county social services agency, mental health service providers, and local law enforcement, if necessary.

Subd. 6. **Initial screening and crisis assessment planning.** (a) Before initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify the parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment must evaluate any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As the opportunity presents itself during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required under subdivision 9.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The crisis treatment plan must be updated as needed to reflect current goals and services. The team must involve the client and the client's family in developing and implementing the plan.

(e) The team must document in progress notes which short-term goals have been met and when no further crisis intervention services are required.

(f) If the client's crisis is stabilized, but the client needs a referral for mental health crisis stabilization services or to other services, the team must provide a referral to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Subd. 7. **Crisis stabilization services.** Crisis stabilization services must be provided by a mental health professional or a mental health practitioner, as defined in section 245.462, subdivision 17, who works under the clinical supervision of a mental health professional and for a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 8;

(2) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community; and

(3) mental health practitioners must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 8. **Treatment plan.** (a) The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;

(4) specific objectives directed toward the achievement of each goal;

(5) documentation of the participants involved in the service planning;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur; and

(8) clear progress notes on the outcome of goals.

(b) The client, if clinically appropriate, must be a participant in the development of the crisis stabilization treatment plan. The client or the client's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the client and the client's legal guardian. The plan should include services arranged, including specific providers where applicable.

(c) A treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. A written plan must be completed within 24 hours of beginning services with the client.

Subd. 9. **Supervision.** (a) A mental health practitioner may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by telephone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by telephone, during the first three hours when a mental health practitioner provides on-site service; and

(4) the mental health professional must review and approve the tentative crisis assessment and crisis treatment plan, document the consultation, and sign the crisis assessment and treatment plan within the next business day.

(b) If the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan. The on-site observation must be documented in the client's record and signed by the mental health professional.

Subd. 10. **Client record.** The provider must maintain a file for each client that complies with the requirements under section 256B.0943, subdivision 11, and contains the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient for not signing the plan;

(2) signed release of information forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records that document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

Subd. 11. **Excluded services.** The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) transportation services under children's mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide children's mental health crisis response services;

(5) crisis response services provided by a residential treatment center to clients in their facility;

(6) services performed by volunteers;

(7) direct billing of time spent "on call" when not delivering services to a recipient;

(8) provider service time included in case management reimbursement;

(9) outreach services to potential recipients; and

(10) a mental health service that is not medically necessary.

256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.

Subd. 5. **Service authorization.** The commissioner will administer authorizations for services under this section in compliance with section 256B.0625, subdivision 25.

256B.097 STATE QUALITY ASSURANCE, QUALITY IMPROVEMENT, AND LICENSING SYSTEM.

Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a State Quality Assurance, Quality Improvement, and Licensing System for Minnesotans receiving disability services is enacted. This system is a partnership between the Department of Human Services and the State Quality Council established under subdivision 3.

(b) This system is a result of the recommendations from the Department of Human Services' licensing and alternative quality assurance study mandated under Laws 2005, First Special Session chapter 4, article 7, section 57, and presented to the legislature in February 2007.

(c) The disability services eligible under this section include:

(1) the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, or section 256B.49, including brain injuries and services for those who qualify for nursing facility level of care or hospital facility level of care and any other services licensed under chapter 245D;

(2) home care services under section 256B.0651;

(3) family support grants under section 252.32;

(4) consumer support grants under section 256.476;

(5) semi-independent living services under section 252.275; and

(6) services provided through an intermediate care facility for the developmentally disabled.

(d) For purposes of this section, the following definitions apply:

(1) "commissioner" means the commissioner of human services;

(2) "council" means the State Quality Council under subdivision 3;

(3) "Quality Assurance Commission" means the commission under section 256B.0951; and

(4) "system" means the State Quality Assurance, Quality Improvement and Licensing System under this section.

Subd. 2. **Duties of commissioner of human services.** (a) The commissioner of human services shall establish the State Quality Council under subdivision 3.

(b) The commissioner shall initially delegate authority to perform licensing functions and activities according to section 245A.16 to a host county in Region 10. The commissioner must not license or reimburse a participating facility, program, or service located in Region 10 if the commissioner has received notification from the host county that the facility, program, or service has failed to qualify for licensure.

(c) The commissioner may conduct random licensing inspections based on outcomes adopted under section 256B.0951, subdivision 3, at facilities or programs, and of services eligible under this section. The role of the random inspections is to verify that the system protects the safety and well-being of persons served and maintains the availability of high-quality services for persons with disabilities.

(d) The commissioner shall ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety and health or violated services-related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

(e) The commissioner shall seek a federal waiver by July 1, 2012, to allow intermediate care facilities for persons with developmental disabilities to participate in this system.

Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality Council which must define regional quality councils, and carry out a community-based, person-directed quality review component, and a comprehensive system for effective incident reporting, investigation, analysis, and follow-up.

(b) By August 1, 2011, the commissioner of human services shall appoint the members of the initial State Quality Council. Members shall include representatives from the following groups:

(1) disability service recipients and their family members;

(2) during the first four years of the State Quality Council, there must be at least three members from the Region 10 stakeholders. As regional quality councils are formed under subdivision 4, each regional quality council shall appoint one member;

(3) disability service providers;

(4) disability advocacy groups; and

(5) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(c) Members of the council who do not receive a salary or wages from an employer for time spent on council duties may receive a per diem payment when performing council duties and functions.

(d) The State Quality Council shall:

(1) assist the Department of Human Services in fulfilling federally mandated obligations by monitoring disability service quality and quality assurance and improvement practices in Minnesota;

(2) establish state quality improvement priorities with methods for achieving results and provide an annual report to the legislative committees with jurisdiction over policy and funding of disability services on the outcomes, improvement priorities, and activities undertaken by the commission during the previous state fiscal year;

(3) identify issues pertaining to financial and personal risk that impede Minnesotans with disabilities from optimizing choice of community-based services; and

(4) recommend to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and civil law by January 15, 2014, statutory and rule changes related to the findings under clause (3) that promote individualized service and housing choices balanced with appropriate individualized protection.

(e) The State Quality Council, in partnership with the commissioner, shall:

(1) approve and direct implementation of the community-based, person-directed system established in this section;

(2) recommend an appropriate method of funding this system, and determine the feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

(3) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems;

(4) establish variable licensure periods not to exceed three years based on outcomes achieved; and

(5) in cooperation with the Quality Assurance Commission, design a transition plan for licensed providers from Region 10 into the alternative licensing system.

(f) The State Quality Council shall notify the commissioner of human services that a facility, program, or service has been reviewed by quality assurance team members under subdivision 4, paragraph (b), clause (13), and qualifies for a license.

(g) The State Quality Council, in partnership with the commissioner, shall establish an ongoing review process for the system. The review shall take into account the comprehensive nature of the system which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to persons with disabilities. The review shall address efficiencies and effectiveness of the system.

(h) The State Quality Council may recommend to the commissioner certain variances from the standards governing licensure of programs for persons with disabilities in order to improve the quality of services so long as the recommended variances do not adversely affect the health or safety of persons being served or compromise the qualifications of staff to provide services.

(i) The safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make recommendations to the commissioner or to the legislature in the report required under paragraph (c) regarding alternatives or modifications to the safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c).

(j) The State Quality Council may hire staff to perform the duties assigned in this subdivision.

Subd. 4. **Regional quality councils.** (a) The commissioner shall establish, as selected by the State Quality Council, regional quality councils of key stakeholders, including regional representatives of:

(1) disability service recipients and their family members;

(2) disability service providers;

(3) disability advocacy groups; and

(4) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(b) Each regional quality council shall:

(1) direct and monitor the community-based, person-directed quality assurance system in this section;

(2) approve a training program for quality assurance team members under clause (13);

(3) review summary reports from quality assurance team reviews and make recommendations to the State Quality Council regarding program licensure;

(4) make recommendations to the State Quality Council regarding the system;

(5) resolve complaints between the quality assurance teams, counties, providers, persons receiving services, their families, and legal representatives;

(6) analyze and review quality outcomes and critical incident data reporting incidents of life safety concerns immediately to the Department of Human Services licensing division;

(7) provide information and training programs for persons with disabilities and their families and legal representatives on service options and quality expectations;

(8) disseminate information and resources developed to other regional quality councils;

(9) respond to state-level priorities;

(10) establish regional priorities for quality improvement;

(11) submit an annual report to the State Quality Council on the status, outcomes, improvement priorities, and activities in the region;

(12) choose a representative to participate on the State Quality Council and assume other responsibilities consistent with the priorities of the State Quality Council; and

(13) recruit, train, and assign duties to members of quality assurance teams, taking into account the size of the service provider, the number of services to be reviewed, the skills necessary for the team members to complete the process, and ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with anyone served at the facility, program, or service. Quality assurance teams must be comprised of county staff, persons receiving services or the person's families, legal representatives, members of advocacy organizations, providers, and other involved community members. Team members must complete the training program approved by the regional quality council and must demonstrate performance-based competency. Team members may be paid a per diem and reimbursed for expenses related to their participation in the quality assurance process.

(c) The commissioner shall monitor the safety standards, rights, and procedural protections for the monitoring of psychotropic medications and those identified under sections 245.825; 245.91 to 245.97; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivision 1b, clause (7); and 626.557; and chapter 260E.

(d) The regional quality councils may hire staff to perform the duties assigned in this subdivision.

(e) The regional quality councils may charge fees for their services.

(f) The quality assurance process undertaken by a regional quality council consists of an evaluation by a quality assurance team of the facility, program, or service. The process must include an evaluation of a random sample of persons served. The sample must be representative of each service provided. The sample size must be at least five percent but not less than two persons served. All persons must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.

(g) A facility, program, or service may contest a licensing decision of the regional quality council as permitted under chapter 245A.

Subd. 5. **Annual survey of service recipients.** The commissioner, in consultation with the State Quality Council, shall conduct an annual independent statewide survey of service recipients, randomly selected, to determine the effectiveness and quality of disability services. The survey must be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services (CMS) Quality Framework. The survey must analyze whether desired outcomes

for persons with different demographic, diagnostic, health, and functional needs, who are receiving different types of services in different settings and with different costs, have been achieved. Annual statewide and regional reports of the results must be published and used to assist regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 6. **Mandated reporters.** Members of the State Quality Council under subdivision 3, the regional quality councils under subdivision 4, and quality assurance team members under subdivision 4, paragraph (b), clause (13), are mandated reporters as defined in sections 260E.06, subdivision 1, and 626.5572, subdivision 16.

256B.4905 HOME AND COMMUNITY-BASED SERVICES POLICY STATEMENT.

Subdivision 1. **Employment first policy.** It is the policy of this state that all working-age Minnesotans with disabilities can work, want to work, and can achieve competitive integrated employment, and that each working-age Minnesotan with a disability be offered the opportunity to work and earn a competitive wage before being offered other supports and services.

Subd. 2. **Employment first implementation for disability waiver services.** The commissioner of human services shall ensure that:

(1) the disability waivers under sections 256B.092 and 256B.49 support the presumption that all working-age Minnesotans with disabilities can work, want to work, and can achieve competitive integrated employment; and

(2) each waiver recipient of working age be offered, after an informed decision-making process and during a person-centered planning process, the opportunity to work and earn a competitive wage before being offered exclusively day services as defined in section 245D.03, subdivision 1, paragraph (c), clause (4), or successor provisions.

Subd. 3. **Independent living first policy.** It is the policy of this state that all adult Minnesotans with disabilities can and want to live independently with proper supports and services and that each adult Minnesotan with a disability be offered the opportunity to live as independently as possible before being offered supports and services in provider-controlled settings.

Subd. 4. **Independent living first implementation for disability waiver services.** The commissioner of human services shall ensure that:

(1) the disability waivers under sections 256B.092 and 256B.49 support the presumption that all adult Minnesotans with disabilities can and want to live independently with proper services and supports as needed; and

(2) each adult waiver recipient be offered, after an informed decision-making process and during a person-centered planning process, the opportunity to live as independently as possible before being offered customized living services provided in a single family home or residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), or successor provisions, unless the residential supports and services are provided in a family adult foster care residence under a shared living option as described in Laws 2013, chapter 108, article 7, section 62.

Subd. 5. **Self-direction first policy.** It is the policy of this state that adult Minnesotans with disabilities and families of children with disabilities can and want to use self-directed services and supports and that each adult Minnesotan with a disability and each family of the child with a disability be offered the opportunity to choose self-directed services and supports before being offered services and supports that are not self-directed.

Subd. 6. **Self-directed first implementation for disability waiver services.** The commissioner of human services shall ensure that:

(1) the disability waivers under sections 256B.092 and 256B.49 support the presumption that adult Minnesotans with disabilities and families of children with disabilities can and want to use self-directed services and supports, including self-directed funding options; and

(2) each waiver recipient be offered, after an informed decision-making process and during a person-centered planning process, the opportunity to choose self-directed services and supports, including self-directed funding options, before being offered services and supports that are not self-directed.

256D.051 SNAP EMPLOYMENT AND TRAINING PROGRAM.

