This Document can be made available in alternative formats upon request

State of Minnesota

Printed Page No. 171

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 2128

03/11/2021 Authored by Liebling, Schultz and Bernardy
The bill was read for the first time and referred to the Committee on Health Finance and Policy
04/12/2021 Adoption of Report: Amended and re-referred to the Committee on Ways and Means
04/16/2021 Adoption of Report: Placed on the General Register as Amended
Read for the Second Time
04/19/2021 By motion, re-referred to the Committee on Ways and Means
04/21/2021 Adoption of Report: Placed on the General Register as Amended
Read for the Second Time

1.1 A bill for an act

1.2 relating to state government; modifying provisions governing health, health care,
1.3 human services, human services licensing and background studies, health-related
1.4 licensing boards, prescription drugs, health insurance, telehealth, children and
1.5 family services, behavioral health, direct care and treatment, disability services
1.6 and continuing care for older adults, community supports, and chemical and mental
1.7 health services; establishing a budget for health and human services; making
1.8 forecast adjustments; making technical and conforming changes; requiring reports;
1.9 transferring money; appropriating money; amending Minnesota Statutes 2020,
1.10 sections 62A.04, subdivision 2; 62A.10, by adding a subdivision; 62A.15,
1.11 subdivision 4, by adding a subdivision; 62A.152, subdivision 3; 62A.3094,
1.12 subdivision 1; 62A.65, subdivision 1, by adding a subdivision; 62C.01, by adding
1.13 a subdivision; 62D.01, by adding a subdivision; 62D.095, subdivisions 2, 3, 4, 5;
1.14 62J.495, subdivisions 1, 2, 3, 4; 62J.497, subdivisions 1, 3; 62J.498; 62J.4981;
1.15 62J.4982; 62J.63, subdivisions 1, 2; 62Q.01, subdivision 2a; 62Q.02; 62Q.096;
1.16 62Q.46; 62Q.677, by adding a subdivision; 62Q.81; 62U.04, subdivisions 4, 5,
1.17 11; 62V.05, by adding a subdivision; 62W.11; 103H.201, subdivision 1; 119B.011,
1.18 subdivision 15; 119B.025, subdivision 4; 119B.03, subdivisions 4, 6; 119B.09,
1.19 subdivision 4; 119B.11, subdivision 2a; 119B.125, subdivision 1; 119B.13,
1.20 subdivisions 1, 1a, 6, 7; 119B.25, subdivision 3; 122A.18, subdivision 8; 136A.128,
1.21 subdivisions 2, 4; 144.0724, subdivisions 1, 2, 3a, 4, 5, 7, 8, 9, 12; 144.1205,
1.22 subdivisions 2, 4, 8, 9, by adding a subdivision; 144.125, subdivision 1; 144.1481,
1.23 subdivision 1; 144.1501, subdivisions 1, 2, 3; 144.1911, subdivision 6; 144.212,
1.24 by adding a subdivision; 144.225, subdivisions 2, 7; 144.226, by adding
1.25 subdivisions; 144.55, subdivisions 4, 6; 144.551, subdivision 1, by adding a
1.26 subdivision; 144.555; 144.651, subdivision 2; 144.9501, subdivision 17; 144.9502,
1.27 subdivision 3; 144.9504, subdivisions 2, 5; 144D.01, subdivision 4; 144G.08,
1.28 subdivision 7, as amended; 144G.54, subdivision 3; 144G.84; 145.893, subdivision
1.29 1; 145.894; 145.897; 145.899; 145.901, subdivisions 2, 4; 147.033; 148.90,
1.30 subdivision 2; 148.911; 148B.30, subdivision 1; 148B.31; 148B.51; 148B.5301,
1.31 subdivision 2; 148B.54, subdivision 2; 148E.010, by adding a subdivision;
1.32 148E.120, subdivision 2; 148E.130, subdivision 1, by adding a subdivision;
1.33 148F.11, subdivision 1; 151.01, by adding subdivisions; 151.071, subdivisions 1,
1.34 2; 151.37, subdivision 2; 151.555, subdivisions 1, 7, 11, by adding a subdivision;
1.35 152.01, subdivision 23; 152.02, subdivisions 2, 3; 152.11, subdivision 1a, by
1.36 adding a subdivision; 152.12, by adding a subdivision; 152.125, subdivision 3;
1.37 152.22, subdivisions 6, 11, by adding subdivisions; 152.23; 152.25, by adding a
1.38 subdivision; 152.26; 152.27, subdivisions 3, 4, 6; 152.28, subdivision 1; 152.29,

2.1 subdivisions 1, 3, by adding subdivisions; 152.31; 152.32, subdivision 3; 156.12,
2.2 subdivision 2; 171.07, by adding a subdivision; 174.30, subdivision 3; 245.462,
2.3 subdivisions 1, 6, 8, 9, 14, 16, 17, 18, 21, 23, by adding a subdivision; 245.4661,
2.4 subdivision 5; 245.4662, subdivision 1; 245.467, subdivisions 2, 3; 245.469,
2.5 subdivisions 1, 2; 245.470, subdivision 1; 245.4712, subdivision 2; 245.472,
2.6 subdivision 2; 245.4863; 245.4871, subdivisions 9a, 10, 11a, 17, 21, 26, 27, 29,
2.7 31, 32, 34, by adding a subdivision; 245.4876, subdivisions 2, 3; 245.4879,
2.8 subdivision 1; 245.488, subdivision 1; 245.4882, subdivisions 1, 3; 245.4885,
2.9 subdivision 1; 245.4889, subdivision 1; 245.4901, subdivision 2; 245.62,
2.10 subdivision 2; 245.735, subdivisions 3, 5, by adding a subdivision; 245A.02, by
2.11 adding subdivisions; 245A.03, subdivision 7; 245A.04, subdivision 5; 245A.041,
2.12 by adding a subdivision; 245A.043, subdivision 3; 245A.05; 245A.07, subdivision
2.13 1; 245A.10, subdivision 4; 245A.14, subdivision 4; 245A.16, by adding a
2.14 subdivision; 245A.50, subdivisions 7, 9; 245A.65, subdivision 2; 245C.02,
2.15 subdivisions 4a, 5, by adding subdivisions; 245C.03; 245C.05, subdivisions 1, 2,
2.16 2a, 2b, 2c, 2d, 4; 245C.08, subdivision 3, by adding a subdivision; 245C.10,
2.17 subdivision 15, by adding subdivisions; 245C.13, subdivision 2; 245C.14,
2.18 subdivision 1, by adding a subdivision; 245C.15, by adding a subdivision; 245C.16,
2.19 subdivisions 1, 2; 245C.17, subdivision 1, by adding a subdivision; 245C.18;
2.20 245C.24, subdivisions 2, 3, 4, by adding a subdivision; 245C.32, subdivision 1a;
2.21 245D.02, subdivision 20; 245F.04, subdivision 2; 245G.01, subdivisions 13, 26;
2.22 245G.03, subdivision 2; 245G.06, subdivision 1; 246.54, subdivision 1b; 254A.19,
2.23 subdivision 5; 254B.01, subdivision 4a, by adding a subdivision; 254B.05,
2.24 subdivision 5; 254B.12, by adding a subdivision; 256.01, subdivisions 14b, 28;
2.25 256.0112, subdivision 6; 256.041; 256.042, subdivisions 2, 4; 256.043, subdivision
2.26 3; 256.969, subdivisions 2b, 9, by adding a subdivision; 256.9695, subdivision 1;
2.27 256.9741, subdivision 1; 256.98, subdivision 1; 256.983; 256B.04, subdivisions
2.28 12, 14; 256B.055, subdivision 6; 256B.056, subdivision 10; 256B.057, subdivision
2.29 3; 256B.06, subdivision 4; 256B.0615, subdivisions 1, 5; 256B.0616, subdivisions
2.30 1, 3, 5; 256B.0621, subdivision 10; 256B.0622, subdivisions 1, 2, 3a, 4, 7, 7a, 7b,
2.31 7d; 256B.0623, subdivisions 1, 2, 3, 4, 5, 6, 9, 12; 256B.0624; 256B.0625,
2.32 subdivisions 3b, 3c, 3d, 3e, 5, 5m, 9, 10, 13, 13c, 13d, 13e, 13h, 17, 17b, 18, 18b,
2.33 19c, 20, 20b, 28a, 30, 31, 42, 46, 48, 49, 52, 56a, 58, by adding subdivisions;
2.34 256B.0631, subdivision 1; 256B.0638, subdivisions 3, 5, 6; 256B.0659, subdivision
2.35 13; 256B.0757, subdivision 4c; 256B.0759, subdivisions 2, 4, by adding
2.36 subdivisions; 256B.0911, subdivisions 1a, 3a, 3f, 4d; 256B.092, subdivisions 4,
2.37 5, 12; 256B.0924, subdivision 6; 256B.094, subdivision 6; 256B.0941, subdivision
2.38 1; 256B.0943, subdivisions 1, 2, 3, 4, 5, 5a, 6, 7, 9, 11; 256B.0946, subdivisions
2.39 1, 1a, 2, 3, 4, 6; 256B.0947, subdivisions 1, 2, 3, 3a, 5, 6, 7; 256B.0949,
2.40 subdivisions 2, 4, 5a, by adding a subdivision; 256B.097, by adding subdivisions;
2.41 256B.196, subdivision 2; 256B.25, subdivision 3; 256B.439, by adding
2.42 subdivisions; 256B.49, subdivisions 11, 11a, 14, 17, by adding a subdivision;
2.43 256B.4914, subdivisions 5, 6, 7, 8, 9, by adding a subdivision; 256B.69,
2.44 subdivisions 5a, 6, 6d, by adding subdivisions; 256B.6928, subdivision 5; 256B.75;
2.45 256B.76, subdivisions 2, 4; 256B.761; 256B.763; 256B.79, subdivisions 1, 3;
2.46 256B.85, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 11b, 12, 12b, 13, 13a, 15,
2.47 17a, 18a, 20b, 23, 23a, by adding subdivisions; 256D.03, by adding a subdivision;
2.48 256D.051, by adding subdivisions; 256D.0515; 256D.0516, subdivision 2; 256E.34,
2.49 subdivision 1; 256I.03, subdivision 13; 256I.04, subdivision 3; 256I.05, subdivisions
2.50 1a, 1c, 11; 256I.06, subdivisions 6, 8; 256J.08, subdivisions 15, 71, 79; 256J.09,
2.51 subdivision 3; 256J.10; 256J.21, subdivisions 3, 4, 5; 256J.24, subdivision 5;
2.52 256J.30, subdivision 8; 256J.33, subdivisions 1, 2, 4; 256J.37, subdivisions 1, 1b,
2.53 3, 3a; 256J.45, subdivision 1; 256J.626, subdivision 1; 256J.95, subdivision 9;
2.54 256L.01, subdivision 5; 256L.03, subdivision 5; 256L.04, subdivision 7b; 256L.05,
2.55 subdivision 3a; 256L.07, subdivision 2; 256L.11, subdivisions 6a, 7; 256L.15,
2.56 subdivision 2; 256N.25, subdivisions 2, 3; 256N.26, subdivisions 11, 13; 256P.01,
2.57 subdivisions 3, 6a, by adding a subdivision; 256P.04, subdivisions 4, 8; 256P.06,
2.58 subdivisions 2, 3; 256P.07; 256S.05, subdivision 2; 256S.18, subdivision 7;

3.1 256S.20, subdivision 1; 257.0755, subdivision 1; 257.076, subdivisions 3, 5;
3.2 257.0768, subdivisions 1, 6; 257.0769; 260.761, subdivision 2; 260C.007,
3.3 subdivisions 6, 14, 26c, 31; 260C.157, subdivision 3; 260C.212, subdivisions 1a,
3.4 13; 260C.215, subdivision 4; 260C.4412; 260C.452; 260C.704; 260C.706;
3.5 260C.708; 260C.71; 260C.712; 260C.714; 260D.01; 260D.05; 260D.06, subdivision
3.6 2; 260D.07; 260D.08; 260D.14; 260E.01; 260E.02, subdivision 1; 260E.03,
3.7 subdivision 22, by adding subdivisions; 260E.06, subdivision 1; 260E.14,
3.8 subdivisions 2, 5; 260E.17, subdivision 1; 260E.18; 260E.20, subdivision 2;
3.9 260E.24, subdivisions 2, 7; 260E.31, subdivision 1; 260E.33, subdivision 1, by
3.10 adding a subdivision; 260E.35, subdivision 6; 260E.36, by adding a subdivision;
3.11 295.50, subdivision 9b; 295.53, subdivision 1; 325F.721, subdivision 1; 326.71,
3.12 subdivision 4; 326.75, subdivisions 1, 2, 3; Laws 2019, First Special Session
3.13 chapter 9, article 14, section 3, as amended; Laws 2020, First Special Session
3.14 chapter 7, section 1, subdivision 2, as amended; Laws 2020, Fifth Special Session
3.15 chapter 3, article 10, section 3; Laws 2020, Seventh Special Session chapter 1,
3.16 article 6, section 12, subdivision 4; proposing coding for new law in Minnesota
3.17 Statutes, chapters 3; 62A; 62J; 62Q; 62W; 119B; 144; 145; 151; 245; 245A; 245C;
3.18 254B; 256B; 256P; 256S; proposing coding for new law as Minnesota Statutes,
3.19 chapter 245I; repealing Minnesota Statutes 2020, sections 16A.724, subdivision
3.20 2; 62A.67; 62A.671; 62A.672; 62J.63, subdivision 3; 119B.125, subdivision 5;
3.21 144.0721, subdivision 1; 144.0722; 144.0724, subdivision 10; 144.693; 245.462,
3.22 subdivision 4a; 245.4871, subdivision 32a; 245.4879, subdivision 2; 245.62,
3.23 subdivisions 3, 4; 245.69, subdivision 2; 245.735, subdivisions 1, 2, 4; 245C.10,
3.24 subdivisions 2, 2a, 3, 4, 5, 6, 7, 8, 9, 9a, 10, 11, 12, 13, 14, 16; 256B.0596;
3.25 256B.0615, subdivision 2; 256B.0616, subdivision 2; 256B.0622, subdivisions 3,
3.26 5a; 256B.0623, subdivisions 7, 8, 10, 11; 256B.0625, subdivisions 5l, 18c, 18d,
3.27 18e, 18h, 35a, 35b, 61, 62, 65; 256B.0916, subdivisions 2, 3, 4, 5, 8, 11, 12;
3.28 256B.0924, subdivision 4a; 256B.0943, subdivisions 8, 10; 256B.0944; 256B.0946,
3.29 subdivision 5; 256B.097, subdivisions 1, 2, 3, 4, 5, 6; 256B.49, subdivisions 26,
3.30 27; 256D.051, subdivisions 1, 1a, 2, 2a, 3, 3a, 3b, 6b, 6c, 7, 8, 9, 18; 256D.052,
3.31 subdivision 3; 256J.08, subdivisions 10, 53, 61, 62, 81, 83; 256J.21, subdivisions
3.32 1, 2; 256J.30, subdivisions 5, 7, 8; 256J.33, subdivisions 3, 4, 5; 256J.34,
3.33 subdivisions 1, 2, 3, 4; 256J.37, subdivision 10; 256S.20, subdivision 2; Minnesota
3.34 Rules, parts 9505.0275; 9505.0370; 9505.0371; 9505.0372; 9505.1693; 9505.1696,
3.35 subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22;
3.36 9505.1699; 9505.1701; 9505.1703; 9505.1706; 9505.1712; 9505.1715; 9505.1718;
3.37 9505.1724; 9505.1727; 9505.1730; 9505.1733; 9505.1736; 9505.1739; 9505.1742;
3.38 9505.1745; 9505.1748; 9520.0010; 9520.0020; 9520.0030; 9520.0040; 9520.0050;
3.39 9520.0060; 9520.0070; 9520.0080; 9520.0090; 9520.0100; 9520.0110; 9520.0120;
3.40 9520.0130; 9520.0140; 9520.0150; 9520.0160; 9520.0170; 9520.0180; 9520.0190;
3.41 9520.0200; 9520.0210; 9520.0230; 9520.0750; 9520.0760; 9520.0770; 9520.0780;
3.42 9520.0790; 9520.0800; 9520.0810; 9520.0820; 9520.0830; 9520.0840; 9520.0850;
3.43 9520.0860; 9520.0870; 9530.6800; 9530.6810.

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

3.45 **ARTICLE 1**

3.46 **DEPARTMENT OF HUMAN SERVICES HEALTH CARE PROGRAMS**

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

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

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

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

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

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

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

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

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

4.16 **62Q.02 APPLICABILITY OF CHAPTER.**

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

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

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

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

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

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

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

5.16 (c) For vehicles designated as protected transport under section 256B.0625, subdivision
5.17 17, paragraph ~~(h)~~ (g), the commissioner of transportation, during the commissioner's
5.18 inspection, shall check to ensure the safety provisions contained in that paragraph are in
5.19 working order.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.11 (1) pediatric services;

7.12 (2) behavioral health services;

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

7.14 (4) transplant services;

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

7.17 (6) outlier admissions;

7.18 (7) low-volume providers; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.26 (6) geographic location.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(f)~~ (g) An additional payment adjustment shall be established by the commissioner under this subdivision for a hospital that provides high levels of administering high-cost drugs to enrollees in fee-for-service medical assistance. The commissioner shall consider factors including fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, or if the hospital qualifies for the alternative payment rate described in subdivision 2e, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed ~~$1,500,000~~ $9,750,000 in fiscal year 2023 and $14,000,000 per year beginning July 1, 2023.

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

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

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

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

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

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

13.5 **256.983 FRAUD PREVENTION INVESTIGATIONS.**

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

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

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

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

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

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

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

14.22 (b) If, upon investigation, a preponderance of evidence shows a provider committed an
14.23 intentional program violation, intentionally gave the county or tribe materially false
14.24 information on the provider's billing forms, provided false attendance records to a county,
14.25 tribe, or the commissioner, or committed financial misconduct as described in section
14.26 245E.01, subdivision 8, the county or tribal agency may suspend a provider's payment
14.27 pursuant to chapter 245E, or deny or revoke a provider's authorization pursuant to section
14.28 119B.13, subdivision 6, paragraph (d), clause (2), prior to pursuing other available remedies.
14.29 The county or tribe must send notice in accordance with the requirements of section
14.30 119B.161, subdivision 2. If a provider's payment is suspended under this section, the payment
14.31 suspension shall remain in effect until: (1) the commissioner, county, tribe, or a law
14.32 enforcement authority determines that there is insufficient evidence warranting the action
14.33 and a county, tribe, or the commissioner does not pursue an additional administrative remedy
14.34 under chapter 119B or 245E, or section 256.046 or 256.98; or (2) all criminal, civil, and

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

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

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

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

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

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

15.16 (1) provider recruitment, contracting, and assistance;

15.17 (2) recipient outreach and assistance;

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

15.19 (4) dental claims processing;

15.20 (5) coordination of dental care with other services;

15.21 (6) management of fraud and abuse;

15.22 (7) monitoring access to dental services;

15.23 (8) performance measurement;

15.24 (9) quality improvement and evaluation; and

15.25 (10) management of third-party liability requirements.

15.26 (c) Payments to contracted dental providers must be at the rates established under section
15.27 256B.76.

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

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

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

16.7 ~~The rules shall provide:~~

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

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

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

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

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

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

16.32 (1) eyeglasses;

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

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

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

17.6 (i) hospital beds;

17.7 (ii) commodes;

17.8 (iii) glide-about chairs;

17.9 (iv) patient lift apparatus;

17.10 (v) wheelchairs and accessories;

17.11 (vi) oxygen administration equipment;

17.12 (vii) respiratory therapy equipment;

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

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

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

17.19 (6) drugs.

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

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

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

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

18.1 that is not reasonably compatible with such attestation. For purposes of this subdivision, a
18.2 woman is considered pregnant for ~~60 days~~ 12 months postpartum.

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

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

18.7 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are
18.8 applying for the continuation of medical assistance coverage following the end of the ~~60-day~~
18.9 12-month postpartum period to update their income and asset information and to submit
18.10 any required income or asset verification.

18.11 (b) The commissioner shall determine the eligibility of private-sector health care coverage
18.12 for infants less than one year of age eligible under section 256B.055, subdivision 10, or
18.13 256B.057, subdivision 1, paragraph (c), and shall pay for private-sector coverage if this is
18.14 determined to be cost-effective.

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

18.17 (d) The commissioner shall utilize information obtained through the electronic service
18.18 established by the secretary of the United States Department of Health and Human Services
18.19 and other available electronic data sources in Code of Federal Regulations, title 42, sections
18.20 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish
18.21 standards to define when information obtained electronically is reasonably compatible with
18.22 information provided by applicants and enrollees, including use of self-attestation, to
18.23 accomplish real-time eligibility determinations and maintain program integrity.

18.24 (e) Each person applying for or receiving medical assistance under section 256B.055,
18.25 subdivision 7, and any other person whose resources are required by law to be disclosed to
18.26 determine the applicant's or recipient's eligibility must authorize the commissioner to obtain
18.27 information from financial institutions to identify unreported accounts as required in section
18.28 256.01, subdivision 18f. If a person refuses or revokes the authorization, the commissioner
18.29 may determine that the applicant or recipient is ineligible for medical assistance. For purposes
18.30 of this paragraph, an authorization to identify unreported accounts meets the requirements
18.31 of the Right to Financial Privacy Act, United States Code, title 12, chapter 35, and need not
18.32 be furnished to the financial institution.

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

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

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

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

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

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

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

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

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

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

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

20.1 persons residing lawfully in the United States. Citizens or nationals of the United States
20.2 must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality
20.3 according to the requirements of the federal Deficit Reduction Act of 2005, Public Law
20.4 109-171.

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

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

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

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

20.11 (4) granted withholding of deportation according to United States Code, title 8, section
20.12 1253(h);

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

20.15 (6) granted conditional entrant status according to United States Code, title 8, section
20.16 1153(a)(7);

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

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

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

20.26 (c) All qualified noncitizens who were residing in the United States before August 22,
20.27 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical
20.28 assistance with federal financial participation.

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

21.1 (1) refugees admitted to the United States according to United States Code, title 8, section
21.2 1157;

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

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

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

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

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

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

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

21.24 (g) For purposes of this subdivision, the term "emergency medical condition" means a
21.25 medical condition that meets the requirements of United States Code, title 42, section
21.26 1396b(v).

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

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

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

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

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

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

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

22.8 (iii) services for routine prenatal care;

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

22.11 (v) elective surgery;

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

22.14 (vii) preventative health care and family planning services;

22.15 (viii) rehabilitation services;

22.16 (ix) physical, occupational, or speech therapy;

22.17 (x) transportation services;

22.18 (xi) case management;

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

22.20 (xiii) dental services;

22.21 (xiv) hospice care;

22.22 (xv) audiology services and hearing aids;

22.23 (xvi) podiatry services;

22.24 (xvii) chiropractic services;

22.25 (xviii) immunizations;

22.26 (xix) vision services and eyeglasses;

22.27 (xx) waiver services;

22.28 (xxi) individualized education programs; or

23.1 (xxii) chemical dependency treatment.

23.2 (i) Pregnant noncitizens who are ineligible for federally funded medical assistance
23.3 because of immigration status, are not covered by a group health plan or health insurance
23.4 coverage according to Code of Federal Regulations, title 42, section 457.310, and who
23.5 otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance
23.6 through the period of pregnancy, including labor and delivery, and ~~60 days~~ 12 months
23.7 postpartum~~, to the extent federal funds are available under title XXI of the Social Security~~
23.8 ~~Act, and the state children's health insurance program~~.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) the development of dental delivery models; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27.7 (3) limited exams;

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

27.9 (5) periapical x-rays;

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

27.14 (7) prophylaxis, limited to one per year;

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

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

27.17 (10) anterior fillings;

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

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

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

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

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

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

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

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

27.29 (2) general anesthesia; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30.3 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
30.4 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
30.5 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
30.6 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
30.7 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
30.8 individuals, medical assistance may cover drugs from the drug classes listed in United States
30.9 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
30.10 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
30.11 not be covered.

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

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

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

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

30.25 (4) the aggregate cost of drugs purchased during the prior calendar year through the
30.26 340B program;

30.27 (5) the aggregate cost of drugs purchased during the prior calendar year outside of the
30.28 340B program;

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

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

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

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

31.10 (g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal
31.11 contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section
31.12 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a
31.13 licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists
31.14 used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed
31.15 pharmacist in accordance with section 151.37, subdivision 16.

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

31.18 Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations
31.19 from professional medical associations and professional pharmacy associations, and consumer
31.20 groups shall designate a Formulary Committee to carry out duties as described in subdivisions
31.21 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively
31.22 engaged in the practice of medicine in Minnesota, one of whom must be actively engaged
31.23 in the treatment of persons with mental illness; at least three licensed pharmacists actively
31.24 engaged in the practice of pharmacy in Minnesota; and one consumer representative; the
31.25 remainder to be made up of health care professionals who are licensed in their field and
31.26 have recognized knowledge in the clinically appropriate prescribing, dispensing, and
31.27 monitoring of covered outpatient drugs. Members of the Formulary Committee shall not
31.28 be employed by the Department of Human Services, but the committee shall be staffed by
31.29 an employee of the department who shall serve as an ex officio, nonvoting member of the
31.30 committee. The department's medical director shall also serve as an ex officio, nonvoting
31.31 member for the committee. Committee members shall serve three-year terms and may be
31.32 reappointed by the commissioner. The Formulary Committee shall meet at least twice per
31.33 year. The commissioner may require more frequent Formulary Committee meetings as
31.34 needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid

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

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

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

(b) The formulary shall not include:

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

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

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

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

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

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

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

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

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

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

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

34.5 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
34.6 an automated drug distribution system meeting the requirements of section 151.58, or a
34.7 packaging system meeting the packaging standards set forth in Minnesota Rules, part
34.8 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
34.9 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
34.10 retrospectively billing pharmacy must submit a claim only for the quantity of medication
34.11 used by the enrolled recipient during the defined billing period. A retrospectively billing
34.12 pharmacy must use a billing period not less than one calendar month or 30 days.

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

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

34.24 (e) The basis for determining the amount of payment for drugs administered in an
34.25 outpatient setting shall be the lower of the usual and customary cost submitted by the
34.26 provider, 106 percent of the average sales price as determined by the United States
34.27 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
34.28 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
34.29 set by the commissioner. If average sales price is unavailable, the amount of payment must
34.30 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
34.31 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
34.32 The commissioner shall discount the payment rate for drugs obtained through the federal
34.33 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an
34.34 outpatient setting shall be made to the administering facility or practitioner. A retail or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37.6 (2) the provider has initiated background studies on the individuals specified in section
37.7 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) investigate all complaints and appeals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41.11 (3) each entry in the record must document:

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

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

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

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

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

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

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

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

41.26 (ix) whether the service was ambulatory or nonambulatory;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

45.32 (i) general social services and administrative costs;

45.33 (ii) retail pharmacy;

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

46.2 (iv) external lab and x-ray;

46.3 (v) navigation services;

46.4 (vi) health care taxes;

46.5 (vii) advertising, public relations, and marketing;

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

46.7 (ix) contributions and donations;

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

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

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

46.11 (xiii) research and associated administrative costs;

46.12 (xiv) nonpaid workers;

46.13 (xv) lobbying;

46.14 (xvi) scholarships and student aid; and

46.15 (xvii) nonmedical assistance covered services;

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

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

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

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

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

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

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

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

47.8 (6) the commissioner shall annually inflate the applicable organization encounter rates
47.9 for FQHCs and rural health clinics from the base year payment rate to the effective date by
47.10 using the CMS FQHC Market Basket inflator established under United States Code, title
47.11 42, section 1395m(o), less productivity;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

49.20 (1) can withstand repeated use;

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

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

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

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

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

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

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

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

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

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

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

50.16 (i) the benefits of preventative health care visits;

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

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

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

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

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

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

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

51.3 (d) The payment amount for a complete EPSDT screening shall not include charges for
51.4 health care services and products that are available at no cost to the provider and shall not
51.5 exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October
51.6 1, 2010.

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

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

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

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

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

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

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

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

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

51.30 (3) a dehumidifier and filters;

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

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

52.3 (6) a damp mopping system;

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

52.5 (8) for homeowners only, furnace filters.

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

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

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

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

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

52.23 (1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this
52.24 subdivision, a visit means an episode of service which is required because of a recipient's
52.25 symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting
52.26 by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced
52.27 practice nurse, audiologist, optician, or optometrist;

52.28 (2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this
52.29 co-payment shall be increased to $20 upon federal approval;

52.30 (3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject
52.31 to a $12 per month maximum for prescription drug co-payments. No co-payments shall
52.32 apply to antipsychotic drugs when used for the treatment of mental illness. No co-payments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

54.19 (9) one member of the Health Services Policy Committee established under section
54.20 256B.0625, subdivisions 3c to 3e;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) monitor prescribing practices more frequently than annually;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

58.2 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision
58.3 3, the commissioner shall determine the fee-for-service outpatient hospital services upper
58.4 payment limit for nonstate government hospitals. The commissioner shall then determine
58.5 the amount of a supplemental payment to Hennepin County Medical Center and Regions
58.6 Hospital for these services that would increase medical assistance spending in this category
58.7 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.
58.8 In making this determination, the commissioner shall allot the available increases between
58.9 Hennepin County Medical Center and Regions Hospital based on the ratio of medical
58.10 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner
58.11 shall adjust this allotment as necessary based on federal approvals, the amount of
58.12 intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,
58.13 in order to maximize the additional total payments. The commissioner shall inform Hennepin
58.14 County and Ramsey County of the periodic intergovernmental transfers necessary to match
58.15 federal Medicaid payments available under this subdivision in order to make supplementary
58.16 medical assistance payments to Hennepin County Medical Center and Regions Hospital
58.17 equal to an amount that when combined with existing medical assistance payments to
58.18 nonstate governmental hospitals would increase total payments to hospitals in this category
58.19 for outpatient services to the aggregate upper payment limit for all hospitals in this category
58.20 in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make
58.21 supplementary payments to Hennepin County Medical Center and Regions Hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

61.16 (d) "High medical assistance utilization" means a medical assistance utilization rate
61.17 equal to the standard established in section 256.969, subdivision 9, paragraph (d), clause
61.18 (6).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

63.33 (1) physician services - prenatal and preventive;

64.1 (2) physician services - nonprenatal and nonpreventive;

64.2 (3) dental services;

64.3 (4) inpatient hospital services;

64.4 (5) outpatient hospital services; and

64.5 (6) mental health services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

65.27 (6) is not renewed automatically.

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

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

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

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

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

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

66.7 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

66.8 (a) For outpatient hospital facility fee payments for services rendered on or after October
66.9 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,
66.10 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for
66.11 which there is a federal maximum allowable payment. Effective for services rendered on
66.12 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and
66.13 emergency room facility fees shall be increased by eight percent over the rates in effect on
66.14 December 31, 1999, except for those services for which there is a federal maximum allowable
66.15 payment. Services for which there is a federal maximum allowable payment shall be paid
66.16 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total
66.17 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare
66.18 upper limit. If it is determined that a provision of this section conflicts with existing or
66.19 future requirements of the United States government with respect to federal financial
66.20 participation in medical assistance, the federal requirements prevail. The commissioner
66.21 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial
66.22 participation resulting from rates that are in excess of the Medicare upper limitations.

66.23 (b) (1) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory
66.24 surgery hospital facility fee services for critical access hospitals designated under section
66.25 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the
66.26 cost-finding methods and allowable costs of the Medicare program. Effective for services
66.27 provided on or after July 1, 2015, rates established for critical access hospitals under this
66.28 paragraph for the applicable payment year shall be the final payment and shall not be settled
66.29 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal
66.30 year ending in 2017, the rate for outpatient hospital services shall be computed using
66.31 information from each hospital's Medicare cost report as filed with Medicare for the year
66.32 that is two years before the year that the rate is being computed. Rates shall be computed
66.33 using information from Worksheet C series until the department finalizes the medical
66.34 assistance cost reporting process for critical access hospitals. After the cost reporting process

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

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

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

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

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

67.26 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
67.27 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
67.28 hospital facility services before third-party liability and spenddown, is reduced three percent
67.29 from the current statutory rates. Mental health services and facilities defined under section
67.30 256.969, subdivision 16, are excluded from this paragraph.

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

68.2 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October
68.3 1, 1992, through December 31, 2022, the commissioner shall make payments for dental
68.4 services as follows:

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

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

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

68.12 (c) Effective for services rendered on or after January 1, 2000, through December 31,
68.13 2022, payment rates for dental services shall be increased by three percent over the rates in
68.14 effect on December 31, 1999.

68.15 (d) Effective for services provided on or after January 1, 2002, through December 31,
68.16 2022, payment for diagnostic examinations and dental x-rays provided to children under
68.17 age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999
68.18 charges.

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

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

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

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

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

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

69.6 ~~(j)~~ (i) Effective for services rendered on or after January 1, 2014, through December 31,
69.7 2022, payment rates for dental services shall be increased by five percent from the rates in
69.8 effect on December 31, 2013. This increase does not apply to state-operated dental clinics
69.9 in paragraph (f), federally qualified health centers, rural health centers, and Indian health
69.10 services. Effective January 1, 2014, payments made to managed care plans and county-based
69.11 purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment
69.12 increase described in this paragraph.

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

69.25 ~~(l)~~ (j) Effective for services provided on or after January 1, 2017, through December 31,
69.26 2022, the commissioner shall increase payment rates by 9.65 percent for dental services
69.27 provided outside of the seven-county metropolitan area. This increase does not apply to
69.28 state-operated dental clinics in paragraph (f), federally qualified health centers, rural health
69.29 centers, or Indian health services. Effective January 1, 2017, payments to managed care
69.30 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect
69.31 the payment increase described in this paragraph.

69.32 ~~(m)~~ (k) Effective for services provided on or after July 1, 2017, through December 31,
69.33 2022, the commissioner shall increase payment rates by 23.8 percent for dental services
69.34 provided to enrollees under the age of 21. This rate increase does not apply to state-operated

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

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

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

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

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

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

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

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

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

71.8 (1) nonprofit community clinics that:

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

71.10 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
71.11 501(c)(3);

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

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

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

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

71.19 (vii) have free care available as needed;

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

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

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

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

71.28 (6) private practicing dentists if:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

74.11 Sec. 56. Minnesota Statutes 2020, section 256L.07, subdivision 2, is amended to read:

74.12 Subd. 2. **Must not have access to employer-subsidized minimum essential**
74.13 **coverage.** (a) To be eligible, a family or individual must not have access to subsidized health
74.14 coverage that is affordable and provides minimum value as defined in Code of Federal
74.15 Regulations, title 26, section 1.36B-2.

74.16 (b) Notwithstanding paragraph (a), an individual who has access through a spouse's or
74.17 parent's employer to subsidized health coverage that is deemed minimum essential coverage
74.18 under Code of Federal Regulations, title 26, section 1.36B-2, is eligible for MinnesotaCare
74.19 if the employee's portion of the annual premium for employee and dependent coverage
74.20 exceeds the required contribution percentage, as defined for premium tax credit eligibility
74.21 under United States Code, title 26, section 36B(c)(2)(C)(i)(II), as indexed according to item
74.22 (iv) of that section, of the individual's household income for the coverage year.

74.23 (c) This subdivision does not apply to a family or individual who no longer has
74.24 employer-subsidized coverage due to the employer terminating health care coverage as an
74.25 employee benefit.

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

74.27 Sec. 57. Minnesota Statutes 2020, section 256L.11, subdivision 6a, is amended to read:

74.28 Subd. 6a. **Dental providers.** Effective for dental services provided to MinnesotaCare
74.29 enrollees on or after January 1, 2018, through December 31, 2022, the commissioner shall
74.30 increase payment rates to dental providers by 54 percent. Payments made to prepaid health
74.31 plans under section 256L.12 shall reflect the payment increase described in this subdivision.
74.32 The prepaid health plans under contract with the commissioner shall provide payments to

dental providers that are at least equal to a rate that includes the payment rate specified in this subdivision, and if applicable to the provider, the rates described under subdivision 7.

Sec. 58. Minnesota Statutes 2020, section 256L.11, subdivision 7, is amended to read:

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

Sec. 59. Minnesota Statutes 2020, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).

(c) Paragraph (b) does not apply to:

(1) children 20 years of age or younger; and

(2) individuals with household incomes below 35 percent of the federal poverty guidelines.

(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
35%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10

100%	110%	$12
110%	120%	$14
120%	130%	$15
130%	140%	$16
140%	150%	$25
150%	160%	$37
160%	170%	$44
170%	180%	$52
180%	190%	$61
190%	200%	$71
200%		$80

(e) Retroactive to January 1, 2021, the commissioner shall adjust the premium schedule under paragraph (d) to ensure that MinnesotaCare premiums do not exceed the amount that an individual would have been required to pay if the individual was enrolled in an applicable benchmark plan in accordance with Code of Federal Regulations, title 42, section 600.505(a)(1).

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

Sec. 60. Minnesota Statutes 2020, section 295.53, subdivision 1, is amended to read:

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

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

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

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

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

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

77.3 (1) payments received for services provided under the Medicare program, including
77.4 payments received from the government and organizations governed by sections 1833,
77.5 1853, and 1876 of title XVIII of the federal Social Security Act, United States Code, title
77.6 42, section 1395; and enrollee deductibles, co-insurance, and co-payments, whether paid
77.7 by the Medicare enrollee, by Medicare supplemental coverage as described in section
77.8 62A.011, subdivision 3, clause (10), or by Medicaid payments under title XIX of the federal
77.9 Social Security Act. Payments for services not covered by Medicare are taxable;

77.10 (2) payments received for home health care services;

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

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

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

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

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

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

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

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

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

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

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

78.12 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December
78.13 31, 2021.

78.14 Sec. 61. **COURT RULING ON AFFORDABLE CARE ACT.**

78.15 In the event the United States Supreme Court reverses, in whole or in part, Public Law
78.16 111-148, as amended by Public Law 111-152, the commissioner of human services shall
78.17 take all actions necessary to maintain the current policies of the medical assistance and
78.18 MinnesotaCare programs, including but not limited to pursuing federal funds, or if federal
78.19 funding is not available, operating programs with state funding for at least one year following
78.20 the date of the Supreme Court decision or until the conclusion of the next regular legislative
78.21 session, whichever is later. Nothing in this section prohibits the commissioner from making
78.22 changes necessary to comply with federal or state requirements for the medical assistance
78.23 or MinnesotaCare programs that were not affected by the Supreme Court decision.

78.24 Sec. 62. **DELIVERY REFORM ANALYSIS REPORT.**

78.25 (a) The commissioner of human services shall present to the chairs and ranking minority
78.26 members of the legislative committees with jurisdiction over health care policy and finance,
78.27 by January 15, 2023, a report comparing service delivery and payment system models for
78.28 delivering services to Medical Assistance enrollees for whom income eligibility is determined
78.29 using the modified adjusted gross income methodology under Minnesota Statutes, section
78.30 256B.056, subdivision 1a, paragraph (b), clause (1), and MinnesotaCare enrollees eligible
78.31 under Minnesota Statutes, chapter 256L. The report must compare the current delivery
78.32 model with at least two alternative models. The alternative models must include a state-based

79.1 model in which the state holds the plan risk as the insurer and may contract with a third-party
79.2 administrator for claims processing and plan administration. The alternative models may
79.3 include but are not limited to:

79.4 (1) expanding the use of integrated health partnerships under Minnesota Statutes, section
79.5 256B.0755;

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

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

79.10 (b) The report must include:

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

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

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

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

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

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

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

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

79.22 Sec. 63. **DENTAL HOME DEMONSTRATION PROJECT.**

79.23 (a) The Dental Services Advisory Committee, in collaboration with stakeholders, shall
79.24 design a dental home demonstration project and present recommendations by February 1,
79.25 2022, to the commissioner and the chairs and ranking minority members of the legislative
79.26 committees with jurisdiction over health finance and policy.

79.27 (b) The Dental Services Advisory Committee, at a minimum, shall engage with the
79.28 following stakeholders: the Minnesota Department of Health, the Minnesota Dental
79.29 Association, the Minnesota Dental Hygienists' Association, the University of Minnesota
79.30 School of Dentistry, dental programs operated by the Minnesota State Colleges and

80.1 Universities system, and representatives of each of the following dental provider types
80.2 serving medical assistance and MinnesotaCare enrollees:

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

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

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

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

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

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

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

80.15 (8) multispecialty hospital-based dental clinics.

80.16 (c) The dental home demonstration project shall give incentives for qualified providers
80.17 that provide high-quality, patient-centered, comprehensive, and coordinated oral health
80.18 services. The demonstration project shall seek to increase the number of new dental providers
80.19 serving medical assistance and MinnesotaCare enrollees and increase the capacity of existing
80.20 providers. The demonstration project must test payment methods that establish value-based
80.21 incentives to:

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

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

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

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

81.1 Sec. 64. **DIRECTION TO COMMISSIONER; INCOME AND ASSET EXCLUSION**
81.2 **FOR ST. PAUL GUARANTEED INCOME DEMONSTRATION PROJECT.**

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

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

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

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

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

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

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

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

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

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

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

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

82.1 Sec. 65. **EXPANSION OF OUTPATIENT DRUG CARVE OUT; PRESCRIPTION**
82.2 **DRUG PURCHASING PROGRAM.**

82.3 The commissioner of human services, in consultation with the commissioners of
82.4 commerce and health, shall assess the feasibility of, and develop recommendations for: (1)
82.5 expanding the outpatient prescription drug carve out under Minnesota Statutes, section
82.6 256B.69, subdivision 6d, to include MinnesotaCare enrollees; and (2) establishing a
82.7 prescription drug purchasing program to serve nonpublic program enrollees of health plan
82.8 companies. The recommendations must address the process and terms by which the
82.9 commissioner would contract with health plan companies to administer prescription drug
82.10 benefits for the companies' enrollees and develop and manage a formulary. The commissioner
82.11 shall present recommendations to the chairs and ranking minority members of the legislative
82.12 committees with jurisdiction over commerce and health and human services policy and
82.13 finance by December 15, 2023.

82.14 Sec. 66. **FEDERAL APPROVAL; EXTENSION OF POSTPARTUM COVERAGE.**

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

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

82.19 Sec. 67. **PROPOSAL FOR A PUBLIC OPTION.**

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

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

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

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

83.4 (4) allow the state to:

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

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

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

83.14 (b) Each public option proposal must include:

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

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

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

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

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

83.31 (d) The commissioner shall present the proposal to the chairs and ranking minority
83.32 members of the legislative committees with jurisdiction over health care policy and finance

84.1 by December 15, 2021. The proposal must include recommendations on any legislative
84.2 changes necessary to implement the public option. Any implementation of the proposal that
84.3 requires a state financial contribution must be contingent on legislative approval.

84.4 Sec. 68. **RESPONSE TO COVID-19 PUBLIC HEALTH EMERGENCY.**

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

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

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

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

84.21 Sec. 69. **REVISOR INSTRUCTION.**

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

84.26 Sec. 70. **REPEALER.**

84.27 (a) Minnesota Rules, parts 9505.0275; 9505.1693; 9505.1696, subparts 1, 2, 3, 4, 5, 6,
84.28 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, and 22; 9505.1699; 9505.1701; 9505.1703;
84.29 9505.1706; 9505.1712; 9505.1715; 9505.1718; 9505.1724; 9505.1727; 9505.1730;
84.30 9505.1733; 9505.1736; 9505.1739; 9505.1742; 9505.1745; and 9505.1748, are repealed.

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

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

85.5 **ARTICLE 2**

85.6 **DEPARTMENT OF HUMAN SERVICES LICENSING AND BACKGROUND**
85.7 **STUDIES**

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

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

85.12 (1) each navigator;

85.13 (2) each in-person assister; and

85.14 (3) each certified application counselor.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

87.26 Subd. 5. **Independence of action.** In carrying out the duties under this section, the
87.27 ombudsperson may act independently of the department to provide testimony to the
87.28 legislature, make periodic reports to the legislature, and address areas of concern to child
87.29 care providers.

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

87.33 Subd. 7. **Qualifications.** The ombudsperson must be a person who has knowledge and
87.34 experience concerning the provision of family child care. The ombudsperson must be

88.1 experienced in dealing with governmental entities, interpretation of laws and regulations,
88.2 investigations, record keeping, report writing, public speaking, and management. A person
88.3 is not eligible to serve as the ombudsperson while holding public office or while holding a
88.4 family child care license.

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

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

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

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

88.18 Subd. 3. **Change of ownership process.** (a) When a change in ownership is proposed
88.19 and the party intends to assume operation without an interruption in service longer than 60
88.20 days after acquiring the program or service, the license holder must provide the commissioner
88.21 with written notice of the proposed change on a form provided by the commissioner at least
88.22 60 days before the anticipated date of the change in ownership. For purposes of this
88.23 subdivision and subdivision 4, "party" means the party that intends to operate the service
88.24 or program.

88.25 (b) The party must submit a license application under this chapter on the form and in
88.26 the manner prescribed by the commissioner at least 30 days before the change in ownership
88.27 is complete, and must include documentation to support the upcoming change. The party
88.28 must comply with background study requirements under chapter 245C and shall pay the
88.29 application fee required under section 245A.10. ~~A party that intends to assume operation~~
88.30 ~~without an interruption in service longer than 60 days after acquiring the program or service~~
88.31 ~~is exempt from the requirements of Minnesota Rules, part 9530.6800.~~

88.32 (c) The commissioner may streamline application procedures when the party is an existing
88.33 license holder under this chapter and is acquiring a program licensed under this chapter or

89.1 service in the same service class as one or more licensed programs or services the party
89.2 operates and those licenses are in substantial compliance. For purposes of this subdivision,
89.3 "substantial compliance" means within the previous 12 months the commissioner did not
89.4 (1) issue a sanction under section 245A.07 against a license held by the party, or (2) make
89.5 a license held by the party conditional according to section 245A.06.

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

89.10 (e) If a licensing inspection of the program or service was conducted within the previous
89.11 12 months and the existing license holder's license record demonstrates substantial
89.12 compliance with the applicable licensing requirements, the commissioner may waive the
89.13 party's inspection required by section 245A.04, subdivision 4. The party must submit to the
89.14 commissioner (1) proof that the premises was inspected by a fire marshal or that the fire
89.15 marshal deemed that an inspection was not warranted, and (2) proof that the premises was
89.16 inspected for compliance with the building code or that no inspection was deemed warranted.

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

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

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

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

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

90.2 **245A.05 DENIAL OF APPLICATION.**

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

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

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

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

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

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

90.15 (6) is associated with an individual who received a background study under section
90.16 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to
90.17 children or vulnerable adults, and who has a disqualification that has not been set aside
90.18 under section 245C.22, and no variance has been granted;

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

90.20 (8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision
90.21 6;

90.22 (9) has a history of noncompliance as a license holder or controlling individual with
90.23 applicable laws or rules, including but not limited to this chapter and chapters 119B and
90.24 245C; ~~or~~

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

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

90.29 (b) An applicant whose application has been denied by the commissioner must be given
90.30 notice of the denial, which must state the reasons for the denial in plain language. Notice
90.31 must be given by certified mail or personal service. The notice must state the reasons the

91.1 application was denied and must inform the applicant of the right to a contested case hearing
91.2 under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may
91.3 appeal the denial by notifying the commissioner in writing by certified mail or personal
91.4 service. If mailed, the appeal must be postmarked and sent to the commissioner within 20
91.5 calendar days after the applicant received the notice of denial. If an appeal request is made
91.6 by personal service, it must be received by the commissioner within 20 calendar days after
91.7 the applicant received the notice of denial. Section 245A.08 applies to hearings held to
91.8 appeal the commissioner's denial of an application.

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

91.10 Sec. 6. Minnesota Statutes 2020, section 245A.07, subdivision 1, is amended to read:

91.11 Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional
91.12 under section 245A.06, the commissioner may suspend or revoke the license, impose a fine,
91.13 or secure an injunction against the continuing operation of the program of a license holder
91.14 who does not comply with applicable law or rule, or who has nondisqualifying background
91.15 study information, as described in section 245C.05, subdivision 4, that reflects on the license
91.16 holder's ability to safely provide care to foster children. When applying sanctions authorized
91.17 under this section, the commissioner shall consider the nature, chronicity, or severity of the
91.18 violation of law or rule and the effect of the violation on the health, safety, or rights of
91.19 persons served by the program.

91.20 (b) If a license holder appeals the suspension or revocation of a license and the license
91.21 holder continues to operate the program pending a final order on the appeal, the commissioner
91.22 shall issue the license holder a temporary provisional license. Unless otherwise specified
91.23 by the commissioner, variances in effect on the date of the license sanction under appeal
91.24 continue under the temporary provisional license. If a license holder fails to comply with
91.25 applicable law or rule while operating under a temporary provisional license, the
91.26 commissioner may impose additional sanctions under this section and section 245A.06, and
91.27 may terminate any prior variance. If a temporary provisional license is set to expire, a new
91.28 temporary provisional license shall be issued to the license holder upon payment of any fee
91.29 required under section 245A.10. The temporary provisional license shall expire on the date
91.30 the final order is issued. If the license holder prevails on the appeal, a new nonprovisional
91.31 license shall be issued for the remainder of the current license period.

91.32 (c) If a license holder is under investigation and the license issued under this chapter is
91.33 due to expire before completion of the investigation, the program shall be issued a new
91.34 license upon completion of the reapplication requirements and payment of any applicable

92.1 license fee. Upon completion of the investigation, a licensing sanction may be imposed
92.2 against the new license under this section, section 245A.06, or 245A.08.

92.3 (d) Failure to reapply or closure of a license issued under this chapter by the license
92.4 holder prior to the completion of any investigation shall not preclude the commissioner
92.5 from issuing a licensing sanction under this section or section 245A.06 at the conclusion
92.6 of the investigation.

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

92.8 Sec. 7. Minnesota Statutes 2020, section 245A.10, subdivision 4, is amended to read:

92.9 Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall
92.10 pay an annual nonrefundable license fee based on the following schedule:

	Licensed Capacity	Child Care Center License Fee
92.13	1 to 24 persons	$200
92.14	25 to 49 persons	$300
92.15	50 to 74 persons	$400
92.16	75 to 99 persons	$500
92.17	100 to 124 persons	$600
92.18	125 to 149 persons	$700
92.19	150 to 174 persons	$800
92.20	175 to 199 persons	$900
92.21	200 to 224 persons	$1,000
92.22	225 or more persons	$1,100

92.23 (b)(1) A program licensed to provide one or more of the home and community-based
92.24 services and supports identified under chapter 245D to persons with disabilities or age 65
92.25 and older, shall pay an annual nonrefundable license fee based on revenues derived from
92.26 the provision of services that would require licensure under chapter 245D during the calendar
92.27 year immediately preceding the year in which the license fee is paid, according to the
92.28 following schedule:

	License Holder Annual Revenue	License Fee
92.30	less than or equal to $10,000	$200
92.31–92.32	greater than $10,000 but less than or equal to $25,000	$300
92.33–92.34	greater than $25,000 but less than or equal to $50,000	$400

93.1 greater than $50,000 but less than or 93.2 equal to $100,000	$500
93.3 greater than $100,000 but less than or 93.4 equal to $150,000	$600
93.5 greater than $150,000 but less than or 93.6 equal to $200,000	$800
93.7 greater than $200,000 but less than or 93.8 equal to $250,000	$1,000
93.9 greater than $250,000 but less than or 93.10 equal to $300,000	$1,200
93.11 greater than $300,000 but less than or 93.12 equal to $350,000	$1,400
93.13 greater than $350,000 but less than or 93.14 equal to $400,000	$1,600
93.15 greater than $400,000 but less than or 93.16 equal to $450,000	$1,800
93.17 greater than $450,000 but less than or 93.18 equal to $500,000	$2,000
93.19 greater than $500,000 but less than or 93.20 equal to $600,000	$2,250
93.21 greater than $600,000 but less than or 93.22 equal to $700,000	$2,500
93.23 greater than $700,000 but less than or 93.24 equal to $800,000	$2,750
93.25 greater than $800,000 but less than or 93.26 equal to $900,000	$3,000
93.27 greater than $900,000 but less than or 93.28 equal to $1,000,000	$3,250
93.29 greater than $1,000,000 but less than or 93.30 equal to $1,250,000	$3,500
93.31 greater than $1,250,000 but less than or 93.32 equal to $1,500,000	$3,750
93.33 greater than $1,500,000 but less than or 93.34 equal to $1,750,000	$4,000
93.35 greater than $1,750,000 but less than or 93.36 equal to $2,000,000	$4,250
93.37 greater than $2,000,000 but less than or 93.38 equal to $2,500,000	$4,500
93.39 greater than $2,500,000 but less than or 93.40 equal to $3,000,000	$4,750
93.41 greater than $3,000,000 but less than or 93.42 equal to $3,500,000	$5,000
93.43 greater than $3,500,000 but less than or 93.44 equal to $4,000,000	$5,500
93.45 greater than $4,000,000 but less than or 93.46 equal to $4,500,000	$6,000

greater than $4,500,000 but less than or equal to $5,000,000	$6,500
greater than $5,000,000 but less than or equal to $7,500,000	$7,000
greater than $7,500,000 but less than or equal to $10,000,000	$8,500
greater than $10,000,000 but less than or equal to $12,500,000	$10,000
greater than $12,500,000 but less than or equal to $15,000,000	$14,000
greater than $15,000,000	$18,000

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(5) Notwithstanding clause (1), a license holder providing services under one or more licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license holder for all licenses held under chapter 245B for calendar year 2013. For calendar year 2017 and thereafter, the license holder shall pay an annual license fee according to clause (1).

(c) A chemical dependency treatment program licensed under chapter 245G, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

(d) A ~~chemical dependency~~ detoxification program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, ~~to provide detoxification services~~ or a withdrawal management

95.1 program licensed under chapter 245F shall pay an annual nonrefundable license fee based
95.2 on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

95.7 A detoxification program that also operates a withdrawal management program at the same
95.8 location shall only pay one fee based upon the licensed capacity of the program with the
95.9 higher overall capacity.

95.10 (e) Except for child foster care, a residential facility licensed under Minnesota Rules,
95.11 chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the
95.12 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

95.19 (f) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670,
95.20 to serve persons with mental illness shall pay an annual nonrefundable license fee based on
95.21 the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

95.25 (g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400,
95.26 to serve persons with physical disabilities shall pay an annual nonrefundable license fee
95.27 based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(h) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of $1,500.

(i) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

(j) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900
75 to 99 persons	$1,100
100 or more persons	$1,300

(k) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(l) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of $1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

Sec. 8. Minnesota Statutes 2020, section 245A.14, subdivision 4, is amended to read:

Subd. 4. **Special family ~~day~~ child care homes.** Nonresidential child care programs serving 14 or fewer children that are conducted at a location other than the license holder's own residence shall be licensed under this section and the rules governing family ~~day~~ child care or group family ~~day~~ child care if:

(a) the license holder is the primary provider of care and the nonresidential child care program is conducted in a dwelling that is located on a residential lot;

(b) the license holder is an employer who may or may not be the primary provider of care, and the purpose for the child care program is to provide child care services to children of the license holder's employees;

(c) the license holder is a church or religious organization;

97.1 (d) the license holder is a community collaborative child care provider. For purposes of
97.2 this subdivision, a community collaborative child care provider is a provider participating
97.3 in a cooperative agreement with a community action agency as defined in section 256E.31;

97.4 (e) the license holder is a not-for-profit agency that provides child care in a dwelling
97.5 located on a residential lot and the license holder maintains two or more contracts with
97.6 community employers or other community organizations to provide child care services.
97.7 The county licensing agency may grant a capacity variance to a license holder licensed
97.8 under this paragraph to exceed the licensed capacity of 14 children by no more than five
97.9 children during transition periods related to the work schedules of parents, if the license
97.10 holder meets the following requirements:

97.11 (1) the program does not exceed a capacity of 14 children more than a cumulative total
97.12 of four hours per day;

97.13 (2) the program meets a one to seven staff-to-child ratio during the variance period;

97.14 (3) all employees receive at least an extra four hours of training per year than required
97.15 in the rules governing family child care each year;

97.16 (4) the facility has square footage required per child under Minnesota Rules, part
97.17 9502.0425;

97.18 (5) the program is in compliance with local zoning regulations;

97.19 (6) the program is in compliance with the applicable fire code as follows:

97.20 (i) if the program serves more than five children older than 2-1/2 years of age, but no
97.21 more than five children 2-1/2 years of age or less, the applicable fire code is educational
97.22 occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2015,
97.23 Section 202; or

97.24 (ii) if the program serves more than five children 2-1/2 years of age or less, the applicable
97.25 fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code 2015,
97.26 Section 202, unless the rooms in which the children are cared for are located on a level of
97.27 exit discharge and each of these child care rooms has an exit door directly to the exterior,
97.28 then the applicable fire code is Group E occupancies, as provided in the Minnesota State
97.29 Fire Code 2015, Section 202; and

97.30 (7) any age and capacity limitations required by the fire code inspection and square
97.31 footage determinations shall be printed on the license; or

(f) the license holder is the primary provider of care and has located the licensed child care program in a commercial space, if the license holder meets the following requirements:

(1) the program is in compliance with local zoning regulations;

(2) the program is in compliance with the applicable fire code as follows:

(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2015, Section 202; or

(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire Code 2015, Section 202;

(3) any age and capacity limitations required by the fire code inspection and square footage determinations are printed on the license; and

(4) the license holder prominently displays the license issued by the commissioner which contains the statement "This special family child care provider is not licensed as a child care center."

(g) ~~The commissioner may approve two or more licenses under paragraphs (a) to (f) to be issued at the same location or under one contiguous roof, if each license holder is able to demonstrate compliance with all applicable rules and laws. Each license holder must operate the license holder's respective licensed program as a distinct program and within the capacity, age, and ratio distributions of each license.~~ Notwithstanding Minnesota Rules, part 9502.0335, subpart 12, the commissioner may issue up to four licenses to an organization licensed under paragraphs (b), (c), or (e). Each license must have its own primary provider of care as required under paragraph (i). Each license must operate as a distinct and separate program in compliance with all applicable laws and regulations.

(h) ~~The commissioner may grant variances to this section to allow a primary provider of care, a not-for-profit organization, a church or religious organization, an employer, or a community collaborative to be licensed to provide child care under paragraphs (e) and (f) if the license holder meets the other requirements of the statute.~~ For licenses issued under paragraphs (b), (c), (d), (e), or (f), the commissioner may approve up to four licenses at the same location or under one contiguous roof if each license holder is able to demonstrate compliance with all applicable rules and laws. Each licensed program must operate as a distinct program and within the capacity, age, and ratio distributions of each license.

99.1 (i) For a license issued under paragraphs (b), (c), or (e), the license holder must designate
99.2 a person to be the primary provider of care at the licensed location on a form and in a manner
99.3 prescribed by the commissioner. The license holder shall notify the commissioner in writing
99.4 before there is a change of the person designated to be the primary provider of care. The
99.5 primary provider of care:

99.6 (1) must be the person who will be the provider of care at the program and present during
99.7 the hours of operation;

99.8 (2) must operate the program in compliance with applicable laws and regulations under
99.9 chapter 245A and Minnesota Rules, chapter 9502;

99.10 (3) is considered a child care background study subject as defined in section 245C.02,
99.11 subdivision 6a, and must comply with background study requirements in chapter 245C; and

99.12 (4) must complete the training that is required of license holders in section 245A.50.

99.13 (j) For any license issued under this subdivision, the license holder must ensure that any
99.14 other caregiver, substitute, or helper who assists in the care of children meets the training
99.15 requirements in section 245A.50 and background study requirements under chapter 245C.

99.16 Sec. 9. Minnesota Statutes 2020, section 245A.16, is amended by adding a subdivision to
99.17 read:

99.18 Subd. 9. **Licensed family foster settings.** (a) Before recommending to grant a license,
99.19 deny a license under section 245A.05, or revoke a license under section 245A.07 for
99.20 nondisqualifying background study information received under section 245C.05, subdivision
99.21 4, paragraph (a), clause (3), for a licensed family foster setting, a county agency or private
99.22 agency that has been designated or licensed by the commissioner must review the following:

99.23 (1) the type of offenses;

99.24 (2) the number of offenses;

99.25 (3) the nature of the offenses;

99.26 (4) the age of the individual at the time of the offenses;

99.27 (5) the length of time that has elapsed since the last offense;

99.28 (6) the relationship of the offenses and the capacity to care for a child;

99.29 (7) evidence of rehabilitation;

99.30 (8) information or knowledge from community members regarding the individual's
99.31 capacity to provide foster care;

100.1 (9) any available information regarding child maltreatment reports or child in need of
100.2 protection or services petitions, or related cases, in which the individual has been involved
100.3 or implicated, and documentation that the individual has remedied issues or conditions
100.4 identified in child protection or court records that are relevant to safely caring for a child;

100.5 (10) a statement from the study subject;

100.6 (11) a statement from the license holder; and

100.7 (12) other aggravating and mitigating factors.

100.8 (b) For purposes of this section, "evidence of rehabilitation" includes but is not limited
100.9 to the following:

100.10 (1) maintaining a safe and stable residence;

100.11 (2) continuous, regular, or stable employment;

100.12 (3) successful participation in an education or job training program;

100.13 (4) positive involvement with the community or extended family;

100.14 (5) compliance with the terms and conditions of probation or parole following the
100.15 individual's most recent conviction;

100.16 (6) if the individual has had a substance use disorder, successful completion of a substance
100.17 use disorder assessment, substance use disorder treatment, and recommended continuing
100.18 care, if applicable, demonstrated abstinence from controlled substances, as defined in section
100.19 152.01, subdivision 4, or the establishment of a sober network;

100.20 (7) if the individual has had a mental illness or documented mental health issues,
100.21 demonstrated completion of a mental health evaluation, participation in therapy or other
100.22 recommended mental health treatment, or appropriate medication management, if applicable;

100.23 (8) if the individual's offense or conduct involved domestic violence, demonstrated
100.24 completion of a domestic violence or anger management program, and the absence of any
100.25 orders for protection or harassment restraining orders against the individual since the previous
100.26 offense or conduct;

100.27 (9) written letters of support from individuals of good repute, including but not limited
100.28 to employers, members of the clergy, probation or parole officers, volunteer supervisors,
100.29 or social services workers;

100.30 (10) demonstrated remorse for convictions or conduct, or demonstrated positive behavior
100.31 changes; and

101.1 (11) absence of convictions or arrests since the previous offense or conduct, including
101.2 any convictions that were expunged or pardoned.

101.3 (c) An applicant for a family foster setting license must sign all releases of information
101.4 requested by the county or private licensing agency.

101.5 (d) When licensing a relative for a family foster setting, the commissioner shall also
101.6 consider the importance of maintaining the child's relationship with relatives as an additional
101.7 significant factor in determining whether an application will be denied.

101.8 (e) When recommending that the commissioner deny or revoke a license, the county or
101.9 private licensing agency must send a summary of the review completed according to
101.10 paragraph (a), on a form developed by the commissioner, to the commissioner and include
101.11 any recommendation for licensing action.

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

101.13 Sec. 10. Minnesota Statutes 2020, section 245A.50, subdivision 7, is amended to read:

101.14 Subd. 7. **Training requirements for family and group family child care.** (a) For
101.15 purposes of family and group family child care, the license holder and each second adult
101.16 caregiver must complete 16 hours of ongoing training each year. Repeat of topical training
101.17 requirements in subdivisions 2 to 8 shall count toward the annual 16-hour training
101.18 requirement. Additional ongoing training subjects to meet the annual 16-hour training
101.19 requirement must be selected from the following areas:

101.20 (1) child development and learning training in understanding how a child develops
101.21 physically, cognitively, emotionally, and socially, and how a child learns as part of the
101.22 child's family, culture, and community;

101.23 (2) developmentally appropriate learning experiences, including training in creating
101.24 positive learning experiences, promoting cognitive development, promoting social and
101.25 emotional development, promoting physical development, promoting creative development;
101.26 and behavior guidance;

101.27 (3) relationships with families, including training in building a positive, respectful
101.28 relationship with the child's family;

101.29 (4) assessment, evaluation, and individualization, including training in observing,
101.30 recording, and assessing development; assessing and using information to plan; and assessing
101.31 and using information to enhance and maintain program quality;

102.1 (5) historical and contemporary development of early childhood education, including
102.2 training in past and current practices in early childhood education and how current events
102.3 and issues affect children, families, and programs;

102.4 (6) professionalism, including training in knowledge, skills, and abilities that promote
102.5 ongoing professional development; and

102.6 (7) health, safety, and nutrition, including training in establishing healthy practices;
102.7 ensuring safety; and providing healthy nutrition.

102.8 (b) A provider who is approved as a trainer through the Develop data system may count
102.9 up to two hours of training instruction toward the annual 16-hour training requirement in
102.10 paragraph (a). The provider may only count training instruction hours for the first instance
102.11 in which they deliver a particular content-specific training during each licensing year. Hours
102.12 counted as training instruction must be approved through the Develop data system with
102.13 attendance verified on the trainer's individual learning record and must be in Knowledge
102.14 and Competency Framework content area VII A (Establishing Healthy Practices) or B
102.15 (Ensuring Safety).

102.16 Sec. 11. Minnesota Statutes 2020, section 245A.50, subdivision 9, is amended to read:

102.17 Subd. 9. **Supervising for safety; training requirement.** (a) Courses required by this
102.18 subdivision must include the following health and safety topics:

102.19 (1) preventing and controlling infectious diseases;

102.20 (2) administering medication;

102.21 (3) preventing and responding to allergies;

102.22 (4) ensuring building and physical premises safety;

102.23 (5) handling and storing biological contaminants;

102.24 (6) preventing and reporting child abuse and maltreatment; and

102.25 (7) emergency preparedness.

102.26 (b) Before initial licensure and before caring for a child, all family child care license
102.27 holders and each second adult caregiver shall complete and document the completion of
102.28 the six-hour Supervising for Safety for Family Child Care course developed by the
102.29 commissioner.

102.30 (c) The license holder must ensure and document that, before caring for a child, all
102.31 substitutes have completed the four-hour Basics of Licensed Family Child Care for

103.1 Substitutes course developed by the commissioner, which must include health and safety
103.2 topics as well as child development and learning.

103.3 (d) The family child care license holder and each second adult caregiver shall complete
103.4 and document:

103.5 (1) the annual completion of either:

103.6 (i) a two-hour active supervision course developed by the commissioner; or

103.7 (ii) any courses in the ensuring safety competency area under the health, safety, and
103.8 nutrition standard of the Knowledge and Competency Framework that the commissioner
103.9 has identified as an active supervision training course; and

103.10 (2) the completion at least once every five years of the two-hour courses Health and
103.11 Safety I and Health and Safety II. When the training is due for the first time or expires, it
103.12 must be taken no later than the day before the anniversary of the license holder's license
103.13 effective date. A license holder's or second adult caregiver's completion of either training
103.14 in a given year meets the annual active supervision training requirement in clause (1).

103.15 (e) At least once every three years, license holders must ensure and document that
103.16 substitutes have completed the four-hour Basics of Licensed Family Child Care for
103.17 Substitutes course. When the training expires, it must be retaken no later than the day before
103.18 the anniversary of the license holder's license effective date.

103.19 Sec. 12. Minnesota Statutes 2020, section 245C.02, subdivision 4a, is amended to read:

103.20 Subd. 4a. **Authorized fingerprint collection vendor.** "Authorized fingerprint collection
103.21 vendor" means a qualified organization under a written contract with the commissioner to
103.22 provide services in accordance with section 245C.05, subdivision 5, paragraph (b). The
103.23 commissioner may retain the services of more than one authorized fingerprint collection
103.24 vendor.

103.25 Sec. 13. Minnesota Statutes 2020, section 245C.02, subdivision 5, is amended to read:

103.26 Subd. 5. **Background study.** "Background study" means:

103.27 (1) the collection and processing of a background study subject's fingerprints, including
103.28 the process of obtaining a background study subject's classifiable fingerprints and photograph
103.29 as required by section 245C.05, subdivision 5, paragraph (b); and

103.30 (2) the review of records conducted by the commissioner to determine whether a subject
103.31 is disqualified from direct contact with persons served by a program and, where specifically

104.1 provided in statutes, whether a subject is disqualified from having access to persons served
104.2 by a program and from working in a children's residential facility or foster residence setting.

104.3 Sec. 14. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision
104.4 to read:

104.5 Subd. 5b. **Alternative background study.** "Alternative background study" means:

104.6 (1) the collection and processing of a background study subject's fingerprints, including
104.7 the process of obtaining a background study subject's classifiable fingerprints and photograph
104.8 as required by section 245C.05, subdivision 5, paragraph (b); and

104.9 (2) a review of records conducted by the commissioner pursuant to section 245C.08 in
104.10 order to forward the background study investigating information to the entity that submitted
104.11 the alternative background study request under section 245C.031, subdivision 2. The
104.12 commissioner shall not make any eligibility determinations on background studies conducted
104.13 under section 245C.031.

104.14 Sec. 15. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision
104.15 to read:

104.16 Subd. 11c. **Entity.** "Entity" means any program, organization, or agency initiating a
104.17 background study.

104.18 Sec. 16. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision
104.19 to read:

104.20 Subd. 16a. **Results.** "Results" means a determination that a study subject is eligible,
104.21 disqualified, set aside, granted a variance, or that more time is needed to complete the
104.22 background study.

104.23 Sec. 17. Minnesota Statutes 2020, section 245C.03, is amended to read:

104.24 **245C.03 BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.**

104.25 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background
104.26 study on:

104.27 (1) the person or persons applying for a license;

104.28 (2) an individual age 13 and over living in the household where the licensed program
104.29 will be provided who is not receiving licensed services from the program;

105.1 (3) current or prospective employees or contractors of the applicant who will have direct
105.2 contact with persons served by the facility, agency, or program;

105.3 (4) volunteers or student volunteers who will have direct contact with persons served
105.4 by the program to provide program services if the contact is not under the continuous, direct
105.5 supervision by an individual listed in clause (1) or (3);

105.6 (5) an individual age ten to 12 living in the household where the licensed services will
105.7 be provided when the commissioner has reasonable cause as defined in section 245C.02,
105.8 subdivision 15;

105.9 (6) an individual who, without providing direct contact services at a licensed program,
105.10 may have unsupervised access to children or vulnerable adults receiving services from a
105.11 program, when the commissioner has reasonable cause as defined in section 245C.02,
105.12 subdivision 15;

105.13 (7) all controlling individuals as defined in section 245A.02, subdivision 5a;

105.14 (8) notwithstanding the other requirements in this subdivision, child care background
105.15 study subjects as defined in section 245C.02, subdivision 6a; and

105.16 (9) notwithstanding clause (3), for children's residential facilities and foster residence
105.17 settings, any adult working in the facility, whether or not the individual will have direct
105.18 contact with persons served by the facility.