Subdivision 1. **SNAP employment and training program.** The commissioner shall implement a SNAP employment and training program in order to meet the SNAP employment and training participation requirements of the United States Department of Agriculture. Unless exempt under subdivision 3a, each adult recipient in the unit must participate in the SNAP employment and training program each month that the person is eligible for SNAP benefits. The person's participation in SNAP employment and training services must begin no later than the first day of the calendar month following the determination of eligibility for SNAP benefits. With the county agency's consent, and to the extent of available resources, the person may voluntarily continue to participate in SNAP employment and training services for up to three additional consecutive months immediately following termination of SNAP benefits in order to complete the provisions of the person's employability development plan.

Subd. 1a. **Notices and sanctions.** (a) At the time the county agency notifies the household that it is eligible for SNAP benefits, the county agency must inform all mandatory employment and training services participants as identified in subdivision 1 in the household that they must comply with all SNAP employment and training program requirements each month, including the requirement to attend an initial orientation to the SNAP employment and training program and that SNAP eligibility will end unless the participants comply with the requirements specified in the notice.

(b) A participant who fails without good cause to comply with SNAP employment and training program requirements of this section, including attendance at orientation, will lose SNAP eligibility for the following periods:

(1) for the first occurrence, for one month or until the person complies with the requirements not previously complied with, whichever is longer;

(2) for the second occurrence, for three months or until the person complies with the requirements not previously complied with, whichever is longer; or

(3) for the third and any subsequent occurrence, for six months or until the person complies with the requirements not previously complied with, whichever is longer.

If the participant is not the SNAP head of household, the person shall be considered an ineligible household member for SNAP purposes. If the participant is the SNAP head of household, the entire household is ineligible for SNAP as provided in Code of Federal Regulations, title 7, section 273.7(g). "Good cause" means circumstances beyond the control of the participant, such as illness or injury, illness or injury of another household member requiring the participant's presence, a household emergency, or the inability to obtain child care for children between the ages of six and 12 or to obtain transportation needed in order for the participant to meet the SNAP employment and training program participation requirements.

(c) The county agency shall mail or hand deliver a notice to the participant not later than five days after determining that the participant has failed without good cause to comply with SNAP employment and training program requirements which specifies the requirements that were not complied with, the factual basis for the determination of noncompliance, and the right to reinstate eligibility upon a showing of good cause for failure to meet the requirements. The notice must ask the reason for the noncompliance and identify the participant's appeal rights. The notice must request that the participant inform the county agency if the participant believes that good cause existed for the failure to comply and must state that the county agency intends to terminate eligibility for SNAP benefits due to failure to comply with SNAP employment and training program requirements.

(d) If the county agency determines that the participant did not comply during the month with all SNAP employment and training program requirements that were in effect, and if the county agency determines that good cause was not present, the county must provide a ten-day notice of termination of SNAP benefits. The amount of SNAP benefits that are withheld from the household and determination of the impact of the sanction on other household members is governed by Code of Federal Regulations, title 7, section 273.7.

(e) The participant may appeal the termination of SNAP benefits under the provisions of section 256.045.

Subd. 2. **County agency duties.** (a) The county agency shall provide to SNAP benefit recipients a SNAP employment and training program. The program must include:

(1) orientation to the SNAP employment and training program;

(2) an individualized employability assessment and an individualized employability development plan that includes assessment of literacy, ability to communicate in the English language, educational and employment history, and that estimates the length of time it will take the participant to obtain employment. The employability assessment and development plan must be completed in consultation with the participant, must assess the participant's assets, barriers, and strengths, and must identify steps necessary to overcome barriers to employment. A copy of the employability development plan must be provided to the registrant;

(3) referral to available accredited remedial or skills training programs designed to address participant's barriers to employment;

(4) referral to available programs that provide subsidized or unsubsidized employment as necessary;

(5) a job search program, including job seeking skills training; and

(6) other activities, to the extent of available resources designed by the county agency to prepare the participant for permanent employment.

In order to allow time for job search, the county agency may not require an individual to participate in the SNAP employment and training program for more than 32 hours a week. The county agency shall require an individual to spend at least eight hours a week in job search or other SNAP employment and training program activities.

(b) The county agency shall prepare an annual plan for the operation of its SNAP employment and training program. The plan must be submitted to and approved by the commissioner of employment and economic development. The plan must include:

(1) a description of the services to be offered by the county agency;

(2) a plan to coordinate the activities of all public entities providing employment-related services in order to avoid duplication of effort and to provide services more efficiently;

(3) a description of the factors that will be taken into account when determining a client's employability development plan; and

(4) provisions to ensure that the county agency's employment and training service provider provides each recipient with an orientation, employability assessment, and employability development plan as specified in paragraph (a), clauses (1) and (2), within 30 days of the recipient's eligibility for assistance.

Subd. 2a. **Duties of commissioner.** In addition to any other duties imposed by law, the commissioner shall:

(1) based on this section and section 256D.052 and Code of Federal Regulations, title 7, section 273.7, supervise the administration of SNAP employment and training services to county agencies;

(2) disburse money appropriated for SNAP employment and training services to county agencies based upon the county's costs as specified in section 256D.051, subdivision 6c;

(3) accept and supervise the disbursement of any funds that may be provided by the federal government or from other sources for use in this state for SNAP employment and training services;

(4) cooperate with other agencies including any agency of the United States or of another state in all matters concerning the powers and duties of the commissioner under this section and section 256D.052; and

(5) in cooperation with the commissioner of employment and economic development, ensure that each component of an employment and training program carried out under this section is delivered through a statewide workforce development system, unless the component is not available locally through such a system.

Subd. 3. **Participant duties.** In order to receive SNAP assistance, a registrant shall: (1) cooperate with the county agency in all aspects of the SNAP employment and training program; (2) accept any suitable employment, including employment offered through the Job Training Partnership Act, and other employment and training options; and (3) participate in SNAP employment and training activities assigned by the county agency. The county agency may terminate assistance to a registrant who fails to cooperate in the SNAP employment and training program, as provided in subdivision 1a.

Subd. 3a. **Requirement to register work.** (a) To the extent required under Code of Federal Regulations, title 7, section 273.7(a), each applicant for and recipient of SNAP benefits is required to register for work as a condition of eligibility for SNAP benefits. Applicants and recipients are registered by signing an application or annual reapplication for SNAP benefits, and must be informed that they are registering for work by signing the form.

(b) The commissioner shall determine, within federal requirements, persons required to participate in the SNAP employment and training program.

(c) The following SNAP benefit recipients are exempt from mandatory participation in SNAP employment and training services:

(1) recipients of benefits under the Minnesota family investment program, Minnesota supplemental aid program, or the general assistance program;

(2) a child;

(3) a recipient over age 55;

(4) a recipient who has a mental or physical illness, injury, or incapacity which is expected to continue for at least 30 days and which impairs the recipient's ability to obtain or retain employment as evidenced by professional certification or the receipt of temporary or permanent disability benefits issued by a private or government source;

(5) a parent or other household member responsible for the care of either a dependent child in the household who is under age six or a person in the household who is professionally certified as having a physical or mental illness, injury, or incapacity. Only one parent or other household member may claim exemption under this provision;

(6) a recipient receiving unemployment insurance or who has applied for unemployment insurance and has been required to register for work with the Department of Employment and Economic Development as part of the unemployment insurance application process;

(7) a recipient participating each week in a drug addiction or alcohol abuse treatment and rehabilitation program, provided the operators of the treatment and rehabilitation program, in consultation with the county agency, recommend that the recipient not participate in the SNAP employment and training program;

(8) a recipient employed or self-employed for 30 or more hours per week at employment paying at least minimum wage, or who earns wages from employment equal to or exceeding 30 hours multiplied by the federal minimum wage; or

(9) a student enrolled at least half time in any school, training program, or institution of higher education. When determining if a student meets this criteria, the school's, program's or institution's criteria for being enrolled half time shall be used.

Subd. 3b. **Orientation.** The county agency or its employment and training service provider must provide an orientation to SNAP employment and training services to each nonexempt SNAP benefit recipient within 30 days of the date that SNAP eligibility is determined. The orientation must inform the participant of the requirement to participate in services, the date, time, and address to report to for services, the name and telephone number of the SNAP employment and training service provider, the consequences for failure without good cause to comply, the services and support services available through SNAP employment and training services and other providers of similar services, and must encourage the participant to view the SNAP benefits program as a temporary means of supplementing the family's food needs until the family achieves self-sufficiency through employment. The orientation may be provided through audio-visual methods, but the participant must have the opportunity for face-to-face interaction with county agency staff.

Subd. 6b. **Federal reimbursement.** (a) Federal financial participation from the United States Department of Agriculture for SNAP employment and training expenditures that are eligible for reimbursement through the SNAP employment and training program are dedicated funds and are annually appropriated to the commissioner of human services for the operation of the SNAP employment and training program.

(b) The appropriation must be used for skill attainment through employment, training, and support services for SNAP participants.

(c) Federal financial participation for the nonstate portion of SNAP employment and training costs must be paid to the county agency or service provider that incurred the costs.

Subd. 6c. **Program funding.** Within the limits of available resources, the commissioner shall reimburse the actual costs of county agencies and their employment and training service providers for the provision of SNAP employment and training services, including participant support services, direct program services, and program administrative activities. The cost of services for each county's SNAP employment and training program shall not exceed the annual allocated amount. No more than 15 percent of program funds may be used for administrative activities. The county agency may expend county funds in excess of the limits of this subdivision without state reimbursement.

Program funds shall be allocated based on the county's average number of SNAP eligible cases as compared to the statewide total number of such cases. The average number of cases shall be based on counts of cases as of March 31, June 30, September 30, and December 31 of the previous calendar year. The commissioner may reallocate unexpended money appropriated under this section to those county agencies that demonstrate a need for additional funds.

Subd. 7. **Registrant status.** A registrant under this section is not an employee for the purposes of workers' compensation, unemployment benefits, retirement, or civil service laws, and shall not perform work ordinarily performed by a regular public employee.

Subd. 8. **Voluntary quit.** A person who is required to participate in SNAP employment and training services is not eligible for SNAP benefits if, without good cause, the person refuses a legitimate offer of, or quits, suitable employment within 60 days before the date of application. A person who is required to participate in SNAP employment and training services and, without good cause, voluntarily quits suitable employment or refuses a legitimate offer of suitable employment while receiving SNAP benefits shall be terminated from the SNAP program as specified in subdivision 1a.

Subd. 9. **Subcontractors.** A county agency may, at its option, subcontract any or all of the duties under this section to a public or private entity approved by the commissioner of employment and economic development.

Subd. 18. **Work experience placements.** (a) To the extent of available resources, each county agency must establish and operate a work experience component in the SNAP employment and training program for recipients who are subject to a federal limit of three months of SNAP eligibility in any 36-month period. The purpose of the work experience component is to enhance the participant's employability, self-sufficiency, and to provide meaningful, productive work activities.

(b) The commissioner shall assist counties in the design and implementation of these components. The commissioner must ensure that job placements under a work experience component comply with section 256J.72. Written or oral concurrence with job duties of persons placed under the community work experience program shall be obtained from the appropriate exclusive bargaining representative.

(c) Worksites developed under this section are limited to projects that serve a useful public service such as health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, community service, services to aged citizens or citizens with a disability, and child care. To the extent possible, the prior training, skills, and experience of a recipient must be used in making appropriate work experience assignments.

(d) Structured, supervised volunteer work with an agency or organization that is monitored by the county service provider may, with the approval of the county agency, be used as a work experience placement.

(e) As a condition of placing a person receiving SNAP benefits in a program under this subdivision, the county agency shall first provide the recipient the opportunity:

(1) for placement in suitable subsidized or unsubsidized employment through participation in job search under section 256D.051; or

(2) for placement in suitable employment through participation in on-the-job training, if such employment is available.

(f) The county agency shall limit the maximum monthly number of hours that any participant may work in a work experience placement to a number equal to the amount of the family's monthly SNAP benefit allotment divided by the greater of the federal minimum wage or the applicable state minimum wage.

After a participant has been assigned to a position for nine months, the participant may not continue in that assignment unless the maximum number of hours a participant works is no greater

than the amount of the SNAP benefit divided by the rate of pay for individuals employed in the same or similar occupations by the same employer at the same site.

(g) The participant's employability development plan must include the length of time needed in the work experience program, the need to continue job seeking activities while participating in work experience, and the participant's employment goals.

(h) After each six months of a recipient's participation in a work experience job placement, and at the conclusion of each work experience assignment under this section, the county agency shall reassess and revise, as appropriate, the participant's employability development plan.

(i) A participant has good cause for failure to cooperate with a work experience job placement if, in the judgment of the employment and training service provider, the reason for failure is reasonable and justified. Good cause for purposes of this section is defined in subdivision 1a, paragraph (b).

(j) A recipient who has failed without good cause to participate in or comply with the work experience job placement shall be terminated from participation in work experience job activities. If the recipient is not exempt from mandatory SNAP employment and training program participation under subdivision 3a, the recipient will be assigned to other mandatory program activities. If the recipient is exempt from mandatory participation but is participating as a volunteer, the person shall be terminated from the SNAP employment and training program.

256D.052 LITERACY TRAINING FOR RECIPIENTS.

Subd. 3. **Participant literacy transportation costs.** Within the limits of the state appropriation the county agency must provide transportation to enable Supplemental Nutrition Assistance Program (SNAP) employment and training participants to participate in literacy training under this section. The state shall reimburse county agencies for the costs of providing transportation under this section up to the amount of the state appropriation. Counties must make every effort to ensure that child care is available as needed by recipients who are pursuing literacy training.

259A.70 REIMBURSEMENT OF NONRECURRING ADOPTION EXPENSES.

(a) The commissioner of human services shall provide reimbursement to an adoptive parent for costs incurred in an adoption of a child with special needs according to section 259A.10, subdivision 2. Reimbursement shall be made for expenses that are reasonable and necessary for the adoption to occur, subject to a maximum of $2,000. The expenses must directly relate to the legal adoption of the child, must not be incurred in violation of state or federal law, and must not have been reimbursed from other sources or funds.

(b) Children who have special needs but are not citizens or residents of the United States and were either adopted in another country or brought to this country for the purposes of adoption are categorically ineligible for this reimbursement program, except if the child meets the eligibility criteria after the dissolution of the international adoption.

(c) An adoptive parent, in consultation with the responsible child-placing agency, may request reimbursement of nonrecurring adoption expenses by submitting a complete application, according to the requirements and procedures and on forms prescribed by the commissioner.

(d) The commissioner shall determine the child's eligibility for adoption expense reimbursement under title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676. If determined eligible, the commissioner of human services shall sign the agreement for nonrecurring adoption expense reimbursement, making this a fully executed agreement. To be eligible, the agreement must be fully executed prior to the child's adoption finalization.

(e) An adoptive parent who has an adoption assistance agreement under section 259A.15, subdivision 2, is not required to make a separate application for reimbursement of nonrecurring adoption expenses for the child who is the subject of that agreement.

(f) If determined eligible, the adoptive parent shall submit reimbursement requests within 21 months of the date of the child's adoption decree, and according to requirements and procedures prescribed by the commissioner.

Laws 2019, First Special Session chapter 9, article 5, section 90

Sec. 90. **DAY TRAINING AND HABILITATION DISABILITY WAIVER RATE SYSTEM TRANSITION GRANTS.**

(a) The commissioner of human services shall establish annual grants to day training and habilitation providers that are projected to experience a funding gap upon the full implementation of Minnesota Statutes, section 256B.4914.

(b) In order to be eligible for a grant under this section, a day training and habilitation disability waiver provider must:

(1) serve at least 100 waiver service participants;

(2) be projected to receive a reduction in annual revenue from medical assistance for day services during the first year of full implementation of disability waiver rate system framework rates under Minnesota Statutes, section 256B.4914, of at least 15 percent and at least $300,000 compared to the annual medical assistance revenue for day services the provider received during the last full year during which banded rates under Minnesota Statutes, section 256B.4913, subdivision 4a, were effective; and

(3) agree to develop, submit, and implement a sustainability plan as provided in paragraph

(c) A recipient of a grant under this section must develop a sustainability plan in partnership with the commissioner of human services. The sustainability plan must include:

(1) a review of all the provider's costs and an assessment of whether the provider is implementing available cost-control options appropriately;

(2) a review of all the provider's revenue and an assessment of whether the provider is leveraging available resources appropriately; and

(3) a practical strategy for closing the funding gap described in paragraph (b), clause (2).

(d) The commissioner of human services shall provide technical assistance and financial management advice to grant recipients as they develop and implement their sustainability plans.

(e) In order to be eligible for an annual grant renewal, a grant recipient must demonstrate to the commissioner of human services that it made a good faith effort to close the revenue gap described in paragraph (b), clause (2).

9505.0370 DEFINITIONS.

Subpart 1. **Scope.** For parts 9505.0370 to 9505.0372, the following terms have the meanings given them.

Subp. 2. **Adult day treatment.** "Adult day treatment" or "adult day treatment program" means a structured program of treatment and care.

Subp. 3. **Child.** "Child" means a person under 18 years of age.

Subp. 4. **Client.** "Client" means an eligible recipient who is determined to have or who is being assessed for a mental illness as specified in part 9505.0371.

Subp. 5. **Clinical summary.** "Clinical summary" means a written description of a clinician's formulation of the cause of the client's mental health symptoms, the client's prognosis, and the likely consequences of the symptoms; how the client meets the criteria for the diagnosis by describing the client's symptoms, the duration of symptoms, and functional impairment; an analysis of the client's other symptoms, strengths, relationships, life situations, cultural influences, and health concerns and their potential interaction with the diagnosis and formulation of the client's mental health condition; and alternative diagnoses that were considered and ruled out.

Subp. 6. **Clinical supervision.** "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

Subp. 7. **Clinical supervisor.** "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

Subp. 8. **Cultural competence or culturally competent.** "Cultural competence" or "culturally competent" means the mental health provider's:

A. awareness of the provider's own cultural background, and the related assumptions, values, biases, and preferences that influence assessment and intervention processes;

B. ability and will to respond to the unique needs of an individual client that arise from the client's culture;

C. ability to utilize the client's culture as a resource and as a means to optimize mental health care; and

D. willingness to seek educational, consultative, and learning experiences to expand knowledge of and increase effectiveness with culturally diverse populations.

Subp. 9. **Cultural influences.** "Cultural influences" means historical, geographical, and familial factors that affect assessment and intervention processes. Cultural influences that are relevant to the client may include the client's:

A. racial or ethnic self-identification;

B. experience of cultural bias as a stressor;

C. immigration history and status;

D. level of acculturation;

E. time orientation;

F. social orientation;

G. verbal communication style;

H. locus of control;

I. spiritual beliefs; and

J. health beliefs and the endorsement of or engagement in culturally specific healing practices.

Subp. 10. **Culture.** "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

Subp. 11. **Diagnostic assessment.** "Diagnostic assessment" means a written assessment that documents a clinical and functional face-to-face evaluation of the client's mental health, including the nature, severity and impact of behavioral difficulties, functional impairment, and subjective distress of the client, and identifies the client's strengths and resources.

Subp. 12. **Dialectical behavior therapy.** "Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program is certified by the commissioner and involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

Subp. 13. **Explanation of findings.** "Explanation of findings" means the explanation of a client's diagnostic assessment, psychological testing, treatment program, and consultation with culturally informed mental health consultants as required under parts 9520.0900 to 9520.0926, or other accumulated data and recommendations to the client, client's family, primary caregiver, or other responsible persons.

Subp. 14. **Family.** "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, or persons who are presently residing together as a family unit.

Subp. 15. **Individual treatment plan.** "Individual treatment plan" means a written plan that outlines and defines the course of treatment. It delineates the goals, measurable objectives, target dates for achieving specific goals, main participants in treatment process, and recommended services that are based on the client's diagnostic assessment and other meaningful data that are needed to aid the client's recovery and enhance resiliency.

Subp. 16. **Medication management.** "Medication management" means a service that determines the need for or effectiveness of the medication prescribed for the treatment of a client's symptoms of a mental illness.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a person who is qualified according to part 9505.0371, subpart 5, items B and C, and provides mental health services to a client with a mental illness under the clinical supervision of a mental health professional.

Subp. 18. **Mental health professional.** "Mental health professional" means a person who is enrolled to provide medical assistance services and is qualified according to part 9505.0371, subpart 5, item A.

Subp. 19. **Mental health telemedicine.** "Mental health telemedicine" has the meaning given in Minnesota Statutes, section 256B.0625, subdivision 46.

Subp. 20. **Mental illness.** "Mental illness" has the meaning given in Minnesota Statutes, section 245.462, subdivision 20. "Mental illness" includes "emotional disturbance" as defined in Minnesota Statutes, section 245.4871, subdivision 15.

Subp. 21. **Multidisciplinary staff.** "Multidisciplinary staff" means a group of individuals from diverse disciplines who come together to provide services to clients under part 9505.0372, subparts 8, 9, and 10.

Subp. 22. **Neuropsychological assessment.** "Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist.

Subp. 23. **Neuropsychological testing.** "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn and recall information; and use problem-solving and judgment.

Subp. 24. **Partial hospitalization program.** "Partial hospitalization program" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x, (ff), that is provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services.

Subp. 25. **Primary caregiver.** "Primary caregiver" means a person, other than the facility staff, who has primary legal responsibility for providing the client with food, clothing, shelter, direction, guidance, and nurturance.

Subp. 26. **Psychological testing.** "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the recipient's mental, intellectual, and emotional functioning.

Subp. 27. **Psychotherapy.** "Psychotherapy" means treatment of a client with mental illness that applies the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client.

Subp. 28. **Supervisee.** "Supervisee" means an individual who requires clinical supervision because the individual does not meet mental health professional standards in part 9505.0371, subpart 5, item A.

9505.0371 MEDICAL ASSISTANCE COVERAGE REQUIREMENTS FOR OUTPATIENT MENTAL HEALTH SERVICES.

Subpart 1. **Purpose.** This part describes the requirements that outpatient mental health services must meet to receive medical assistance reimbursement.

Subp. 2. **Client eligibility for mental health services.** The following requirements apply to mental health services:

A. The provider must use a diagnostic assessment as specified in part 9505.0372 to determine a client's eligibility for mental health services under this part, except:

(1) prior to completion of a client's initial diagnostic assessment, a client is eligible for:

(a) one explanation of findings;

(b) one psychological testing; and

(c) either one individual psychotherapy session, one family psychotherapy session, or one group psychotherapy session; and

(2) for a client who is not currently receiving mental health services covered by medical assistance, a crisis assessment as specified in Minnesota Statutes, section 256B.0624 or 256B.0944, conducted in the past 60 days may be used to allow up to ten sessions of mental health services within a 12-month period.

B. A brief diagnostic assessment must meet the requirements of part 9505.0372, subpart 1, item D, and:

(1) may be used to allow up to ten sessions of mental health services as specified in part 9505.0372 within a 12-month period before a standard or extended diagnostic assessment is required when the client is:

(a) a new client; or

(b) an existing client who has had fewer than ten sessions of psychotherapy in the previous 12 months and is projected to need fewer than ten sessions of psychotherapy in the next 12 months, or who only needs medication management; and

(2) may be used for a subsequent annual assessment, if based upon the client's treatment history and the provider's clinical judgment, the client will need ten or fewer sessions of mental health services in the upcoming 12-month period; and

(3) must not be used for:

(a) a client or client's family who requires a language interpreter to participate in the assessment unless the client meets the requirements of subitem (1), unit (b), or (2); or

(b) more than ten sessions of mental health services in a 12-month period. If, after completion of ten sessions of mental health services, the mental health professional determines the need for additional sessions, a standard assessment or extended assessment must be completed.

C. For a child, a new standard or extended diagnostic assessment must be completed:

(1) when the child does not meet the criteria for a brief diagnostic assessment;

(2) at least annually following the initial diagnostic assessment, if:

(a) additional services are needed; and

(b) the child does not meet criteria for brief assessment;

(3) when the child's mental health condition has changed markedly since the child's most recent diagnostic assessment; or

(4) when the child's current mental health condition does not meet criteria of the child's current diagnosis.

D. For an adult, a new standard diagnostic assessment or extended diagnostic assessment must be completed:

(1) when the adult does not meet the criteria for a brief diagnostic assessment or an adult diagnostic assessment update;

(2) at least every three years following the initial diagnostic assessment for an adult who receives mental health services;

(3) when the adult's mental health condition has changed markedly since the adult's most recent diagnostic assessment; or

(4) when the adult's current mental health condition does not meet criteria of the current diagnosis.

E. An adult diagnostic assessment update must be completed at least annually unless a new standard or extended diagnostic assessment is performed. An adult diagnostic assessment update must include an update of the most recent standard or extended diagnostic assessment and any recent adult diagnostic assessment updates that have occurred since the last standard or extended diagnostic assessment.

Subp. 3. **Authorization for mental health services.** Mental health services under this part are subject to authorization criteria and standards published by the commissioner according to Minnesota Statutes, section 256B.0625, subdivision 25.

Subp. 4. **Clinical supervision.**

A. Clinical supervision must be based on each supervisee's written supervision plan and must:

(1) promote professional knowledge, skills, and values development;

(2) model ethical standards of practice;

(3) promote cultural competency by:

(a) developing the supervisee's knowledge of cultural norms of behavior for individual clients and generally for the clients served by the supervisee regarding the client's cultural influences, age, class, gender, sexual orientation, literacy, and mental or physical disability;

(b) addressing how the supervisor's and supervisee's own cultures and privileges affect service delivery;

(c) developing the supervisee's ability to assess their own cultural competence and to identify when consultation or referral of the client to another provider is needed; and

(d) emphasizing the supervisee's commitment to maintaining cultural competence as an ongoing process;

(4) recognize that the client's family has knowledge about the client and will continue to play a role in the client's life and encourage participation among the client, client's family, and providers as treatment is planned and implemented; and

(5) monitor, evaluate, and document the supervisee's performance of assessment, treatment planning, and service delivery.

B. Clinical supervision must be conducted by a qualified supervisor using individual or group supervision. Individual or group face-to-face supervision may be conducted via electronic communications that utilize interactive telecommunications equipment that includes at a minimum audio and video equipment for two-way, real-time, interactive communication between the supervisor and supervisee, and meet the equipment and connection standards of part 9505.0370, subpart 19.