105.19 (b) For child foster care when the license holder resides in the home where foster care
105.20 services are provided, a short-term substitute caregiver providing direct contact services for
105.21 a child for less than 72 hours of continuous care is not required to receive a background
105.22 study under this chapter.

105.23 (c) This subdivision applies to the following programs that must be licensed under
105.24 chapter 245A:

105.25 (1) adult foster care;

105.26 (2) child foster care;

105.27 (3) children's residential facilities;

105.28 (4) family child care;

105.29 (5) licensed child care centers;

105.30 (6) licensed home and community-based services under chapter 245D;

105.31 (7) residential mental health programs for adults;

106.1 (8) substance use disorder treatment programs under chapter 245G;

106.2 (9) withdrawal management programs under chapter 245F;

106.3 (10) programs that provide treatment services to persons with sexual psychopathic
106.4 personalities or sexually dangerous persons;

106.5 (11) adult day care centers;

106.6 (12) family adult day services;

106.7 (13) independent living assistance for youth;

106.8 (14) detoxification programs;

106.9 (15) community residential settings; and

106.10 (16) intensive residential treatment services and residential crisis stabilization under
106.11 chapter 245I.

106.12 Subd. 1a. **Procedure.** (a) Individuals and organizations that are required under this
106.13 section to have or initiate background studies shall comply with the requirements of this
106.14 chapter.

106.15 (b) All studies conducted under this section shall be conducted according to sections
106.16 299C.60 to 299C.64. This requirement does not apply to subdivisions 1, paragraph (c),
106.17 clauses (2) to (5), and 6a.

106.18 Subd. 2. **Personal care provider organizations.** The commissioner shall conduct
106.19 background studies on any individual required under sections 256B.0651 to 256B.0654 and
106.20 256B.0659 to have a background study completed under this chapter.

106.21 Subd. 3. **Supplemental nursing services agencies.** The commissioner shall conduct all
106.22 background studies required under this chapter and initiated by supplemental nursing services
106.23 agencies registered under section 144A.71, subdivision 1.

106.24 Subd. 3a. **Personal care assistance provider agency; background studies.** Personal
106.25 care assistance provider agencies enrolled to provide personal care assistance services under
106.26 the medical assistance program must meet the following requirements:

106.27 (1) owners who have a five percent interest or more and all managing employees are
106.28 subject to a background study as provided in this chapter. This requirement applies to
106.29 currently enrolled personal care assistance provider agencies and agencies seeking enrollment
106.30 as a personal care assistance provider agency. "Managing employee" has the same meaning

107.1 as Code of Federal Regulations, title 42, section 455.101. An organization is barred from
107.2 enrollment if:

107.3 (i) the organization has not initiated background studies of owners and managing
107.4 employees; or

107.5 (ii) the organization has initiated background studies of owners and managing employees
107.6 and the commissioner has sent the organization a notice that an owner or managing employee
107.7 of the organization has been disqualified under section 245C.14, and the owner or managing
107.8 employee has not received a set aside of the disqualification under section 245C.22; and

107.9 (2) a background study must be initiated and completed for all qualified professionals.

107.10 Subd. 3b. **Exception to personal care assistant; requirements.** The personal care
107.11 assistant for a recipient may be allowed to enroll with a different personal care assistance
107.12 provider agency upon initiation of a new background study according to this chapter if:

107.13 (1) the commissioner determines that a change in enrollment or affiliation of the personal
107.14 care assistant is needed in order to ensure continuity of services and protect the health and
107.15 safety of the recipient;

107.16 (2) the chosen agency has been continuously enrolled as a personal care assistance
107.17 provider agency for at least two years;

107.18 (3) the recipient chooses to transfer to the personal care assistance provider agency;

107.19 (4) the personal care assistant has been continuously enrolled with the former personal
107.20 care assistance provider agency since the last background study was completed; and

107.21 (5) the personal care assistant continues to meet requirements of section 256B.0659,
107.22 subdivision 11, notwithstanding paragraph (a), clause (3).

107.23 Subd. 4. **Personnel agencies; educational programs; professional services**
107.24 **agencies.** The commissioner also may conduct studies on individuals specified in subdivision
107.25 1, paragraph (a), clauses (3) and (4), when the studies are initiated by:

107.26 (1) personnel pool agencies;

107.27 (2) temporary personnel agencies;

107.28 (3) educational programs that train individuals by providing direct contact services in
107.29 licensed programs; and

107.30 (4) professional services agencies that are not licensed and which contract with licensed
107.31 programs to provide direct contact services or individuals who provide direct contact services.

108.1 Subd. 5. **Other state agencies.** The commissioner shall conduct background studies on
108.2 applicants and license holders under the jurisdiction of other state agencies who are required
108.3 in other statutory sections to initiate background studies under this chapter, including the
108.4 applicant's or license holder's employees, contractors, and volunteers when required under
108.5 other statutory sections.

108.6 Subd. 5a. **Facilities serving children or adults licensed or regulated by the**
108.7 **Department of Health.** (a) The commissioner shall conduct background studies of:

108.8 (1) individuals providing services who have direct contact, as defined under section
108.9 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes,
108.10 outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and
108.11 home care agencies licensed under chapter 144A; assisted living facilities and assisted living
108.12 facilities with dementia care licensed under chapter 144G; and board and lodging
108.13 establishments that are registered to provide supportive or health supervision services under
108.14 section 157.17;

108.15 (2) individuals specified in subdivision 2 who provide direct contact services in a nursing
108.16 home or a home care agency licensed under chapter 144A; an assisted living facility or
108.17 assisted living facility with dementia care licensed under chapter 144G; or a boarding care
108.18 home licensed under sections 144.50 to 144.58. If the individual undergoing a study resides
108.19 outside of Minnesota, the study must include a check for substantiated findings of
108.20 maltreatment of adults and children in the individual's state of residence when the state
108.21 makes the information available;

108.22 (3) all other employees in assisted living facilities or assisted living facilities with
108.23 dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A,
108.24 and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of
108.25 an individual in this section shall disqualify the individual from positions allowing direct
108.26 contact with or access to patients or residents receiving services. "Access" means physical
108.27 access to a client or the client's personal property without continuous, direct supervision as
108.28 defined in section 245C.02, subdivision 8, when the employee's employment responsibilities
108.29 do not include providing direct contact services;

108.30 (4) individuals employed by a supplemental nursing services agency, as defined under
108.31 section 144A.70, who are providing services in health care facilities; and

108.32 (5) controlling persons of a supplemental nursing services agency, as defined by section
108.33 144A.70.

109.1 (b) If a facility or program is licensed by the Department of Human Services and the
109.2 Department of Health and is subject to the background study provisions of this chapter, the
109.3 Department of Human Services is solely responsible for the background studies of individuals
109.4 in the jointly licensed program.

109.5 (c) The commissioner of health shall review and make decisions regarding reconsideration
109.6 requests, including whether to grant variances, according to the procedures and criteria in
109.7 this chapter. The commissioner of health shall inform the requesting individual and the
109.8 Department of Human Services of the commissioner of health's decision regarding the
109.9 reconsideration. The commissioner of health's decision to grant or deny a reconsideration
109.10 of a disqualification is a final administrative agency action.

109.11 Subd. 5b. **Facilities serving children or youth licensed by the Department of**
109.12 **Corrections.** (a) The commissioner shall conduct background studies of individuals working
109.13 in secure and nonsecure children's residential facilities, juvenile detention facilities, and
109.14 foster residence settings, whether or not the individual will have direct contact, as defined
109.15 under section 245C.02, subdivision 11, with persons served in the facilities or settings.

109.16 (b) A clerk or administrator of any court, the Bureau of Criminal Apprehension, a
109.17 prosecuting attorney, a county sheriff, or a chief of a local police department shall assist in
109.18 conducting background studies by providing the commissioner of human services or the
109.19 commissioner's representative all criminal conviction data available from local and state
109.20 criminal history record repositories related to applicants, operators, all persons living in a
109.21 household, and all staff of any facility subject to background studies under this subdivision.

109.22 (c) For the purpose of this subdivision, the term "secure and nonsecure residential facility
109.23 and detention facility" includes programs licensed or certified under section 241.021,
109.24 subdivision 2.

109.25 (d) If an individual is disqualified, the Department of Human Services shall notify the
109.26 disqualified individual and the facility in which the disqualified individual provides services
109.27 of the disqualification and shall inform the disqualified individual of the right to request a
109.28 reconsideration of the disqualification by submitting the request to the Department of
109.29 Corrections.

109.30 (e) The commissioner of corrections shall review and make decisions regarding
109.31 reconsideration requests, including whether to grant variances, according to the procedures
109.32 and criteria in this chapter. The commissioner of corrections shall inform the requesting
109.33 individual and the Department of Human Services of the commissioner of corrections'

110.1 decision regarding the reconsideration. The commissioner of corrections' decision to grant
110.2 or deny a reconsideration of a disqualification is the final administrative agency action.

110.3 Subd. 6. **Unlicensed home and community-based waiver providers of service to**
110.4 **seniors and individuals with disabilities.** (a) The commissioner shall conduct background
110.5 studies ~~on~~ of any individual ~~required under section 256B.4912 to have a background study~~
110.6 ~~completed under this chapter~~ who provides direct contact, as defined in section 245C.02,
110.7 subdivision 11, for services specified in the federally approved home and community-based
110.8 waiver plans under section 256B.4912. The individual studied must meet the requirements
110.9 of this chapter prior to providing waiver services and as part of ongoing enrollment.

110.10 (b) The requirements in paragraph (a) apply to consumer-directed community supports
110.11 under section 256B.4911.

110.12 Subd. 6a. **Legal nonlicensed and certified child care programs.** The commissioner
110.13 shall conduct background studies ~~on an individual~~ of the following individuals as required
110.14 ~~under~~ by sections 119B.125 and 245H.10 ~~to complete a background study under this chapter.~~:

110.15 (1) every individual who applies for certification;

110.16 (2) every member of a provider's household who is age 13 and older and lives in the
110.17 household where nonlicensed child care is provided; and

110.18 (3) an individual who is at least ten years of age and under 13 years of age and lives in
110.19 the household where the nonlicensed child care will be provided when the county has
110.20 reasonable cause as defined under section 245C.02, subdivision 15.

110.21 Subd. 7. **Children's therapeutic services and supports providers.** The commissioner
110.22 shall conduct background studies ~~according to this chapter when initiated by a children's~~
110.23 ~~therapeutic services and supports provider~~ of all direct service providers and volunteers for
110.24 children's therapeutic services and supports providers under section 256B.0943.

110.25 ~~Subd. 8. **Self-initiated background studies.** Upon implementation of NETStudy 2.0,~~
110.26 ~~the commissioner shall conduct background studies according to this chapter when initiated~~
110.27 ~~by an individual who is not on the master roster. A subject under this subdivision who is~~
110.28 ~~not disqualified must be placed on the inactive roster.~~

110.29 Subd. 9. **Community first services and supports and financial management services**
110.30 **organizations.** ~~The commissioner shall conduct background studies on any individual~~
110.31 ~~required under section 256B.85 to have a background study completed under this chapter.~~
110.32 Individuals affiliated with Community First Services and Supports (CFSS) agency-providers

111.1 and Financial Management Services (FMS) providers enrolled to provide CFSS services
111.2 under the medical assistance program must meet the following requirements:

111.3 (1) owners who have a five percent interest or more and all managing employees are
111.4 subject to a background study under this chapter. This requirement applies to currently
111.5 enrolled providers and agencies seeking enrollment. "Managing employee" has the meaning
111.6 given in Code of Federal Regulations, title 42, section 455.101. An organization is barred
111.7 from enrollment if:

111.8 (i) the organization has not initiated background studies of owners and managing
111.9 employees; or

111.10 (ii) the organization has initiated background studies of owners and managing employees
111.11 and the commissioner has sent the organization a notice that an owner or managing employee
111.12 of the organization has been disqualified under section 245C.14 and the owner or managing
111.13 employee has not received a set aside of the disqualification under section 245C.22;

111.14 (2) a background study must be initiated and completed for all staff who will have direct
111.15 contact with the participant to provide worker training and development; and

111.16 (3) a background study must be initiated and completed for all support workers.

111.17 Subd. 9a. **Exception to support worker requirements for continuity of services.** The
111.18 support worker for a participant may enroll with a different Community First Services and
111.19 Supports (CFSS) agency-provider or Financial Management Services (FMS) provider upon
111.20 initiation, rather than completion, of a new background study according to this chapter if:

111.21 (1) the commissioner determines that the support worker's change in enrollment or
111.22 affiliation is necessary to ensure continuity of services and to protect the health and safety
111.23 of the participant;

111.24 (2) the chosen agency-provider or FMS provider has been continuously enrolled as a
111.25 CFSS agency-provider or FMS provider for at least two years or since the inception of the
111.26 CFSS program, whichever is shorter;

111.27 (3) the participant served by the support worker chooses to transfer to the CFSS
111.28 agency-provider or the FMS provider to which the support worker is transferring;

111.29 (4) the support worker has been continuously enrolled with the former CFSS
111.30 agency-provider or FMS provider since the support worker's last background study was
111.31 completed; and

112.1 (5) the support worker continues to meet the requirements of section 256B.85, subdivision
112.2 16, notwithstanding paragraph (a), clause (1).

112.3 Subd. 10. **Providers of group residential housing or supplementary services.** (a) The
112.4 commissioner shall conduct background studies ~~on any individual required under section~~
112.5 ~~256I.04 to have a background study completed under this chapter.~~ of the following individuals
112.6 who provide services under section 256I.04:

112.7 (1) controlling individuals as defined in section 245A.02;

112.8 (2) managerial officials as defined in section 245A.02; and

112.9 (3) all employees and volunteers of the establishment who have direct contact with
112.10 recipients or who have unsupervised access to recipients, recipients' personal property, or
112.11 recipients' private data.

112.12 (b) The provider of housing support must comply with all requirements for entities
112.13 initiating background studies under this chapter.

112.14 (c) A provider of housing support must demonstrate that all individuals who are required
112.15 to have a background study according to paragraph (a) have a notice stating that:

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

112.17 (2) the individual is disqualified and the individual has been issued a set aside of the
112.18 disqualification for the setting under section 245C.22.

112.19 ~~Subd. 11.~~ ~~**Child protection workers or social services staff having responsibility for**~~
112.20 ~~**child protective duties.**~~ ~~(a) The commissioner must complete background studies, according~~
112.21 ~~to paragraph (b) and section 245C.04, subdivision 10, when initiated by a county social~~
112.22 ~~services agency or by a local welfare agency according to section 626.559, subdivision 1b.~~

112.23 ~~(b) For background studies completed by the commissioner under this subdivision, the~~
112.24 ~~commissioner shall not make a disqualification decision, but shall provide the background~~
112.25 ~~study information received to the county that initiated the study.~~

112.26 Subd. 12. **Providers of special transportation service.** (a) The commissioner shall
112.27 conduct background studies ~~on any individual required under section 174.30 to have a~~
112.28 ~~background study completed under this chapter.~~ of the following individuals who provide
112.29 special transportation services under section 174.30:

112.30 (1) each person with a direct or indirect ownership interest of five percent or higher in
112.31 a transportation service provider;

112.32 (2) each controlling individual as defined under section 245A.02;

113.1 (3) a managerial official as defined in section 245A.02;

113.2 (4) each driver employed by the transportation service provider;

113.3 (5) each individual employed by the transportation service provider to assist a passenger
113.4 during transport; and

113.5 (6) each employee of the transportation service agency who provides administrative
113.6 support, including an employee who:

113.7 (i) may have face-to-face contact with or access to passengers, passengers' personal
113.8 property, or passengers' private data;

113.9 (ii) performs any scheduling or dispatching tasks; or

113.10 (iii) performs any billing activities.

113.11 (b) When a local or contracted agency is authorizing a ride under section 256B.0625,
113.12 subdivision 17, by a volunteer driver, and the agency authorizing the ride has a reason to
113.13 believe that the volunteer driver has a history that would disqualify the volunteer driver or
113.14 that may pose a risk to the health or safety of passengers, the agency may initiate a
113.15 background study that shall be completed according to this chapter using the commissioner
113.16 of human services' online NETStudy system, or by contacting the Department of Human
113.17 Services background study division for assistance. The agency that initiates the background
113.18 study under this paragraph shall be responsible for providing the volunteer driver with the
113.19 privacy notice required by section 245C.05, subdivision 2c, and with the payment for the
113.20 background study required by section 245C.10 before the background study is completed.

113.21 Subd. 13. **Providers of housing support services.** The commissioner shall conduct
113.22 background studies ~~on~~ of any ~~individual~~ provider of housing support services required ~~under~~
113.23 by section 256B.051 to have a background study completed under this chapter.

113.24 Subd. 14. **Tribal nursing facilities.** For completed background studies to comply with
113.25 a Tribal organization's licensing requirements for individuals affiliated with a tribally licensed
113.26 nursing facility, the commissioner shall obtain state and national criminal history data.

113.27 Subd. 15. **Early intensive developmental and behavioral intervention providers.** The
113.28 commissioner shall conduct background studies according to this chapter when initiated by
113.29 an early intensive developmental and behavioral intervention provider under section
113.30 256B.0949.

113.31 **EFFECTIVE DATE.** This section is effective July 1, 2021, except subdivision 6,
113.32 paragraph (b), is effective upon federal approval and subdivision 15 is effective the day

114.1 following final enactment. The commissioner of human services shall notify the revisor of
114.2 statutes when federal approval is obtained.

114.3 Sec. 18. **[245C.031] BACKGROUND STUDY; ALTERNATIVE BACKGROUND**
114.4 **STUDIES.**

114.5 Subdivision 1. **Alternative background studies.** (a) The commissioner shall conduct
114.6 an alternative background study of individuals listed in this section.

114.7 (b) Notwithstanding other sections of this chapter, all alternative background studies
114.8 except subdivision 12 shall be conducted according to this section and with section 299C.60
114.9 to 299C.64.

114.10 (c) All terms in this section shall have the definitions provided in section 245C.02.

114.11 (d) The entity that submits an alternative background study request under this section
114.12 shall submit the request to the commissioner according to section 245C.05.

114.13 (e) The commissioner shall comply with the destruction requirements in section 245C.051.

114.14 (f) Background studies conducted under this section are subject to the provisions of
114.15 section 245C.32.

114.16 (g) The commissioner shall forward all information that the commissioner receives under
114.17 section 245C.08 to the entity that submitted the alternative background study request under
114.18 subdivision 2. The commissioner shall not make any eligibility determinations regarding
114.19 background studies conducted under this section.

114.20 Subd. 2. **Access to information.** Each entity that submits an alternative background
114.21 study request shall enter into an agreement with the commissioner before submitting requests
114.22 for alternative background studies under this section. As a part of the agreement, the entity
114.23 must agree to comply with state and federal law.

114.24 Subd. 3. **Child protection workers or social services staff having responsibility for**
114.25 **child protective duties.** The commissioner shall conduct an alternative background study
114.26 of any person who has responsibility for child protection duties when the background study
114.27 is initiated by a county social services agency or by a local welfare agency according to
114.28 section 260E.36, subdivision 3.

114.29 Subd. 4. **Applicants, licensees, and other occupations regulated by the commissioner**
114.30 **of health.** The commissioner shall conduct an alternative background study, including a
114.31 check of state data, and a national criminal history records check of the following individuals.
114.32 For studies under this section, the following persons shall complete a consent form:

115.1 (1) an applicant for initial licensure, temporary licensure, or relicensure after a lapse in
115.2 licensure as an audiologist or speech-language pathologist or an applicant for initial
115.3 certification as a hearing instrument dispenser who must submit to a background study
115.4 under section 144.0572.

115.5 (2) an applicant for a renewal license or certificate as an audiologist, speech-language
115.6 pathologist, or hearing instrument dispenser who was licensed or obtained a certificate
115.7 before January 1, 2018.

115.8 Subd. 5. **Guardians and conservators.** (a) The commissioner shall conduct an alternative
115.9 background study of:

115.10 (1) every court-appointed guardian and conservator, unless a background study has been
115.11 completed of the person under this section within the previous five years. The alternative
115.12 background study shall be completed prior to the appointment of the guardian or conservator,
115.13 unless a court determines that it would be in the best interests of the ward or protected person
115.14 to appoint a guardian or conservator before the alternative background study can be
115.15 completed. If the court appoints the guardian or conservator while the alternative background
115.16 study is pending, the alternative background study must be completed as soon as reasonably
115.17 possible after the guardian or conservator's appointment and no later than 30 days after the
115.18 guardian or conservator's appointment; and

115.19 (2) a guardian and a conservator once every five years after the guardian or conservator's
115.20 appointment if the person continues to serve as a guardian or conservator.

115.21 (b) An alternative background study is not required if the guardian or conservator is:

115.22 (1) a state agency or county;

115.23 (2) a parent or guardian of a proposed ward or protected person who has a developmental
115.24 disability if the parent or guardian has raised the proposed ward or protected person in the
115.25 family home until the time that the petition is filed, unless counsel appointed for the proposed
115.26 ward or protected person under section 524.5-205, paragraph (d); 524.5-304, paragraph (b);
115.27 524.5-405, paragraph (a); or 524.5-406, paragraph (b), recommends a background study;
115.28 or

115.29 (3) a bank with trust powers, a bank and trust company, or a trust company, organized
115.30 under the laws of any state or of the United States and regulated by the commissioner of
115.31 commerce or a federal regulator.

115.32 Subd. 6. **Guardians and conservators; required checks.** (a) An alternative background
115.33 study for a guardian or conservator pursuant to subdivision 5 shall include:

116.1 (1) criminal history data from the Bureau of Criminal Apprehension and other criminal
116.2 history data obtained by the commissioner of human services;

116.3 (2) data regarding whether the person has been a perpetrator of substantiated maltreatment
116.4 of a vulnerable adult under section 626.557 or a minor under chapter 260E. If the subject
116.5 of the study has been the perpetrator of substantiated maltreatment of a vulnerable adult or
116.6 a minor, the commissioner must include a copy of the public portion of the investigation
116.7 memorandum under section 626.557, subdivision 12b, or the public portion of the
116.8 investigation memorandum under section 260E.30. The commissioner shall provide the
116.9 court with information from a review of information according to subdivision 7 if the study
116.10 subject provided information that the study subject has a current or prior affiliation with a
116.11 state licensing agency;

116.12 (3) criminal history data from a national criminal history record check as defined in
116.13 section 245C.02, subdivision 13c; and

116.14 (4) state licensing agency data if a search of the database or databases of the agencies
116.15 listed in subdivision 7 shows that the proposed guardian or conservator has held a
116.16 professional license directly related to the responsibilities of a professional fiduciary from
116.17 an agency listed in subdivision 7 that was conditioned, suspended, revoked, or canceled.

116.18 (b) If the guardian or conservator is not an individual, the background study must be
116.19 completed of all individuals who are currently employed by the proposed guardian or
116.20 conservator who are responsible for exercising powers and duties under the guardianship
116.21 or conservatorship.

116.22 Subd. 7. **Guardians and conservators; state licensing data.** (a) Within 25 working
116.23 days of receiving the request for an alternative background study of a guardian or conservator,
116.24 the commissioner shall provide the court with licensing agency data for licenses directly
116.25 related to the responsibilities of a guardian or conservator if the study subject has a current
116.26 or prior affiliation with the:

116.27 (1) Lawyers Responsibility Board;

116.28 (2) State Board of Accountancy;

116.29 (3) Board of Social Work;

116.30 (4) Board of Psychology;

116.31 (5) Board or Nursing;

116.32 (6) Board of Medical Practice;

117.1 (7) Department of Education;

117.2 (8) Department of Commerce;

117.3 (9) Board of Chiropractic Examiners;

117.4 (10) Board of Dentistry;

117.5 (11) Board of Marriage and Family Therapy;

117.6 (12) Department of Human Services;

117.7 (13) Peace Officer Standards and Training (POST) Board; and

117.8 (14) Professional Educator Licensing and Standards Board.

117.9 (b) The commissioner and each of the agencies listed above, except for the Department
117.10 of Human Services, shall enter into a written agreement to provide the commissioner with
117.11 electronic access to the relevant licensing data and to provide the commissioner with a
117.12 quarterly list of new sanctions issued by the agency.

117.13 (c) The commissioner shall provide to the court the electronically available data
117.14 maintained in the agency's database, including whether the proposed guardian or conservator
117.15 is or has been licensed by the agency and whether a disciplinary action or a sanction against
117.16 the individual's license, including a condition, suspension, revocation, or cancellation, is in
117.17 the licensing agency's database.

117.18 (d) If the proposed guardian or conservator has resided in a state other than Minnesota
117.19 during the previous ten years, licensing agency data under this section shall also include
117.20 licensing agency data from any other state where the proposed guardian or conservator
117.21 reported to have resided during the previous ten years if the study subject has a current or
117.22 prior affiliation to the licensing agency. If the proposed guardian or conservator has or has
117.23 had a professional license in another state that is directly related to the responsibilities of a
117.24 guardian or conservator from one of the agencies listed under paragraph (a), state licensing
117.25 agency data shall also include data from the relevant licensing agency of the other state.

117.26 (e) The commissioner is not required to repeat a search for Minnesota or out-of-state
117.27 licensing data on an individual if the commissioner has provided this information to the
117.28 court within the prior five years.

117.29 (f) The commissioner shall review the information in paragraph (c) at least once every
117.30 four months to determine whether an individual who has been studied within the previous
117.31 five years:

117.32 (1) has any new disciplinary action or sanction against the individual's license; or

118.1 (2) did not disclose a prior or current affiliation with a Minnesota licensing agency.

118.2 (g) If the commissioner's review in paragraph (f) identifies new information, the
118.3 commissioner shall provide any new information to the court.

118.4 Subd. 8. **Guardians ad litem.** The commissioner shall conduct an alternative background
118.5 study of:

118.6 (1) a guardian ad litem appointed under section 518.165 if a background study of the
118.7 guardian ad litem has not been completed within the past three years. The background study
118.8 of the guardian ad litem must be completed before the court appoints the guardian ad litem,
118.9 unless the court determines that it is in the best interests of the child to appoint the guardian
118.10 ad litem before a background study is completed by the commissioner.

118.11 (2) a guardian ad litem once every three years after the guardian has been appointed, as
118.12 long as the individual continues to serve as a guardian ad litem.

118.13 Subd. 9. **Guardians ad litem; required checks.** (a) An alternative background study
118.14 for a guardian ad litem under subdivision 8 must include:

118.15 (1) criminal history data from the Bureau of Criminal Apprehension and other criminal
118.16 history data obtained by the commissioner of human services; and

118.17 (2) data regarding whether the person has been a perpetrator of substantiated maltreatment
118.18 of a minor or a vulnerable adult. If the study subject has been determined by the Department
118.19 of Human Services or the Department of Health to be the perpetrator of substantiated
118.20 maltreatment of a minor or a vulnerable adult in a licensed facility, the response must include
118.21 a copy of the public portion of the investigation memorandum under section 260E.30 or the
118.22 public portion of the investigation memorandum under section 626.557, subdivision 12b.
118.23 When the background study shows that the subject has been determined by a county adult
118.24 protection or child protection agency to have been responsible for maltreatment, the court
118.25 shall be informed of the county, the date of the finding, and the nature of the maltreatment
118.26 that was substantiated.

118.27 (b) For checks of records under paragraph (a), clauses (1) and (2), the commissioner
118.28 shall provide the records within 15 working days of receiving the request. The information
118.29 obtained under sections 245C.05 and 245C.08 from a national criminal history records
118.30 check shall be provided within three working days of the commissioner's receipt of the data.

118.31 (c) Notwithstanding section 260E.30 or 626.557, subdivision 12b, if the commissioner
118.32 or county lead agency or lead investigative agency has information that a person of whom
118.33 a background study was previously completed under this section has been determined to

119.1 be a perpetrator of maltreatment of a minor or vulnerable adult, the commissioner or the
119.2 county may provide this information to the court that requested the background study.

119.3 Subd. 10. **First-time applicants for educator licenses with the Professional Educator**
119.4 **Licensing and Standards Board.** The Professional Educator Licensing and Standards
119.5 Board shall make all eligibility determinations for alternative background studies conducted
119.6 under this section for the Professional Educator Licensing and Standards Board. The
119.7 commissioner may conduct an alternative background study of all first-time applicants for
119.8 educator licenses pursuant to section 122A.18, subdivision 8. The alternative background
119.9 study for all first-time applicants for educator licenses must include a review of information
119.10 from the Bureau of Criminal Apprehension, including criminal history data as defined in
119.11 section 13.87, and must also include a review of the national criminal records repository.

119.12 Subd. 11. **First-time applicants for administrator licenses with the Board of School**
119.13 **Administrators.** The Board of School Administrators shall make all eligibility determinations
119.14 for alternative background studies conducted under this section for the Board of School
119.15 Administrators. The commissioner may conduct an alternative background study of all
119.16 first-time applicants for administrator licenses pursuant to section 122A.18, subdivision 8.
119.17 The alternative background study for all first-time applicants for administrator licenses must
119.18 include a review of information from the Bureau of Criminal Apprehension, including
119.19 criminal history data as defined in section 13.87, and must also include a review of the
119.20 national criminal records repository.

119.21 Subd. 12. **Occupations regulated by MNsure.** (a) The commissioner shall conduct a
119.22 background study of any individual required under section 62V.05 to have a background
119.23 study completed under this chapter. Notwithstanding subdivision 1, paragraph (g), the
119.24 commissioner shall conduct a background study only based on Minnesota criminal records
119.25 of:

119.26 (1) each navigator;

119.27 (2) each in-person assister; and

119.28 (3) each certified application counselor.

119.29 (b) The MNsure board of directors may initiate background studies required by paragraph
119.30 (a) using the online NETStudy 2.0 system operated by the commissioner.

119.31 (c) The commissioner shall review information that the commissioner receives to
119.32 determine if the study subject has potentially disqualifying offenses. The commissioner
119.33 shall send a letter to the subject indicating any of the subject's potential disqualifications as

120.1 well as any relevant records. The commissioner shall send a copy of the letter indicating
120.2 any of the subject's potential disqualifications to the MNsure board.

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

120.7 Sec. 19. Minnesota Statutes 2020, section 245C.05, subdivision 1, is amended to read:

120.8 Subdivision 1. **Individual studied.** (a) The individual who is the subject of the
120.9 background study must provide the applicant, license holder, or other entity under section
120.10 245C.04 with sufficient information to ensure an accurate study, including:

120.11 (1) the individual's first, middle, and last name and all other names by which the
120.12 individual has been known;

120.13 (2) current home address, city, and state of residence;

120.14 (3) current zip code;

120.15 (4) sex;

120.16 (5) date of birth;

120.17 (6) driver's license number or state identification number; and

120.18 (7) upon implementation of NETStudy 2.0, the home address, city, county, and state of
120.19 residence for the past five years.

120.20 (b) Every subject of a background study conducted or initiated by counties or private
120.21 agencies under this chapter must also provide the home address, city, county, and state of
120.22 residence for the past five years.

120.23 (c) Every subject of a background study related to private agency adoptions or related
120.24 to child foster care licensed through a private agency, who is 18 years of age or older, shall
120.25 also provide the commissioner a signed consent for the release of any information received
120.26 from national crime information databases to the private agency that initiated the background
120.27 study.

120.28 (d) The subject of a background study shall provide fingerprints and a photograph as
120.29 required in subdivision 5.

120.30 (e) The subject of a background study shall submit a completed criminal and maltreatment
120.31 history records check consent form for applicable national and state level record checks.

121.1 Sec. 20. Minnesota Statutes 2020, section 245C.05, subdivision 2, is amended to read:

121.2 Subd. 2. **Applicant, license holder, or other entity.** (a) The applicant, license holder,
121.3 or other ~~entities~~ entity initiating the background study as provided in this chapter shall verify
121.4 that the information collected under subdivision 1 about an individual who is the subject of
121.5 the background study is correct and must provide the information on forms or in a format
121.6 prescribed by the commissioner.

121.7 (b) The information collected under subdivision 1 about an individual who is the subject
121.8 of a completed background study may only be viewable by an entity that initiates a
121.9 subsequent background study on that individual under NETStudy 2.0 after the entity has
121.10 paid the applicable fee for the study and has provided the individual with the privacy notice
121.11 in subdivision 2c.

121.12 Sec. 21. Minnesota Statutes 2020, section 245C.05, subdivision 2a, is amended to read:

121.13 Subd. 2a. **County or private agency.** For background studies related to child foster care
121.14 when the applicant or license holder resides in the home where child foster care services
121.15 are provided, county and private agencies initiating the background study must collect the
121.16 information under subdivision 1 and forward it to the commissioner.

121.17 Sec. 22. Minnesota Statutes 2020, section 245C.05, subdivision 2b, is amended to read:

121.18 Subd. 2b. **County agency to collect and forward information to commissioner.** (a)
121.19 For background studies related to all family adult day services and to adult foster care when
121.20 the adult foster care license holder resides in the adult foster care residence, the county
121.21 agency or private agency initiating the background study must collect the information
121.22 required under subdivision 1 and forward it to the commissioner.

121.23 (b) Upon implementation of NETStudy 2.0, for background studies related to family
121.24 child care and legal nonlicensed child care authorized under chapter 119B, the county agency
121.25 initiating the background study must collect the information required under subdivision 1
121.26 and provide the information to the commissioner.

121.27 Sec. 23. Minnesota Statutes 2020, section 245C.05, subdivision 2c, is amended to read:

121.28 Subd. 2c. **Privacy notice to background study subject.** (a) Prior to initiating each
121.29 background study, the entity initiating the study must provide the commissioner's privacy
121.30 notice to the background study subject required under section 13.04, subdivision 2. The
121.31 notice must be available through the commissioner's electronic NETStudy and NETStudy
121.32 2.0 systems and shall include the information in paragraphs (b) and (c).

122.1 (b) The background study subject shall be informed that any previous background studies
122.2 that received a set-aside will be reviewed, and without further contact with the background
122.3 study subject, the commissioner may notify the agency that initiated the subsequent
122.4 background study:

122.5 (1) that the individual has a disqualification that has been set aside for the program or
122.6 agency that initiated the study;

122.7 (2) the reason for the disqualification; and

122.8 (3) that information about the decision to set aside the disqualification will be available
122.9 to the license holder upon request without the consent of the background study subject.

122.10 (c) The background study subject must also be informed that:

122.11 (1) the subject's fingerprints collected for purposes of completing the background study
122.12 under this chapter must not be retained by the Department of Public Safety, Bureau of
122.13 Criminal Apprehension, or by the commissioner. The Federal Bureau of Investigation will
122.14 ~~only retain fingerprints of subjects with a criminal history~~ not retain background study
122.15 subjects' fingerprints;

122.16 (2) effective upon implementation of NETStudy 2.0, the subject's photographic image
122.17 will be retained by the commissioner, and if the subject has provided the subject's Social
122.18 Security number for purposes of the background study, the photographic image will be
122.19 available to prospective employers and agencies initiating background studies under this
122.20 chapter to verify the identity of the subject of the background study;

122.21 (3) the commissioner's authorized fingerprint collection vendor or vendors shall, for
122.22 purposes of verifying the identity of the background study subject, be able to view the
122.23 identifying information entered into NETStudy 2.0 by the entity that initiated the background
122.24 study, but shall not retain the subject's fingerprints, photograph, or information from
122.25 NETStudy 2.0. The authorized fingerprint collection vendor or vendors shall retain no more
122.26 than the subject's name and the date and time the subject's fingerprints were recorded and
122.27 sent, only as necessary for auditing and billing activities;

122.28 (4) the commissioner shall provide the subject notice, as required in section 245C.17,
122.29 subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

122.30 (5) the subject may request in writing a report listing the entities that initiated a
122.31 background study on the individual as provided in section 245C.17, subdivision 1, paragraph
122.32 (b);

123.1 (6) the subject may request in writing that information used to complete the individual's
123.2 background study in NETStudy 2.0 be destroyed if the requirements of section 245C.051,
123.3 paragraph (a), are met; and

123.4 (7) notwithstanding clause (6), the commissioner shall destroy:

123.5 (i) the subject's photograph after a period of two years when the requirements of section
123.6 245C.051, paragraph (c), are met; and

123.7 (ii) any data collected on a subject under this chapter after a period of two years following
123.8 the individual's death as provided in section 245C.051, paragraph (d).