(1) Individual supervision means one or more designated clinical supervisors and one supervisee.

(2) Group supervision means one clinical supervisor and two to six supervisees in face-to-face supervision.

C. The supervision plan must be developed by the supervisor and the supervisee. The plan must be reviewed and updated at least annually. For new staff the plan must be completed and implemented within 30 days of the new staff person's employment. The supervision plan must include:

(1) the name and qualifications of the supervisee and the name of the agency in which the supervisee is being supervised;

(2) the name, licensure, and qualifications of the supervisor;

(3) the number of hours of individual and group supervision to be completed by the supervisee including whether supervision will be in person or by some other method approved by the commissioner;

(4) the policy and method that the supervisee must use to contact the clinical supervisor during service provision to a supervisee;

(5) procedures that the supervisee must use to respond to client emergencies; and

(6) authorized scope of practices, including:

(a) description of the supervisee's service responsibilities;

(b) description of client population; and

(c) treatment methods and modalities.

D. Clinical supervision must be recorded in the supervisee's supervision record. The documentation must include:

(1) date and duration of supervision;

(2) identification of supervision type as individual or group supervision;

(3) name of the clinical supervisor;

(4) subsequent actions that the supervisee must take; and

(5) date and signature of the clinical supervisor.

E. Clinical supervision pertinent to client treatment changes must be recorded by a case notation in the client record after supervision occurs.

Subp. 5. **Qualified providers.** Medical assistance covers mental health services according to part 9505.0372 when the services are provided by mental health professionals or mental health practitioners qualified under this subpart.

A. A mental health professional must be qualified in one of the following ways:

(1) in clinical social work, a person must be licensed as an independent clinical social worker by the Minnesota Board of Social Work under Minnesota Statutes, chapter 148D until August 1, 2011, and thereafter under Minnesota Statutes, chapter 148E;

(2) in psychology, a person licensed by the Minnesota Board of Psychology under Minnesota Statutes, sections 148.88 to 148.98, who has stated to the board competencies in the diagnosis and treatment of mental illness;

(3) in psychiatry, a physician licensed under Minnesota Statutes, chapter 147, who is certified by the American Board of Psychiatry and Neurology or is eligible for board certification;

(4) in marriage and family therapy, a person licensed as a marriage and family therapist by the Minnesota Board of Marriage and Family Therapy under Minnesota Statutes, sections 148B.29 to 148B.39, and defined in parts 5300.0100 to 5300.0350;

(5) in professional counseling, a person licensed as a professional clinical counselor by the Minnesota Board of Behavioral Health and Therapy under Minnesota Statutes, section 148B.5301;

(6) a tribally approved mental health care professional, who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), and who is serving a federally recognized Indian tribe; or

(7) in psychiatric nursing, a registered nurse who is licensed under Minnesota Statutes, sections 148.171 to 148.285, and meets one of the following criteria:

(a) is certified as a clinical nurse specialist;

(b) for children, is certified as a nurse practitioner in child or adolescent or family psychiatric and mental health nursing by a national nurse certification organization; or

(c) for adults, is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization.

B. A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults. A mental health practitioner must be qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university; and

(a) has at least 2,000 hours of supervised experience in the delivery of mental health services to clients with mental illness; or

(b) is fluent in the non-English language of the cultural group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once a week until the requirements of 2,000 hours of supervised experience are met;

(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to clients with mental illness. Hours worked as a mental health behavioral aide I or II under Minnesota Statutes, section 256B.0943, subdivision 7, may be included in the 6,000 hours of experience for child clients;

(3) is a graduate student in one of the mental health professional disciplines defined in item A and is formally assigned by an accredited college or university to an agency or facility for clinical training;

(4) holds a master's or other graduate degree in one of the mental health professional disciplines defined in item A from an accredited college or university; or

(5) is an individual who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), who is serving a federally recognized Indian tribe.

C. Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy performed by a mental health practitioner working as a clinical trainee when:

(1) the mental health practitioner is:

(a) complying with requirements for licensure or board certification as a mental health professional, as defined in item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or

(b) a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional defined in item A; and

(2) the mental health practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of:

(a) direct practice;

(b) treatment team collaboration;

(c) continued professional learning; and

(d) job management.

D. A clinical supervisor must:

(1) be a mental health professional licensed as specified in item A;

(2) hold a license without restrictions that has been in good standing for at least one year while having performed at least 1,000 hours of clinical practice;

(3) be approved, certified, or in some other manner recognized as a qualified clinical supervisor by the person's professional licensing board, when this is a board requirement;

(4) be competent as demonstrated by experience and graduate-level training in the area of practice and the activities being supervised;

(5) not be the supervisee's blood or legal relative or cohabitant, or someone who has acted as the supervisee's therapist within the past two years;

(6) have experience and skills that are informed by advanced training, years of experience, and mastery of a range of competencies that demonstrate the following:

(a) capacity to provide services that incorporate best practice;

(b) ability to recognize and evaluate competencies in supervisees;

(c) ability to review assessments and treatment plans for accuracy and appropriateness;

(d) ability to give clear direction to mental health staff related to alternative strategies when a client is struggling with moving towards recovery; and

(e) ability to coach, teach, and practice skills with supervisees;

(7) accept full professional liability for a supervisee's direction of a client's mental health services;

(8) instruct a supervisee in the supervisee's work, and oversee the quality and outcome of the supervisee's work with clients;

(9) review, approve, and sign the diagnostic assessment, individual treatment plans, and treatment plan reviews of clients treated by a supervisee;

(10) review and approve the progress notes of clients treated by the supervisee according to the supervisee's supervision plan;

(11) apply evidence-based practices and research-informed models to treat clients;

(12) be employed by or under contract with the same agency as the supervisee;

(13) develop a clinical supervision plan for each supervisee;

(14) ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices;

(15) establish an evaluation process that identifies the performance and competence of each supervisee; and

(16) document clinical supervision of each supervisee and securely maintain the documentation record.

Subp. 6. **Release of information.** Providers who receive a request for client information and providers who request client information must:

A. comply with data practices and medical records standards in Minnesota Statutes, chapter 13, and Code of Federal Regulations, title 45, part 164; and

B. subject to the limitations in item A, promptly provide client information, including a written diagnostic assessment, to other providers who are treating the client to ensure that the client will get services without undue delay.

Subp. 7. **Individual treatment plan.** Except as provided in subpart 2, item A, subitem (1), a medical assistance payment is available only for services provided in accordance with the client's written individual treatment plan (ITP). The client must be involved in the development, review, and revision of the client's ITP. For all mental health services, except

as provided in subpart 2, item A, subitem (1), and medication management, the ITP and subsequent revisions of the ITP must be signed by the client before treatment begins. The mental health professional or practitioner shall request the client, or other person authorized by statute to consent to mental health services for the client, to sign the client's ITP or revision of the ITP. In the case of a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child shall be asked to sign the child's ITP and revisions of the ITP. If the client or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the refusal to sign the plan and the reason or reasons for the refusal. A client's individual treatment plan must be:

A. based on the client's current diagnostic assessment;

B. developed by identifying the client's service needs and considering relevant cultural influences to identify planned interventions that contain specific treatment goals and measurable objectives for the client; and

C. reviewed at least once every 90 days, and revised as necessary. Revisions to the initial individual treatment plan do not require a new diagnostic assessment unless the client's mental health status has changed markedly as provided in subpart 2.

Subp. 8. **Documentation.** To obtain medical assistance payment for an outpatient mental health service, a mental health professional or a mental health practitioner must promptly document:

A. in the client's mental health record:

(1) each occurrence of service to the client including the date, type of service, start and stop time, scope of the mental health service, name and title of the person who gave the service, and date of documentation; and

(2) all diagnostic assessments and other assessments, psychological test results, treatment plans, and treatment plan reviews;

B. the provider's contact with persons interested in the client such as representatives of the courts, corrections systems, or schools, or the client's other mental health providers, case manager, family, primary caregiver, legal representative, including the name and date of the contact or, if applicable, the reason the client's family, primary caregiver, or legal representative was not contacted; and

C. dates that treatment begins and ends and reason for the discontinuation of the mental health service.

Subp. 9. **Service coordination.** The provider must coordinate client services as authorized by the client as follows:

A. When a recipient receives mental health services from more than one mental health provider, each provider must coordinate mental health services they provide to the client with other mental health service providers to ensure services are provided in the most efficient manner to achieve maximum benefit for the client.

B. The mental health provider must coordinate mental health care with the client's physical health provider.

Subp. 10. **Telemedicine services.** Mental health services in part 9505.0372 covered as direct face-to-face services may be provided via two-way interactive video if it is medically appropriate to the client's condition and needs. The interactive video equipment and connection must comply with Medicare standards that are in effect at the time of service. The commissioner may specify parameters within which mental health services can be provided via telemedicine.

9505.0372 COVERED SERVICES.

Subpart 1. **Diagnostic assessment.** Medical assistance covers four types of diagnostic assessments when they are provided in accordance with the requirements in this subpart.

A. To be eligible for medical assistance payment, a diagnostic assessment must:

(1) identify a mental health diagnosis and recommended mental health services, which are the factual basis to develop the recipient's mental health services and treatment plan; or

(2) include a finding that the client does not meet the criteria for a mental health disorder.

B. A standard diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The standard diagnostic assessment must be done within the cultural context of the client and must include relevant information about:

(1) the client's current life situation, including the client's:

(a) age;

(b) current living situation, including household membership and housing status;

(c) basic needs status including economic status;

(d) education level and employment status;

(e) significant personal relationships, including the client's evaluation of relationship quality;

(f) strengths and resources, including the extent and quality of social networks;

(g) belief systems;

(h) contextual nonpersonal factors contributing to the client's presenting concerns;

(i) general physical health and relationship to client's culture; and

(j) current medications;

(2) the reason for the assessment, including the client's:

(a) perceptions of the client's condition;

(b) description of symptoms, including reason for referral;

(c) history of mental health treatment, including review of the client's records;

(d) important developmental incidents;

(e) maltreatment, trauma, or abuse issues;

(f) history of alcohol and drug usage and treatment;

(g) health history and family health history, including physical, chemical, and mental health history; and

(h) cultural influences and their impact on the client;

(3) the client's mental status examination;

(4) the assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(5) the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

(6) assessment methods and use of standardized assessment tools by the provider as determined and periodically updated by the commissioner;

(7) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(8) the client data that is adequate to support the findings on all axes of the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and any differential diagnosis.

C. An extended diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The face-to-face interview is conducted over three or more assessment appointments because the client's complex needs necessitate significant additional assessment time. Complex needs are those caused by acuity of psychotic disorder; cognitive or neurocognitive impairment; need to consider past diagnoses and determine their current applicability; co-occurring substance abuse use disorder; or disruptive or changing environments, communication barriers, or cultural considerations as documented in the assessment. For child clients, the appointments may be conducted outside the diagnostician's office for face-to-face consultation and information gathering with family members, doctors, caregivers, teachers, and other providers, with or without the child present, and may involve directly observing the child in various settings that the child frequents such as home, school, or care settings. To complete the diagnostic assessment with adult clients, the appointments may be conducted outside of the diagnostician's office for face-to-face assessment with the adult client. The appointment may involve directly observing the adult client in various settings that the adult frequents, such as home, school, job, service settings, or community settings. The appointments may include face-to-face meetings with the adult client and the client's family members, doctors, caregivers, teachers, social support network members, recovery support resource representatives, and other providers for consultation and information gathering for the diagnostic assessment. The components of an extended diagnostic assessment include the following relevant information:

(1) for children under age 5:

(a) utilization of the DC:0-3R diagnostic system for young children;

(b) an early childhood mental status exam that assesses the client's developmental, social, and emotional functioning and style both within the family and with the examiner and includes:

i. physical appearance including dysmorphic features;

ii. reaction to new setting and people and adaptation during evaluation;

iii. self-regulation, including sensory regulation, unusual behaviors, activity level, attention span, and frustration tolerance;

iv. physical aspects, including motor function, muscle tone, coordination, tics, abnormal movements, and seizure activity;

v. vocalization and speech production, including expressive and receptive language;

vi. thought, including fears, nightmares, dissociative states, and hallucinations;

vii. affect and mood, including modes of expression, range, responsiveness, duration, and intensity;

viii. play, including structure, content, symbolic functioning, and modulation of aggression;

ix. cognitive functioning; and

x. relatedness to parents, other caregivers, and examiner; and

(c) other assessment tools as determined and periodically revised by the commissioner;

(2) for children ages 5 to 18, completion of other assessment standards for children as determined and periodically revised by the commissioner; and

(3) for adults, completion of other assessment standards for adults as determined and periodically revised by the commissioner.

D. A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The professional or practitioner must gather initial background information using the components of a standard diagnostic assessment in item B, subitems (1), (2), unit (b), (3), and (5), and draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem. Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.

E. Adult diagnostic assessment update includes a face-to-face interview with the client, and contains a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C, who reviews a standard or extended diagnostic assessment. The adult diagnostic assessment update must update the most recent assessment document in writing in the following areas:

(1) review of the client's life situation, including an interview with the client about the client's current life situation, and a written update of those parts where significant new or changed information exists, and documentation where there has not been significant change;

(2) review of the client's presenting problems, including an interview with the client about current presenting problems and a written update of those parts where there is significant new or changed information, and note parts where there has not been significant change;

(3) screenings for substance use, abuse, or dependency and other screenings as determined by the commissioner;

(4) the client's mental health status examination;

(5) assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(6) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary, or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(7) the client's diagnosis on all axes of the current edition of the Diagnostic and Statistical Manual and any differential diagnosis.

Subp. 2. **Neuropsychological assessment.** A neuropsychological assessment must include a face-to-face interview with the client, the interpretation of the test results, and preparation and completion of a report. A client is eligible for a neuropsychological assessment if at least one of the following criteria is met:

A. There is a known or strongly suspected brain disorder based on medical history or neurological evaluation such as a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorders, significant exposure to neurotoxins, central nervous system infections, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformations of the brain; or

B. In the absence of a medically verified brain disorder based on medical history or neurological evaluation, there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology, or suspected neuropsychological impairment in addition to functional psychopathology. Examples include:

(1) poor memory or impaired problem solving;

(2) change in mental status evidenced by lethargy, confusion, or disorientation;

(3) deterioration in level of functioning;

(4) marked behavioral or personality change;

(5) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;

(6) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers; and

(7) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

C. If neither criterion in item A nor B is fulfilled, neuropsychological evaluation is not indicated.

D. The neuropsychological assessment must be conducted by a neuropsychologist with competence in the area of neuropsychological assessment as stated to the Minnesota Board of Psychology who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program:

(a) completed an internship, or its equivalent, in a clinically relevant area of professional psychology;

(b) completed the equivalent of two full-time years of experience and specialized training, at least one which is at the postdoctoral level, in the study and practices of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist; and

(c) holds a current license to practice psychology independently in accordance with Minnesota Statutes, sections 148.88 to 148.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in subitem (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010.

Subp. 3. **Neuropsychological testing.**

A. Medical assistance covers neuropsychological testing when the client has either:

(1) a significant mental status change that is not a result of a metabolic disorder that has failed to respond to treatment;

(2) in children or adolescents, a significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers;

(3) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities, as required to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(a) traumatic brain injury;

(b) stroke;

(c) brain tumor;

(d) substance abuse or dependence;

(e) cerebral anoxic or hypoxic episode;

(f) central nervous system infection or other infectious disease;

(g) neoplasms or vascular injury of the central nervous system;

(h) neurodegenerative disorders;

(i) demyelinating disease;

(j) extrapyramidal disease;

(k) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(l) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders such as lupus, erythematosis, or celiac disease;

(m) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, such as phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(n) severe or prolonged nutrition or malabsorption syndromes; or

(o) a condition presenting in a manner making it difficult for a clinician to distinguish between:

i. the neurocognitive effects of a neurogenic syndrome such as dementia or encephalopathy; and

ii. a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function, or another disorder such as autism, selective mutism, anxiety disorder, or reactive attachment disorder.

B. Neuropsychological testing must be administered or clinically supervised by a neuropsychologist qualified as defined in subpart 2, item D.

C. Neuropsychological testing is not covered when performed:

(1) primarily for educational purposes;

(2) primarily for vocational counseling or training;

(3) for personnel or employment testing;

(4) as a routine battery of psychological tests given at inpatient admission or continued stay; or

(5) for legal or forensic purposes.

Subp. 4. **Psychological testing.** Psychological testing must meet the following requirements:

A. The psychological testing must:

(1) be administered or clinically supervised by a licensed psychologist with competence in the area of psychological testing as stated to the Minnesota Board of Psychology; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a mental health practitioner working as a clinical psychology trainee as required by part 9505.0371, subpart 5, item C, under the clinical supervision of a licensed psychologist according to part 9505.0371, subpart 5, item A, subitem (2).

B. The administration, scoring, and interpretation of the psychological tests must be done under the clinical supervision of a licensed psychologist when performed by a technician, psychometrist, or psychological assistant or as part of a computer-assisted psychological testing program.

C. The report resulting from the psychological testing must be:

(1) signed by the psychologist conducting the face-to-face interview;

(2) placed in the client's record; and

(3) released to each person authorized by the client.

Subp. 5. **Explanations of findings.** To be eligible for medical assistance payment, the mental health professional providing the explanation of findings must obtain the authorization of the client or the client's representative to release the information as required in part 9505.0371, subpart 6. Explanation of findings is provided to the client, client's family, and caregivers, or to other providers to help them understand the results of the testing or diagnostic assessment, better understand the client's illness, and provide professional insight needed to carry out a plan of treatment. An explanation of findings is not paid separately when the results of psychological testing or a diagnostic assessment are explained to the client or the client's representative as part of the psychological testing or a diagnostic assessment.

Subp. 6. **Psychotherapy.** Medical assistance covers psychotherapy as conducted by a mental health professional or a mental health practitioner as defined in part 9505.0371, subpart 5, item C, as provided in this subpart.

A. Individual psychotherapy is psychotherapy designed for one client.

B. Family psychotherapy is designed for the client and one or more family members or the client's primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance. For purposes of this subpart, the phrase "whose participation is necessary to accomplish the client's treatment goals" does not include shift or facility staff members at the client's residence. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes

the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of time of the exclusion. The mental health professional must also document the reason or reasons why a member of the client's family is excluded.

C. Group psychotherapy is appropriate for individuals who because of the nature of their emotional, behavioral, or social dysfunctions can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or practitioner is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two mental health practitioners or one mental health professional and one mental health practitioner is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 persons.

D. A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in client's treatment plan. If the client is excluded, the mental health professional or practitioner must document the reason for and the length of the time of the exclusion. The mental health professional or practitioner must document the reasons why a member of the client's family is excluded.

Subp. 7. **Medication management.** The determination or evaluation of the effectiveness of a client's prescribed drug must be carried out by a physician or by an advanced practice registered nurse, as defined in Minnesota Statutes, sections 148.171 to 148.285, who is qualified in psychiatric nursing.

Subp. 8. **Adult day treatment.** Adult day treatment payment limitations include the following conditions.

A. Adult day treatment must consist of at least one hour of group psychotherapy, and must include group time focused on rehabilitative interventions, or other therapeutic services that are provided by a multidisciplinary staff. Adult day treatment is an intensive psychotherapeutic treatment. The services must stabilize the client's mental health status, and develop and improve the client's independent living and socialization skills. The goal of adult day treatment is to reduce or relieve the effects of mental illness so that an individual is able to benefit from a lower level of care and to enable the client to live and function more independently in the community. Day treatment services are not a part of inpatient or residential treatment services.

B. To be eligible for medical assistance payment, a day treatment program must:

(1) be reviewed by and approved by the commissioner;

(2) be provided to a group of clients by a multidisciplinary staff under the clinical supervision of a mental health professional;

(3) be available to the client at least two days a week for at least three consecutive hours per day. The day treatment may be longer than three hours per day, but medical assistance must not reimburse a provider for more than 15 hours per week;

(4) include group psychotherapy done by a mental health professional, or mental health practitioner qualified according to part 9505.0371, subpart 5, item C, and rehabilitative interventions done by a mental health professional or mental health practitioner daily;

(5) be included in the client's individual treatment plan as necessary and appropriate. The individual treatment plan must include attainable, measurable goals as they relate to services and must be completed before the first day treatment session. The vendor must review the recipient's progress and update the treatment plan at least every 30 days until the client is discharged and include an available discharge plan for the client in the treatment plan; and

(6) document the interventions provided and the client's response daily.

C. To be eligible for adult day treatment, a recipient must:

(1) be 18 years of age or older;

(2) not be residing in a nursing facility, hospital, institute of mental disease, or regional treatment center, unless the recipient has an active discharge plan that indicates a move to an independent living arrangement within 180 days;

(3) have a diagnosis of mental illness as determined by a diagnostic assessment;

(4) have the capacity to engage in the rehabilitative nature, the structured setting, and the therapeutic parts of psychotherapy and skills activities of a day treatment program and demonstrate measurable improvements in the recipient's functioning related to the recipient's mental illness that would result from participating in the day treatment program;

(5) have at least three areas of functional impairment as determined by a functional assessment with the domains prescribed by Minnesota Statutes, section 245.462, subdivision 11a;

(6) have a level of care determination that supports the need for the level of intensity and duration of a day treatment program; and

(7) be determined to need day treatment by a mental health professional who must deem the day treatment services medically necessary.

D. The following services are not covered by medical assistance if they are provided by a day treatment program:

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

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

(3) consultation with other providers or service agency staff about the care or progress of a client;

(4) prevention or education programs provided to the community;

(5) day treatment for recipients with primary diagnoses of alcohol or other drug abuse;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours daily; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Subp. 9. **Partial hospitalization.** Partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission as specified in part 9505.0520, subpart 1, and who has the family and community resources necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services provided by a multidisciplinary staff to treat the client's mental illness.

Subp. 10. **Dialectical behavior therapy (DBT).** Dialectical behavior therapy (DBT) treatment services must meet the following criteria:

A. DBT must be provided according to this subpart and Minnesota Statutes, section 256B.0625, subdivision 5l.

B. DBT is an outpatient service that is determined to be medically necessary by either: (1) a mental health professional qualified according to part 9505.0371, subpart 5, or (2) a mental health practitioner working as a clinical trainee according to part 9505.0371, subpart 5, item C, who is under the clinical supervision of a mental health professional according to part 9505.0371, subpart 5, item D, with specialized skill in dialectical behavior therapy. The treatment recommendation must be based upon a comprehensive evaluation that includes a diagnostic assessment and functional assessment of the client, and review of the client's prior treatment history. Treatment services must be provided pursuant to the client's individual treatment plan and provided to a client who satisfies the criteria in item C.

C. To be eligible for DBT, a client must:

(1) be 18 years of age or older;

(2) have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services;

(3) meet one of the following criteria:

(a) have a diagnosis of borderline personality disorder; or

(b) have multiple mental health diagnoses and exhibit behaviors characterized by impulsivity, intentional self-harm behavior, and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas;

(4) understand and be cognitively capable of participating in DBT as an intensive therapy program and be able and willing to follow program policies and rules assuring safety of self and others; and

(5) be at significant risk of one or more of the following if DBT is not provided:

(a) mental health crisis;

(b) requiring a more restrictive setting such as hospitalization;

(c) decompensation; or

(d) engaging in intentional self-harm behavior.

D. The treatment components of DBT are individual therapy and group skills as follows:

(1) Individual DBT combines individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and reinforce the use of adaptive skillful behaviors. The therapist must:

(a) identify, prioritize, and sequence behavioral targets;

(b) treat behavioral targets;

(c) generalize DBT skills to the client's natural environment through telephone coaching outside of the treatment session;

(d) measure the client's progress toward DBT targets;

(e) help the client manage crisis and life-threatening behaviors; and

(f) help the client learn and apply effective behaviors when working with other treatment providers.

(2) Individual DBT therapy is provided by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

(3) Group DBT skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce the client's suicidal and other dysfunctional coping behaviors and restore function by teaching the client adaptive skills in the following areas:

(a) mindfulness;

(b) interpersonal effectiveness;

(c) emotional regulation; and

(d) distress tolerance.

(4) Group DBT skills training is provided by two mental health professionals, or by a mental health professional cofacilitating with a mental health practitioner.

(5) The need for individual DBT skills training must be determined by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

E. A program must be certified by the commissioner as a DBT provider. To qualify for certification, a provider must:

(1) hold current accreditation as a DBT program from a nationally recognized certification body approved by the commissioner or submit to the commissioner's inspection and provide evidence that the DBT program's policies, procedures, and practices will continuously meet the requirements of this subpart;

(2) be enrolled as a MHCP provider;

(3) collect and report client outcomes as specified by the commissioner; and

(4) have a manual that outlines the DBT program's policies, procedures, and practices which meet the requirements of this subpart.

F. The DBT treatment team must consist of persons who are trained in DBT treatment. The DBT treatment team may include persons from more than one agency. Professional and clinical affiliations with the DBT team must be delineated:

(1) A DBT team leader must:

(a) be a mental health professional employed by, affiliated with, or contracted by a DBT program certified by the commissioner;

(b) have appropriate competencies and working knowledge of the DBT principles and practices; and

(c) have knowledge of and ability to apply the principles and DBT practices that are consistent with evidence-based practices.

(2) DBT team members who provide individual DBT or group skills training must:

(a) be a mental health professional or be a mental health practitioner, who is employed by, affiliated with, or contracted with a DBT program certified by the commissioner;

(b) have or obtain appropriate competencies and working knowledge of DBT principles and practices within the first six months of becoming a part of the DBT program;

(c) have or obtain knowledge of and ability to apply the principles and practices of DBT consistently with evidence-based practices within the first six months of working at the DBT program;

(d) participate in DBT consultation team meetings; and

(e) require mental health practitioners to have ongoing clinical supervision by a mental health professional who has appropriate competencies and working knowledge of DBT principles and practices.