123.9 Sec. 24. Minnesota Statutes 2020, section 245C.05, subdivision 2d, is amended to read:

123.10 Subd. 2d. **Fingerprint data notification.** The commissioner of human services shall
123.11 notify all background study subjects under this chapter that the Department of Human
123.12 Services, Department of Public Safety, and the Bureau of Criminal Apprehension do not
123.13 retain fingerprint data after a background study is completed, and that the Federal Bureau
123.14 of Investigation ~~only retains the fingerprints of subjects who have a criminal history~~ does
123.15 not retain background study subjects' fingerprints.

123.16 Sec. 25. Minnesota Statutes 2020, section 245C.05, subdivision 4, is amended to read:

123.17 Subd. 4. **Electronic transmission.** (a) For background studies conducted by the
123.18 Department of Human Services, the commissioner shall implement a secure system for the
123.19 electronic transmission of:

123.20 (1) background study information to the commissioner;

123.21 (2) background study results to the license holder;

123.22 (3) background study ~~results~~ information obtained under this section and section 245C.08
123.23 to counties and private agencies for background studies conducted by the commissioner for
123.24 child foster care, including a summary of nondisqualifying results, except as prohibited by
123.25 law; and

123.26 (4) background study results to county agencies for background studies conducted by
123.27 the commissioner for adult foster care and family adult day services and, upon
123.28 implementation of NETStudy 2.0, family child care and legal nonlicensed child care
123.29 authorized under chapter 119B.

123.30 (b) Unless the commissioner has granted a hardship variance under paragraph (c), a
123.31 license holder or an applicant must use the electronic transmission system known as

124.1 NETStudy or NETStudy 2.0 to submit all requests for background studies to the
124.2 commissioner as required by this chapter.

124.3 (c) A license holder or applicant whose program is located in an area in which high-speed
124.4 Internet is inaccessible may request the commissioner to grant a variance to the electronic
124.5 transmission requirement.

124.6 (d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under
124.7 this subdivision.

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

124.9 Sec. 26. Minnesota Statutes 2020, section 245C.08, subdivision 3, is amended to read:

124.10 Subd. 3. **Arrest and investigative information.** (a) For any background study completed
124.11 under this section, if the commissioner has reasonable cause to believe the information is
124.12 pertinent to the disqualification of an individual, the commissioner also may review arrest
124.13 and investigative information from:

124.14 (1) the Bureau of Criminal Apprehension;

124.15 (2) the commissioners of health and human services;

124.16 (3) a county attorney;

124.17 (4) a county sheriff;

124.18 (5) a county agency;

124.19 (6) a local chief of police;

124.20 (7) other states;

124.21 (8) the courts;

124.22 (9) the Federal Bureau of Investigation;

124.23 (10) the National Criminal Records Repository; and

124.24 (11) criminal records from other states.

124.25 (b) Except when specifically required by law, the commissioner is not required to conduct
124.26 more than one review of a subject's records from the Federal Bureau of Investigation if a
124.27 review of the subject's criminal history with the Federal Bureau of Investigation has already
124.28 been completed by the commissioner and there has been no break in the subject's affiliation
124.29 with the entity that initiated the background study.

125.1 (c) If the commissioner conducts a national criminal history record check when required
125.2 by law and uses the information from the national criminal history record check to make a
125.3 disqualification determination, the data obtained is private data and cannot be shared with
125.4 ~~county agencies,~~ private agencies~~,~~ or prospective employers of the background study subject.

125.5 (d) If the commissioner conducts a national criminal history record check when required
125.6 by law and uses the information from the national criminal history record check to make a
125.7 disqualification determination, the license holder or entity that submitted the study is not
125.8 required to obtain a copy of the background study subject's disqualification letter under
125.9 section 245C.17, subdivision 3.

125.10 Sec. 27. Minnesota Statutes 2020, section 245C.08, is amended by adding a subdivision
125.11 to read:

125.12 Subd. 5. **Authorization.** The commissioner of human services shall be authorized to
125.13 receive information under this chapter.

125.14 Sec. 28. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision
125.15 to read:

125.16 Subd. 1b. **Background study fees.** (a) The commissioner shall recover the cost of
125.17 background studies. Except as otherwise provided in subdivisions 1c and 1d, the fees
125.18 collected under this section shall be appropriated to the commissioner for the purpose of
125.19 conducting background studies under this chapter. Fees under this section are charges under
125.20 section 16A.1283, paragraph (b), clause (3).

125.21 (b) Background study fees may include:

125.22 (1) a fee to compensate the commissioner's authorized fingerprint collection vendor or
125.23 vendors for obtaining and processing a background study subject's classifiable fingerprints
125.24 and photograph pursuant to subdivision 1c; and

125.25 (2) a separate fee under subdivision 1c to complete a review of background-study-related
125.26 records as authorized under this chapter.

125.27 (c) Fees charged under paragraph (b) may be paid in whole or part when authorized by
125.28 law by a state agency or board; by state court administration; by a service provider, employer,
125.29 license holder, or other organization that initiates the background study; by the commissioner
125.30 or other organization with duly appropriated funds; by a background study subject; or by
125.31 some combination of these sources.

126.1 Sec. 29. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision
126.2 to read:

126.3 Subd. 1c. **Fingerprint and photograph processing fees.** The commissioner shall enter
126.4 into a contract with a qualified vendor or vendors to obtain and process a background study
126.5 subject's classifiable fingerprints and photograph as required by section 245C.05. The
126.6 commissioner may, at their discretion, directly collect fees and reimburse the commissioner's
126.7 authorized fingerprint collection vendor for the vendor's services or require the vendor to
126.8 collect the fees. The authorized vendor is responsible for reimbursing the vendor's
126.9 subcontractors at a rate specified in the contract with the commissioner.

126.10 Sec. 30. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision
126.11 to read:

126.12 Subd. 1d. **Background studies fee schedule.** (a) By March 1 each year, the commissioner
126.13 shall publish a schedule of fees sufficient to administer and conduct background studies
126.14 under this chapter. The published schedule of fees shall be effective on July 1 each year.

126.15 (b) Fees shall be based on the actual costs of administering and conducting background
126.16 studies, including payments to external agencies, department indirect cost payments under
126.17 section 16A.127, processing fees, and costs related to due process.

126.18 (c) The commissioner shall publish a notice of fees by posting fee amounts on the
126.19 department website. The notice shall specify the actual costs that comprise the fees including
126.20 the categories described in paragraph (b).

126.21 (d) The published schedule of fees shall remain in effect from July 1 to June 30 each
126.22 year.

126.23 (e) The fees collected under this subdivision are appropriated to the commissioner for
126.24 the purpose of conducting background studies, alternative background studies, and criminal
126.25 background checks.

126.26 **EFFECTIVE DATE.** This section is effective July 1, 2021. The commissioner of human
126.27 services shall publish the initial fee schedule on the Department of Human Services website
126.28 on July 1, 2021, and the initial fee schedule is effective September 1, 2021.

126.29 Sec. 31. Minnesota Statutes 2020, section 245C.10, subdivision 15, is amended to read:

126.30 Subd. 15. **Guardians and conservators.** The ~~commissioner shall recover the cost of~~
126.31 ~~conducting background studies for guardians and conservators under section 524.5-118~~
126.32 ~~through a fee of no more than $110 per study. The fees collected under this subdivision are~~

127.1 ~~appropriated to the commissioner for the purpose of conducting background studies.~~ fee
127.2 for conducting an alternative background study for appointment of a professional guardian
127.3 or conservator must be paid by the guardian or conservator. In other cases, the fee must be
127.4 paid as follows:

127.5 (1) if the matter is proceeding in forma pauperis, the fee must be paid as an expense for
127.6 purposes of section 524.5-502, paragraph (a);

127.7 (2) if there is an estate of the ward or protected person, the fee must be paid from the
127.8 estate; or

127.9 (3) in the case of a guardianship or conservatorship of a person that is not proceeding
127.10 in forma pauperis, the fee must be paid by the guardian, conservator, or the court.

127.11 Sec. 32. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision
127.12 to read:

127.13 Subd. 17. **Early intensive developmental and behavioral intervention providers.** The
127.14 commissioner shall recover the cost of background studies required under section 245C.03,
127.15 subdivision 15, for the purposes of early intensive developmental and behavioral intervention
127.16 under section 256B.0949, through a fee of no more than $20 per study charged to the enrolled
127.17 agency. The fees collected under this subdivision are appropriated to the commissioner for
127.18 the purpose of conducting background studies.

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

127.20 Sec. 33. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision
127.21 to read:

127.22 Subd. 18. **Applicants, licensees, and other occupations regulated by commissioner**
127.23 **of health.** The applicant or license holder is responsible for paying to the Department of
127.24 Human Services all fees associated with the preparation of the fingerprints, the criminal
127.25 records check consent form, and the criminal background check.

127.26 Sec. 34. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision
127.27 to read:

127.28 Subd. 19. **Occupations regulated by MNsure.** The commissioner shall set fees to
127.29 recover the cost of background studies and criminal background checks initiated by MNsure
127.30 under sections 62V.05 and 245C.031. The fee amount shall be established through
127.31 interagency agreement between the commissioner and the board of MNsure or its designee.

128.1 The fees collected under this subdivision shall be deposited in the special revenue fund and
128.2 are appropriated to the commissioner for the purpose of conducting background studies and
128.3 criminal background checks.

128.4 Sec. 35. Minnesota Statutes 2020, section 245C.13, subdivision 2, is amended to read:

128.5 Subd. 2. **Activities pending completion of background study.** The subject of a
128.6 background study may not perform any activity requiring a background study under
128.7 paragraph (c) until the commissioner has issued one of the notices under paragraph (a).

128.8 (a) Notices from the commissioner required prior to activity under paragraph (c) include:

128.9 (1) a notice of the study results under section 245C.17 stating that:

128.10 (i) the individual is not disqualified; or

128.11 (ii) more time is needed to complete the study but the individual is not required to be
128.12 removed from direct contact or access to people receiving services prior to completion of
128.13 the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice
128.14 that more time is needed to complete the study must also indicate whether the individual is
128.15 required to be under continuous direct supervision prior to completion of the background
128.16 study. When more time is necessary to complete a background study of an individual
128.17 affiliated with a Title IV-E eligible children's residential facility or foster residence setting,
128.18 the individual may not work in the facility or setting regardless of whether or not the
128.19 individual is supervised;

128.20 (2) a notice that a disqualification has been set aside under section 245C.23; or

128.21 (3) a notice that a variance has been granted related to the individual under section
128.22 245C.30.

128.23 (b) For a background study affiliated with a licensed child care center or certified
128.24 license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii),
128.25 must require the individual to be under continuous direct supervision prior to completion
128.26 of the background study except as permitted in subdivision 3.

128.27 (c) Activities prohibited prior to receipt of notice under paragraph (a) include:

128.28 (1) being issued a license;

128.29 (2) living in the household where the licensed program will be provided;

128.30 (3) providing direct contact services to persons served by a program unless the subject
128.31 is under continuous direct supervision;

129.1 (4) having access to persons receiving services if the background study was completed
129.2 under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2),
129.3 (5), or (6), unless the subject is under continuous direct supervision;

129.4 (5) for licensed child care centers and certified license-exempt child care centers,
129.5 providing direct contact services to persons served by the program; ~~or~~

129.6 (6) for children's residential facilities or foster residence settings, working in the facility
129.7 or setting~~.~~; or

129.8 (7) for background studies affiliated with a personal care provider organization, except
129.9 as provided in section 245C.03, subdivision 3b, before a personal care assistant provides
129.10 services, the personal care assistance provider agency must initiate a background study of
129.11 the personal care assistant under this chapter and the personal care assistance provider
129.12 agency must have received a notice from the commissioner that the personal care assistant
129.13 is:

129.14 (i) not disqualified under section 245C.14; or

129.15 (ii) disqualified, but the personal care assistant has received a set aside of the
129.16 disqualification under section 245C.22.

129.17 Sec. 36. Minnesota Statutes 2020, section 245C.14, subdivision 1, is amended to read:

129.18 Subdivision 1. **Disqualification from direct contact.** (a) The commissioner shall
129.19 disqualify an individual who is the subject of a background study from any position allowing
129.20 direct contact with persons receiving services from the license holder or entity identified in
129.21 section 245C.03, upon receipt of information showing, or when a background study
129.22 completed under this chapter shows any of the following:

129.23 (1) a conviction of, admission to, or Alford plea to one or more crimes listed in section
129.24 245C.15, regardless of whether the conviction or admission is a felony, gross misdemeanor,
129.25 or misdemeanor level crime;

129.26 (2) a preponderance of the evidence indicates the individual has committed an act or
129.27 acts that meet the definition of any of the crimes listed in section 245C.15, regardless of
129.28 whether the preponderance of the evidence is for a felony, gross misdemeanor, or
129.29 misdemeanor level crime; or

129.30 (3) an investigation results in an administrative determination listed under section
129.31 245C.15, subdivision 4, paragraph (b).

130.1 (b) No individual who is disqualified following a background study under section
130.2 245C.03, subdivisions 1 and 2, may be retained in a position involving direct contact with
130.3 persons served by a program or entity identified in section 245C.03, unless the commissioner
130.4 has provided written notice under section 245C.17 stating that:

130.5 (1) the individual may remain in direct contact during the period in which the individual
130.6 may request reconsideration as provided in section 245C.21, subdivision 2;

130.7 (2) the commissioner has set aside the individual's disqualification for that program or
130.8 entity identified in section 245C.03, as provided in section 245C.22, subdivision 4; or

130.9 (3) the license holder has been granted a variance for the disqualified individual under
130.10 section 245C.30.

130.11 (c) Notwithstanding paragraph (a), for the purposes of a background study affiliated
130.12 with a licensed family foster setting, the commissioner shall disqualify an individual who
130.13 is the subject of a background study from any position allowing direct contact with persons
130.14 receiving services from the license holder or entity identified in section 245C.03, upon
130.15 receipt of information showing or when a background study completed under this chapter
130.16 shows reason for disqualification under section 245C.15, subdivision 4a.

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

130.18 Sec. 37. Minnesota Statutes 2020, section 245C.14, is amended by adding a subdivision
130.19 to read:

130.20 Subd. 4. **Disqualification from working in licensed child care centers or certified**
130.21 **license-exempt child care centers.** (a) For a background study affiliated with a licensed
130.22 child care center or certified license-exempt child care center, if an individual is disqualified
130.23 from direct contact under subdivision 1, the commissioner must also disqualify the individual
130.24 from working in any position regardless of whether the individual would have direct contact
130.25 with or access to children served in the licensed child care center or certified license-exempt
130.26 child care center and from having access to a person receiving services from the center.

130.27 (b) Notwithstanding any other requirement of this chapter, for a background study
130.28 affiliated with a licensed child care center or a certified license-exempt child care center, if
130.29 an individual is disqualified, the individual may not work in the child care center until the
130.30 commissioner has issued a notice stating that:

130.31 (1) the individual is not disqualified;

130.32 (2) a disqualification has been set aside under section 245C.23; or

131.1 (3) a variance has been granted related to the individual under section 245C.30.

131.2 Sec. 38. Minnesota Statutes 2020, section 245C.15, is amended by adding a subdivision
131.3 to read:

131.4 Subd. 4a. **Licensed family foster setting disqualifications.** (a) Notwithstanding
131.5 subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting,
131.6 regardless of how much time has passed, an individual is disqualified under section 245C.14
131.7 if the individual committed an act that resulted in a felony-level conviction for sections:
131.8 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder
131.9 in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in
131.10 the second degree); 609.2112 (criminal vehicular homicide); 609.221 (assault in the first
131.11 degree); 609.223, subdivision 2 (assault in the third degree, past pattern of child abuse);
131.12 609.223, subdivision 3 (assault in the third degree, victim under four); a felony offense
131.13 under sections 609.2242 and 609.2243 (domestic assault, spousal abuse, child abuse or
131.14 neglect, or a crime against children); 609.2247 (domestic assault by strangulation); 609.2325
131.15 (criminal abuse of a vulnerable adult resulting in the death of a vulnerable adult); 609.245
131.16 (aggravated robbery); 609.25 (kidnapping); 609.255 (false imprisonment); 609.2661 (murder
131.17 of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second
131.18 degree); 609.2663 (murder of an unborn child in the third degree); 609.2664 (manslaughter
131.19 of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the
131.20 second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault
131.21 of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the
131.22 commission of a crime); 609.322, subdivision 1 (solicitation, inducement, and promotion
131.23 of prostitution; sex trafficking in the first degree); 609.324, subdivision 1 (other prohibited
131.24 acts; engaging in, hiring, or agreeing to hire minor to engage in prostitution); 609.342
131.25 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second
131.26 degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual
131.27 conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree);
131.28 609.3453 (criminal sexual predatory conduct); 609.352 (solicitation of children to engage
131.29 in sexual conduct); 609.377 (malicious punishment of a child); 609.378 (neglect or
131.30 endangerment of a child); 609.561 (arson in the first degree); 609.582, subdivision 1 (burglary
131.31 in the first degree); 609.746 (interference with privacy); 617.23 (indecent exposure); 617.246
131.32 (use of minors in sexual performance prohibited); or 617.247 (possession of pictorial
131.33 representations of minors).

132.1 (b) Notwithstanding subdivisions 1 to 4, for the purposes of a background study affiliated
132.2 with a licensed family foster setting, an individual is disqualified under section 245C.14,
132.3 regardless of how much time has passed, if the individual:

132.4 (1) committed an action under paragraph (d) that resulted in death or involved sexual
132.5 abuse, as defined in section 260E.03, subdivision 20;

132.6 (2) committed an act that resulted in a gross misdemeanor-level conviction for section
132.7 609.3451 (criminal sexual conduct in the fifth degree);

132.8 (3) committed an act against or involving a minor that resulted in a felony-level conviction
132.9 for: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the
132.10 third degree); 609.2231 (assault in the fourth degree); or 609.224 (assault in the fifth degree);
132.11 or

132.12 (4) committed an act that resulted in a misdemeanor or gross misdemeanor-level
132.13 conviction for section 617.293 (dissemination and display of harmful materials to minors).

132.14 (c) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed
132.15 family foster setting, an individual is disqualified under section 245C.14 if less than 20
132.16 years have passed since the termination of the individual's parental rights under section
132.17 260C.301, subdivision 1, paragraph (b), or if the individual consented to a termination of
132.18 parental rights under section 260C.301, subdivision 1, paragraph (a), to settle a petition to
132.19 involuntarily terminate parental rights. An individual is disqualified under section 245C.14
132.20 if less than 20 years have passed since the termination of the individual's parental rights in
132.21 any other state or country, where the conditions for the individual's termination of parental
132.22 rights are substantially similar to the conditions in section 260C.301, subdivision 1, paragraph
132.23 (b).

132.24 (d) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed
132.25 family foster setting, an individual is disqualified under section 245C.14 if less than five
132.26 years have passed since a felony-level violation for sections: 152.021 (controlled substance
132.27 crime in the first degree); 152.022 (controlled substance crime in the second degree); 152.023
132.28 (controlled substance crime in the third degree); 152.024 (controlled substance crime in the
132.29 fourth degree); 152.025 (controlled substance crime in the fifth degree); 152.0261 (importing
132.30 controlled substances across state borders); 152.0262, subdivision 1, paragraph (b)
132.31 (possession of substance with intent to manufacture methamphetamine); 152.027, subdivision
132.32 6, paragraph (c) (sale or possession of synthetic cannabinoids); 152.096 (conspiracies
132.33 prohibited); 152.097 (simulated controlled substances); 152.136 (anhydrous ammonia;
132.34 prohibited conduct; criminal penalties; civil liabilities); 152.137 (methamphetamine-related

133.1 crimes involving children or vulnerable adults); 169A.24 (felony first-degree driving while
133.2 impaired); 243.166 (violation of predatory offender registration requirements); 609.2113
133.3 (criminal vehicular operation; bodily harm); 609.2114 (criminal vehicular operation; unborn
133.4 child); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal
133.5 abuse of a vulnerable adult not resulting in the death of a vulnerable adult); 609.233 (criminal
133.6 neglect); 609.235 (use of drugs to injure or facilitate a crime); 609.24 (simple robbery);
133.7 609.322, subdivision 1a (solicitation, inducement, and promotion of prostitution; sex
133.8 trafficking in the second degree); 609.498, subdivision 1 (tampering with a witness in the
133.9 first degree); 609.498, subdivision 1b (aggravated first-degree witness tampering); 609.562
133.10 (arson in the second degree); 609.563 (arson in the third degree); 609.582, subdivision 2
133.11 (burglary in the second degree); 609.66 (felony dangerous weapons); 609.687 (adulteration);
133.12 609.713 (terroristic threats); 609.749, subdivision 3, 4, or 5 (felony-level harassment or
133.13 stalking); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); or
133.14 624.713 (certain people not to possess firearms).

133.15 (e) Notwithstanding subdivisions 1 to 4, except as provided in paragraph (a), for a
133.16 background study affiliated with a licensed family child foster care license, an individual
133.17 is disqualified under section 245C.14 if less than five years have passed since:

133.18 (1) a felony-level violation for an act not against or involving a minor that constitutes:
133.19 section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third
133.20 degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the
133.21 fifth degree);

133.22 (2) a violation of an order for protection under section 518B.01, subdivision 14;

133.23 (3) a determination or disposition of the individual's failure to make required reports
133.24 under section 260E.06 or 626.557, subdivision 3, for incidents in which the final disposition
133.25 under chapter 260E or section 626.557 was substantiated maltreatment and the maltreatment
133.26 was recurring or serious;

133.27 (4) a determination or disposition of the individual's substantiated serious or recurring
133.28 maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or
133.29 serious or recurring maltreatment in any other state, the elements of which are substantially
133.30 similar to the elements of maltreatment under chapter 260E or section 626.557 and meet
133.31 the definition of serious maltreatment or recurring maltreatment;

133.32 (5) a gross misdemeanor-level violation for sections: 609.224, subdivision 2 (assault in
133.33 the fifth degree); 609.2242 and 609.2243 (domestic assault); 609.233 (criminal neglect);

134.1 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child);
134.2 609.746 (interference with privacy); 609.749 (stalking); or 617.23 (indecent exposure); or

134.3 (6) committing an act against or involving a minor that resulted in a misdemeanor-level
134.4 violation of section 609.224, subdivision 1 (assault in the fifth degree).

134.5 (f) For purposes of this subdivision, the disqualification begins from:

134.6 (1) the date of the alleged violation, if the individual was not convicted;

134.7 (2) the date of conviction, if the individual was convicted of the violation but not
134.8 committed to the custody of the commissioner of corrections; or

134.9 (3) the date of release from prison, if the individual was convicted of the violation and
134.10 committed to the custody of the commissioner of corrections.

134.11 Notwithstanding clause (3), if the individual is subsequently reincarcerated for a violation
134.12 of the individual's supervised release, the disqualification begins from the date of release
134.13 from the subsequent incarceration.

134.14 (g) An individual's aiding and abetting, attempt, or conspiracy to commit any of the
134.15 offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota
134.16 Statutes, permanently disqualifies the individual under section 245C.14. An individual is
134.17 disqualified under section 245C.14 if less than five years have passed since the individual's
134.18 aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs
134.19 (d) and (e).

134.20 (h) An individual's offense in any other state or country, where the elements of the
134.21 offense are substantially similar to any of the offenses listed in paragraphs (a) and (b),
134.22 permanently disqualifies the individual under section 245C.14. An individual is disqualified
134.23 under section 245C.14 if less than five years has passed since an offense in any other state
134.24 or country, the elements of which are substantially similar to the elements of any offense
134.25 listed in paragraphs (d) and (e).

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

134.27 Sec. 39. Minnesota Statutes 2020, section 245C.16, subdivision 1, is amended to read:

134.28 Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines
134.29 that the individual studied has a disqualifying characteristic, the commissioner shall review
134.30 the information immediately available and make a determination as to the subject's immediate
134.31 risk of harm to persons served by the program where the individual studied will have direct
134.32 contact with, or access to, people receiving services.

135.1 (b) The commissioner shall consider all relevant information available, including the
135.2 following factors in determining the immediate risk of harm:

135.3 (1) the recency of the disqualifying characteristic;

135.4 (2) the recency of discharge from probation for the crimes;

135.5 (3) the number of disqualifying characteristics;

135.6 (4) the intrusiveness or violence of the disqualifying characteristic;

135.7 (5) the vulnerability of the victim involved in the disqualifying characteristic;

135.8 (6) the similarity of the victim to the persons served by the program where the individual
135.9 studied will have direct contact;

135.10 (7) whether the individual has a disqualification from a previous background study that
135.11 has not been set aside; ~~and~~

135.12 (8) if the individual has a disqualification which may not be set aside because it is a
135.13 permanent bar under section 245C.24, subdivision 1, or the individual is a child care
135.14 background study subject who has a felony-level conviction for a drug-related offense in
135.15 the last five years, the commissioner may order the immediate removal of the individual
135.16 from any position allowing direct contact with, or access to, persons receiving services from
135.17 the program and from working in a children's residential facility or foster residence setting~~.~~;
135.18 and

135.19 (9) if the individual has a disqualification which may not be set aside because it is a
135.20 permanent bar under section 245C.24, subdivision 2, or the individual is a child care
135.21 background study subject who has a felony-level conviction for a drug-related offense during
135.22 the last five years, the commissioner may order the immediate removal of the individual
135.23 from any position allowing direct contact with or access to persons receiving services from
135.24 the center and from working in a licensed child care center or certified license-exempt child
135.25 care center.

135.26 (c) This section does not apply when the subject of a background study is regulated by
135.27 a health-related licensing board as defined in chapter 214, and the subject is determined to
135.28 be responsible for substantiated maltreatment under section 626.557 or chapter 260E.

135.29 (d) This section does not apply to a background study related to an initial application
135.30 for a child foster family setting license.

135.31 (e) Except for paragraph (f), this section does not apply to a background study that is
135.32 also subject to the requirements under section 256B.0659, subdivisions 11 and 13, for a

136.1 personal care assistant or a qualified professional as defined in section 256B.0659,
136.2 subdivision 1.

136.3 (f) If the commissioner has reason to believe, based on arrest information or an active
136.4 maltreatment investigation, that an individual poses an imminent risk of harm to persons
136.5 receiving services, the commissioner may order that the person be continuously supervised
136.6 or immediately removed pending the conclusion of the maltreatment investigation or criminal
136.7 proceedings.

136.8 Sec. 40. Minnesota Statutes 2020, section 245C.16, subdivision 2, is amended to read:

136.9 Subd. 2. **Findings.** (a) After evaluating the information immediately available under
136.10 subdivision 1, the commissioner may have reason to believe one of the following:

136.11 (1) the individual poses an imminent risk of harm to persons served by the program
136.12 where the individual studied will have direct contact or access to persons served by the
136.13 program or where the individual studied will work;

136.14 (2) the individual poses a risk of harm requiring continuous, direct supervision while
136.15 providing direct contact services during the period in which the subject may request a
136.16 reconsideration; or

136.17 (3) the individual does not pose an imminent risk of harm or a risk of harm requiring
136.18 continuous, direct supervision while providing direct contact services during the period in
136.19 which the subject may request a reconsideration.

136.20 (b) After determining an individual's risk of harm under this section, the commissioner
136.21 must notify the subject of the background study and the applicant or license holder as
136.22 required under section 245C.17.

136.23 (c) For Title IV-E eligible children's residential facilities and foster residence settings,
136.24 the commissioner is prohibited from making the findings in paragraph (a), clause (2) or (3).

136.25 (d) For licensed child care centers or certified license-exempt child care centers, the
136.26 commissioner is prohibited from making the findings in paragraph (a), clause (2) or (3).

136.27 Sec. 41. Minnesota Statutes 2020, section 245C.17, subdivision 1, is amended to read:

136.28 Subdivision 1. **Time frame for notice of study results and auditing system access.** (a)
136.29 Within three working days after the commissioner's receipt of a request for a background
136.30 study submitted through the commissioner's NETStudy or NETStudy 2.0 system, the
136.31 commissioner shall notify the background study subject and the license holder or other

137.1 entity as provided in this chapter in writing or by electronic transmission of the results of
137.2 the study or that more time is needed to complete the study. The notice to the individual
137.3 shall include the identity of the entity that initiated the background study.

137.4 (b) Before being provided access to NETStudy 2.0, the license holder or other entity
137.5 under section 245C.04 shall sign an acknowledgment of responsibilities form developed
137.6 by the commissioner that includes identifying the sensitive background study information
137.7 person, who must be an employee of the license holder or entity. All queries to NETStudy
137.8 2.0 are electronically recorded and subject to audit by the commissioner. The electronic
137.9 record shall identify the specific user. A background study subject may request in writing
137.10 to the commissioner a report listing the entities that initiated a background study on the
137.11 individual.

137.12 (c) When the commissioner has completed a prior background study on an individual
137.13 that resulted in an order for immediate removal and more time is necessary to complete a
137.14 subsequent study, the notice that more time is needed that is issued under paragraph (a)
137.15 shall include an order for immediate removal of the individual from any position allowing
137.16 direct contact with or access to people receiving services and from working in a children's
137.17 residential facility ~~or~~, foster residence setting, child care center, or certified license-exempt
137.18 child care center pending completion of the background study.

137.19 Sec. 42. Minnesota Statutes 2020, section 245C.17, is amended by adding a subdivision
137.20 to read:

137.21 Subd. 8. **Disqualification notice to child care centers and certified license-exempt**
137.22 **child care centers.** (a) For child care centers and certified license-exempt child care centers,
137.23 all notices under this section that order the license holder to immediately remove the
137.24 individual studied from any position allowing direct contact with, or access to a person
137.25 served by the center, must also order the license holder to immediately remove the individual
137.26 studied from working in any position regardless of whether the individual would have direct
137.27 contact with or access to children served in the center.

137.28 (b) For child care centers and certified license-exempt child care centers, notices under
137.29 this section must not allow an individual to work in the center.

138.1 Sec. 43. Minnesota Statutes 2020, section 245C.18, is amended to read:

138.2 **245C.18 OBLIGATION TO REMOVE DISQUALIFIED INDIVIDUAL FROM**
138.3 **DIRECT CONTACT AND FROM WORKING IN A PROGRAM, FACILITY, ~~OR~~**
138.4 **SETTING, OR CENTER.**

138.5 (a) Upon receipt of notice from the commissioner, the license holder must remove a
138.6 disqualified individual from direct contact with persons served by the licensed program if:

138.7 (1) the individual does not request reconsideration under section 245C.21 within the
138.8 prescribed time;

138.9 (2) the individual submits a timely request for reconsideration, the commissioner does
138.10 not set aside the disqualification under section 245C.22, subdivision 4, and the individual
138.11 does not submit a timely request for a hearing under sections 245C.27 and 256.045, or
138.12 245C.28 and chapter 14; or

138.13 (3) the individual submits a timely request for a hearing under sections 245C.27 and
138.14 256.045, or 245C.28 and chapter 14, and the commissioner does not set aside or rescind the
138.15 disqualification under section 245A.08, subdivision 5, or 256.045.

138.16 (b) For children's residential facility and foster residence setting license holders, upon
138.17 receipt of notice from the commissioner under paragraph (a), the license holder must also
138.18 remove the disqualified individual from working in the program, facility, or setting and
138.19 from access to persons served by the licensed program.

138.20 (c) For Title IV-E eligible children's residential facility and foster residence setting
138.21 license holders, upon receipt of notice from the commissioner under paragraph (a), the
138.22 license holder must also remove the disqualified individual from working in the program
138.23 and from access to persons served by the program and must not allow the individual to work
138.24 in the facility or setting until the commissioner has issued a notice stating that:

138.25 (1) the individual is not disqualified;

138.26 (2) a disqualification has been set aside under section 245C.23; or

138.27 (3) a variance has been granted related to the individual under section 245C.30.

138.28 (d) For licensed child care center and certified license-exempt child care center license
138.29 holders, upon receipt of notice from the commissioner under paragraph (a), the license
138.30 holder must remove the disqualified individual from working in any position regardless of
138.31 whether the individual would have direct contact with or access to children served in the

139.1 center and from having access to persons served by the center and must not allow the
139.2 individual to work in the center until the commissioner has issued a notice stating that:

139.3 (1) the individual is not disqualified;

139.4 (2) a disqualification has been set aside under section 245C.23; or

139.5 (3) a variance has been granted related to the individual under section 245C.30.

139.6 Sec. 44. Minnesota Statutes 2020, section 245C.24, subdivision 2, is amended to read:

139.7 Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in
139.8 paragraphs (b) to ~~(e)~~ (f), the commissioner may not set aside the disqualification of any
139.9 individual disqualified pursuant to this chapter, regardless of how much time has passed,
139.10 if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision
139.11 1.

139.12 (b) For an individual in the chemical dependency or corrections field who was disqualified
139.13 for a crime or conduct listed under section 245C.15, subdivision 1, and whose disqualification
139.14 was set aside prior to July 1, 2005, the commissioner must consider granting a variance
139.15 pursuant to section 245C.30 for the license holder for a program dealing primarily with
139.16 adults. A request for reconsideration evaluated under this paragraph must include a letter
139.17 of recommendation from the license holder that was subject to the prior set-aside decision
139.18 addressing the individual's quality of care to children or vulnerable adults and the
139.19 circumstances of the individual's departure from that service.

139.20 (c) If an individual who requires a background study for nonemergency medical
139.21 transportation services under section 245C.03, subdivision 12, was disqualified for a crime
139.22 or conduct listed under section 245C.15, subdivision 1, and if more than 40 years have
139.23 passed since the discharge of the sentence imposed, the commissioner may consider granting
139.24 a set-aside pursuant to section 245C.22. A request for reconsideration evaluated under this
139.25 paragraph must include a letter of recommendation from the employer. This paragraph does
139.26 not apply to a person disqualified based on a violation of sections 243.166; 609.185 to
139.27 609.205; 609.25; 609.342 to 609.3453; 609.352; 617.23, subdivision 2, clause (1), or 3,
139.28 clause (1); 617.246; or 617.247.

139.29 (d) When a licensed foster care provider adopts an individual who had received foster
139.30 care services from the provider for over six months, and the adopted individual is required
139.31 to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause
139.32 (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30
139.33 to permit the adopted individual with a permanent disqualification to remain affiliated with

140.1 the license holder under the conditions of the variance when the variance is recommended
140.2 by the county of responsibility for each of the remaining individuals in placement in the
140.3 home and the licensing agency for the home.

140.4 <u>(e) For an individual 18 years of age or older affiliated with a licensed family foster</u>
140.5 <u>setting, the commissioner must not set aside or grant a variance for the disqualification of</u>
140.6 <u>any individual disqualified pursuant to this chapter, regardless of how much time has passed,</u>
140.7 <u>if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision</u>
140.8 <u>4a, paragraphs (a) and (b).</u>

140.9 <u>(f) In connection with a family foster setting license, the commissioner may grant a</u>
140.10 <u>variance to the disqualification for an individual who is under 18 years of age at the time</u>
140.11 <u>the background study is submitted.</u>

140.12 <u>**EFFECTIVE DATE.** This section is effective July 1, 2022.</u>

140.13 Sec. 45. Minnesota Statutes 2020, section 245C.24, subdivision 3, is amended to read:

140.14 Subd. 3. **Ten-year bar to set aside disqualification.** (a) The commissioner may not set
140.15 aside the disqualification of an individual in connection with a license to provide family
140.16 child care for children~~, foster care for children in the provider's home,~~ or foster care or day
140.17 care services for adults in the provider's home if: (1) less than ten years has passed since
140.18 the discharge of the sentence imposed, if any, for the offense; or (2) when disqualified based
140.19 on a preponderance of evidence determination under section 245C.14, subdivision 1,
140.20 paragraph (a), clause (2), or an admission under section 245C.14, subdivision 1, paragraph
140.21 (a), clause (1), and less than ten years has passed since the individual committed the act or
140.22 admitted to committing the act, whichever is later; and (3) the individual has committed a
140.23 violation of any of the following offenses: sections 609.165 (felon ineligible to possess
140.24 firearm); criminal vehicular homicide or criminal vehicular operation causing death under
140.25 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (aiding
140.26 suicide or aiding attempted suicide); felony violations under 609.223 or 609.2231 (assault
140.27 in the third or fourth degree); 609.229 (crimes committed for benefit of a gang); 609.713
140.28 (terroristic threats); 609.235 (use of drugs to injure or to facilitate crime); 609.24 (simple
140.29 robbery); 609.255 (false imprisonment); 609.562 (arson in the second degree); 609.71 (riot);
140.30 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a
140.31 witness); burglary in the first or second degree under 609.582 (burglary); 609.66 (dangerous
140.32 weapon); 609.665 (spring guns); 609.67 (machine guns and short-barreled shotguns);
140.33 609.749, subdivision 2 (gross misdemeanor harassment); 152.021 or 152.022 (controlled
140.34 substance crime in the first or second degree); 152.023, subdivision 1, clause (3) or (4) or

141.1 subdivision 2, clause (4) (controlled substance crime in the third degree); 152.024,
141.2 subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree);
141.3 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable
141.4 adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or
141.5 patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a
141.6 vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure
141.7 to report); 609.265 (abduction); 609.2664 to 609.2665 (manslaughter of an unborn child in
141.8 the first or second degree); 609.267 to 609.2672 (assault of an unborn child in the first,
141.9 second, or third degree); 609.268 (injury or death of an unborn child in the commission of
141.10 a crime); repeat offenses under 617.23 (indecent exposure); 617.293 (disseminating or
141.11 displaying harmful material to minors); a felony-level conviction involving alcohol or drug
141.12 use, a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts); a
141.13 gross misdemeanor offense under 609.378 (neglect or endangerment of a child); a gross
141.14 misdemeanor offense under 609.377 (malicious punishment of a child); 609.72, subdivision
141.15 3 (disorderly conduct against a vulnerable adult); or 624.713 (certain persons not to possess
141.16 firearms); or Minnesota Statutes 2012, section 609.21.

141.17 (b) The commissioner may not set aside the disqualification of an individual if less than
141.18 ten years have passed since the individual's aiding and abetting, attempt, or conspiracy to
141.19 commit any of the offenses listed in paragraph (a) as each of these offenses is defined in
141.20 Minnesota Statutes.

141.21 (c) The commissioner may not set aside the disqualification of an individual if less than
141.22 ten years have passed since the discharge of the sentence imposed for an offense in any
141.23 other state or country, the elements of which are substantially similar to the elements of any
141.24 of the offenses listed in paragraph (a).

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

141.26 Sec. 46. Minnesota Statutes 2020, section 245C.24, subdivision 4, is amended to read:

141.27 Subd. 4. **Seven-year bar to set aside disqualification.** The commissioner may not set
141.28 aside the disqualification of an individual in connection with a license to provide family
141.29 child care for children~~, foster care for children in the provider's home,~~ or foster care or day
141.30 care services for adults in the provider's home if within seven years preceding the study:

141.31 (1) the individual committed an act that constitutes maltreatment of a child under sections
141.32 260E.24, subdivisions 1, 2, and 3, and 260E.30, subdivisions 1, 2, and 4, and the maltreatment
141.33 resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial

142.1 mental or emotional harm as supported by competent psychological or psychiatric evidence;
142.2 or

142.3 (2) the individual was determined under section 626.557 to be the perpetrator of a
142.4 substantiated incident of maltreatment of a vulnerable adult that resulted in substantial
142.5 bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional
142.6 harm as supported by competent psychological or psychiatric evidence.

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

142.8 Sec. 47. Minnesota Statutes 2020, section 245C.24, is amended by adding a subdivision
142.9 to read:

142.10 Subd. 6. **Five-year bar to set aside disqualification; family foster setting.** (a) The
142.11 commissioner shall not set aside or grant a variance for the disqualification of an individual
142.12 18 years of age or older in connection with a foster family setting license if within five years
142.13 preceding the study the individual is convicted of a felony in section 245C.15, subdivision
142.14 4a, paragraph (d).

142.15 (b) In connection with a foster family setting license, the commissioner may set aside
142.16 or grant a variance to the disqualification for an individual who is under 18 years of age at
142.17 the time the background study is submitted.

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

142.19 Sec. 48. Minnesota Statutes 2020, section 245C.32, subdivision 1a, is amended to read:

142.20 Subd. 1a. **NETStudy 2.0 system.** (a) The commissioner shall design, develop, and test
142.21 the NETStudy 2.0 system and implement it no later than September 1, 2015.

142.22 (b) The NETStudy 2.0 system developed and implemented by the commissioner shall
142.23 incorporate and meet all applicable data security standards and policies required by the
142.24 Federal Bureau of Investigation (FBI), Department of Public Safety, Bureau of Criminal
142.25 Apprehension, and the Office of MN.IT Services. The system shall meet all required
142.26 standards for encryption of data at the database level as well as encryption of data that
142.27 travels electronically among agencies initiating background studies, the commissioner's
142.28 authorized fingerprint collection vendor or vendors, the commissioner, the Bureau of Criminal
142.29 Apprehension, and in cases involving national criminal record checks, the FBI.

142.30 (c) The data system developed and implemented by the commissioner shall incorporate
142.31 a system of data security that allows the commissioner to control access to the data field
142.32 level by the commissioner's employees. The commissioner shall establish that employees

143.1 have access to the minimum amount of private data on any individual as is necessary to
143.2 perform their duties under this chapter.

143.3 (d) The commissioner shall oversee regular quality and compliance audits of the
143.4 authorized fingerprint collection vendor or vendors.

143.5 Sec. 49. Minnesota Statutes 2020, section 245F.04, subdivision 2, is amended to read:

143.6 Subd. 2. **Contents of application.** Prior to the issuance of a license, an applicant must
143.7 submit, on forms provided by the commissioner, documentation demonstrating the following:

143.8 (1) compliance with this section;

143.9 (2) compliance with applicable building, fire, and safety codes; health rules; zoning
143.10 ordinances; and other applicable rules and regulations or documentation that a waiver has
143.11 been granted. The granting of a waiver does not constitute modification of any requirement
143.12 of this section; and

143.13 ~~(3) completion of an assessment of need for a new or expanded program as required by~~
143.14 ~~Minnesota Rules, part 9530.6800; and~~

143.15 ~~(4)~~ (3) insurance coverage, including bonding, sufficient to cover all patient funds,
143.16 property, and interests.

143.17 Sec. 50. Minnesota Statutes 2020, section 245G.03, subdivision 2, is amended to read:

143.18 Subd. 2. **Application.** (a) Before the commissioner issues a license, an applicant must
143.19 submit, on forms provided by the commissioner, any documents the commissioner requires.

143.20 (b) At least 60 days prior to submitting an application for licensure under this chapter,
143.21 the applicant must notify the county human services director in writing of the applicant's
143.22 intent to open a new treatment program. The written notification must include, at a minimum:

143.23 (1) a description of the proposed treatment program;

143.24 (2) a description of the target population to be served by the treatment program; and

143.25 (3) a copy of the program's abuse prevention plan, as required under section 245A.65,
143.26 subdivision 2.

143.27 (c) The county human services director may submit a written statement to the
143.28 commissioner regarding the county's support of or opposition to the opening of the new
143.29 treatment program. The written statement must include documentation of the rationale for
143.30 the county's determination. The commissioner shall consider the county's written statement

144.1 when determining whether to issue a license for the treatment program. If the county does
144.2 not submit a written statement, the commissioner shall confirm with the county that the
144.3 county received the notification required by paragraph (b).

144.4 Sec. 51. Minnesota Statutes 2020, section 256B.0949, is amended by adding a subdivision
144.5 to read:

144.6 Subd. 16a. **Background studies.** The requirements for background studies under this
144.7 section shall be met by an early intensive developmental and behavioral intervention services
144.8 agency through the commissioner's NETStudy system as provided under sections 245C.03,
144.9 subdivision 15, and 245C.10, subdivision 17.

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

144.11 Sec. 52. Minnesota Statutes 2020, section 260C.215, subdivision 4, is amended to read:

144.12 Subd. 4. **Duties of commissioner.** The commissioner of human services shall:

144.13 (1) provide practice guidance to responsible social services agencies and licensed
144.14 child-placing agencies that reflect federal and state laws and policy direction on placement
144.15 of children;

144.16 (2) develop criteria for determining whether a prospective adoptive or foster family has
144.17 the ability to understand and validate the child's cultural background;

144.18 (3) provide a standardized training curriculum for adoption and foster care workers and
144.19 administrators who work with children. Training must address the following objectives:

144.20 (i) developing and maintaining sensitivity to all cultures;

144.21 (ii) assessing values and their cultural implications;

144.22 (iii) making individualized placement decisions that advance the best interests of a
144.23 particular child under section 260C.212, subdivision 2; and

144.24 (iv) issues related to cross-cultural placement;

144.25 (4) provide a training curriculum for all prospective adoptive and foster families that
144.26 prepares them to care for the needs of adoptive and foster children taking into consideration
144.27 the needs of children outlined in section 260C.212, subdivision 2, paragraph (b), and, as
144.28 necessary, preparation is continued after placement of the child and includes the knowledge
144.29 and skills related to reasonable and prudent parenting standards for the participation of the
144.30 child in age or developmentally appropriate activities, according to section 260C.212,
144.31 subdivision 14;

145.1 (5) develop and provide to responsible social services agencies and licensed child-placing
145.2 agencies a home study format to assess the capacities and needs of prospective adoptive
145.3 and foster families. The format must address problem-solving skills; parenting skills; evaluate
145.4 the degree to which the prospective family has the ability to understand and validate the
145.5 child's cultural background, and other issues needed to provide sufficient information for
145.6 agencies to make an individualized placement decision consistent with section 260C.212,
145.7 subdivision 2. For a study of a prospective foster parent, the format must also address the
145.8 capacity of the prospective foster parent to provide a safe, healthy, smoke-free home
145.9 environment. If a prospective adoptive parent has also been a foster parent, any update
145.10 necessary to a home study for the purpose of adoption may be completed by the licensing
145.11 authority responsible for the foster parent's license. If a prospective adoptive parent with
145.12 an approved adoptive home study also applies for a foster care license, the license application
145.13 may be made with the same agency which provided the adoptive home study; ~~and~~

145.14 (6) consult with representatives reflecting diverse populations from the councils
145.15 established under sections 3.922 and 15.0145, and other state, local, and community
145.16 organizations~~.~~; and

145.17 (7) establish family foster setting licensing guidelines for county agencies and private
145.18 agencies designated or licensed by the commissioner to perform licensing functions and
145.19 activities under section 245A.04. Guidelines that the commissioner establishes under this
145.20 clause shall be considered directives of the commissioner under section 245A.16.

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

145.22 Sec. 53. Laws 2020, First Special Session chapter 7, section 1, as amended by Laws 2020,
145.23 Third Special Session chapter 1, section 3, is amended by adding a subdivision to read:

145.24 Subd. 5. **Waivers and modifications; extension for 180 days.** When the peacetime
145.25 emergency declared by the governor in response to the COVID-19 outbreak expires, is
145.26 terminated, or is rescinded by the proper authority, waiver CV23: modifying background
145.27 study requirements, issued by the commissioner of human services pursuant to Executive
145.28 Orders 20-11 and 20-12, including any amendments to the modification issued before the
145.29 peacetime emergency expires, shall remain in effect for 180 days after the peacetime
145.30 emergency ends.

145.31 **EFFECTIVE DATE.** This section is effective the day following final enactment or
145.32 retroactively from the date the peacetime emergency declared by the governor in response
145.33 to the COVID-19 outbreak ends, whichever is earlier.

146.1 Sec. 54. **CHILD CARE CENTER REGULATION MODERNIZATION.**

146.2 (a) The commissioner of human services shall contract with an experienced and
146.3 independent organization or individual consultant to conduct the work outlined in this
146.4 section. If practicable, the commissioner must contract with the National Association for
146.5 Regulatory Administration.

146.6 (b) The consultant must develop a proposal for revised licensing standards that includes
146.7 a risk-based model for monitoring compliance with child care center licensing standards,
146.8 grounded in national regulatory best practices. Violations in the new model must be weighted
146.9 to reflect the potential risk that the violations pose to children's health and safety, and
146.10 licensing sanctions must be tied to the potential risk. The proposed new model must protect
146.11 the health and safety of children in child care centers and be child-centered, family-friendly,
146.12 and fair to providers.

146.13 (c) The consultant shall develop and implement a stakeholder engagement process that
146.14 solicits input from parents, licensed child care centers, staff of the Department of Human
146.15 Services, and experts in child development about appropriate licensing standards, appropriate
146.16 tiers for violations of the standards based on the potential risk of harm that each violation
146.17 poses, and appropriate licensing sanctions for each tier.

146.18 (d) The consultant shall solicit input from parents, licensed child care centers, and staff
146.19 of the Department of Human Services about which child care centers should be eligible for
146.20 abbreviated inspections that predict compliance with other licensing standards for licensed
146.21 child care centers using key indicators previously identified by an empirically based statistical
146.22 methodology developed by the National Association for Regulatory Administration and the
146.23 Research Institute for Key Indicators.

146.24 (e) No later than February 1, 2024, the commissioner shall submit a report and proposed
146.25 legislation required to implement the new licensing model to the chairs and ranking minority
146.26 members of the legislative committees with jurisdiction over child care regulation.

146.27 Sec. 55. **CHILD FOSTER CARE LICENSING GUIDELINES.**

146.28 By July 1, 2023, the commissioner of human services shall, in consultation with
146.29 stakeholders with expertise in child protection and children's behavioral health, develop
146.30 family foster setting licensing guidelines for county agencies and private agencies that
146.31 perform licensing functions. Stakeholders include but are not limited to child advocates,
146.32 representatives from community organizations, representatives of the state ethnic councils,
146.33 the ombudsperson for families, family foster setting providers, youth who have experienced

147.1 family foster setting placements, county child protection staff, and representatives of county
147.2 and private licensing agencies.

147.3 Sec. 56. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; FAMILY**
147.4 **CHILD CARE ONE-STOP ASSISTANCE NETWORK.**

147.5 By January 1, 2022, the commissioner of human services shall, in consultation with
147.6 county agencies, providers, and other relevant stakeholders, develop a proposal to create,
147.7 advertise, and implement a one-stop regional assistance network comprised of individuals
147.8 who have experience starting a licensed family or group family child care program or
147.9 technical expertise regarding the applicable licensing statutes and procedures, in order to
147.10 assist individuals with matters relating to starting or sustaining a licensed family or group
147.11 family child care program. The proposal shall include an estimated timeline for
147.12 implementation of the assistance network, an estimated budget of the cost of the assistance
147.13 network, and any necessary legislative proposals to implement the assistance network. The
147.14 proposal shall also include a plan to raise awareness and distribute contact information for
147.15 the assistance network to all licensed family or group family child care providers.

147.16 Sec. 57. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
147.17 **RECOMMENDED FAMILY CHILD CARE ORIENTATION TRAINING.**

147.18 (a) By July 1, 2022, the commissioner of human services shall develop, in consultation
147.19 with licensed family child care providers and representatives from counties, recommended
147.20 orientation training for family child care license applicants to ensure that all family child
147.21 care license applicants have access to information about Minnesota Statutes, chapters 245A
147.22 and 245C, and Minnesota Rules, chapter 9502.

147.23 (b) The orientation training is voluntary and completion of the orientation is not required
147.24 to receive or maintain a family child care license.

147.25 Sec. 58. **FAMILY CHILD CARE REGULATION MODERNIZATION.**

147.26 (a) The commissioner of human services shall contract with an experienced and
147.27 independent organization or individual consultant to conduct the work outlined in this
147.28 section. If practicable, the commissioner must contract with the National Association for
147.29 Regulatory Administration.

147.30 (b) The consultant must develop a proposal for updated family child care licensing
147.31 standards and solicit input from stakeholders as described in paragraph (d).

148.1 (c) The consultant must develop a proposal for a risk-based model for monitoring
148.2 compliance with family child care licensing standards, grounded in national regulatory best
148.3 practices. Violations in the new model must be weighted to reflect the potential risk they
148.4 pose to children's health and safety, and licensing sanctions must be tied to the potential
148.5 risk. The proposed new model must protect the health and safety of children in family child
148.6 care programs and be child-centered, family-friendly, and fair to providers.

148.7 (d) The consultant shall develop and implement a stakeholder engagement process that
148.8 solicits input from parents, licensed family child care providers, county licensors, staff of
148.9 the Department of Human Services, and experts in child development about licensing
148.10 standards, tiers for violations of the standards based on the potential risk of harm that each
148.11 violation poses, and licensing sanctions for each tier.

148.12 (e) The consultant shall solicit input from parents, licensed family child care providers,
148.13 county licensors, and staff of the Department of Human Services about which family child
148.14 care providers should be eligible for abbreviated inspections that predict compliance with
148.15 other licensing standards for licensed family child care providers using key indicators
148.16 previously identified by an empirically based statistical methodology developed by the
148.17 National Association for Regulatory Administration and the Research Institute for Key
148.18 Indicators.

148.19 (f) No later than February 1, 2024, the commissioner shall submit a report and proposed
148.20 legislation required to implement the new licensing model and the new licensing standards
148.21 to the chairs and ranking minority members of the legislative committees with jurisdiction
148.22 over child care regulation.

148.23 Sec. 59. **FAMILY CHILD CARE TRAINING ADVISORY COMMITTEE.**

148.24 Subdivision 1. **Formation; duties.** (a) The Family Child Care Training Advisory
148.25 Committee shall advise the commissioner of human services on the training requirements
148.26 for licensed family and group family child care providers. Beginning January 1, 2022, the
148.27 advisory committee shall meet at least twice per year. The advisory committee shall annually
148.28 elect a chair from among its members who shall establish the agenda for each meeting. The
148.29 commissioner or commissioner's designee shall attend all advisory committee meetings.

148.30 (b) The Family Child Care Training Advisory Committee shall advise and make
148.31 recommendations to the commissioner of human services and the contractors working on
148.32 the family child care licensing modernization project on:

149.1 (1) updates to the rules and statutes governing family child care training, including
149.2 technical updates to facilitate providers' understanding of training requirements;

149.3 (2) difficulties facing family child care providers in completing training requirements,
149.4 including proposed solutions to provider difficulties; and

149.5 (3) other ideas for improving access to and quality of training for family child care
149.6 providers.

149.7 (c) The Family Child Care Training Advisory Committee shall expire December 1, 2025.

149.8 Subd. 2. **Advisory committee members.** (a) The Family Child Care Training Advisory
149.9 Committee consists of:

149.10 (1) four members representing family child care providers from greater Minnesota,
149.11 including two appointed by the speaker of the house and two appointed by the senate majority
149.12 leader;

149.13 (2) two members representing family child care providers from the seven-county
149.14 metropolitan area as defined in Minnesota Statutes, section 473.121, subdivision 2, including
149.15 one appointed by the speaker of the house and one appointed by the senate majority leader;

149.16 (3) one member appointed by the Minnesota Association of Child Care Professionals;

149.17 (4) one member appointed by the Minnesota Child Care Provider Information Network;

149.18 (5) two members appointed by the Association of Minnesota Child Care Licensors,
149.19 including one from greater Minnesota and one from the seven-county metropolitan area, as
149.20 defined in Minnesota Statutes, section 473.121, subdivision 2; and

149.21 (6) five members with experience in child development, instructional design, and training
149.22 delivery, with:

149.23 (i) one member appointed by Child Care Aware of Minnesota;

149.24 (ii) one member appointed by the Minnesota Initiative Foundations;

149.25 (iii) one member appointed by the Center for Inclusive Child Care;

149.26 (iv) one member appointed by the Greater Minnesota Partnership; and

149.27 (v) one member appointed by Achieve, the Minnesota Center for Professional
149.28 Development.

149.29 (b) Advisory committee members shall not be employed by the Department of Human
149.30 Services. Advisory committee members shall receive no compensation for their participation
149.31 in the advisory committee.

150.1 (c) Advisory committee members must include representatives of diverse cultural
150.2 communities.

150.3 (d) Advisory committee members shall serve two-year terms. Initial appointments to
150.4 the advisory committee must be made by December 1, 2021. Subsequent appointments to
150.5 the advisory committee must be made by December 1 of the year in which the member's
150.6 term expires.

150.7 Subd. 3. **Commissioner report.** The commissioner of human services shall report
150.8 annually by November 1 to the chairs and ranking minority members of the legislative
150.9 committees with jurisdiction over early care and education programs on any recommendations
150.10 from the Family Child Care Training Advisory Committee.

150.11 Sec. 60. **REVISOR INSTRUCTION.**

150.12 The revisor of statutes shall renumber Minnesota Statutes, section 245C.02, so that the
150.13 subdivisions are alphabetical. The revisor shall correct any cross-references that arise as a
150.14 result of the renumbering.

150.15 Sec. 61. **REPEALER.**

150.16 (a) Minnesota Statutes 2020, section 245C.10, subdivisions 2, 2a, 3, 4, 5, 6, 7, 8, 9, 9a,
150.17 10, 11, 12, 13, 14, and 16, are repealed.

150.18 (b) Minnesota Rules, parts 9530.6800; and 9530.6810, are repealed.

150.19 **EFFECTIVE DATE.** Paragraph (b) is effective the day following final enactment.

150.20 **ARTICLE 3**
150.21 **HEALTH DEPARTMENT**

150.22 Section 1. Minnesota Statutes 2020, section 62J.495, subdivision 1, is amended to read:

150.23 Subdivision 1. **Implementation.** The commissioner of health, in consultation with the
150.24 e-Health Advisory Committee, shall develop uniform standards to be used for the
150.25 interoperable electronic health records system for sharing and synchronizing patient data
150.26 across systems. The standards must be compatible with federal efforts. The uniform standards
150.27 must be developed by January 1, 2009, and updated on an ongoing basis. ~~The commissioner~~
150.28 ~~shall include an update on standards development as part of an annual report to the legislature.~~
150.29 Individual health care providers in private practice with no other providers and health care
150.30 providers that do not accept reimbursement from a group purchaser, as defined in section
150.31 62J.03, subdivision 6, are excluded from the requirements of this section.

151.1 Sec. 2. Minnesota Statutes 2020, section 62J.495, subdivision 2, is amended to read:

151.2 Subd. 2. **E-Health Advisory Committee.** (a) The commissioner shall establish an
151.3 e-Health Advisory Committee governed by section 15.059 to advise the commissioner on
151.4 the following matters:

151.5 (1) assessment of the adoption and effective use of health information technology by
151.6 the state, licensed health care providers and facilities, and local public health agencies;

151.7 (2) recommendations for implementing a statewide interoperable health information
151.8 infrastructure, to include estimates of necessary resources, and for determining standards
151.9 for clinical data exchange, clinical support programs, patient privacy requirements, and
151.10 maintenance of the security and confidentiality of individual patient data;

151.11 (3) recommendations for encouraging use of innovative health care applications using
151.12 information technology and systems to improve patient care and reduce the cost of care,
151.13 including applications relating to disease management and personal health management
151.14 that enable remote monitoring of patients' conditions, especially those with chronic
151.15 conditions; and

151.16 (4) other related issues as requested by the commissioner.

151.17 (b) The members of the e-Health Advisory Committee shall include the commissioners,
151.18 or commissioners' designees, of health, human services, administration, and commerce and
151.19 additional members to be appointed by the commissioner to include persons representing
151.20 Minnesota's local public health agencies, licensed hospitals and other licensed facilities and
151.21 providers, private purchasers, the medical and nursing professions, health insurers and health
151.22 plans, the state quality improvement organization, academic and research institutions,
151.23 consumer advisory organizations with an interest and expertise in health information
151.24 technology, and other stakeholders as identified by the commissioner to fulfill the
151.25 requirements of section 3013, paragraph (g), of the HITECH Act.

151.26 (c) ~~The commissioner shall prepare and issue an annual report not later than January 30~~
151.27 ~~of each year outlining progress to date in implementing a statewide health information~~
151.28 ~~infrastructure and recommending action on policy and necessary resources to continue the~~
151.29 ~~promotion of adoption and effective use of health information technology.~~

151.30 ~~(d)~~ This subdivision expires June 30, ~~2021~~ 2031.

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

152.1 Sec. 3. Minnesota Statutes 2020, section 62J.495, subdivision 3, is amended to read:

152.2 Subd. 3. **Interoperable electronic health record requirements.** (a) Hospitals and health
152.3 care providers must meet the following criteria when implementing an interoperable
152.4 electronic health records system within their hospital system or clinical practice setting.

152.5 (b) The electronic health record must be a qualified electronic health record.

152.6 (c) The electronic health record must be certified by the Office of the National
152.7 Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health
152.8 care providers if a certified electronic health record product for the provider's particular
152.9 practice setting is available. This criterion shall be considered met if a hospital or health
152.10 care provider is using an electronic health records system that has been certified within the
152.11 last three years, even if a more current version of the system has been certified within the
152.12 three-year period.

152.13 (d) The electronic health record must meet the standards established according to section
152.14 3004 of the HITECH Act as applicable.

152.15 (e) The electronic health record must have the ability to generate information on clinical
152.16 quality measures and other measures reported under sections 4101, 4102, and 4201 of the
152.17 HITECH Act.

152.18 (f) The electronic health record system must be connected to a state-certified health
152.19 information organization either directly or through a connection facilitated by a ~~state-certified~~
152.20 health data intermediary as defined in section 62J.498.

152.21 (g) A health care provider who is a prescriber or dispenser of legend drugs must have
152.22 an electronic health record system that meets the requirements of section 62J.497.

152.23 Sec. 4. Minnesota Statutes 2020, section 62J.495, subdivision 4, is amended to read:

152.24 Subd. 4. **Coordination with national HIT activities.** (a) The commissioner, in
152.25 consultation with the e-Health Advisory Committee, shall update the statewide
152.26 implementation plan required under subdivision 2 and released June 2008, to be consistent
152.27 with the updated federal ~~HIT Strategic Plan released by the Office of the National Coordinator~~
152.28 ~~in accordance with section 3001 of the HITECH Act. The statewide plan shall meet the~~
152.29 ~~requirements for a plan required under section 3013 of the HITECH Act~~ plans.

152.30 (b) The commissioner, in consultation with the e-Health Advisory Committee, shall
152.31 work to ensure coordination between state, regional, and national efforts to support and
152.32 accelerate efforts to effectively use health information technology to improve the quality

and coordination of health care and the continuity of patient care among health care providers, to reduce medical errors, to improve population health, to reduce health disparities, and to reduce chronic disease. The commissioner's coordination efforts shall include but not be limited to:

~~(1) assisting in the development and support of health information technology regional extension centers established under section 3012(c) of the HITECH Act to provide technical assistance and disseminate best practices;~~

~~(2) providing supplemental information to the best practices gathered by regional centers to ensure that the information is relayed in a meaningful way to the Minnesota health care community;~~

~~(3)~~ (1) providing financial and technical support to Minnesota health care providers to encourage implementation of admission, discharge and transfer alerts, and care summary document exchange transactions and to evaluate the impact of health information technology on cost and quality of care. Communications about available financial and technical support shall include clear information about the interoperable health record requirements in subdivision 1, including a separate statement in bold-face type clarifying the exceptions to those requirements;

~~(4)~~ (2) providing educational resources and technical assistance to health care providers and patients related to state and national privacy, security, and consent laws governing clinical health information, including the requirements in sections 144.291 to 144.298. In carrying out these activities, the commissioner's technical assistance does not constitute legal advice;

~~(5)~~ (3) assessing Minnesota's legal, financial, and regulatory framework for health information exchange, including the requirements in sections 144.291 to 144.298, and making recommendations for modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable; and

~~(6)~~ (4) seeking public input on both patient impact and costs associated with requirements related to patient consent for release of health records for the purposes of treatment, payment, and health care operations, as required in section 144.293, subdivision 2. The commissioner shall provide a report to the legislature on the findings of this public input process no later than February 1, 2017.

(c) The commissioner, in consultation with the e-Health Advisory Committee, shall monitor national activity related to health information technology and shall coordinate

154.1 statewide input on policy development. The commissioner shall coordinate statewide
154.2 responses to proposed federal health information technology regulations in order to ensure
154.3 that the needs of the Minnesota health care community are adequately and efficiently
154.4 addressed in the proposed regulations. The commissioner's responses may include, but are
154.5 not limited to:

154.6 (1) reviewing and evaluating any standard, implementation specification, or certification
154.7 criteria proposed by the national HIT standards ~~committee~~ committees;

154.8 (2) reviewing and evaluating policy proposed by ~~the~~ national HIT policy ~~committee~~
154.9 committees relating to the implementation of a nationwide health information technology
154.10 infrastructure; and

154.11 (3) ~~monitoring and responding to activity related to the development of quality measures~~
154.12 ~~and other measures as required by section 4101 of the HITECH Act. Any response related~~
154.13 ~~to quality measures shall consider and address the quality efforts required under chapter~~
154.14 ~~62U; and~~

154.15 ~~(4)~~ monitoring and responding to national activity related to privacy, security, and data
154.16 stewardship of electronic health information and individually identifiable health information.

154.17 (d) To the extent that the state is either required or allowed to apply, or designate an
154.18 entity to apply for or carry out activities and programs ~~under section 3013 of the HITECH~~
154.19 ~~Act~~, the commissioner of health, in consultation with the e-Health Advisory Committee
154.20 and the commissioner of human services, shall be the lead applicant or sole designating
154.21 authority. The commissioner shall make such designations consistent with the goals and
154.22 objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

154.23 (e) The commissioner of human services shall apply for funding necessary to administer
154.24 the incentive payments to providers authorized under title IV of the American Recovery
154.25 and Reinvestment Act.

154.26 ~~(f) The commissioner shall include in the report to the legislature information on the~~
154.27 ~~activities of this subdivision and provide recommendations on any relevant policy changes~~
154.28 ~~that should be considered in Minnesota.~~

154.29 Sec. 5. Minnesota Statutes 2020, section 62J.497, subdivision 1, is amended to read:

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

155.1 ~~(b) "Backward compatible" means that the newer version of a data transmission standard~~
155.2 ~~would retain, at a minimum, the full functionality of the versions previously adopted, and~~
155.3 ~~would permit the successful completion of the applicable transactions with entities that~~
155.4 ~~continue to use the older versions.~~

155.5 ~~(c)~~ (b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision
155.6 30. Dispensing does not include the direct administering of a controlled substance to a
155.7 patient by a licensed health care professional.

155.8 ~~(d)~~ (c) "Dispenser" means a person authorized by law to dispense a controlled substance,
155.9 pursuant to a valid prescription.

155.10 ~~(e)~~ (d) "Electronic media" has the meaning given under Code of Federal Regulations,
155.11 title 45, part 160.103.

155.12 ~~(f)~~ (e) "E-prescribing" means the transmission using electronic media of prescription or
155.13 prescription-related information between a prescriber, dispenser, pharmacy benefit manager,
155.14 or group purchaser, either directly or through an intermediary, including an e-prescribing
155.15 network. E-prescribing includes, but is not limited to, two-way transmissions between the
155.16 point of care and the dispenser and two-way transmissions related to eligibility, formulary,
155.17 and medication history information.

155.18 ~~(g)~~ (f) "Electronic prescription drug program" means a program that provides for
155.19 e-prescribing.

155.20 ~~(h)~~ (g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

155.21 ~~(i)~~ (h) "HL7 messages" means a standard approved by the standards development
155.22 organization known as Health Level Seven.

155.23 ~~(j)~~ (i) "National Provider Identifier" or "NPI" means the identifier described under Code
155.24 of Federal Regulations, title 45, part 162.406.

155.25 ~~(k)~~ (j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

155.26 ~~(l)~~ (k) "NCPDP Formulary and Benefits Standard" means the most recent version of the
155.27 National Council for Prescription Drug Programs Formulary and Benefits Standard~~,~~
155.28 ~~Implementation Guide, Version 1, Release 0, October 2005~~ or the most recent standard
155.29 adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare
155.30 Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act and regulations
155.31 adopted under it. The standards shall be implemented according to the Centers for Medicare
155.32 and Medicaid Services schedule for compliance.

156.1 ~~(m)~~ (l) "NCPDP SCRIPT Standard" means the most recent version of the National
156.2 Council for Prescription Drug Programs ~~Prescriber/Pharmacist Interface~~ SCRIPT Standard,
156.3 ~~Implementation Guide Version 8, Release 1 (Version 8.1), October 2005,~~ or the most recent
156.4 standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under
156.5 Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and
156.6 regulations adopted under it. The standards shall be implemented according to the Centers
156.7 for Medicare and Medicaid Services schedule for compliance. ~~Subsequently released versions~~
156.8 ~~of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard~~
156.9 ~~is backward compatible to the current version adopted by the Centers for Medicare and~~
156.10 ~~Medicaid Services.~~

156.11 ~~(n)~~ (m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

156.12 ~~(o)~~ (n) "Prescriber" means a licensed health care practitioner, other than a veterinarian,
156.13 as defined in section 151.01, subdivision 23.

156.14 ~~(p)~~ (o) "Prescription-related information" means information regarding eligibility for
156.15 drug benefits, medication history, or related health or drug information.

156.16 ~~(q)~~ (p) "Provider" or "health care provider" has the meaning given in section 62J.03,
156.17 subdivision 8.

156.18 Sec. 6. Minnesota Statutes 2020, section 62J.497, subdivision 3, is amended to read:

156.19 Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use
156.20 the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related
156.21 information. ~~The NCPDP SCRIPT Standard shall be used to conduct the following~~
156.22 ~~transactions:~~

156.23 ~~(1) get message transaction;~~

156.24 ~~(2) status response transaction;~~

156.25 ~~(3) error response transaction;~~

156.26 ~~(4) new prescription transaction;~~

156.27 ~~(5) prescription change request transaction;~~

156.28 ~~(6) prescription change response transaction;~~

156.29 ~~(7) refill prescription request transaction;~~

156.30 ~~(8) refill prescription response transaction;~~

156.31 ~~(9) verification transaction;~~

157.1 ~~(10) password change transaction;~~

157.2 ~~(11) cancel prescription request transaction; and~~

157.3 ~~(12) cancel prescription response transaction.~~

157.4 (b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT
157.5 Standard for communicating and transmitting medication history information.

157.6 (c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP
157.7 Formulary and Benefits Standard for communicating and transmitting formulary and benefit
157.8 information.