Subp. 11. **Noncovered services.** The mental health services in items A to J are not eligible for medical assistance payment under this part:

A. a mental health service that is not medically necessary;

B. a neuropsychological assessment carried out by a person other than a neuropsychologist who is qualified according to part 9505.0372, subpart 2, item D;

C. a service ordered by a court that is solely for legal purposes and not related to the recipient's diagnosis or treatment for mental illness;

D. services dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health;

E. a service that is only for a vocational purpose or an educational purpose that is not mental health related;

F. staff training that is not related to a client's individual treatment plan or plan of care;

G. child and adult protection services;

H. fund-raising activities;

I. community planning; and

J. client transportation.

9520.0010 STATUTORY AUTHORITY AND PURPOSE.

Parts 9520.0010 to 9520.0230 provide methods and procedures relating to the establishment and operation of area-wide, comprehensive, community-based mental health, developmental disability, and chemical dependency programs under state grant-in-aid as provided under Minnesota Statutes, sections 245.61 to 245.69. Minnesota Statutes, sections 245.61 to 245.69 are entitled The Community Mental Health Services Act. For purposes of these parts, "community mental health services" includes services to persons who have mental or emotional disorders or other psychiatric disabilities, developmental disabilities, and chemical dependency, including drug abuse and alcoholism.

9520.0020 BOARD DUTIES.

The community mental health board has the responsibility for ensuring the planning, development, implementation, coordination, and evaluation of the community comprehensive mental health program for the mentally ill/behaviorally disabled, developmentally disabled, and chemically dependent populations in the geographic area it serves. It also has the responsibility for ensuring delivery of services designated by statute.

9520.0030 DEFINITIONS.

Parts 9520.0040 and 9520.0050 also set forth definitions of community mental health centers and community mental health clinics.

9520.0040 COMMUNITY MENTAL HEALTH CENTER.

A community mental health center means an agency which includes all of the following:

A. Established under the provision of Minnesota Statutes, sections 245.61 to 245.69.

B. Provides as a minimum the following services for individuals with mental or emotional disorders, developmental disabilities, alcoholism, drug abuse, and other psychiatric conditions. The extent of each service to be provided by the center shall be indicated in the program plan, which is to reflect the problems, needs, and resources of the community served:

(1) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, developmental disability, alcoholism, drug abuse, and other psychiatric disorders;

(2) informational and educational services to schools, courts, health and welfare agencies, both public and private;

(3) informational and educational services to the general public, lay, and professional groups;

(4) consultative services to schools, courts, and health and welfare agencies, both public and private;

(5) outpatient diagnostic and treatment services; and

(6) rehabilitative services, particularly for those who have received prior treatment in an inpatient facility.

C. Provides or contracts for detoxification, evaluation, and referral for chemical dependency services (Minnesota Statutes, section 254A.08).

D. Provides specific coordination for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. (Minnesota Statutes, sections 254A.07 and 245.61).

E. Has a competent multidisciplinary mental health/developmental disability/chemical dependency professional team whose members meet the professional standards in their respective fields.

F. The professional mental health team is qualified by specific mental health training and experience and shall include as a minimum the services of each of the following:

(1) a licensed physician, who has completed an approved residency program in psychiatry; and

(2) a doctoral clinical, counseling, or health care psychologist, who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

(3) a clinical social worker with a master's degree in social work from an accredited college or university; and/or

(4) a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health nursing with mental health major, maternal and child health with mental health major, etc.

G. The multidisciplinary staff shall be sufficient in number to implement and operate the described program of the center. In addition to the above, this team should include other professionals, paraprofessionals, and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner. If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the center, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts

to acquire such staff and show evidence of how the specialized functions of the required professionals are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0050 COMMUNITY MENTAL HEALTH CLINIC.

Subpart 1. **Definitions.** A community mental health clinic is an agency which devotes, as its major service, at least two-thirds of its resources for outpatient mental health diagnosis, treatment, and consultation by a multidisciplinary professional mental health team. The multidisciplinary professional mental health team is qualified by special mental health training and experience and shall include as a minimum the services of each of the following:

A. a licensed physician, who has completed an approved residency program in psychiatry; and

B. a doctoral clinical, or counseling or health care psychologist who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

C. a clinical social worker with a master's degree in social work from an accredited college or university; and/or

D. a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health with a mental health major, maternal and child health with a mental health major.

Subp. 2. **Other members of multidisciplinary team.** The multidisciplinary team shall be sufficient in number to implement and operate the described program of the clinic. In addition to the above, this team should include other professionals, paraprofessionals and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner.

Subp. 3. **Efforts to acquire staff.** If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the clinic, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts to acquire such staff and evidence of how the specialized functions of the required professional positions are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0060 ANNUAL PLAN AND BUDGET.

On or before the date designated by the commissioner, each year the chair of the community mental health board or director of the community mental health program, provided for in Minnesota Statutes, section 245.62, shall submit an annual plan identifying program priorities in accordance with state grant-in-aid guidelines, and a budget on prescribed report forms for the next state fiscal year, together with the recommendations of the community mental health board, to the commissioner of human services for approval as provided under Minnesota Statutes, section 245.63.

9520.0070 FISCAL AFFILIATES.

Other providers of community mental health services may affiliate with the community mental health center and may be approved and eligible for state grant-in-aid funds. The state funding for other community mental health services shall be contingent upon appropriate inclusion in the center's community mental health plan for the continuum of community mental health services and conformity with the state's appropriate disability plan for mental health, developmental disability, or chemical dependency. Fiscal affiliates (funded contracting agencies) providing specialized services under contract must meet all rules and standards that apply to the services they are providing.

9520.0080 OTHER REQUIRED REPORTS.

The program director of the community mental health program shall provide the commissioner of human services with such reports of program activities as the commissioner may require.

9520.0090 FUNDING.

All state community mental health funding shall go directly to the community mental health board or to a human service board established pursuant to Laws of Minnesota 1975, chapter 402, which itself provides or contracts with another agency to provide the community mental health program. Such programs must meet the standards and rules for community mental health programs as enunciated in parts 9520.0010 to 9520.0230 in accordance with Laws of Minnesota 1975, chapter 402.

9520.0100 OPERATION OF OTHER PROGRAMS.

When the governing authority of the community mental health program operates other programs, services, or activities, only the community mental health center program shall be subject to these parts.

9520.0110 APPLICATIONS AND AGREEMENTS BY LOCAL COUNTIES.

New applications for state assistance or applications for renewal of support must be accompanied by an agreement executed by designated signatories on behalf of the participating counties that specifies the involved counties, the amount and source of local funds in each case, and the period of support. The local funds to be used to match state grant-in-aid must be assured in writing on Department of Human Services forms by the local funding authority(ies).

9520.0120 USE OF MATCHING FUNDS.

Funds utilized by the director as authorized by the community mental health board to match a state grant-in-aid must be available to that director for expenditures for the same general purpose as the state grant-in-aid funds.

9520.0130 QUARTERLY REPORTS.

The director of the community mental health program shall, within 20 days after the end of the quarter, submit quarterly prescribed reports to the commissioner of human services (controller's office), containing all receipts, expenditures, and cash balance, subject to an annual audit by the commissioner or his/her designee.

9520.0140 PAYMENTS.

Payments on approved grants will be made subsequent to the department's receipt of the program's quarterly reporting forms, unless the commissioner of human services has determined that funds allocated to a program are not needed for that program. Payments shall be in an amount of at least equal to the quarterly allocation minus any unexpended balance from the previous quarter providing this payment does not exceed the program grant award. In the event the program does not report within the prescribed time, the department will withhold the process of the program's payment until the next quarterly cycle.

9520.0150 FEES.

No fees shall be charged until the director with approval of the community mental health board has established fee schedules for the services rendered and they have been submitted to the commissioner of human services at least two months prior to the effective date thereof and have been approved by him/her. All fees shall conform to the approved schedules, which are accessible to the public.

9520.0160 SUPPLEMENTAL AWARDS.

The commissioner of human services may make supplemental awards to the community mental health boards.

9520.0170 WITHDRAWAL OF FUNDS.

The commissioner of human services may withdraw funds from any program that is not administered in accordance with its approved plan and budget. Written notice of such intended action will be provided to the director and community mental health board. Opportunity for hearing before the commissioner or his/her designee shall be provided.

9520.0180 BUDGET TRANSFERS.

Community mental health boards may make budget transfers within specified limits during any fiscal year without prior approval of the department. The specified limit which can be transferred in any fiscal year between program activity budgets shall be up to ten percent or up to $5,000 whichever is less. Transfers within an activity can be made into or out of line items with a specified limit of up to ten percent or up to $5,000 whichever is less. No line item can be increased or decreased by more than $5,000 or ten percent in a fiscal year without prior approval of the commissioner. Transfers above the specified limits can be made with prior approval from the commissioner. All transfers within and into program budget activities and/or line items must have prior approval by the community mental health board and this approval must be reflected in the minutes of its meeting, it must be reported to the commissioner with the reasons therefor, including a statement of how the transfer will affect program objectives.

9520.0190 BUDGET ADJUSTMENTS.

Budget adjustments made necessary by funding limitations shall be made by the commissioner and provided in writing to the director and board of the community mental health center.

9520.0200 CENTER DIRECTOR.

Every community mental health board receiving state funds for a community mental health program shall have a center director, who is the full-time qualified professional staff member who serves as the executive officer. To be considered qualified, the individual must have professional training to at least the level of graduate degree in his/her clinical and/or administrative discipline, which is relevant to MH-DD-CD and a minimum of two years experience in community mental health programs. The center director is responsible for the planning/design, development, coordination, and evaluation of a comprehensive, area-wide program and for the overall administration of services operated by the board.

The center director shall be appointed by the community mental health board and shall be approved by the commissioner of human services.

9520.0210 DEADLINE FOR APPROVAL OR DENIAL OF REQUEST FOR APPROVAL STATUS.

The commissioner shall approve or deny, in whole or in part, an application for state financial assistance within 90 days of receipt of the grant-in-aid application or by the beginning of the state fiscal year, whichever is the later.

9520.0230 ADVISORY COMMITTEE.

Subpart 1. **Purpose.** To assist the community mental health board in meeting its responsibilities as described in Minnesota Statutes, section 245.68 and to provide opportunity for broad community representation necessary for effective comprehensive mental health, developmental disability, and chemical dependency program planning, each community

mental health board shall appoint a separate advisory committee in at least the three disability areas of mental health, developmental disability, and chemical dependency.

Subp. 2. **Membership.** The advisory committees shall consist of residents of the geographic area served who are interested and knowledgeable in the area governed by such committee.

Subp. 3. **Nominations for membership.** Nominations for appointments as members of the advisory committees are to be made to the community mental health board from agencies, organizations, groups, and individuals within the area served by the community mental health center. Appointments to the advisory committees are made by the community mental health board.

Subp. 4. **Board member on committee.** One community mental health board member shall serve on each advisory committee.

Subp. 5. **Nonprovider members.** Each advisory committee shall have at least one-half of its membership composed of individuals who are not providers of services to the three disability groups.

Subp. 6. **Representative membership.** Membership of each advisory committee shall generally reflect the population distribution of the service delivery area of the community mental health center.

Subp. 7. **Chairperson appointed.** The community mental health board shall appoint a chairperson for each advisory committee. The chairperson shall not be a community mental health board member nor a staff member. The power to appoint the chairperson may be delegated by the community mental health board to the individual advisory committee.

Subp. 8. **Committee responsibility to board.** Each advisory committee shall be directly responsible to the community mental health board. Direct communication shall be effected and maintained through contact between the chairperson of the particular advisory committee, or his/her designee, and the chairperson of the community mental health board, or his/her designee.

Subp. 9. **Staff.** Staff shall be assigned by the director to serve the staffing needs of each advisory committee.

Subp. 10. **Study groups and task forces.** Each advisory committee may appoint study groups and task forces upon consultation with the community mental health board. It is strongly recommended that specific attention be given to the aging and children and youth populations.

Subp. 11. **Quarterly meetings required.** Each advisory committee shall meet at least quarterly.

Subp. 12. **Annual report required.** Each advisory committee must make a formal written and oral report on its work to the community mental health board at least annually.

Subp. 13. **Minutes.** Each advisory committee shall submit copies of minutes of their meetings to the community mental health board and to the Department of Human Services (respective disability group program divisions).

Subp. 14. **Duties of advisory committee.** The advisory committees shall be charged by the community mental health board with assisting in the identification of the community's needs for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. The advisory committee also assists the community mental health board in determining priorities for the community programs. Based on the priorities, each advisory committee shall recommend to the community mental health board ways in which the limited available community resources (work force, facilities, and finances) can be put to maximum and optimal use.

Subp. 15. **Recommendations.** The advisory committee recommendations made to the community mental health board shall be included as a separate section in the grant-in-aid request submitted to the Department of Human Services by the community mental health board.

Subp. 16. **Assessment of programs.** The advisory committees shall assist the community mental health board in assessing the programs carried on by the community mental health board, and make recommendations regarding the reordering of priorities and modifying of programs where necessary.

9520.0750 PURPOSE.

Parts 9520.0750 to 9520.0870 establish standards for approval of mental health centers and mental health clinics for purposes of insurance and subscriber contract reimbursement under Minnesota Statutes, section 62A.152.

9520.0760 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9520.0760 to 9520.0870, the following terms have the meanings given them.

Subp. 2. **Application.** "Application" means the formal statement by a center to the commissioner, on the forms created for this purpose, requesting recognition as meeting the requirements of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 3. **Approval.** "Approval" means the determination by the commissioner that the applicant center has met the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870, and is therefore eligible to claim reimbursement for outpatient clinical services under the terms of Minnesota Statutes, section 62A.152. Approval of a center under these parts does not mean approval of a multidisciplinary staff person of such center to claim reimbursement from medical assistance or other third-party payors when practicing privately. Approval of a center under these parts does not mean approval of such center to claim reimbursement from medical assistance.

Subp. 4. **Case review.** "Case review" means a consultation process thoroughly examining a client's condition and treatment. It includes review of the client's reason for seeking treatment, diagnosis and assessment, and the individual treatment plan; review of the appropriateness, duration, and outcome of treatment provided; and treatment recommendations.

Subp. 5. **Center.** "Center" means a public or private health and human services facility which provides clinical services in the treatment of mental illness. It is an abbreviated term used in place of "mental health center" or "mental health clinic" throughout parts 9520.0750 to 9520.0870.

Subp. 6. **Client.** "Client" means a person accepted by the center to receive clinical services in the diagnosis and treatment of mental illness.

Subp. 7. **Clinical services.** "Clinical services" means services provided to a client to diagnose, describe, predict, and explain that client's status relative to a disabling condition or problem, and where necessary, to treat the client to reduce impairment due to that condition. Clinical services also include individual treatment planning, case review, record keeping required for treatment, peer review, and supervision.

Subp. 8. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or a designated representative.

Subp. 9. **Competent.** "Competent" means having sufficient knowledge of and proficiency in a specific mental illness assessment or treatment service, technique, method, or procedure, documented by experience, education, training, and certification, to be able to provide it to a client with little or no supervision.

Subp. 10. **Consultation.** "Consultation" means the process of deliberating or conferring between multidisciplinary staff regarding a client and the client's treatment.

Subp. 11. **Deferral.** "Deferral" means the determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 and is not approved, but is granted a period of time to comply with these standards and receive a second review without reapplication.

Subp. 12. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 13. **Disapproval or withdrawal of approval.** "Disapproval" or "withdrawal of approval" means a determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 14. **Discipline.** "Discipline" means a branch of professional knowledge or skill acquired through a specific course of study and training and usually documented by a specific educational degree or certification of proficiency. Examples of the mental health disciplines include but are not limited to psychiatry, psychology, clinical social work, and psychiatric nursing.

Subp. 15. **Documentation.** "Documentation" means the automatically or manually produced and maintained evidence that can be read by person or machine, and that will attest to the compliance with requirements of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 16. **Individual treatment plan.** "Individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results for a specific client, and updated as necessary. The plan specifies the goals and objectives in measurable terms, states the treatment strategy, and identifies responsibilities of multidisciplinary staff.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a staff person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

A. by having a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and 2,000 hours of supervised experience in the delivery of clinical services in the treatment of mental illness;

B. by having 6,000 hours of supervised experience in the delivery of clinical services in the treatment of mental illness;

C. by being a graduate student in one of the behavioral sciences or related fields formally assigned to the center for clinical training by an accredited college or university; or

D. by having a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university.

Documentation of compliance with part 9520.0800, subpart 4, item B is required for designation of work as supervised experience in the delivery of clinical services. Documentation of the accreditation of a college or university shall be a listing in Accredited Institutions of Postsecondary Education Programs, Candidates for the year the degree was issued. The master's degree in behavioral sciences or related fields shall include a minimum of 28 semester hours of graduate course credit in mental health theory and supervised clinical training, as documented by an official transcript.

Subp. 18. **Mental health professional.** "Mental health professional" has the meaning given in Minnesota Statutes, section 245.462, subdivision 18.

Subp. 19. **Mental illness.** "Mental illness" means a condition which results in an inability to interpret the environment realistically and in impaired functioning in primary

aspects of daily living such as personal relations, living arrangements, work, and recreation, and which is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), Ninth Revision (1980), code range 290.0-302.99 or 306.0-316, or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III), Third Edition (1980), Axes I, II or III. These publications are available from the State Law Library.

Subp. 20. **Multidisciplinary staff.** "Multidisciplinary staff" means the mental health professionals and mental health practitioners employed by or under contract to the center to provide outpatient clinical services in the treatment of mental illness.

Subp. 21. **Serious violations of policies and procedures.** "Serious violations of policies and procedures" means a violation which threatens the health, safety, or rights of clients or center staff; the repeated nonadherence to center policies and procedures; and the nonadherence to center policies and procedures which result in noncompliance with Minnesota Statutes, section 245.69, subdivision 2 and parts 9520.0760 to 9520.0870.

Subp. 22. **Treatment strategy.** "Treatment strategy" means the particular form of service delivery or intervention which specifically addresses the client's characteristics and mental illness, and describes the process for achievement of individual treatment plan goals.

9520.0770 ORGANIZATIONAL STRUCTURE OF CENTER.

Subpart 1. **Basic unit.** The center or the facility of which it is a unit shall be legally constituted as a partnership, corporation, or government agency. The center shall be either the entire facility or a clearly identified unit within the facility which is administratively and clinically separate from the rest of the facility. All business shall be conducted in the name of the center or facility, except medical assistance billing by individually enrolled providers when the center is not enrolled.

Subp. 2. **Purpose, services.** The center shall document that the prevention, diagnosis, and treatment of mental illness are the main purposes of the center. If the center is a unit within a facility, the rest of the facility shall not provide clinical services in the outpatient treatment of mental illness. The facility may provide services other than clinical services in the treatment of mental illness, including medical services, chemical dependency services, social services, training, and education. The provision of these additional services is not reviewed in granting approval to the center under parts 9520.0760 to 9520.0870.

Subp. 3. **Governing body.** The center shall have a governing body. The governing body shall provide written documentation of its source of authority. The governing body shall be legally responsible for the implementation of the standards set forth in Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 through the establishment of written policy and procedures.

Subp. 4. **Chart or statement of organization.** The center shall have an organizational chart or statement which specifies the relationships among the governing body, any administrative and support staff, mental health professional staff, and mental health practitioner staff; their respective areas of responsibility; the lines of authority involved; the formal liaison between administrative and clinical staff; and the relationship of the center to the rest of the facility and any additional services provided.

9520.0780 SECONDARY LOCATIONS.

Subpart 1. **Main and satellite offices.** The center shall notify the commissioner of all center locations. If there is more than one center location, the center shall designate one as the main office and all secondary locations as satellite offices. The main office as a unit and the center as a whole shall be in compliance with part 9520.0810. The main office shall function as the center records and documentation storage area and house most administrative functions for the center. Each satellite office shall:

A. be included as a part of the legally constituted entity;

B. adhere to the same clinical and administrative policies and procedures as the main office;

C. operate under the authority of the center's governing body;

D. store all center records and the client records of terminated clients at the main office;

E. ensure that a mental health professional is at the satellite office and competent to supervise and intervene in the clinical services provided there, whenever the satellite office is open;

F. ensure that its multidisciplinary staff have access to and interact with main center staff for consultation, supervision, and peer review; and

G. ensure that clients have access to all clinical services provided in the treatment of mental illness and the multidisciplinary staff of the center.

Subp. 2. **Noncompliance.** If the commissioner determines that a secondary location is not in compliance with subpart 1, it is not a satellite office. Outpatient clinical services in the treatment of mental illness delivered by the center or facility of which it is a unit shall cease at that location, or the application shall be disapproved.

9520.0790 MINIMUM TREATMENT STANDARDS.

Subpart 1. **Multidisciplinary approach.** The center shall document that services are provided in a multidisciplinary manner. That documentation shall include evidence that staff interact in providing clinical services, that the services provided to a client involve all needed disciplines represented on the center staff, and that staff participate in case review and consultation procedures as described in subpart 6.

Subp. 2. **Intake and case assignment.** The center shall establish an intake or admission procedure which outlines the intake process, including the determination of the appropriateness of accepting a person as a client by reviewing the client's condition and need for treatment, the clinical services offered by the center, and other available resources. The center shall document that case assignment for assessment, diagnosis, and treatment is made to a multidisciplinary staff person who is competent in the service, in the recommended treatment strategy and in treating the individual client characteristics. Responsibility for each case shall remain with a mental health professional.

Subp. 3. **Assessment and diagnostic process.** The center shall establish an assessment and diagnostic process that determines the client's condition and need for clinical services. The assessment of each client shall include clinical consideration of the client's general physical, medical, developmental, family, social, psychiatric, and psychological history and current condition. The diagnostic statement shall include the diagnosis based on the codes in the International Classification of Diseases or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and refer to the pertinent assessment data. The diagnosis shall be by or under the supervision of and signed by a psychiatrist or licensed psychologist. The diagnostic assessment, as defined by Minnesota Statutes, sections 245.462, subdivision 9, for adults, and 245.4871, subdivision 11, for children, must be provided by a licensed mental health professional in accordance with Minnesota Statutes, section 245.467, subdivision 2.

Subp. 4. **Treatment planning.** The individual treatment plan, based upon a diagnostic assessment of mental illness, shall be jointly developed by the client and the mental health professional. This planning procedure shall ensure that the client has been informed in the following areas: assessment of the client condition; treatment alternatives; possible outcomes and side effects of treatment; treatment recommendations; approximate length, cost, and hoped-for outcome of treatment; the client's rights and responsibilities in implementation of the individual treatment plan; staff rights and responsibilities in the treatment process; the Government Data Practices Act; and procedures for reporting grievances and alleged violation of client rights. If the client is considering chemotherapy, hospitalization, or other

medical treatment, the appropriate medical staff person shall inform the client of the treatment alternatives, the effects of the medical procedures, and possible side effects. Clinical services shall be appropriate to the condition, age, sex, socioeconomic, and ethnic background of the client, and provided in the least restrictive manner. Clinical services shall be provided according to the individual treatment plan and existing professional codes of ethics.

Subp. 5. **Client record.** The center shall maintain a client record for each client. The record must document the assessment process, the development and updating of the treatment plan, the treatment provided and observed client behaviors and response to treatment, and serve as data for the review and evaluation of the treatment provided to a client. The record shall include:

A. a statement of the client's reason for seeking treatment;

B. a record of the assessment process and assessment data;

C. the initial diagnosis based upon the assessment data;

D. the individual treatment plan;

E. a record of all medication prescribed or administered by multidisciplinary staff;

F. documentation of services received by the client, including consultation and progress notes;

G. when necessary, the client's authorization to release private information, and client information obtained from outside sources;

H. at the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome; and

I. correspondence and other necessary information.

Subp. 6. **Consultation; case review.** The center shall establish standards for case review and encourage the ongoing consultation among multidisciplinary staff. The multidisciplinary staff shall attend staff meetings at least twice monthly for a minimum of four hours per month, or a minimum of two hours per month if the multidisciplinary staff person provides clinical services in the treatment of mental illness less than 15 hours per week. The purpose of these meetings shall be case review and consultation. Written minutes of the meeting shall be maintained at the center for at least three years after the meeting.

Subp. 7. **Referrals.** If the necessary treatment or the treatment desired by the client is not available at the center, the center shall facilitate appropriate referrals. The multidisciplinary staff person shall discuss with the client the reason for the referral, potential treatment resources, and what the process will involve. The staff person shall assist in the process to ensure continuity of the planned treatment.

Subp. 8. **Emergency service.** The center shall ensure that clinical services to treat mental illness are available to clients on an emergency basis.

Subp. 9. **Access to hospital.** The center shall document that it has access to hospital admission for psychiatric inpatient care, and shall provide that access when needed by a client. This requirement for access does not require direct hospital admission privileges on the part of qualified multidisciplinary staff.

9520.0800 MINIMUM QUALITY ASSURANCE STANDARDS.

Subpart 1. **Policies and procedures.** The center shall develop written policies and procedures and shall document the implementation of these policies and procedures for each treatment standard and each quality assurance standard in subparts 2 to 7. The policies shall be approved by the governing body. The procedures shall indicate what actions or accomplishments are to be performed, who is responsible for each action, and any documentation or required forms. Multidisciplinary staff shall have access to a copy of the policies and procedures at all times.

Subp. 2. **Peer review.** The center shall have a multidisciplinary peer review system to assess the manner in which multidisciplinary staff provide clinical services in the treatment of mental illness. Peer review shall include the examination of clinical services to determine if the treatment provided was effective, necessary, and sufficient and of client records to determine if the recorded information is necessary and sufficient. The system shall ensure review of a randomly selected sample of five percent or six cases, whichever is less, of the annual caseload of each mental health professional by other mental health professional staff. Peer review findings shall be discussed with staff involved in the case and followed up by any necessary corrective action. Peer review records shall be maintained at the center.