157.9 (d) Providers, group purchasers, prescribers, and dispensers must use the national provider
157.10 identifier to identify a health care provider in e-prescribing or prescription-related transactions
157.11 when a health care provider's identifier is required.

157.12 (e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility
157.13 information and conduct health care eligibility benefit inquiry and response transactions
157.14 according to the requirements of section 62J.536.

157.15 Sec. 7. Minnesota Statutes 2020, section 62J.498, is amended to read:

157.16 **62J.498 HEALTH INFORMATION EXCHANGE.**

157.17 Subdivision 1. **Definitions.** (a) The following definitions apply to sections 62J.498 to
157.18 62J.4982:

157.19 (b) "Clinical data repository" means a real time database that consolidates data from a
157.20 variety of clinical sources to present a unified view of a single patient and is used by a
157.21 ~~state-certified~~ health information exchange service provider to enable health information
157.22 exchange among health care providers that are not related health care entities as defined in
157.23 section 144.291, subdivision 2, paragraph (k). This does not include clinical data that are
157.24 submitted to the commissioner for public health purposes required or permitted by law,
157.25 including any rules adopted by the commissioner.

157.26 (c) "Clinical transaction" means any meaningful use transaction or other health
157.27 information exchange transaction that is not covered by section 62J.536.

157.28 (d) "Commissioner" means the commissioner of health.

157.29 (e) "Health care provider" or "provider" means a health care provider or provider as
157.30 defined in section 62J.03, subdivision 8.

(f) "Health data intermediary" means an entity that provides the technical capabilities or related products and services to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This includes but is not limited to health information service providers (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries as defined in section 62J.495.

(g) "Health information exchange" means the electronic transmission of health-related information between organizations according to nationally recognized standards.

(h) "Health information exchange service provider" means a health data intermediary or health information organization.

(i) "Health information organization" means an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k), to improve coordination of patient care and the efficiency of health care delivery.

~~(j) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act as defined in section 62J.495.~~

~~(k)~~ <u>(j)</u> "Major participating entity" means:

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health information exchange service provider;

(2) a participating entity providing administrative, financial, or management services to the health information organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health information organization; and

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors or equivalent governing body of the health information organization.

~~(l)~~ <u>(k)</u> "Master patient index" means an electronic database that holds unique identifiers of patients registered at a care facility and is used by a ~~state-certified~~ health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

~~(m) "Meaningful use" means use of certified electronic health record technology to improve quality, safety, and efficiency and reduce health disparities; engage patients and families; improve care coordination and population and public health; and maintain privacy and security of patient health information as established by the Centers for Medicare and Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

~~(n) "Meaningful use transaction" means an electronic transaction that a health care provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

~~(o)~~ (l) "Participating entity" means any of the following persons, health care providers, companies, or other organizations with which a health information organization ~~or health data intermediary~~ has contracts or other agreements for the provision of health information exchange services:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

~~(p)~~ (m) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of clinical transactions.

~~(q) "State-certified health data intermediary" means a health data intermediary that has been issued a certificate of authority to operate in Minnesota.~~

~~(r)~~ (n) "State-certified health information organization" means a health information organization that has been issued a certificate of authority to operate in Minnesota.

Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from ~~health data intermediaries and~~ health information organizations for certificates of authority to operate in Minnesota;

(2) require information to be provided as needed from health information exchange service providers in order to meet requirements established under sections 62J.498 to 62J.4982;

~~(2)~~ (3) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

~~(3)~~ (4) respond to public complaints related to health information exchange services;

~~(4)~~ (5) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

~~(5)~~ (6) provide a biennial report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences; and

~~(6)~~ (7) other duties necessary to protect the public interest.

(b) As part of the application review process for certification under paragraph (a), prior to issuing a certificate of authority, the commissioner shall:

(1) make all portions of the application classified as public data available to the public for at least ten days while an application is under consideration. At the request of the commissioner, the applicant shall participate in a public hearing by presenting an overview of their application and responding to questions from interested parties; and

(2) consult with hospitals, physicians, and other providers prior to issuing a certificate of authority.

(c) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(d) The commissioner may disclose data classified as protected nonpublic or confidential under paragraph (c) if disclosing the data will protect the health or safety of patients.

(e) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

Sec. 8. Minnesota Statutes 2020, section 62J.4981, is amended to read:

62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.

Subdivision 1. **Authority to require organizations to apply.** The commissioner shall require ~~a health data intermediary or~~ a health information organization to apply for a certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is considered a health information exchange service provider whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

~~Subd. 2.~~ ~~**Certificate of authority for health data intermediaries.**~~ ~~(a) A health data intermediary must be certified by the state and comply with requirements established in this section.~~

~~(b) Notwithstanding any law to the contrary, any corporation organized to do so may apply to the commissioner for a certificate of authority to establish and operate as a health data intermediary in compliance with this section. No person shall establish or operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health data intermediary contract unless the organization has a certificate of authority or has an application under active consideration under this section.~~

162.1 ~~(c) In issuing the certificate of authority, the commissioner shall determine whether the~~
162.2 ~~applicant for the certificate of authority has demonstrated that the applicant meets the~~
162.3 ~~following minimum criteria:~~

162.4 ~~(1) hold reciprocal agreements with at least one state-certified health information~~
162.5 ~~organization to access patient data, and for the transmission and receipt of clinical~~
162.6 ~~transactions. Reciprocal agreements must meet the requirements established in subdivision~~
162.7 ~~5; and~~

162.8 ~~(2) participate in statewide shared health information exchange services as defined by~~
162.9 ~~the commissioner to support interoperability between state-certified health information~~
162.10 ~~organizations and state-certified health data intermediaries.~~

162.11 Subd. 3. **Certificate of authority for health information organizations.** (a) A health
162.12 information organization must obtain a certificate of authority from the commissioner and
162.13 demonstrate compliance with the criteria in paragraph (c).

162.14 (b) Notwithstanding any law to the contrary, an organization may apply for a certificate
162.15 of authority to establish and operate a health information organization under this section.
162.16 No person shall establish or operate a health information organization in this state, nor sell
162.17 or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in
162.18 conjunction with a health information organization or health information contract unless
162.19 the organization has a certificate of authority under this section.

162.20 (c) In issuing the certificate of authority, the commissioner shall determine whether the
162.21 applicant for the certificate of authority has demonstrated that the applicant meets the
162.22 following minimum criteria:

162.23 (1) the entity is a legally established organization;

162.24 (2) appropriate insurance, including liability insurance, for the operation of the health
162.25 information organization is in place and sufficient to protect the interest of the public and
162.26 participating entities;

162.27 (3) strategic and operational plans address governance, technical infrastructure, legal
162.28 and policy issues, finance, and business operations in regard to how the organization will
162.29 expand to support providers in achieving health information exchange goals over time;

162.30 (4) the entity addresses the parameters to be used with participating entities and other
162.31 health information exchange service providers for clinical transactions, compliance with
162.32 Minnesota law, and interstate health information exchange trust agreements;

163.1 (5) the entity's board of directors or equivalent governing body is composed of members
163.2 that broadly represent the health information organization's participating entities and
163.3 consumers;

163.4 (6) the entity maintains a professional staff responsible to the board of directors or
163.5 equivalent governing body with the capacity to ensure accountability to the organization's
163.6 mission;

163.7 (7) the organization is compliant with national certification and accreditation programs
163.8 designated by the commissioner;

163.9 (8) the entity maintains the capability to query for patient information based on national
163.10 standards. The query capability may utilize a master patient index, clinical data repository,
163.11 or record locator service as defined in section 144.291, subdivision 2, paragraph (j). The
163.12 entity must be compliant with the requirements of section 144.293, subdivision 8, when
163.13 conducting clinical transactions;

163.14 (9) the organization demonstrates interoperability with all other state-certified health
163.15 information organizations using nationally recognized standards;

163.16 (10) the organization demonstrates compliance with all privacy and security requirements
163.17 required by state and federal law; and

163.18 (11) the organization uses financial policies and procedures consistent with generally
163.19 accepted accounting principles and has an independent audit of the organization's financials
163.20 on an annual basis.

163.21 (d) Health information organizations that have obtained a certificate of authority must:

163.22 (1) meet the requirements established for connecting to the National eHealth Exchange;

163.23 (2) annually submit strategic and operational plans for review by the commissioner that
163.24 address:

163.25 (i) progress in achieving objectives included in previously submitted strategic and
163.26 operational plans across the following domains: business and technical operations, technical
163.27 infrastructure, legal and policy issues, finance, and organizational governance;

163.28 (ii) plans for ensuring the necessary capacity to support clinical transactions;

163.29 (iii) approach for attaining financial sustainability, including public and private financing
163.30 strategies, and rate structures;

163.31 (iv) rates of adoption, utilization, and transaction volume, and mechanisms to support
163.32 health information exchange; and

164.1 (v) an explanation of methods employed to address the needs of community clinics,
164.2 critical access hospitals, and free clinics in accessing health information exchange services;

164.3 (3) enter into reciprocal agreements with all other state-certified health information
164.4 organizations ~~and state-certified health data intermediaries~~ to enable access to patient data,
164.5 and for the transmission and receipt of clinical transactions. Reciprocal agreements must
164.6 meet the requirements in subdivision 5;

164.7 (4) participate in statewide shared health information exchange services as defined by
164.8 the commissioner to support interoperability ~~between state-certified health information~~
164.9 ~~organizations and state-certified health data intermediaries~~; and

164.10 (5) comply with additional requirements for the certification or recertification of health
164.11 information organizations that may be established by the commissioner.

164.12 Subd. 4. **Application for certificate of authority for health information ~~exchange~~**
164.13 **~~service providers~~ organizations.** (a) Each application for a certificate of authority shall
164.14 be in a form prescribed by the commissioner and verified by an officer or authorized
164.15 representative of the applicant. Each application shall include the following in addition to
164.16 information described in the criteria in ~~subdivisions 2 and~~ subdivision 3:

164.17 (1) ~~for health information organizations only,~~ a copy of the basic organizational document,
164.18 if any, of the applicant and of each major participating entity, such as the articles of
164.19 incorporation, or other applicable documents, and all amendments to it;

164.20 (2) ~~for health information organizations only,~~ a list of the names, addresses, and official
164.21 positions of the following:

164.22 (i) all members of the board of directors or equivalent governing body, and the principal
164.23 officers and, if applicable, shareholders of the applicant organization; and

164.24 (ii) all members of the board of directors or equivalent governing body, and the principal
164.25 officers of each major participating entity and, if applicable, each shareholder beneficially
164.26 owning more than ten percent of any voting stock of the major participating entity;

164.27 (3) ~~for health information organizations only,~~ the name and address of each participating
164.28 entity and the agreed-upon duration of each contract or agreement if applicable;

164.29 (4) a copy of each standard agreement or contract intended to bind the participating
164.30 entities and the health information ~~exchange service provider~~ organization. Contractual
164.31 provisions shall be consistent with the purposes of this section, in regard to the services to
164.32 be performed under the standard agreement or contract, the manner in which payment for

165.1 services is determined, the nature and extent of responsibilities to be retained by the health
165.2 information organization, and contractual termination provisions;

165.3 (5) a statement generally describing the health information ~~exchange service provider~~
165.4 organization, its health information exchange contracts, facilities, and personnel, including
165.5 a statement describing the manner in which the applicant proposes to provide participants
165.6 with comprehensive health information exchange services;

165.7 (6) a statement reasonably describing the geographic area or areas to be served and the
165.8 type or types of participants to be served;

165.9 (7) a description of the complaint procedures to be used as required under this section;

165.10 (8) a description of the mechanism by which participating entities will have an opportunity
165.11 to participate in matters of policy and operation;

165.12 (9) a copy of any pertinent agreements between the health information organization and
165.13 insurers, including liability insurers, demonstrating coverage is in place;

165.14 (10) a copy of the conflict of interest policy that applies to all members of the board of
165.15 directors or equivalent governing body and the principal officers of the health information
165.16 organization; and

165.17 (11) other information as the commissioner may reasonably require to be provided.

165.18 (b) Within 45 days after the receipt of the application for a certificate of authority, the
165.19 commissioner shall determine whether or not the application submitted meets the
165.20 requirements for completion in paragraph (a), and notify the applicant of any further
165.21 information required for the application to be processed.

165.22 (c) Within 90 days after the receipt of a complete application for a certificate of authority,
165.23 the commissioner shall issue a certificate of authority to the applicant if the commissioner
165.24 determines that the applicant meets the minimum criteria requirements of ~~subdivision 2 for~~
165.25 ~~health data intermediaries or~~ subdivision 3 ~~for health information organizations~~. If the
165.26 commissioner determines that the applicant is not qualified, the commissioner shall notify
165.27 the applicant and specify the reasons for disqualification.

165.28 (d) Upon being granted a certificate of authority to operate as a state-certified health
165.29 information organization ~~or state-certified health data intermediary~~, the organization must
165.30 operate in compliance with the provisions of this section. Noncompliance may result in the
165.31 imposition of a fine or the suspension or revocation of the certificate of authority according
165.32 to section 62J.4982.

166.1 Subd. 5. **Reciprocal agreements between health information ~~exchange entities~~**
166.2 **organizations.** (a) Reciprocal agreements between two health information organizations
166.3 ~~or between a health information organization and a health data intermediary~~ must include
166.4 a fair and equitable model for charges between the entities that:

166.5 (1) does not impede the secure transmission of clinical transactions;

166.6 (2) does not charge a fee for the exchange of ~~meaningful use~~ transactions transmitted
166.7 according to nationally recognized standards where no additional value-added service is
166.8 rendered to the sending or receiving health information organization ~~or health data~~
166.9 ~~intermediary~~ either directly or on behalf of the client;

166.10 (3) is consistent with fair market value and proportionately reflects the value-added
166.11 services accessed as a result of the agreement; and

166.12 (4) prevents health care stakeholders from being charged multiple times for the same
166.13 service.

166.14 (b) Reciprocal agreements must include comparable quality of service standards that
166.15 ensure equitable levels of services.

166.16 (c) Reciprocal agreements are subject to review and approval by the commissioner.

166.17 (d) Nothing in this section precludes a state-certified health information organization ~~or~~
166.18 ~~state-certified health data intermediary~~ from entering into contractual agreements for the
166.19 provision of value-added services ~~beyond meaningful use transactions~~.

166.20 Sec. 9. Minnesota Statutes 2020, section 62J.4982, is amended to read:

166.21 **62J.4982 ENFORCEMENT AUTHORITY; COMPLIANCE.**

166.22 Subdivision 1. **Penalties and enforcement.** (a) The commissioner may, for any violation
166.23 of statute or rule applicable to a health information ~~exchange service provider~~ organization,
166.24 levy an administrative penalty in an amount up to $25,000 for each violation. In determining
166.25 the level of an administrative penalty, the commissioner shall consider the following factors:

166.26 (1) the number of participating entities affected by the violation;

166.27 (2) the effect of the violation on participating entities' access to health information
166.28 exchange services;

166.29 (3) if only one participating entity is affected, the effect of the violation on the patients
166.30 of that entity;

166.31 (4) whether the violation is an isolated incident or part of a pattern of violations;

(5) the economic benefits derived by the health information organization ~~or a health data intermediary~~ by virtue of the violation;

(6) whether the violation hindered or facilitated an individual's ability to obtain health care;

(7) whether the violation was intentional;

(8) whether the violation was beyond the direct control of the health information ~~exchange service provider~~ organization;

(9) any history of prior compliance with the provisions of this section, including violations;

(10) whether and to what extent the health information ~~exchange service provider~~ organization attempted to correct previous violations;

(11) how the health information ~~exchange service provider~~ organization responded to technical assistance from the commissioner provided in the context of a compliance effort; and

(12) the financial condition of the health information ~~exchange service provider~~ organization including~~,~~ but not limited to~~,~~ whether the health information ~~exchange service provider~~ organization had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information ~~exchange service provider~~ organization to continue to deliver health information exchange services.

The commissioner shall give reasonable notice in writing to the health information ~~exchange service provider~~ organization of the intent to levy the penalty and the reasons for it. A health information ~~exchange service provider~~ organization may have 15 days within which to contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982, according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(b) If the commissioner has reason to believe that a violation of section 62J.4981 or 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved before commencing action under subdivision 2. The commissioner may notify the health information ~~exchange service provider~~ organization and the representatives, or other persons who appear to be involved in the suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives. The purpose of the conference is to attempt to learn the facts about the suspected violation and, if it appears that a violation

168.1 has occurred or is threatened, to find a way to correct or prevent it. The conference is not
168.2 governed by any formal procedural requirements, and may be conducted as the commissioner
168.3 considers appropriate.

168.4 (c) The commissioner may issue an order directing a health information ~~exchange service~~
168.5 ~~provider~~ organization or a representative of a health information ~~exchange service provider~~
168.6 organization to cease and desist from engaging in any act or practice in violation of sections
168.7 62J.4981 and 62J.4982.

168.8 (d) Within 20 days after service of the order to cease and desist, a health information
168.9 ~~exchange service provider~~ organization may contest whether the facts found constitute a
168.10 violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial
168.11 review provisions of sections 14.57 to 14.69.

168.12 (e) In the event of noncompliance with a cease and desist order issued under this
168.13 subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other
168.14 appropriate relief in Ramsey County District Court.

168.15 Subd. 2. **Suspension or revocation of certificates of authority.** (a) The commissioner
168.16 may suspend or revoke a certificate of authority issued to a ~~health data intermediary or~~
168.17 health information organization under section 62J.4981 if the commissioner finds that:

168.18 (1) the health information ~~exchange service provider~~ organization is operating
168.19 significantly in contravention of its basic organizational document, or in a manner contrary
168.20 to that described in and reasonably inferred from any other information submitted under
168.21 section 62J.4981, unless amendments to the submissions have been filed with and approved
168.22 by the commissioner;

168.23 (2) the health information ~~exchange service provider~~ organization is unable to fulfill its
168.24 obligations to furnish comprehensive health information exchange services as required
168.25 under its health information exchange contract;

168.26 (3) the health information ~~exchange service provider~~ organization is no longer financially
168.27 solvent or may not reasonably be expected to meet its obligations to participating entities;

168.28 (4) the health information ~~exchange service provider~~ organization has failed to implement
168.29 the complaint system in a manner designed to reasonably resolve valid complaints;

168.30 (5) the health information ~~exchange service provider~~ organization, or any person acting
168.31 with its sanction, has advertised or merchandised its services in an untrue, misleading,
168.32 deceptive, or unfair manner;

(6) the continued operation of the health information ~~exchange service provider~~ organization would be hazardous to its participating entities or the patients served by the participating entities; or

(7) the health information ~~exchange service provider~~ organization has otherwise failed to substantially comply with section 62J.4981 or with any other statute or administrative rule applicable to health information exchange service providers, or has submitted false information in any report required under sections 62J.498 to 62J.4982.

(b) A certificate of authority shall be suspended or revoked only after meeting the requirements of subdivision 3.

(c) If the certificate of authority of a health information ~~exchange service provider~~ organization is suspended, the health information ~~exchange service provider~~ organization shall not, during the period of suspension, enroll any additional participating entities, and shall not engage in any advertising or solicitation.

(d) If the certificate of authority of a health information ~~exchange service provider~~ organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may, by written order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the greatest practical opportunity to access continuing health information exchange services.

Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a) When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, the commissioner shall notify the health information ~~exchange service provider~~ organization in writing stating the grounds for denial, suspension, or revocation and setting a time within 20 days for a hearing on the matter.

(b) After a hearing before the commissioner at which the health information ~~exchange service provider~~ organization may respond to the grounds for denial, suspension, or revocation, or upon the failure of the health information ~~exchange service provider~~ organization to appear at the hearing, the commissioner shall take action as deemed necessary and shall issue written findings and mail them to the health information ~~exchange service provider~~ organization.

170.1 (c) If suspension, revocation, or administrative penalty is proposed according to this
170.2 section, the commissioner must deliver, or send by certified mail with return receipt
170.3 requested, to the health information ~~exchange service provider~~ organization written notice
170.4 of the commissioner's intent to impose a penalty. This notice of proposed determination
170.5 must include:

170.6 (1) a reference to the statutory basis for the penalty;

170.7 (2) a description of the findings of fact regarding the violations with respect to which
170.8 the penalty is proposed;

170.9 (3) the nature and amount of the proposed penalty;

170.10 (4) any circumstances described in subdivision 1, paragraph (a), that were considered
170.11 in determining the amount of the proposed penalty;

170.12 (5) instructions for responding to the notice, including a statement of the health
170.13 information ~~exchange service provider's~~ organization's right to a contested case proceeding
170.14 and a statement that failure to request a contested case proceeding within 30 calendar days
170.15 permits the imposition of the proposed penalty; and

170.16 (6) the address to which the contested case proceeding request must be sent.

170.17 Subd. 4. **Coordination.** The commissioner shall, to the extent possible, seek the advice
170.18 of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the
170.19 certification and recertification of health information ~~exchange service providers~~
170.20 organizations when implementing sections 62J.498 to 62J.4982.

170.21 Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every
170.22 health information ~~exchange service provider~~ organization subject to sections 62J.4981 and
170.23 62J.4982 as follows:

170.24 (1) filing an application for certificate of authority to operate as a health information
170.25 organization, $7,000; and

170.26 (2) ~~filing an application for certificate of authority to operate as a health data intermediary,~~
170.27 ~~$7,000;~~

170.28 ~~(3)~~ annual health information organization certificate fee, $7,000~~; and~~.

170.29 ~~(4) annual health data intermediary certificate fee, $7,000.~~

170.30 (b) Fees collected under this section shall be deposited in the state treasury and credited
170.31 to the state government special revenue fund.

(c) Administrative monetary penalties imposed under this subdivision shall be credited to an account in the special revenue fund and are appropriated to the commissioner for the purposes of sections 62J.498 to 62J.4982.

Sec. 10. Minnesota Statutes 2020, section 62J.63, subdivision 1, is amended to read:

Subdivision 1. **~~Establishment; administration~~ Support for state health care purchasing and performance measurement.** The commissioner of health shall ~~establish and administer the Center for Health Care Purchasing Improvement as an administrative unit within the Department of Health. The Center for Health Care Purchasing Improvement shall~~ support the state in its efforts to be a more prudent and efficient purchaser of quality health care services~~. The center shall~~, aid the state in developing and using more common strategies and approaches for health care performance measurement and health care purchasing~~. The common strategies and approaches shall~~, promote greater transparency of health care costs and quality~~,~~ and greater accountability for health care results and improvement~~. The center shall also~~, and identify barriers to more efficient, effective, quality health care and options for overcoming the barriers.

Sec. 11. Minnesota Statutes 2020, section 62J.63, subdivision 2, is amended to read:

Subd. 2. **~~Staffing;~~ Duties; scope.** ~~(a)~~ The commissioner of health may ~~appoint a director, and up to three additional senior-level staff or codirectors, and other staff as needed who are under the direction of the commissioner. The staff of the center are in the unclassified service.~~:

~~(b) With the authorization of the commissioner of health, and in consultation or interagency agreement with the appropriate commissioners of state agencies, the director, or codirectors, may:~~

~~(1) initiate projects to develop plan designs for state health care purchasing;~~

~~(2)~~ (1) require reports or surveys to evaluate the performance of current health care purchasing or administrative simplification strategies;

~~(3)~~ (2) calculate fiscal impacts, including net savings and return on investment, of health care purchasing strategies and initiatives;

~~(4) conduct policy audits of state programs to measure conformity to state statute or other purchasing initiatives or objectives;~~

172.1 ~~(5)~~ (3) support the Administrative Uniformity Committee under ~~section~~ sections 62J.50
172.2 and 62J.536 and other relevant groups or activities to advance agreement on health care
172.3 administrative process streamlining;

172.4 ~~(6) consult with the Health Economics Unit of the Department of Health regarding~~
172.5 ~~reports and assessments of the health care marketplace;~~

172.6 ~~(7) consult with the Department of Commerce regarding health care regulatory issues~~
172.7 ~~and legislative initiatives;~~

172.8 ~~(8) work with appropriate Department of Human Services staff and the Centers for~~
172.9 ~~Medicare and Medicaid Services to address federal requirements and conformity issues for~~
172.10 ~~health care purchasing;~~

172.11 ~~(9) assist the Minnesota Comprehensive Health Association in health care purchasing~~
172.12 ~~strategies;~~

172.13 ~~(10) convene medical directors of agencies engaged in health care purchasing for advice,~~
172.14 ~~collaboration, and exploring possible synergies;~~

172.15 ~~(11)~~ (4) contact and participate with other relevant health care task forces, study activities,
172.16 and similar efforts with regard to health care performance measurement and
172.17 performance-based purchasing; and

172.18 ~~(12)~~ (5) assist in seeking external funding through appropriate grants or other funding
172.19 opportunities and may administer grants and externally funded projects.

172.20 Sec. 12. **[62J.826] MEDICAL PRACTICES; CURRENT STANDARD CHARGES.**

172.21 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

172.22 (b) "Chargemaster" means the list of all individual items and services maintained by a
172.23 medical practice for which the medical practice has established a charge.

172.24 (c) "Diagnostic laboratory testing" means a service charged using a CPT code within
172.25 the CPT code range of 80047 to 89398.

172.26 (d) "Diagnostic radiology service" means a service charged using a CPT code within
172.27 the CPT code range of 70010 to 7999 and includes the provision of x-rays, computed
172.28 tomography scans, positron emission tomography scans, magnetic resonance imaging scans,
172.29 and mammographies.

172.30 (e) "Hospital" means an acute care institution licensed under sections 144.50 to 144.58,
172.31 but does not include a health care institution conducted for those who rely primarily upon

173.1 treatment by prayer or spiritual means in accordance with the creed or tenets of any church
173.2 or denomination.

173.3 (f) "Medical practice" means a business that:

173.4 (1) earns revenue by providing medical care to the public;

173.5 (2) issues payment claims to health plan companies and other payers; and

173.6 (3) may be identified by its federal tax identification number.

173.7 (g) "Outpatient surgical center" means a health care facility other than a hospital offering
173.8 elective outpatient surgery under a license issued under sections 144.50 to 144.58.

173.9 Subd. 2. **Requirement; current standard charges.** The following medical practices
173.10 must make available to the public a list of the medical practice's current standard charges,
173.11 as reflected in the medical practice's chargemaster, for all items and services provided by
173.12 the medical practice:

173.13 (1) hospitals;

173.14 (2) outpatient surgical centers; and

173.15 (3) any other medical practice that has revenue of greater than $50,000,000 per year and
173.16 that derives the majority of the medical practice's revenue by providing one or more of the
173.17 following services:

173.18 (i) diagnostic radiology services;

173.19 (ii) diagnostic laboratory testing;

173.20 (iii) orthopedic surgical procedures, including joint arthroplasty procedures within the
173.21 CPT code range of 26990 to 27899;

173.22 (iv) ophthalmologic surgical procedures, including cataract surgery coded using CPT
173.23 code 66982 or 66984, or refractive correction surgery to improve visual acuity;

173.24 (v) anesthesia services commonly provided as an ancillary to services provided at a
173.25 hospital, outpatient surgical center, or medical practice that provides orthopedic surgical
173.26 procedures or ophthalmologic surgical procedures; or

173.27 (vi) oncology services, including radiation oncology treatments within the CPT code
173.28 range of 77261 to 77799 and drug infusions.

173.29 Subd. 3. **Required file format and data attributes.** (a) A medical practice required to
173.30 post the medical practice's current standard charges must post the following data attributes
173.31 in the listed order:

174.1 (1) federal tax identification number for the medical practice;

174.2 (2) name of the medical practice, defined as the provider name that the medical practice
174.3 enters on the CMS claim form 1500 or a successor form when the medical practice submits
174.4 health care claims to a payer organization;

174.5 (3) internal chargemaster record identification, defined as the internal record identifier
174.6 for this chargemaster line item in the medical practice's billing system;

174.7 (4) service billing code system, defined as a code signifying the HIPAA-compliant
174.8 billing code system from which the service billing code was drawn;

174.9 (5) service billing code, defined as a specific billing code drawn from the service billing
174.10 code system denoted by the value in the service billing code type field;

174.11 (6) service description, defined as the shortest, nonabbreviated official description
174.12 associated with the service billing code in the applicable service billing code system;

174.13 (7) revenue code, defined as the National Uniform Billing Committee revenue code
174.14 denoting the patient's location within the medical practice where the patient will receive the
174.15 item or service subject to this charge. This value is required only if the charge amount is
174.16 dependent on the location within the medical practice where the item or service is provided;

174.17 (8) revenue code description, defined as the description provided by the National Uniform
174.18 Billing Committee for the revenue code. This value is required only if the charge amount
174.19 is dependent on the location within the medical practice where the item or service is provided;

174.20 (9) national drug code, defined as the national drug code for a drug that is administered
174.21 as part of the service subject to this charge. This field is required only when the charge
174.22 amount is dependent on which, if any, drug is being administered as part of this service;

174.23 (10) national drug code description, defined as the official description associated with
174.24 the national drug code for a drug that is administered as part of the service subject to this
174.25 charge. This field is required only when the charge amount is dependent on which, if any,
174.26 drug is being administered as part of this service;

174.27 (11) inpatient gross charge, defined as the charge for an individual item or service that
174.28 is reflected on a hospital's chargemaster, absent any discounts as defined in Code of Federal
174.29 Regulations, title 45, section 180.20, for an item or service provided on an inpatient basis;

174.30 (12) outpatient gross charge, defined as the charge for an individual item or service that
174.31 is reflected on a chargemaster, absent any discounts as defined in Code of Federal
174.32 Regulations, title 45, section 180.20, for an item or service provided on an outpatient basis;

175.1 (13) inpatient discounted cash price, defined as the charge that applies to an individual
175.2 who pays cash or a cash equivalent for an item or service being reported under this section
175.3 and provided on an inpatient basis;

175.4 (14) outpatient discounted cash price, defined as the charge that applies to an individual
175.5 who pays cash or a cash equivalent for an item or service being reported under this section
175.6 and provided on an outpatient basis;

175.7 (15) charge unit, defined as the unit cost basis for the charge;

175.8 (16) effective date of the charge; and

175.9 (17) payer-specific negotiated charges, as defined in Code of Federal Regulations, title
175.10 45, section 180.20. There must be a separate field for each payer's rate and the payers must
175.11 be listed in alphabetical order.

175.12 (b) The data attributes specified in paragraph (a) must be posted in the form of a
175.13 comma-separated values file, with all text values quoted and all leading and trailing white
175.14 spaces trimmed before and after data attribute values.

175.15 (c) The data attributes specified in paragraph (a) must be posted on a web page labeled
175.16 "Cost of Care at [Name of Medical Practice]" which members of the public can access via
175.17 a direct, clearly labeled link on the medical practice's main billing web page, and which is
175.18 searchable by entering the words "cost of care at [name of medical practice]" into an Internet
175.19 search engine. The consumer-friendly list of standard charges for a limited set of shoppable
175.20 services required under Code of Federal Regulations, title 45, section 180.60, must be
175.21 presented on the same web page.

175.22 (d) The file must be named according to the following convention:
175.23 <ein>_<hospital-name>_standardcharges.csv as required by Code of Federal Regulations,
175.24 title 45, section 180.50.

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

175.26 Sec. 13. Minnesota Statutes 2020, section 62U.04, subdivision 4, is amended to read:

175.27 Subd. 4. **Encounter data.** (a) ~~Beginning July 1, 2009, and every six months thereafter,~~
175.28 All health plan companies and third-party administrators shall submit encounter data on a
175.29 monthly basis to a private entity designated by the commissioner of health. The data shall
175.30 be submitted in a form and manner specified by the commissioner subject to the following
175.31 requirements:

176.1 (1) the data must be de-identified data as described under the Code of Federal Regulations,
176.2 title 45, section 164.514;

176.3 (2) the data for each encounter must include an identifier for the patient's health care
176.4 home if the patient has selected a health care home and, for claims incurred on or after
176.5 January 1, 2019, data deemed necessary by the commissioner to uniquely identify claims
176.6 in the individual health insurance market; and

176.7 (3) except for the identifier described in clause (2), the data must not include information
176.8 that is not included in a health care claim or equivalent encounter information transaction
176.9 that is required under section 62J.536.

176.10 (b) The commissioner or the commissioner's designee shall only use the data submitted
176.11 under paragraph (a) to carry out the commissioner's responsibilities in this section, including
176.12 supplying the data to providers so they can verify their results of the peer grouping process
176.13 consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d),
176.14 and adopted by the commissioner and, if necessary, submit comments to the commissioner
176.15 or initiate an appeal.

176.16 (c) Data on providers collected under this subdivision are private data on individuals or
176.17 nonpublic data, as defined in section 13.02. Notwithstanding the data classifications in this
176.18 paragraph, data on providers collected under this subdivision may be released or published
176.19 as authorized in subdivision 11. Notwithstanding the definition of summary data in section
176.20 13.02, subdivision 19, summary data prepared under this subdivision may be derived from
176.21 nonpublic data. The commissioner or the commissioner's designee shall establish procedures
176.22 and safeguards to protect the integrity and confidentiality of any data that it maintains.

176.23 (d) The commissioner or the commissioner's designee shall not publish analyses or
176.24 reports that identify, or could potentially identify, individual patients.

176.25 (e) The commissioner shall compile summary information on the data submitted under
176.26 this subdivision. The commissioner shall work with its vendors to assess the data submitted
176.27 in terms of compliance with the data submission requirements and the completeness of the
176.28 data submitted by comparing the data with summary information compiled by the
176.29 commissioner and with established and emerging data quality standards to ensure data
176.30 quality.

176.31 Sec. 14. Minnesota Statutes 2020, section 62U.04, subdivision 5, is amended to read:

176.32 Subd. 5. **Pricing data.** (a) Beginning July 1, 2009, and annually on January 1 thereafter,
176.33 all health plan companies and third-party administrators shall submit data on their contracted

177.1 prices with health care providers to a private entity designated by the commissioner of health
177.2 for the purposes of performing the analyses required under this subdivision. The data shall
177.3 be submitted in the form and manner specified by the commissioner of health.

177.4 (b) The commissioner or the commissioner's designee shall only use the data submitted
177.5 under this subdivision to carry out the commissioner's responsibilities under this section,
177.6 including supplying the data to providers so they can verify their results of the peer grouping
177.7 process consistent with the recommendations developed pursuant to subdivision 3c, paragraph
177.8 (d), and adopted by the commissioner and, if necessary, submit comments to the
177.9 commissioner or initiate an appeal.

177.10 (c) Data collected under this subdivision are nonpublic data as defined in section 13.02.
177.11 Notwithstanding the data classification in this paragraph, data collected under this subdivision
177.12 may be released or published as authorized in subdivision 11. Notwithstanding the definition
177.13 of summary data in section 13.02, subdivision 19, summary data prepared under this section
177.14 may be derived from nonpublic data. The commissioner shall establish procedures and
177.15 safeguards to protect the integrity and confidentiality of any data that it maintains.