Subp. 3. **Internal utilization review.** The center shall have a system of internal utilization review to examine the quality and efficiency of resource usage and clinical service delivery. The center shall develop and carry out a review procedure consistent with its size and organization which includes collection or review of information, analysis or interpretation of information, and application of findings to center operations. The review procedure shall minimally include, within any three year period of time, review of the appropriateness of intake, the provision of certain patterns of services, and the duration of treatment. Criteria may be established for treatment length and the provision of services for certain client conditions. Utilization review records shall be maintained, with an annual report to the governing body for applicability of findings to center operations.

Subp. 4. **Staff supervision.** Staff supervision:

A. The center shall have a clinical evaluation and supervision procedure which identifies each multidisciplinary staff person's areas of competence and documents that each multidisciplinary staff person receives the guidance and support needed to provide clinical services for the treatment of mental illness in the areas they are permitted to practice.

B. A mental health professional shall be responsible for the supervision of the mental health practitioner, including approval of the individual treatment plan and bimonthly case review of every client receiving clinical services from the practitioner. This supervision shall include a minimum of one hour of face-to-face, client-specific supervisory contact for each 40 hours of clinical services in the treatment of mental illness provided by the practitioner.

Subp. 5. **Continuing education.** The center shall require that each multidisciplinary staff person attend a minimum of 36 clock hours every two years of academic or practical course work and training. This education shall augment job-related knowledge, understanding, and skills to update or enhance staff competencies in the delivery of clinical services to treat mental illness. Continued licensure as a mental health professional may be substituted for the continuing education requirement of this subpart.

Subp. 6. **Violations of standards.** The center shall have procedures for the reporting and investigating of alleged unethical, illegal, or grossly negligent acts, and of the serious violation of written policies and procedures. The center shall document that the reported behaviors have been reviewed and that responsible disciplinary or corrective action has been taken if the behavior was substantiated. The procedures shall address both client and staff reporting of complaints or grievances regarding center procedures, staff, and services. Clients and staff shall be informed they may file the complaint with the department if it was not resolved to mutual satisfaction. The center shall have procedures for the reporting of suspected abuse or neglect of clients, in accordance with Minnesota Statutes, sections 611A.32, subdivision 5; 626.556; and 626.557.

Subp. 7. **Data classification.** Client information compiled by the center, including client records and minutes of case review and consultation meetings, shall be protected as private data under the Minnesota Government Data Practices Act.

9520.0810 MINIMUM STAFFING STANDARDS.

Subpart 1. **Required staff.** Required staff:

A. The multidisciplinary staff of a center shall consist of at least four mental health professionals. At least two of the mental health professionals shall each be employed or under contract for a minimum of 35 hours a week by the center. Those two mental health professionals shall be of different disciplines.

B. The mental health professional staff shall include a psychiatrist and a licensed psychologist.

C. The mental health professional employed or under contract to the center to meet the requirement of item B shall be at the main office of the center and providing clinical services in the treatment of mental illness at least eight hours every two weeks.

Subp. 2. **Additional staff; staffing balance.** Additional mental health professional staff may be employed by or under contract to the center provided that no single mental health discipline or combination of allied fields shall comprise more than 60 percent of the full-time equivalent mental health professional staff. This provision does not apply to a center with fewer than six full-time equivalent mental health professional staff. Mental health practitioners may also be employed by or under contract to a center to provide clinical services for the treatment of mental illness in their documented area of competence. Mental health practitioners shall not comprise more than 25 percent of the full-time equivalent multidisciplinary staff. In determination of full-time equivalence, only time spent in clinical services for the treatment of mental illness shall be considered.

Subp. 3. **Multidisciplinary staff records.** The center shall maintain records sufficient to document that the center has determined and verified the clinical service qualifications of each multidisciplinary staff person, and sufficient to document each multidisciplinary staff person's terms of employment.

Subp. 4. **Credentialed occupations.** The center shall adhere to the qualifications and standards specified by rule for any human service occupation credentialed under Minnesota Statutes, section 214.13 and employed by or under contract to the center.

9520.0820 APPLICATION PROCEDURES.

Subpart 1. **Form.** A facility seeking approval as a center for insurance reimbursement of its outpatient clinical services in treatment of mental illness must make formal application to the commissioner for such approval. The application form for this purpose may be obtained from the Mental Illness Program Division of the department. The application form shall require only information which is required by statute or rule, and shall require the applicant center to explain and provide documentation of compliance with the minimum standards in Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 2. **Fee.** Each application shall be accompanied by payment of the nonrefundable application fee. The fee shall be established and adjusted in accordance with Minnesota Statutes, section 16A.128 to cover the costs to the department in implementing Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 3. **Completed application.** The application is considered complete on the date the application fee and all information required in the application form are received by the department.

Subp. 4. **Coordinator.** The center shall designate in the application a mental health professional as the coordinator for issues surrounding compliance with parts 9520.0760 to 9520.0870.

9520.0830 REVIEW OF APPLICANT CENTERS.

Subpart 1. **Site visit.** The formal review shall begin after the completed application has been received, and shall include an examination of the written application and a visit to the center. The applicant center shall be offered a choice of site visit dates, with at least one date falling within 60 days of the date on which the department receives the complete application. The site visit shall include interviews with multidisciplinary staff and examination

of a random sample of client records, consultation minutes, quality assurance reports, and multidisciplinary staff records.

Subp. 2. **Documentation.** If implementation of a procedure is too recent to be reliably documented, a written statement of the planned implementation shall be accepted as documentation on the initial application. The evidence of licensure or accreditation through another regulating body shall be accepted as documentation of a specific procedure when the required minimum standard of that body is the same or higher than a specific provision of parts 9520.0760 to 9520.0870.

9520.0840 DECISION ON APPLICATION.

Subpart 1. **Written report.** Upon completion of the site visit, a report shall be written. The report shall include a statement of findings, a recommendation to approve, defer, or disapprove the application, and the reasons for the recommendation.

Subp. 2. **Written notice to center.** The applicant center shall be sent written notice of approval, deferral, or disapproval within 30 days of the completion of the site visit. If the decision is a deferral or a disapproval, the notice shall indicate the specific areas of noncompliance.

Subp. 3. **Noncompliance with statutes and rules.** An application shall be disapproved or deferred if it is the initial application of a center, when the applicant center is not in compliance with Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 4. **Deferral of application.** If an application is deferred, the length of deferral shall not exceed 180 days. If the areas of noncompliance stated in the deferral notice are not satisfactorily corrected by the end of the deferral period, the application shall be disapproved. The applicant center shall allow the commissioner to inspect the center at any time during the deferral period, whether or not the site visit has been announced in advance. A site visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center. At any time during the deferral period, the applicant center may submit documentation indicating correction of noncompliance. The application shall then be approved or disapproved. At any time during the deferral period, the applicant center may submit a written request to the commissioner to change the application status to disapproval. The request shall be complied with within 14 days of receiving this written request. The applicant center is not an approved center for purposes of Minnesota Statutes, section 62A.152 during a deferral period.

Subp. 5. **Effective date of decision.** The effective date of a decision is the date the commissioner signs a letter notifying the applicant center of that decision.

9520.0850 APPEALS.

If an application is disapproved or approval is withdrawn, a contested case hearing and judicial review as provided in Minnesota Statutes, sections 14.48 to 14.69, may be requested by the center within 30 days of the commissioner's decision.

9520.0860 POSTAPPROVAL REQUIREMENTS.

Subpart 1. **Duration of approval.** Initial approval of an application is valid for 12 months from the effective date, subsequent approvals for 24 months, except when approval is withdrawn according to the criteria in subpart 4.

Subp. 2. **Reapplication.** The center shall contact the department for reapplication forms, and submit the completed application at least 90 days prior to the expected expiration date. If an approved center has met the conditions of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870, including reapplication when required, its status as an approved center shall remain in effect pending department processing of the reapplication.

Subp. 3. **Restrictions.** The approval is issued only for the center named in the application and is not transferable or assignable to another center. The approval is issued only for the center location named in the application and is not transferable or assignable to another location. If the commissioner is notified in writing at least 30 days in advance of a change in center location and can determine that compliance with all provisions of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 are maintained, the commissioner shall continue the approval of the center at the new location.

Subp. 4. **Noncompliance.** Changes in center organization, staffing, treatment, or quality assurance procedures that affect the ability of the center to comply with the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 shall be reported in writing by the center to the commissioner within 15 days of occurrence. Review of the change shall be conducted by the commissioner. A center with changes resulting in noncompliance in minimum standards shall receive written notice and may have up to 180 days to correct the areas of noncompliance before losing approval status. Interim procedures to resolve the noncompliance on a temporary basis shall be developed and submitted in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. Nonreporting within 15 days of occurrence of a change that results in noncompliance, failure to develop an approved interim procedure within 30 days of the determination of the noncompliance, or nonresolution of the noncompliance within 180 days shall result in the immediate withdrawal of approval status.

Serious violation of policies or procedures, professional association or board sanctioning or loss of licensure for unethical practices, or the conviction of violating a state or federal statute shall be reported in writing by the center to the commissioner within ten days of the substantiation of such behavior. Review of this report and the action taken by the center shall be conducted by the commissioner. Approval shall be withdrawn immediately unless the commissioner determines that: the center acted with all proper haste and thoroughness in investigating the behavior, the center acted with all proper haste and thoroughness in taking appropriate disciplinary and corrective action, and that no member of the governing body was a party to the behavior. Failure to report such behavior within ten days of its substantiation shall result in immediate withdrawal of approval.

Subp. 5. **Compliance reports.** The center may be required to submit written information to the department during the approval period to document that the center has maintained compliance with the rule and center procedures. The center shall allow the commissioner to inspect the center at any time during the approval period, whether or not the site visit has been announced in advance. A site visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center.

9520.0870 VARIANCES.

Subpart 1. **When allowed.** The standards and procedures established by parts 9520.0760 to 9520.0860 may be varied by the commissioner. Standards and procedures established by statute shall not be varied.

Subp. 2. **Request procedure.** A request for a variance must be submitted in writing to the commissioner, accompanying or following the submission of a completed application for approval under Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870. The request shall state:

A. the standard or procedure to be varied;

B. the specific reasons why the standard or procedure cannot be or should not be complied with; and

C. the equivalent standard or procedure the center will establish to achieve the intent of the standard or procedure to be varied.

Subp. 3. **Decision procedure.** Upon receiving the variance request, the commissioner shall consult with a panel of experts in the mental health disciplines regarding the request. Criteria for granting a variance shall be the commissioner's determination that subpart 2, items A to C are met. Hardship shall not be a sufficient reason to grant a variance. No variance shall be granted that would threaten the health, safety, or rights of clients. Variances granted by the commissioner shall specify in writing the alternative standards or procedures to be implemented and any specific conditions or limitations imposed on the variance by the commissioner. Variances denied by the commissioner shall specify in writing the reason for the denial.

Subp. 4. **Notification.** The commissioner shall send the center a written notice granting or not granting the variance within 90 days of receiving the written variance request. This notice shall not be construed as approval or disapproval of the center under Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

9530.6800 ASSESSMENT OF NEED FOR TREATMENT PROGRAMS.

Subpart 1. **Assessment of need required for licensure.** Before a license or a provisional license may be issued, the need for the chemical dependency treatment or rehabilitation program must be determined by the commissioner. Need for an additional or expanded chemical dependency treatment program must be determined, in part, based on the recommendation of the county board of commissioners of the county in which the program will be located and the documentation submitted by the applicant at the time of application.

If the county board fails to submit a statement to the commissioner within 60 days of the county board's receipt of the written request from an applicant, as required under part 9530.6810, the commissioner shall determine the need for the applicant's proposed chemical dependency treatment program based on the documentation submitted by the applicant at the time of application.

Subp. 2. **Documentation of need requirements.** An applicant for licensure under parts 9530.2500 to 9530.4000 and Minnesota Statutes, chapter 245G, must submit the documentation in items A and B to the commissioner with the application for licensure:

A. The applicant must submit documentation that it has requested the county board of commissioners of the county in which the chemical dependency treatment program will be located to submit to the commissioner both a written statement that supports or does not support the need for the program and documentation of the rationale used by the county board to make its determination.

B. The applicant must submit a plan for attracting an adequate number of clients to maintain its proposed program capacity, including:

(1) a description of the geographic area to be served;

(2) a description of the target population to be served;

(3) documentation that the capacity or program designs of existing programs are not sufficient to meet the service needs of the chemically abusing or chemically dependent target population if that information is available to the applicant;

(4) a list of referral sources, with an estimation as to the number of clients the referral source will refer to the applicant's program in the first year of operation; and

(5) any other information available to the applicant that supports the need for new or expanded chemical dependency treatment capacity.

9530.6810 COUNTY BOARD RESPONSIBILITY TO REVIEW PROGRAM NEED.

When an applicant for licensure under parts 9530.2500 to 9530.4000 or Minnesota Statutes, chapter 245G, requests a written statement of support for a proposed chemical dependency treatment program from the county board of commissioners of the county in

which the proposed program is to be located, the county board, or the county board's designated representative, shall submit a statement to the commissioner that either supports or does not support the need for the applicant's program. The county board's statement must be submitted in accordance with items A and B:

A. the statement must be submitted within 60 days of the county board's receipt of a written request from the applicant for licensure; and

B. the statement must include the rationale used by the county board to make its determination.