177.16 Sec. 15. Minnesota Statutes 2020, section 62U.04, subdivision 11, is amended to read:

177.17 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
177.18 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's
177.19 designee shall only use the data submitted under subdivisions 4 and 5 for the following
177.20 purposes:

177.21 (1) to evaluate the performance of the health care home program as authorized under
177.22 section 62U.03, subdivision 7;

177.23 (2) to study, in collaboration with the reducing avoidable readmissions effectively
177.24 (RARE) campaign, hospital readmission trends and rates;

177.25 (3) to analyze variations in health care costs, quality, utilization, and illness burden based
177.26 on geographical areas or populations;

177.27 (4) to evaluate the state innovation model (SIM) testing grant received by the Departments
177.28 of Health and Human Services, including the analysis of health care cost, quality, and
177.29 utilization baseline and trend information for targeted populations and communities; and

177.30 (5) to compile one or more public use files of summary data or tables that must:

177.31 (i) be available to the public for no or minimal cost by March 1, 2016, and available by
177.32 web-based electronic data download by June 30, 2019;

178.1 (ii) not identify individual patients~~,~~ or payers~~, or providers~~ but that may identify the
178.2 rendering or billing hospital, clinic, or medical practice;

178.3 (iii) be updated by the commissioner, at least annually, with the most current data
178.4 available;

178.5 (iv) contain clear and conspicuous explanations of the characteristics of the data, such
178.6 as the dates of the data contained in the files, the absence of costs of care for uninsured
178.7 patients or nonresidents, and other disclaimers that provide appropriate context; and

178.8 (v) not lead to the collection of additional data elements beyond what is authorized under
178.9 this section as of June 30, 2015.

178.10 (b) The commissioner may publish the results of the authorized uses identified in
178.11 paragraph (a) ~~so long as the data released publicly do not contain information or descriptions~~
178.12 ~~in which the identity of individual hospitals, clinics, or other providers may be discerned~~.
178.13 The data published under this paragraph may identify hospitals, clinics, and medical practices
178.14 so long as no individual health professionals are identified and the commissioner finds the
178.15 data to be accurate, valid, and suitable for publication for such use.

178.16 (c) Nothing in this subdivision shall be construed to prohibit the commissioner from
178.17 using the data collected under subdivision 4 to complete the state-based risk adjustment
178.18 system assessment due to the legislature on October 1, 2015.

178.19 (d) The commissioner or the commissioner's designee may use the data submitted under
178.20 subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,
178.21 2023.

178.22 (e) The commissioner shall consult with the all-payer claims database work group
178.23 established under subdivision 12 regarding the technical considerations necessary to create
178.24 the public use files of summary data described in paragraph (a), clause (5).

178.25 Sec. 16. Minnesota Statutes 2020, section 103H.201, subdivision 1, is amended to read:

178.26 Subdivision 1. **Procedure.** (a) If groundwater quality monitoring results show that there
178.27 is a degradation of groundwater, the commissioner of health may promulgate health risk
178.28 limits under subdivision 2 for substances degrading the groundwater.

178.29 (b) Health risk limits shall be determined by two methods depending on their toxicological
178.30 end point.

179.1 (c) For systemic toxicants that are not carcinogens, the adopted health risk limits shall
179.2 be derived using United States Environmental Protection Agency risk assessment methods
179.3 using a reference dose, a drinking water equivalent, and a relative source contribution factor.

179.4 (d) For toxicants that are known or probable carcinogens, the adopted health risk limits
179.5 shall be derived from a quantitative estimate of the chemical's carcinogenic potency published
179.6 by the United States Environmental Protection Agency ~~and~~ or determined by the
179.7 commissioner to have undergone thorough scientific review.

179.8 Sec. 17. **[144.066] DISTRIBUTION OF COVID-19 VACCINES.**

179.9 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section
179.10 and sections 144.0661 to 144.0663.

179.11 (b) "Commissioner" means the commissioner of health.

179.12 (c) "COVID-19 vaccine" means a vaccine against severe acute respiratory syndrome
179.13 coronavirus 2 (SARS-CoV-2).

179.14 (d) "Department" means the Department of Health.

179.15 (e) "Disproportionately impacted community" means a community or population that
179.16 has been disproportionately and negatively impacted by the COVID-19 pandemic.

179.17 (f) "Local health department" has the meaning given in section 145A.02, subdivision
179.18 8b.

179.19 (g) "Mobile vaccination vehicle" means a vehicle-mounted unit that is either motorized
179.20 or trailered, that is readily movable without disassembling, and at which vaccines are
179.21 provided in more than one geographic location.

179.22 Subd. 2. **Distribution.** The commissioner shall establish and maintain partnerships or
179.23 agreements with local health departments; local health care providers, including community
179.24 health centers and primary care providers; and local pharmacies to administer COVID-19
179.25 vaccines throughout the state. COVID-19 vaccines may also be administered via mobile
179.26 vaccination vehicles authorized under section 144.0662.

179.27 Subd. 3. **Second dose or booster.** For all COVID-19 vaccines for which a second dose
179.28 or booster is required, during the first vaccine appointment the registered vaccine provider
179.29 should be directed by the department during the vaccine provider registration process to
179.30 assist vaccine recipients with scheduling an appointment for the second dose or booster.
179.31 This assistance may be provided during the observation period following vaccine
179.32 administration.

180.1 Subd. 4. **Nondiscrimination.** Nothing in sections 144.066 to 144.0663 shall be construed
180.2 to allow or require the denial of any benefit or opportunity on the basis of race, color, creed,
180.3 marital status, status with regard to public assistance, disability, genetic information, sexual
180.4 orientation, age, religion, national origin, sex, or membership in a local human rights
180.5 commission.

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

180.7 Sec. 18. **[144.0661] EQUITABLE COVID-19 VACCINE DISTRIBUTION.**

180.8 Subdivision 1. **COVID-19 vaccination equity and outreach.** The commissioner shall
180.9 establish positions to continue the department's COVID-19 vaccination equity and outreach
180.10 activities and to plan and implement actions and programs to overcome disparities in
180.11 COVID-19 vaccination rates that are rooted in historic and current racism; biases based on
180.12 ethnicity, income, primary language, immigration status, or disability; geography; or
180.13 transportation access, language access, or Internet access. This work shall be managed by
180.14 a director who shall serve in a leadership role in the department's COVID-19 response.

180.15 Subd. 2. **Vaccine education and outreach campaign; direct delivery of**
180.16 **information.** (a) The commissioner shall administer a COVID-19 vaccine education and
180.17 outreach campaign that engages in direct delivery of information to members of
180.18 disproportionately impacted communities. In this campaign, the commissioner shall contract
180.19 with community-based organizations including community faith-based organizations, tribal
180.20 governments, local health departments, and local health care providers, including community
180.21 health centers and primary care providers, to deliver the following information in a culturally
180.22 relevant and linguistically appropriate manner:

180.23 (1) medically and scientifically accurate information on the safety, efficacy, science,
180.24 and benefits of vaccines generally and COVID-19 vaccines in particular;

180.25 (2) information on how members of disproportionately impacted communities may
180.26 obtain a COVID-19 vaccine including, if applicable, obtaining a vaccine from a mobile
180.27 vaccination vehicle; and

180.28 (3) measures to prevent transmission of COVID-19, including adequate indoor ventilation,
180.29 wearing face coverings, and physical distancing from individuals outside the household.

180.30 (b) This information must be delivered directly by methods that include phone calls,
180.31 text messages, physically distanced door-to-door and street canvassing, and digital
180.32 event-based communication involving live and interactive messengers. For purposes of this

181.1 subdivision, direct delivery shall not include delivery by television, radio, newspaper, or
181.2 other forms of mass media.

181.3 Subd. 3. **Vaccine education and outreach campaign; mass media.** The commissioner
181.4 shall administer a mass media campaign to provide COVID-19 vaccine education and
181.5 outreach to members of disproportionately impacted communities. In this campaign, the
181.6 commissioner shall contract with media vendors to provide the following information to
181.7 members of disproportionately impacted communities in a manner that is culturally relevant
181.8 and linguistically appropriate:

181.9 (1) medically and scientifically accurate information on the safety, efficacy, science,
181.10 and benefits of COVID-19 vaccines; and

181.11 (2) information on how members of disproportionately impacted communities may
181.12 obtain a COVID-19 vaccine.

181.13 Subd. 4. **Community assistance.** The commissioner shall administer a program to help
181.14 members of disproportionately impacted communities arrange for and prepare to obtain a
181.15 COVID-19 vaccine and to support transportation-limited members of these communities
181.16 with transportation to vaccination appointments or otherwise arrange for vaccine providers
181.17 to reach members of these communities.

181.18 Subd. 5. **Equitable distribution of COVID-19 vaccines.** The commissioner shall
181.19 establish a set of metrics to measure the equitable distribution of COVID-19 vaccines in
181.20 the state, and shall set and periodically update goals for COVID-19 vaccine distribution in
181.21 the state that are focused on equity.

181.22 Subd. 6. **Expiration of programs.** The vaccine education and outreach programs in
181.23 subdivisions 2 and 3 and the community assistance program in subdivision 4 shall operate
181.24 until a sufficient percentage of individuals in each county or census tract have received the
181.25 full series of COVID-19 vaccines to protect individuals in each county or census tract from
181.26 COVID-19.

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

181.28 Sec. 19. **[144.0662] MOBILE VACCINATION PROGRAM.**

181.29 Subdivision 1. **Administration.** The commissioner, in partnership with local health
181.30 departments and the regional health care coalitions, shall administer a mobile vaccination
181.31 program in which mobile vaccination vehicles are deployed to communities around the state
181.32 to provide COVID-19 vaccines to individuals. The commissioner shall deploy mobile
181.33 vaccination vehicles to communities to improve access to vaccines based on factors that

182.1 include but are not limited to vulnerability, likelihood of exposure, limits to transportation
182.2 access, rate of vaccine uptake, and limited access to vaccines or barriers to obtaining vaccines.

182.3 Subd. 2. **Eligibility.** Notwithstanding the phases and priorities of the state's COVID-19
182.4 allocation and prioritization plan or guidance, all individuals in a community to which a
182.5 mobile vaccination vehicle is deployed shall be eligible to receive COVID-19 vaccines from
182.6 the vehicle.

182.7 Subd. 3. **Staffing.** Each mobile vaccination vehicle must be staffed in accordance with
182.8 Centers for Disease Control and Prevention guidelines and may be staffed with additional
182.9 support staff based on needs determined by local request. Additional support staff may
182.10 include but are not limited to community partners and translators.

182.11 Subd. 4. **Second doses.** For vaccine recipients who receive a first dose of a COVID-19
182.12 vaccine from a mobile vaccination vehicle, vehicle staff shall provide assistance in scheduling
182.13 an appointment with a mobile vaccination vehicle or with another vaccine provider for any
182.14 needed second dose or booster. The commissioner shall, to the extent possible, deploy
182.15 mobile vaccination vehicles in a manner that allows vaccine recipients to receive second
182.16 doses or boosters from a mobile vaccination vehicle.

182.17 Subd. 5. **Expiration.** The commissioner shall administer the mobile vaccination vehicle
182.18 program until a sufficient percentage of individuals in each county or census tract have
182.19 received the full series of COVID-19 vaccines to protect individuals in each county or
182.20 census tract from the spread of COVID-19.

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

182.22 Sec. 20. **[144.0663] COVID-19 VACCINATION PLAN AND DATA; REPORTS.**

182.23 Subdivision 1. **COVID-19 vaccination plan; implementation protocols.** The
182.24 commissioner shall:

182.25 (1) publish the set of metrics and goals for equitable COVID-19 vaccine distribution
182.26 established by the commissioner under section 144.0661, subdivision 5; and

182.27 (2) publish implementation protocols to address the disparities in COVID-19 vaccination
182.28 rates in certain communities and ensure that members of disproportionately impacted
182.29 communities are given adequate access to COVID-19 vaccines.

182.30 Subd. 2. **Data on COVID-19 vaccines.** On at least a weekly basis, the commissioner
182.31 shall publish on the department website:

183.1 (1) data measuring compliance with the set of metrics and goals for equitable COVID-19
183.2 vaccine distribution established by the commissioner under section 144.0661, subdivision
183.3 5; and

183.4 (2) summary data on individuals who have received one or two doses of a COVID-19
183.5 vaccine, broken out by race, gender, ethnicity, age within an age range, and zip code.

183.6 Subd. 3. **Quarterly reports.** On a quarterly basis while funds are available, the
183.7 commissioner shall report to the chairs and ranking minority members of the legislative
183.8 committees with jurisdiction over finance, ways and means, and health care:

183.9 (1) funds distributed to local health departments for COVID-19 activities and the sources
183.10 of the funds; and

183.11 (2) funds expended to implement sections 144.066 to 144.0663.

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

183.13 Sec. 21. Minnesota Statutes 2020, section 144.0724, subdivision 1, is amended to read:

183.14 Subdivision 1. **Resident reimbursement case mix classifications.** The commissioner
183.15 of health shall establish resident reimbursement case mix classifications based upon the
183.16 assessments of residents of nursing homes and boarding care homes conducted under this
183.17 section and according to section 256R.17.

183.18 Sec. 22. Minnesota Statutes 2020, section 144.0724, subdivision 2, is amended to read:

183.19 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
183.20 given.

183.21 (a) "Assessment reference date" or "ARD" means the specific end point for look-back
183.22 periods in the MDS assessment process. This look-back period is also called the observation
183.23 or assessment period.

183.24 (b) "Case mix index" means the weighting factors assigned to the RUG-IV classifications.

183.25 (c) "Index maximization" means classifying a resident who could be assigned to more
183.26 than one category, to the category with the highest case mix index.

183.27 (d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment,
183.28 and functional status elements, that include common definitions and coding categories
183.29 specified by the Centers for Medicare and Medicaid Services and designated by the
183.30 ~~Minnesota~~ Department of Health.

184.1 (e) "Representative" means a person who is the resident's guardian or conservator, the
184.2 person authorized to pay the nursing home expenses of the resident, a representative of the
184.3 Office of Ombudsman for Long-Term Care whose assistance has been requested, or any
184.4 other individual designated by the resident.

184.5 (f) "Resource utilization groups" or "RUG" means the system for grouping a nursing
184.6 facility's residents according to their clinical and functional status identified in data supplied
184.7 by the facility's Minimum Data Set.

184.8 (g) "Activities of daily living" ~~means grooming,~~ includes personal hygiene, dressing,
184.9 bathing, transferring, bed mobility, ~~positioning,~~ locomotion, eating, and toileting.

184.10 (h) "Nursing facility level of care determination" means the assessment process that
184.11 results in a determination of a resident's or prospective resident's need for nursing facility
184.12 level of care as established in subdivision 11 for purposes of medical assistance payment
184.13 of long-term care services for:

184.14 (1) nursing facility services under section 256B.434 or chapter 256R;

184.15 (2) elderly waiver services under chapter 256S;

184.16 (3) CADI and BI waiver services under section 256B.49; and

184.17 (4) state payment of alternative care services under section 256B.0913.

184.18 Sec. 23. Minnesota Statutes 2020, section 144.0724, subdivision 3a, is amended to read:

184.19 Subd. 3a. **Resident reimbursement case mix classifications beginning January 1,**
184.20 **2012.** (a) Beginning January 1, 2012, resident reimbursement case mix classifications shall
184.21 be based on the Minimum Data Set, version 3.0 assessment instrument, or its successor
184.22 version mandated by the Centers for Medicare and Medicaid Services that nursing facilities
184.23 are required to complete for all residents. The commissioner of health shall establish resident
184.24 classifications according to the RUG-IV, 48 group, resource utilization groups. Resident
184.25 classification must be established based on the individual items on the Minimum Data Set,
184.26 which must be completed according to the Long Term Care Facility Resident Assessment
184.27 Instrument User's Manual Version 3.0 or its successor issued by the Centers for Medicare
184.28 and Medicaid Services.

184.29 (b) Each resident must be classified based on the information from the Minimum Data
184.30 Set according to general categories ~~as defined in the Case Mix Classification Manual for~~
184.31 ~~Nursing Facilities~~ issued by the Minnesota Department of Health.

185.1 Sec. 24. Minnesota Statutes 2020, section 144.0724, subdivision 5, is amended to read:

185.2 Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an
185.3 admission assessment for all residents who stay in the facility 14 days or less~~.~~, unless the
185.4 resident is admitted and discharged from the facility on the same day, in which case the
185.5 admission assessment is not required. When an admission assessment is not submitted, the
185.6 case mix classification shall be the rate with a case mix index of 1.0.

185.7 (b) Notwithstanding the admission assessment requirements of paragraph (a), a facility
185.8 may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents
185.9 who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make
185.10 this election annually.

185.11 (c) Nursing facilities must elect one of the options described in paragraphs (a) and (b)
185.12 by reporting to the commissioner of health, as prescribed by the commissioner. The election
185.13 is effective on July 1 each year.

185.14 Sec. 25. Minnesota Statutes 2020, section 144.0724, subdivision 7, is amended to read:

185.15 Subd. 7. **Notice of resident reimbursement case mix classification.** (a) The
185.16 commissioner of health shall provide to a nursing facility a notice for each resident of the
185.17 ~~reimbursement~~ classification established under subdivision 1. The notice must inform the
185.18 resident of the case mix classification ~~that was~~ assigned, the opportunity to review the
185.19 documentation supporting the classification, the opportunity to obtain clarification from the
185.20 commissioner, and the opportunity to request a reconsideration of the classification and the
185.21 address and telephone number of the Office of Ombudsman for Long-Term Care. The
185.22 commissioner must transmit the notice of resident classification by electronic means to the
185.23 nursing facility. ~~A~~ The nursing facility is responsible for the distribution of the notice to
185.24 each resident~~, to the person responsible for the payment of the resident's nursing home~~
185.25 ~~expenses, or to another person designated by the resident~~ or the resident's representative.
185.26 This notice must be distributed within three ~~working~~ business days after the facility's receipt
185.27 ~~of the electronic file of notice of case mix classifications from the commissioner of health~~.

185.28 (b) If a facility submits a ~~modification to the most recent assessment used to establish~~
185.29 ~~a case mix classification conducted under subdivision 3 that results~~ modifying assessment
185.30 resulting in a change in the case mix classification, the facility ~~shall give~~ must provide a
185.31 written notice to the resident or the resident's representative ~~about~~ regarding the item or
185.32 items that ~~was~~ were modified and the reason for the ~~modification~~ modifications. The notice
185.33 ~~of modified assessment may~~ must be provided ~~at the same time that the resident or resident's~~

~~representative is provided the resident's modified notice of classification~~ within three business days after distribution of the resident case mix classification notice.

Sec. 26. Minnesota Statutes 2020, section 144.0724, subdivision 8, is amended to read:

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement case mix classification and any item or items changed during the audit process. The request for reconsideration must be submitted in writing to the commissioner ~~within 30 days of the day the resident or the resident's representative receives the resident classification notice~~ of health.

(b) For reconsideration requests initiated by the resident or the resident's representative:

(1) The resident or the resident's representative must submit in writing a reconsideration request to the facility administrator within 30 days of receipt of the resident classification notice. The written request ~~for reconsideration~~ must include the ~~name of the resident, the name and address of the facility in which the resident resides, the~~ reasons for the reconsideration~~, and documentation supporting the~~ request. ~~The documentation accompanying the reconsideration request is limited to a copy of the MDS that determined the classification and other documents that would support or change the MDS findings.~~

(2) Within three business days of receiving the reconsideration request, the nursing facility must submit to the commissioner of health a completed reconsideration request form, a copy of the resident's or resident's representative's written request, and all supporting documentation used to complete the assessment being considered. If the facility fails to provide the required information, the reconsideration will be completed with the information submitted and the facility cannot make further reconsideration requests on this classification.

~~(b)~~ (3) Upon written request and within three business days, the nursing facility must give the resident or the resident's representative a copy of the assessment ~~form~~ being reconsidered and ~~the other~~ all supporting documentation ~~that was given to the commissioner of health~~ used to ~~support~~ complete the assessment ~~findings~~. ~~The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information.~~ Notwithstanding any law to the contrary, the facility may not charge a fee for providing copies of the requested documentation. If a facility fails to provide the ~~material~~ required documents within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10.

187.1 Notwithstanding those sections, any correction order issued under this subdivision must
187.2 require that the nursing facility immediately comply with the request for information, and
187.3 ~~that~~ as of the date of the issuance of the correction order, the facility shall forfeit to the state
187.4 a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50
187.5 increments for each day the noncompliance continues.

187.6 (c) ~~in addition to the information required under paragraphs (a) and (b), a reconsideration~~
187.7 ~~request from a nursing facility must contain the following information: (i) the date the~~
187.8 ~~reimbursement classification notices were received by the facility; (ii) the date the~~
187.9 ~~classification notices were distributed to the resident or the resident's representative; and~~
187.10 ~~(iii)~~ For reconsideration requests initiated by the facility:

187.11 (1) The facility is required to inform the resident or the resident's representative in writing
187.12 that a reconsideration of the resident's case mix classification is being requested. The notice
187.13 must inform the resident or the resident's representative:

187.14 (i) of the date and reason for the reconsideration request;

187.15 (ii) of the potential for a classification and subsequent rate change;

187.16 (iii) of the extent of the potential rate change;

187.17 (iv) that copies of the request and supporting documentation are available for review;
187.18 and

187.19 (v) that the resident or the resident's representative has the right to request a
187.20 reconsideration.

187.21 (2) Within 30 days of receipt of the audit exit report or resident classification notice, the
187.22 facility must submit to the commissioner of health a completed reconsideration request
187.23 form, all supporting documentation used to complete the assessment being reconsidered,
187.24 and a copy of ~~a~~ the notice ~~sent to~~ informing the resident or ~~to~~ the resident's representative~~.~~
187.25 ~~This notice must inform the resident or the resident's representative~~ that a reconsideration
187.26 of the resident's classification is being requested~~, the reason for the request, that the resident's~~
187.27 ~~rate will change if the request is approved by the commissioner, the extent of the change,~~
187.28 ~~that copies of the facility's request and supporting documentation are available for review,~~
187.29 ~~and that the resident also has the right to request a reconsideration~~.

187.30 (3) If the facility fails to provide the required information ~~listed in item (iii) with the~~
187.31 ~~reconsideration request, the commissioner may request that the facility provide the~~
187.32 ~~information within 14 calendar days.~~, the reconsideration request ~~must~~ may be denied ~~if the~~

188.1 ~~information is then not provided,~~ and the facility may not make further reconsideration
188.2 requests on ~~that specific reimbursement~~ this classification.

188.3 (d) Reconsideration by the commissioner must be made by individuals not involved in
188.4 reviewing the assessment, audit, or reconsideration that established the disputed classification.
188.5 The reconsideration must be based upon the assessment that determined the classification
188.6 and upon the information provided to the commissioner of health under paragraphs (a) ~~and~~
188.7 ~~(b)~~ to (c). If necessary for evaluating the reconsideration request, the commissioner may
188.8 conduct on-site reviews. Within 15 ~~working~~ business days of receiving the request for
188.9 reconsideration, the commissioner shall affirm or modify the original resident classification.
188.10 The original classification must be modified if the commissioner determines that the
188.11 assessment resulting in the classification did not accurately reflect characteristics of the
188.12 resident at the time of the assessment. ~~The resident and the nursing facility or boarding care~~
188.13 ~~home shall be notified within five working days after the decision is made.~~ The commissioner
188.14 must transmit the reconsideration classification notice by electronic means to the nursing
188.15 facility. The nursing facility is responsible for the distribution of the notice to the resident
188.16 or the resident's representative. The notice must be distributed by the nursing facility within
188.17 three business days after receipt. A decision by the commissioner under this subdivision is
188.18 the final administrative decision of the agency for the party requesting reconsideration.

188.19 (e) The ~~resident~~ case mix classification established by the commissioner shall be the
188.20 classification ~~that~~ which applies to the resident while the request for reconsideration is
188.21 pending. If a request for reconsideration applies to an assessment used to determine nursing
188.22 facility level of care under subdivision 4, paragraph (c), the resident shall continue to be
188.23 eligible for nursing facility level of care while the request for reconsideration is pending.

188.24 (f) The commissioner may request additional documentation regarding a reconsideration
188.25 necessary to make an accurate reconsideration determination.

188.26 Sec. 27. Minnesota Statutes 2020, section 144.0724, subdivision 9, is amended to read:

188.27 Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident
188.28 assessments performed under section 256R.17 through any of the following: desk audits;
188.29 on-site review of residents and their records; and interviews with staff, residents, or residents'
188.30 families. The commissioner shall reclassify a resident if the commissioner determines that
188.31 the resident was incorrectly classified.

188.32 (b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

189.1 (c) A facility must grant the commissioner access to examine the medical records relating
189.2 to the resident assessments selected for audit under this subdivision. The commissioner may
189.3 also observe and speak to facility staff and residents.

189.4 (d) The commissioner shall consider documentation under the time frames for coding
189.5 items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment
189.6 Instrument User's Manual published by the Centers for Medicare and Medicaid Services.

189.7 (e) The commissioner shall develop an audit selection procedure that includes the
189.8 following factors:

189.9 (1) Each facility shall be audited annually. If a facility has two successive audits in which
189.10 the percentage of change is five percent or less and the facility has not been the subject of
189.11 a special audit in the past 36 months, the facility may be audited biannually. A stratified
189.12 sample of 15 percent, with a minimum of ten assessments, of the most current assessments
189.13 shall be selected for audit. If more than 20 percent of the RUG-IV classifications are changed
189.14 as a result of the audit, the audit shall be expanded to a second 15 percent sample, with a
189.15 minimum of ten assessments. If the total change between the first and second samples is
189.16 35 percent or greater, the commissioner may expand the audit to all of the remaining
189.17 assessments.

189.18 (2) If a facility qualifies for an expanded audit, the commissioner may audit the facility
189.19 again within six months. If a facility has two expanded audits within a 24-month period,
189.20 that facility will be audited at least every six months for the next 18 months.

189.21 (3) The commissioner may conduct special audits if the commissioner determines that
189.22 circumstances exist that could alter or affect the validity of case mix classifications of
189.23 residents. These circumstances include, but are not limited to, the following:

189.24 (i) frequent changes in the administration or management of the facility;

189.25 (ii) an unusually high percentage of residents in a specific case mix classification;

189.26 (iii) a high frequency in the number of reconsideration requests received from a facility;

189.27 (iv) frequent adjustments of case mix classifications as the result of reconsiderations or
189.28 audits;

189.29 (v) a criminal indictment alleging provider fraud;

189.30 (vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

189.31 (vii) an atypical pattern of scoring minimum data set items;

189.32 (viii) nonsubmission of assessments;

190.1 (ix) late submission of assessments; or

190.2 (x) a previous history of audit changes of 35 percent or greater.

190.3 (f) ~~Within 15 working days of completing the audit process, the commissioner shall~~
190.4 ~~make available electronically the results of the audit to the facility. If the results of the audit~~
190.5 ~~reflect a change in the resident's case mix classification, a case mix classification notice~~
190.6 ~~will be made available electronically to the facility, using the procedure in subdivision 7,~~
190.7 ~~paragraph (a). The notice must contain the resident's classification and a statement informing~~
190.8 ~~the resident, the resident's authorized representative, and the facility of their right to review~~
190.9 ~~the commissioner's documents supporting the classification and to request a reconsideration~~
190.10 ~~of the classification. This notice must also include the address and telephone number of the~~
190.11 ~~Office of Ombudsman for Long-Term Care.~~ If the audit results in a case mix classification
190.12 change, the commissioner must transmit the audit classification notice by electronic means
190.13 to the nursing facility within 15 business days of completing an audit. The nursing facility
190.14 is responsible for distribution of the notice to each resident or the resident's representative.
190.15 This notice must be distributed by the nursing facility within three business days after
190.16 receipt. The notice must inform the resident of the case mix classification assigned, the
190.17 opportunity to review the documentation supporting the classification, the opportunity to
190.18 obtain clarification from the commissioner, the opportunity to request a reconsideration of
190.19 the classification, and the address and telephone number of the Office of Ombudsman for
190.20 Long-Term Care.

190.21 Sec. 28. Minnesota Statutes 2020, section 144.0724, subdivision 12, is amended to read:

190.22 Subd. 12. **Appeal of nursing facility level of care determination.** (a) A resident or
190.23 prospective resident whose level of care determination results in a denial of long-term care
190.24 services can appeal the determination as outlined in section 256B.0911, subdivision 3a,
190.25 paragraph (h), clause (9).

190.26 (b) The commissioner of human services shall ensure that notice of changes in eligibility
190.27 due to a nursing facility level of care determination is provided to each affected recipient
190.28 or the recipient's guardian at least 30 days before the effective date of the change. The notice
190.29 shall include the following information:

190.30 (1) how to obtain further information on the changes;

190.31 (2) how to receive assistance in obtaining other services;

190.32 (3) a list of community resources; and

190.33 (4) appeal rights.

191.1 A recipient who meets the criteria in section 256B.0922, subdivision 2, paragraph (a), clauses
191.2 (1) and (2), may request continued services pending appeal within the time period allowed
191.3 to request an appeal under section 256.045, subdivision 3, paragraph (i). This paragraph is
191.4 in effect for appeals filed between January 1, 2015, and December 31, 2016.

191.5 Sec. 29. Minnesota Statutes 2020, section 144.1205, subdivision 2, is amended to read:

191.6 Subd. 2. **Initial and annual fee.** (a) A licensee must pay an initial fee that is equivalent
191.7 to the annual fee upon issuance of the initial license.

191.8 (b) A licensee must pay an annual fee at least 60 days before the anniversary date of the
191.9 issuance of the license. The annual fee is as follows:

	TYPE	ANNUAL LICENSE FEE
191.10–191.11	TYPE	ANNUAL LICENSE FEE
191.12–191.13	Academic broad scope - type A, B, or C	$19,920 $25,896
191.14	Academic broad scope - type B	19,920
191.15	Academic broad scope - type C	19,920
191.16	Academic broad scope - type A, B, or C (4-8 locations)	$31,075
191.17	Academic broad scope - type A, B, or C (9 or more locations)	$36,254
191.18–191.19	Medical broad scope - type A	19,920 $25,896
191.20	Medical broad scope- type A (4-8 locations)	$31,075
191.21	Medical broad scope- type A (9 or more locations)	$36,254
191.22	Medical institution - diagnostic and therapeutic	3,680
191.23–191.25	Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$4,784
191.26–191.28	Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (4-8 locations)	$5,740
191.29–191.31	Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (9 or more locations)	$6,697
191.32	Medical institution - diagnostic (no written directives)	3,680
191.33	Medical private practice - diagnostic and therapeutic	3,680
191.34	Medical private practice - diagnostic (no written directives)	3,680
191.35	Eye applicators	3,680
191.36	Nuclear medical vans	3,680
191.37	High dose rate afterloader	3,680
191.38	Mobile high dose rate afterloader	3,680
191.39	Medical therapy - other emerging technology	3,680

Line	Item	Fee
192.1–192.2	Teletherapy	~~8,960~~ $11,648
192.3–192.4	Gamma knife	~~8,960~~ $11,648
192.5	Veterinary medicine	~~2,000~~ $2,600
192.6	In vitro testing lab	~~2,000~~ $2,600
192.7–192.8	Nuclear pharmacy	~~8,800~~ $11,440
192.9	Nuclear pharmacy (5 or more locations)	$13,728
192.10	Radiopharmaceutical distribution (10 CFR 32.72)	~~3,840~~ $4,992
192.11–192.12	Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~8,800~~ $11,440
192.13–192.14	Radiopharmaceutical processing and distribution (10 CFR 32.72) (5 or more locations)	$13,728
192.15	Medical sealed sources - distribution (10 CFR 32.74)	~~3,840~~ $4,992
192.16–192.17	Medical sealed sources - processing and distribution (10 CFR 32.74)	~~8,800~~ $11,440
192.18–192.19	Medical sealed sources - processing and distribution (10 CFR 32.74) (5 or more locations)	$13,728
192.20	Well logging - sealed sources	~~3,760~~ $4,888
192.21–192.22	Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~2,000~~ $2,600
192.23	~~Measuring systems - portable gauge~~	~~2,000~~
192.24–192.25	Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (4-8 locations)	$3,120
192.26–192.27	Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (9 or more locations)	$3,640
192.28	X-ray fluorescent analyzer	~~1,520~~ $1,976
192.29	~~Measuring systems - gas chromatograph~~	~~2,000~~
192.30	~~Measuring systems - other~~	~~2,000~~
192.31–192.32	~~Broad scope~~ Manufacturing and distribution - type A broad scope	~~19,920~~ $25,896
192.33–192.34	Manufacturing and distribution - type A broad scope (4-8 locations)	$31,075
192.35–192.36	Manufacturing and distribution - type A broad scope (9 or more locations)	$36,254
192.37–192.38	~~Broad scope~~ Manufacturing and distribution - type B or C broad scope	~~17,600~~ $22,880
192.39	~~Broad scope Manufacturing and distribution - type C~~	~~17,600~~
192.40–192.41	Manufacturing and distribution - type B or C broad scope (4-8 locations)	$27,456
192.42–192.43	Manufacturing and distribution - type B or C broad scope (9 or more locations)	$32,032

Line	Item	Fee
193.1	Manufacturing and distribution - other	~~5,280~~ $6,864
193.2	Manufacturing and distribution - other (4-8 locations)	$8,236
193.3	Manufacturing and distribution - other (9 or more locations)	$9,609
193.4-193.5	Nuclear laundry	~~18,640~~ $24,232
193.6	Decontamination services	~~4,960~~ $6,448
193.7	Leak test services only	~~2,000~~ $2,600
193.8	Instrument calibration service only~~, less than 100 curies~~	~~2,000~~ $2,600
193.9	~~Instrument calibration service only, 100 curies or more~~	~~2,000~~
193.10	Service, maintenance, installation, source changes, etc.	~~4,960~~ $6,448
193.11	Waste disposal service, prepackaged only	~~6,000~~ $7,800
193.12-193.13	Waste disposal	~~8,320~~ $10,816
193.14	Distribution - general licensed devices (sealed sources)	~~1,760~~ $2,288
193.15	Distribution - general licensed material (unsealed sources)	~~1,120~~ $1,456
193.16-193.17	Industrial radiography - fixed or temporary location	~~9,840~~ $12,792
193.18	~~Industrial radiography - temporary job sites~~	~~9,840~~
193.19-193.20	Industrial radiography - fixed or temporary location (5 or more locations)	$16,629
193.21	Irradiators, self-shielding~~, less than 10,000 curies~~	~~2,880~~ $3,744
193.22	Irradiators, other, less than 10,000 curies	~~5,360~~ $6,968
193.23	~~Irradiators, self-shielding, 10,000 curies or more~~	~~2,880~~
193.24-193.25	Research and development - type A, B, or C broad scope	~~9,520~~ $12,376
193.26	~~Research and development - type B broad scope~~	~~9,520~~
193.27	~~Research and development - type C broad scope~~	~~9,520~~
193.28-193.29	Research and development - type A, B, or C broad scope (4-8 locations)	$14,851
193.30-193.31	Research and development - type A, B, or C broad scope (9 or more locations)	$17,326
193.32	Research and development - other	~~4,480~~ $5,824
193.33	Storage - no operations	~~2,000~~ $2,600
193.34	Source material - shielding	~~584~~ $759
193.35	Special nuclear material plutonium - neutron source in device	~~3,680~~ $4,784
193.36-193.37	Pacemaker by-product and/or special nuclear material - medical (institution)	~~3,680~~ $4,784
193.38-193.39	Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~5,280~~ $6,864
193.40	Accelerator-produced radioactive material	~~3,840~~ $4,992

194.1 Nonprofit educational institutions	~~300~~ $500
194.2 ~~General license registration~~	~~150~~

194.3 Sec. 30. Minnesota Statutes 2020, section 144.1205, subdivision 4, is amended to read:

194.4 Subd. 4. **Initial and renewal application fee.** A licensee must pay an initial and a
194.5 renewal application fee ~~as follows:~~ according to this subdivision.

194.6 TYPE	APPLICATION FEE
194.7 194.8 Academic broad scope - type A, B, or C	~~$ 5,920~~ $6,808
194.9 ~~Academic broad scope - type B~~	~~5,920~~
194.10 ~~Academic broad scope - type C~~	~~5,920~~
194.11 Medical broad scope - type A	~~3,920~~ $4,508
194.12 Medical - diagnostic, diagnostic and therapeutic, mobile nuclear 194.13 medicine, eye applicators, high dose rate afterloaders, and 194.14 medical therapy emerging technologies	$1,748
194.15 ~~Medical institution - diagnostic and therapeutic~~	~~1,520~~
194.16 ~~Medical institution - diagnostic (no written directives)~~	~~1,520~~
194.17 ~~Medical private practice - diagnostic and therapeutic~~	~~1,520~~
194.18 ~~Medical private practice - diagnostic (no written directives)~~	~~1,520~~
194.19 ~~Eye applicators~~	~~1,520~~
194.20 ~~Nuclear medical vans~~	~~1,520~~
194.21 ~~High dose rate afterloader~~	~~1,520~~
194.22 ~~Mobile high dose rate afterloader~~	~~1,520~~
194.23 ~~Medical therapy - other emerging technology~~	~~1,520~~
194.24 Teletherapy	~~5,520~~ $6,348
194.25 Gamma knife	~~5,520~~ $6,348
194.26 Veterinary medicine	~~960~~ $1,104
194.27 In vitro testing lab	~~960~~ $1,104
194.28 Nuclear pharmacy	~~4,880~~ $5,612
194.29 Radiopharmaceutical distribution (10 CFR 32.72)	~~2,160~~ $2,484
194.30 Radiopharmaceutical processing and distribution (10 CFR 194.31 32.72)	~~4,880~~ $5,612
194.32 Medical sealed sources - distribution (10 CFR 32.74)	~~2,160~~ $2,484
194.33 Medical sealed sources - processing and distribution (10 CFR 194.34 32.74)	~~4,880~~ $5,612
194.35 Well logging - sealed sources	~~1,600~~ $1,840
194.36 Measuring systems - (fixed gauge, portable gauge, gas 194.37 chromatograph, other)	~~960~~ $1,104
194.38 ~~Measuring systems - portable gauge~~	~~960~~

195.1	X-ray fluorescent analyzer	~~584~~ $671
195.2	~~Measuring systems - gas chromatograph~~	~~960~~
195.3	~~Measuring systems - other~~	~~960~~
195.4 195.5	~~Broad scope~~ Manufacturing and distribution - type A, B, and C broad scope	~~5,920~~ $6,854
195.6	~~Broad scope manufacturing and distribution - type B~~	~~5,920~~
195.7	~~Broad scope manufacturing and distribution - type C~~	~~5,920~~
195.8	Manufacturing and distribution - other	~~2,320~~ $2,668
195.9 195.10	Nuclear laundry	~~10,080~~ $11,592
195.11	Decontamination services	~~2,640~~ $3,036
195.12	Leak test services only	~~960~~ $1,104
195.13	Instrument calibration service only~~, less than 100 curies~~	~~960~~ $1,104
195.14	~~Instrument calibration service only, 100 curies or more~~	~~960~~
195.15	Service, maintenance, installation, source changes, etc.	~~2,640~~ $3,036
195.16	Waste disposal service, prepackaged only	~~2,240~~ $2,576
195.17	Waste disposal	~~1,520~~ $1,748
195.18	Distribution - general licensed devices (sealed sources)	~~880~~ $1,012
195.19	Distribution - general licensed material (unsealed sources)	~~520~~ $598
195.20	Industrial radiography - fixed or temporary location	~~2,640~~ $3,036
195.21	~~Industrial radiography - temporary job sites~~	~~2,640~~
195.22	Irradiators, self-shielding~~, less than 10,000 curies~~	~~1,440~~ $1,656
195.23	Irradiators, other, less than 10,000 curies	~~2,960~~ $3,404
195.24	~~Irradiators, self-shielding, 10,000 curies or more~~	~~1,440~~
195.25	Research and development - type A, B, or C broad scope	~~4,960~~ $5,704
195.26	~~Research and development - type B broad scope~~	~~4,960~~
195.27	~~Research and development - type C broad scope~~	~~4,960~~
195.28	Research and development - other	~~2,400~~ $2,760
195.29	Storage - no operations	~~960~~ $1,104
195.30	Source material - shielding	~~136~~ $156
195.31	Special nuclear material plutonium - neutron source in device	~~1,200~~ $1,380
195.32 195.33	Pacemaker by-product and/or special nuclear material - medical (institution)	~~1,200~~ $1,380
195.34 195.35	Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~2,320~~ $2,668
195.36	Accelerator-produced radioactive material	~~4,100~~ $4,715
195.37	Nonprofit educational institutions	~~300~~ $345
195.38	~~General license registration~~	~~0~~
195.39	~~Industrial radiographer certification~~	~~150~~

196.1 Sec. 31. Minnesota Statutes 2020, section 144.1205, subdivision 8, is amended to read:

196.2 Subd. 8. **Reciprocity fee.** A licensee submitting an application for reciprocal recognition
196.3 of a materials license issued by another agreement state or the United States Nuclear
196.4 Regulatory Commission for a period of 180 days or less during a calendar year must pay
196.5 ~~$1,200~~ <u>$2,400</u>. For a period of 181 days or more, the licensee must obtain a license under
196.6 subdivision 4.

196.7 Sec. 32. Minnesota Statutes 2020, section 144.1205, subdivision 9, is amended to read:

196.8 Subd. 9. **Fees for license amendments.** A licensee must pay a fee of ~~$300~~ <u>$600</u> to
196.9 amend a license as follows:

196.10 (1) to amend a license requiring review including, but not limited to, addition of isotopes,
196.11 procedure changes, new authorized users, or a new radiation safety officer; ~~and~~ <u>or</u>

196.12 (2) to amend a license requiring review and a site visit including, but not limited to,
196.13 facility move or addition of processes.

196.14 Sec. 33. Minnesota Statutes 2020, section 144.1205, is amended by adding a subdivision
196.15 to read:

196.16 <u>Subd. 10.</u> <u>**Fees for general license registrations.**</u> <u>A person required to register generally</u>
196.17 <u>licensed devices according to Minnesota Rules, part 4731.3215, must pay an annual</u>
196.18 <u>registration fee of $450.</u>

196.19 Sec. 34. Minnesota Statutes 2020, section 144.125, subdivision 1, is amended to read:

196.20 Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative officer
196.21 or other person in charge of each institution caring for infants 28 days or less of age, (2) the
196.22 person required in pursuance of the provisions of section 144.215, to register the birth of a
196.23 child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have
196.24 administered to every infant or child in its care tests for heritable and congenital disorders
196.25 according to subdivision 2 and rules prescribed by the state commissioner of health.

196.26 (b) Testing, recording of test results, reporting of test results, and follow-up of infants
196.27 with heritable congenital disorders, including hearing loss detected through the early hearing
196.28 detection and intervention program in section 144.966, shall be performed at the times and
196.29 in the manner prescribed by the commissioner of health.

196.30 (c) The fee to support the newborn screening program, including tests administered
196.31 under this section and section 144.966, shall be ~~$135~~ <u>$177</u> per specimen. This fee amount

197.1 shall be deposited in the state treasury and credited to the state government special revenue
197.2 fund.

197.3 (d) The fee to offset the cost of the support services provided under section 144.966,
197.4 subdivision 3a, shall be $15 per specimen. This fee shall be deposited in the state treasury
197.5 and credited to the general fund.

197.6 Sec. 35. **[144.1461] DIGNITY IN PREGNANCY AND CHILDBIRTH.**

197.7 Subdivision 1. **Citation.** This section may be cited as the "Dignity in Pregnancy and
197.8 Childbirth Act."

197.9 Subd. 2. **Continuing education requirement.** (a) Hospitals with obstetric care and birth
197.10 centers must provide continuing education on anti-racism training and implicit bias. The
197.11 continuing education must be evidence-based and must include at a minimum the following
197.12 criteria:

197.13 (1) education aimed at identifying personal, interpersonal, institutional, structural, and
197.14 cultural barriers to inclusion;

197.15 (2) identifying and implementing corrective measures to promote anti-racism practices
197.16 and decrease implicit bias at the interpersonal and institutional levels, including the
197.17 institution's ongoing policies and practices;

197.18 (3) providing information on the ongoing effects of historical and contemporary exclusion
197.19 and oppression of Black and Indigenous communities with the greatest health disparities
197.20 related to maternal and infant mortality and morbidity;

197.21 (4) providing information and discussion of health disparities in the perinatal health care
197.22 field including how systemic racism and implicit bias have different impacts on health
197.23 outcomes for different racial and ethnic communities; and

197.24 (5) soliciting perspectives of diverse, local constituency groups and experts on racial,
197.25 identity, cultural, and provider-community relationship issues.

197.26 (b) In addition to the initial continuing educational requirement in paragraph (a), hospitals
197.27 with obstetric care and birth centers must provide an annual refresher course that reflects
197.28 current trends on race, culture, identity, and anti-racism principles and institutional implicit
197.29 bias.

197.30 (c) Hospitals with obstetric care and birth centers must develop continuing education
197.31 materials on anti-racism and implicit bias that must be provided and updated annually for

198.1 direct care employees and contractors who routinely care for patients who are pregnant or
198.2 postpartum.

198.3 (d) Hospitals with obstetric care and birth centers shall coordinate with health-related
198.4 licensing boards to obtain continuing education credits for the trainings and materials
198.5 required in this section. The commissioner of health shall monitor compliance with this
198.6 section. Initial training for the continuing education requirements in this subdivision must
198.7 be completed by December 31, 2022. The commissioner may inspect the training records
198.8 or require reports on the continuing education materials in this section from hospitals with
198.9 obstetric care and birth centers.

198.10 (e) A facility described in paragraph (d) must provide a certificate of training completion
198.11 to another facility or a training attendee upon request. A facility may accept the training
198.12 certificate from another facility for a health care provider that works in more than one
198.13 facility.

198.14 Sec. 36. Minnesota Statutes 2020, section 144.1481, subdivision 1, is amended to read:

198.15 Subdivision 1. **Establishment; membership.** The commissioner of health shall establish
198.16 a ~~15-member~~ 16-member Rural Health Advisory Committee. The committee shall consist
198.17 of the following members, all of whom must reside outside the seven-county metropolitan
198.18 area, as defined in section 473.121, subdivision 2:

198.19 (1) two members from the house of representatives of the state of Minnesota, one from
198.20 the majority party and one from the minority party;

198.21 (2) two members from the senate of the state of Minnesota, one from the majority party
198.22 and one from the minority party;

198.23 (3) a volunteer member of an ambulance service based outside the seven-county
198.24 metropolitan area;

198.25 (4) a representative of a hospital located outside the seven-county metropolitan area;

198.26 (5) a representative of a nursing home located outside the seven-county metropolitan
198.27 area;

198.28 (6) a medical doctor or doctor of osteopathic medicine licensed under chapter 147;

198.29 (7) a dentist licensed under chapter 150A;

198.30 (8) a midlevel practitioner;

198.31 ~~(8)~~ (9) a registered nurse or licensed practical nurse;

199.1 ~~(9)~~ (10) a licensed health care professional from an occupation not otherwise represented
199.2 on the committee;

199.3 ~~(10)~~ (11) a representative of an institution of higher education located outside the
199.4 seven-county metropolitan area that provides training for rural health care providers; and

199.5 ~~(11)~~ (12) three consumers, at least one of whom must be an advocate for persons who
199.6 are mentally ill or developmentally disabled.

199.7 The commissioner will make recommendations for committee membership. Committee
199.8 members will be appointed by the governor. In making appointments, the governor shall
199.9 ensure that appointments provide geographic balance among those areas of the state outside
199.10 the seven-county metropolitan area. The chair of the committee shall be elected by the
199.11 members. The advisory committee is governed by section 15.059, except that the members
199.12 do not receive per diem compensation.

199.13 Sec. 37. Minnesota Statutes 2020, section 144.1501, subdivision 1, is amended to read:

199.14 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions
199.15 apply.

199.16 (b) "Advanced dental therapist" means an individual who is licensed as a dental therapist
199.17 under section 150A.06, and who is certified as an advanced dental therapist under section
199.18 150A.106.

199.19 (c) "Alcohol and drug counselor" means an individual who is licensed as an alcohol and
199.20 drug counselor under chapter 148F.

199.21 ~~(c)~~ (d) "Dental therapist" means an individual who is licensed as a dental therapist under
199.22 section 150A.06.

199.23 ~~(d)~~ (e) "Dentist" means an individual who is licensed to practice dentistry.

199.24 ~~(e)~~ (f) "Designated rural area" means a statutory and home rule charter city or township
199.25 that is outside the seven-county metropolitan area as defined in section 473.121, subdivision
199.26 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

199.27 ~~(f)~~ (g) "Emergency circumstances" means those conditions that make it impossible for
199.28 the participant to fulfill the service commitment, including death, total and permanent
199.29 disability, or temporary disability lasting more than two years.

199.30 ~~(g)~~ (h) "Mental health professional" means an individual providing clinical services in
199.31 the treatment of mental illness who is qualified in at least one of the ways specified in section
199.32 245.462, subdivision 18.

~~(h)~~ (i) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(i)~~ (j) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

~~(j)~~ (k) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

~~(k)~~ (l) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

~~(l)~~ (m) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners.

~~(m)~~ (n) "Pharmacist" means an individual with a valid license issued under chapter 151.

~~(n)~~ (o) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(o)~~ (p) "Physician assistant" means a person licensed under chapter 147A.

~~(p)~~ (q) "Public health nurse" means a registered nurse licensed in Minnesota who has obtained a registration certificate as a public health nurse from the Board of Nursing in accordance with Minnesota Rules, chapter 6316.

~~(q)~~ (r) "Qualified educational loan" means a government, commercial, or foundation loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

~~(r)~~ (s) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Sec. 38. Minnesota Statutes 2020, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

201.1 (1) for medical residents ~~and~~, mental health professionals, and alcohol and drug
201.2 counselors agreeing to practice in designated rural areas or underserved urban communities
201.3 or specializing in the area of pediatric psychiatry;

201.4 (2) for midlevel practitioners agreeing to practice in designated rural areas or to teach
201.5 at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program
201.6 at the undergraduate level or the equivalent at the graduate level;

201.7 (3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care
201.8 facility for persons with developmental disability; a hospital if the hospital owns and operates
201.9 a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse
201.10 is in the nursing home; a housing with services establishment as defined in section 144D.01,
201.11 subdivision 4; or for a home care provider as defined in section 144A.43, subdivision 4; or
201.12 agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a
201.13 postsecondary program at the undergraduate level or the equivalent at the graduate level;

201.14 (4) for other health care technicians agreeing to teach at least 12 credit hours, or 720
201.15 hours per year in their designated field in a postsecondary program at the undergraduate
201.16 level or the equivalent at the graduate level. The commissioner, in consultation with the
201.17 Healthcare Education-Industry Partnership, shall determine the health care fields where the
201.18 need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory
201.19 technology, radiologic technology, and surgical technology;

201.20 (5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses
201.21 who agree to practice in designated rural areas; and

201.22 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient
201.23 encounters to state public program enrollees or patients receiving sliding fee schedule
201.24 discounts through a formal sliding fee schedule meeting the standards established by the
201.25 United States Department of Health and Human Services under Code of Federal Regulations,
201.26 title 42, section 51, chapter 303.

201.27 (b) Appropriations made to the account do not cancel and are available until expended,
201.28 except that at the end of each biennium, any remaining balance in the account that is not
201.29 committed by contract and not needed to fulfill existing commitments shall cancel to the
201.30 fund.

201.31 Sec. 39. Minnesota Statutes 2020, section 144.1501, subdivision 3, is amended to read:

201.32 Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an
201.33 individual must:

202.1 (1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training or
202.2 education program to become a dentist, dental therapist, advanced dental therapist, mental
202.3 health professional, alcohol and drug counselor, pharmacist, public health nurse, midlevel
202.4 practitioner, registered nurse, or a licensed practical nurse. The commissioner may also
202.5 consider applications submitted by graduates in eligible professions who are licensed and
202.6 in practice; and

202.7 (2) submit an application to the commissioner of health.

202.8 (b) An applicant selected to participate must sign a contract to agree to serve a minimum
202.9 three-year full-time service obligation according to subdivision 2, which shall begin no later
202.10 than March 31 following completion of required training, with the exception of a nurse,
202.11 who must agree to serve a minimum two-year full-time service obligation according to
202.12 subdivision 2, which shall begin no later than March 31 following completion of required
202.13 training.

202.14 Sec. 40. Minnesota Statutes 2020, section 144.1911, subdivision 6, is amended to read:

202.15 Subd. 6. **International medical graduate primary care residency grant program**
202.16 **and revolving account.** (a) The commissioner shall award grants to support primary care
202.17 residency positions designated for Minnesota immigrant physicians who are willing to serve
202.18 in rural or underserved areas of the state. No grant shall exceed $150,000 per residency
202.19 position per year. Eligible primary care residency grant recipients include accredited family
202.20 medicine, general surgery, internal medicine, obstetrics and gynecology, psychiatry, and
202.21 pediatric residency programs. Eligible primary care residency programs shall apply to the
202.22 commissioner. Applications must include the number of anticipated residents to be funded
202.23 using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to
202.24 grantees in a grant agreement do not lapse until the grant agreement expires. Before any
202.25 funds are distributed, a grant recipient shall provide the commissioner with the following:

202.26 (1) a copy of the signed contract between the primary care residency program and the
202.27 participating international medical graduate;

202.28 (2) certification that the participating international medical graduate has lived in
202.29 Minnesota for at least two years and is certified by the Educational Commission on Foreign
202.30 Medical Graduates. Residency programs may also require that participating international
202.31 medical graduates hold a Minnesota certificate of clinical readiness for residency, once the
202.32 certificates become available; and

203.1 (3) verification that the participating international medical graduate has executed a
203.2 participant agreement pursuant to paragraph (b).

203.3 (b) Upon acceptance by a participating residency program, international medical graduates
203.4 shall enter into an agreement with the commissioner to provide primary care for at least
203.5 five years in a rural or underserved area of Minnesota after graduating from the residency
203.6 program and make payments to the revolving international medical graduate residency
203.7 account for five years beginning in their second year of postresidency employment.
203.8 Participants shall pay $15,000 or ten percent of their annual compensation each year,
203.9 whichever is less.

203.10 (c) A revolving international medical graduate residency account is established as an
203.11 account in the special revenue fund in the state treasury. The commissioner of management
203.12 and budget shall credit to the account appropriations, payments, and transfers to the account.
203.13 Earnings, such as interest, dividends, and any other earnings arising from fund assets, must
203.14 be credited to the account. Funds in the account are appropriated annually to the
203.15 commissioner to award grants and administer the grant program established in paragraph
203.16 (a). Notwithstanding any law to the contrary, any funds deposited in the account do not
203.17 expire. The commissioner may accept contributions to the account from private sector
203.18 entities subject to the following provisions:

203.19 (1) the contributing entity may not specify the recipient or recipients of any grant issued
203.20 under this subdivision;

203.21 (2) the commissioner shall make public the identity of any private contributor to the
203.22 account, as well as the amount of the contribution provided; and

203.23 (3) a contributing entity may not specify that the recipient or recipients of any funds use
203.24 specific products or services, nor may the contributing entity imply that a contribution is
203.25 an endorsement of any specific product or service.

203.26 Sec. 41. Minnesota Statutes 2020, section 144.212, is amended by adding a subdivision
203.27 to read:

203.28 Subd. 12. **Homeless youth.** "Homeless youth" has the meaning given in section 256K.45,
203.29 subdivision 1a.

203.30 Sec. 42. Minnesota Statutes 2020, section 144.225, subdivision 2, is amended to read:

203.31 Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data
203.32 pertaining to the birth of a child to a woman who was not married to the child's father when

204.1 the child was conceived nor when the child was born, including the original record of birth
204.2 and the certified vital record, are confidential data. At the time of the birth of a child to a
204.3 woman who was not married to the child's father when the child was conceived nor when
204.4 the child was born, the mother may designate demographic data pertaining to the birth as
204.5 public. Notwithstanding the designation of the data as confidential, it may be disclosed:

204.6 (1) to a parent or guardian of the child;

204.7 (2) to the child when the child is 16 years of age or older, except as provided in clause
204.8 (3);

204.9 (3) to the child if the child is a homeless youth;

204.10 ~~(3)~~ (4) under paragraph (b), (e), ~~or~~ (f), or (g); or

204.11 ~~(4)~~ (5) pursuant to a court order. For purposes of this section, a subpoena does not
204.12 constitute a court order.

204.13 (b) Unless the child is adopted, data pertaining to the birth of a child that are not accessible
204.14 to the public become public data if 100 years have elapsed since the birth of the child who
204.15 is the subject of the data, or as provided under section 13.10, whichever occurs first.

204.16 (c) If a child is adopted, data pertaining to the child's birth are governed by the provisions
204.17 relating to adoption records, including sections 13.10, subdivision 5; 144.218, subdivision
204.18 1; 144.2252; and 259.89.

204.19 (d) The name and address of a mother under paragraph (a) and the child's date of birth
204.20 may be disclosed to the county social services, tribal health department, or public health
204.21 member of a family services collaborative for purposes of providing services under section
204.22 124D.23.

204.23 (e) The commissioner of human services shall have access to birth records for:

204.24 (1) the purposes of administering medical assistance and the MinnesotaCare program;

204.25 (2) child support enforcement purposes; and

204.26 (3) other public health purposes as determined by the commissioner of health.

204.27 (f) Tribal child support programs shall have access to birth records for child support
204.28 enforcement purposes.

204.29 (g) An entity administering a children's savings program that starts at birth shall have
204.30 access to birth records for the purpose of opening an account in the program for the child
204.31 as a beneficiary. For purposes of this paragraph, "children's savings program" means a

205.1 long-term savings or investment program that helps children and their families build savings
205.2 for the future.

205.3 Sec. 43. Minnesota Statutes 2020, section 144.225, subdivision 7, is amended to read:

205.4 Subd. 7. **Certified birth or death record.** (a) The state registrar or local issuance office
205.5 shall issue a certified birth or death record or a statement of no vital record found to an
205.6 individual upon the individual's proper completion of an attestation provided by the
205.7 commissioner and, except as provided in section 144.2255, payment of the required fee:

205.8 (1) to a person who ~~has a tangible interest in the requested vital record. A person who~~
205.9 ~~has a tangible interest~~ is:

205.10 (i) the subject of the vital record;

205.11 (ii) a child of the subject;

205.12 (iii) the spouse of the subject;

205.13 (iv) a parent of the subject;

205.14 (v) the grandparent or grandchild of the subject;

205.15 (vi) if the requested record is a death record, a sibling of the subject;

205.16 ~~(vii) the party responsible for filing the vital record;~~

205.17 ~~(viii)~~ (vii) the legal custodian, guardian or conservator, or health care agent of the subject;

205.18 ~~(ix)~~ (viii) a personal representative, by sworn affidavit of the fact that the certified copy
205.19 is required for administration of the estate;

205.20 ~~(x)~~ (ix) a successor of the subject, as defined in section 524.1-201, if the subject is
205.21 deceased, by sworn affidavit of the fact that the certified copy is required for administration
205.22 of the estate;

205.23 ~~(xi)~~ (x) if the requested record is a death record, a trustee of a trust by sworn affidavit
205.24 of the fact that the certified copy is needed for the proper administration of the trust;

205.25 ~~(xii)~~ (xi) a person or entity who demonstrates that a certified vital record is necessary
205.26 for the determination or protection of a personal or property right, pursuant to rules adopted
205.27 by the commissioner; or

205.28 ~~(xiii)~~ (xii) an adoption agency in order to complete confidential postadoption searches
205.29 as required by section 259.83;

206.1 (2) to any local, state, tribal, or federal governmental agency upon request if the certified
206.2 vital record is necessary for the governmental agency to perform its authorized duties;

206.3 (3) to an attorney representing the subject of the vital record or another person listed in
206.4 clause (1), upon evidence of the attorney's license;

206.5 (4) pursuant to a court order issued by a court of competent jurisdiction. For purposes
206.6 of this section, a subpoena does not constitute a court order; or

206.7 (5) to a representative authorized by a person under clauses (1) to (4).

206.8 (b) The state registrar or local issuance office shall also issue a certified death record to
206.9 an individual described in paragraph (a), clause (1), items (ii) to ~~(viii)~~ (xi), if, on behalf of
206.10 the individual, a licensed mortician furnishes the registrar with a properly completed
206.11 attestation in the form provided by the commissioner within 180 days of the time of death
206.12 of the subject of the death record. This paragraph is not subject to the requirements specified
206.13 in Minnesota Rules, part 4601.2600, subpart 5, item B.

206.14 Sec. 44. **[144.2255] CERTIFIED BIRTH RECORD FOR HOMELESS YOUTH.**

206.15 Subdivision 1. **Application; certified birth record.** A subject of a birth record who is
206.16 a homeless youth in Minnesota or another state may apply to the state registrar or a local
206.17 issuance office for a certified birth record according to this section. The state registrar or
206.18 local issuance office shall issue a certified birth record or statement of no vital record found
206.19 to a subject of a birth record who submits:

206.20 (1) a completed application signed by the subject of the birth record;

206.21 (2) a statement that the subject of the birth record is a homeless youth, signed by the
206.22 subject of the birth record; and

206.23 (3) one of the following:

206.24 (i) a document of identity listed in Minnesota Rules, part 4601.2600, subpart 8, or, at
206.25 the discretion of the state registrar or local issuance office, Minnesota Rules, part 4601.2600,
206.26 subpart 9;

206.27 (ii) a statement that complies with Minnesota Rules, part 4601.2600, subparts 6 and 7;
206.28 or

206.29 (iii) a statement verifying that the subject of the birth record is a homeless youth that
206.30 complies with the requirements in subdivision 2 and is from an employee of a human services
206.31 agency that receives public funding to provide services to homeless youth, runaway youth,

207.1 youth with mental illness, or youth with substance use disorders; a school staff person who
207.2 provides services to homeless youth; or a school social worker.

207.3 Subd. 2. **Statement verifying subject is a homeless youth.** A statement verifying that
207.4 a subject of a birth record is a homeless youth must include:

207.5 (1) the following information regarding the individual providing the statement: first
207.6 name, middle name, if any, and last name; home or business address; telephone number, if
207.7 any; and e-mail address, if any;

207.8 (2) the first name, middle name, if any, and last name of the subject of the birth record;
207.9 and

207.10 (3) a statement specifying the relationship of the individual providing the statement to
207.11 the subject of the birth record and verifying that the subject of the birth record is a homeless
207.12 youth.

207.13 The individual providing the statement must also provide a copy of the individual's
207.14 employment identification.

207.15 Subd. 3. **Expiration; reissuance.** If a subject of a birth record obtains a certified birth
207.16 record under this section using the statement specified in subdivision 1, clause (3), item
207.17 (iii), the certified birth record issued shall expire six months after the date of issuance. Upon
207.18 expiration of the certified birth record, the subject of the birth record may surrender the
207.19 expired birth record to the state registrar or a local issuance office and obtain another birth
207.20 record. Each certified birth record obtained under this subdivision shall expire six months
207.21 after the date of issuance. If the subject of the birth record does not surrender the expired
207.22 birth record, the subject may apply for a certified birth record using the process in subdivision
207.23 1.

207.24 Subd. 4. **Fees waived.** The state registrar or local issuance office shall not charge any
207.25 fee for issuance of a certified birth record or statement of no vital record found under this
207.26 section.

207.27 Subd. 5. **Data practices.** Data listed under subdivision 1, clauses (2) and (3), item (iii),
207.28 are private data on individuals.

207.29 **EFFECTIVE DATE.** This section is effective the day following final enactment for
207.30 applications for and the issuance of certified birth records on or after January 1, 2022.

208.1 Sec. 45. Minnesota Statutes 2020, section 144.226, is amended by adding a subdivision
208.2 to read:

208.3 Subd. 7. **Transaction fees.** The state registrar may charge and permit agents to charge
208.4 a convenience fee and a transaction fee for electronic transactions and transactions by
208.5 telephone or Internet, as well as the fees established under subdivisions 1 to 4. The
208.6 convenience fee may not exceed three percent of the cost of the charges for payment. The
208.7 state registrar may permit agents to charge and retain a transaction fee as payment agreed
208.8 upon under contract. When an electronic convenience fee or transaction fee is charged, the
208.9 agent charging the fee is required to post information on their web page informing individuals
208.10 of the fee. The information must be near the point of payment, clearly visible, include the
208.11 amount of the fee, and state: "This contracted agent is allowed by state law to charge a
208.12 convenience fee and transaction fee for this electronic transaction."

208.13 Sec. 46. Minnesota Statutes 2020, section 144.226, is amended by adding a subdivision
208.14 to read:

208.15 Subd. 8. **Birth record fees waived for homeless youth.** A subject of a birth record who
208.16 is a homeless youth shall not be charged any of the fees specified in this section for a certified
208.17 birth record or statement of no vital record found under section 144.2255.

208.18 **EFFECTIVE DATE.** This section is effective the day following final enactment for
208.19 applications for and the issuance of certified birth records on or after January 1, 2022.

208.20 Sec. 47. Minnesota Statutes 2020, section 144.55, subdivision 4, is amended to read:

208.21 Subd. 4. **Routine inspections; presumption.** Any hospital surveyed and accredited
208.22 under the standards of the hospital accreditation program of an approved accrediting
208.23 organization that submits to the commissioner within a reasonable time copies of (a) its
208.24 currently valid accreditation certificate and accreditation letter, together with accompanying
208.25 recommendations and comments and (b) any further recommendations, progress reports
208.26 and correspondence directly related to the accreditation is presumed to comply with
208.27 application requirements of subdivision 1 and the standards requirements of subdivision 3
208.28 and no further routine inspections or accreditation information shall be required by the
208.29 commissioner to determine compliance. Notwithstanding the provisions of sections 144.54
208.30 and 144.653, subdivisions 2 and 4, hospitals shall be inspected only as provided in this
208.31 section. The provisions of section 144.653 relating to the assessment and collection of fines
208.32 shall not apply to any hospital. The commissioner of health shall annually conduct, with
208.33 notice, validation inspections of a selected sample of the number of hospitals accredited by

209.1 an approved accrediting organization, not to exceed ten percent of accredited hospitals, for
209.2 the purpose of determining compliance with the provisions of subdivision 3. If a validation
209.3 survey discloses a failure to comply with subdivision 3, the provisions of section 144.653
209.4 relating to correction orders, reinspections, and notices of noncompliance shall apply. The
209.5 commissioner shall also conduct any inspection necessary to determine whether hospital
209.6 construction, addition, or remodeling projects comply with standards for construction
209.7 promulgated in rules pursuant to subdivision 3. The commissioner shall also conduct any
209.8 inspections necessary to determine whether a hospital or hospital corporate system continues
209.9 to satisfy the conditions on which a hospital construction moratorium exception was granted
209.10 under section 144.551. Pursuant to section 144.653, the commissioner shall inspect any
209.11 hospital that does not have a currently valid hospital accreditation certificate from an
209.12 approved accrediting organization. Nothing in this subdivision shall be construed to limit
209.13 the investigative powers of the Office of Health Facility Complaints as established in sections
209.14 144A.51 to 144A.54.

209.15 Sec. 48. Minnesota Statutes 2020, section 144.55, subdivision 6, is amended to read:

209.16 Subd. 6. **Suspension, revocation, and refusal to renew.** (a) The commissioner may
209.17 refuse to grant or renew, or may suspend or revoke, a license on any of the following grounds:

209.18 (1) violation of any of the provisions of sections 144.50 to 144.56 or the rules or standards
209.19 issued pursuant thereto, or Minnesota Rules, chapters 4650 and 4675;

209.20 (2) permitting, aiding, or abetting the commission of any illegal act in the institution;

209.21 (3) conduct or practices detrimental to the welfare of the patient; or

209.22 (4) obtaining or attempting to obtain a license by fraud or misrepresentation; or

209.23 (5) with respect to hospitals and outpatient surgical centers, if the commissioner
209.24 determines that there is a pattern of conduct that one or more physicians or advanced practice
209.25 registered nurses who have a "financial or economic interest," as defined in section 144.6521,
209.26 subdivision 3, in the hospital or outpatient surgical center, have not provided the notice and
209.27 disclosure of the financial or economic interest required by section 144.6521.

209.28 (b) The commissioner shall not renew a license for a boarding care bed in a resident
209.29 room with more than four beds.

209.30 (c) The commissioner shall not renew licenses for hospital beds issued to a hospital or
209.31 hospital corporate system pursuant to a hospital construction moratorium exception under
209.32 section 144.551 if the commissioner determines the hospital or hospital corporate system
209.33 is not satisfying the conditions on which the exception was granted.

210.1 **EFFECTIVE DATE.** This section is effective for license renewals occurring on or after
210.2 July 1, 2021.

210.3 Sec. 49. Minnesota Statutes 2020, section 144.551, subdivision 1, is amended to read:

210.4 Subdivision 1. **Restricted construction or modification.** (a) The following construction
210.5 or modification may not be commenced:

210.6 (1) any erection, building, alteration, reconstruction, modernization, improvement,
210.7 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed
210.8 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site
210.9 to another, or otherwise results in an increase or redistribution of hospital beds within the
210.10 state; and

210.11 (2) the establishment of a new hospital.

210.12 (b) This section does not apply to:

210.13 (1) construction or relocation within a county by a hospital, clinic, or other health care
210.14 facility that is a national referral center engaged in substantial programs of patient care,
210.15 medical research, and medical education meeting state and national needs that receives more
210.16 than 40 percent of its patients from outside the state of Minnesota;

210.17 (2) a project for construction or modification for which a health care facility held an
210.18 approved certificate of need on May 1, 1984, regardless of the date of expiration of the
210.19 certificate;

210.20 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely
210.21 appeal results in an order reversing the denial;

210.22 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,
210.23 section 2;

210.24 (5) a project involving consolidation of pediatric specialty hospital services within the
210.25 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number
210.26 of pediatric specialty hospital beds among the hospitals being consolidated;

210.27 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to
210.28 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,
210.29 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in
210.30 the number of hospital beds. Upon completion of the reconstruction, the licenses of both
210.31 hospitals must be reinstated at the capacity that existed on each site before the relocation;

211.1 (7) the relocation or redistribution of hospital beds within a hospital building or
211.2 identifiable complex of buildings provided the relocation or redistribution does not result
211.3 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from
211.4 one physical site or complex to another; or (iii) redistribution of hospital beds within the
211.5 state or a region of the state;

211.6 (8) relocation or redistribution of hospital beds within a hospital corporate system that
211.7 involves the transfer of beds from a closed facility site or complex to an existing site or
211.8 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is
211.9 transferred; (ii) the capacity of the site or complex to which the beds are transferred does
211.10 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal
211.11 health systems agency boundary in place on July 1, 1983; ~~and~~ (iv) the relocation or
211.12 redistribution does not involve the construction of a new hospital building; and (v) the
211.13 transferred beds are used first to replace within the hospital corporate system the total number
211.14 of beds previously used in the closed facility site or complex for mental health services and
211.15 substance use disorder services. Only after the hospital corporate system has fulfilled the
211.16 requirements of this item may the remainder of the available capacity of the closed facility
211.17 site or complex be transferred for any other purpose;

211.18 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice
211.19 County that primarily serves adolescents and that receives more than 70 percent of its
211.20 patients from outside the state of Minnesota;

211.21 (10) a project to replace a hospital or hospitals with a combined licensed capacity of
211.22 130 beds or less if: (i) the new hospital site is located within five miles of the current site;
211.23 and (ii) the total licensed capacity of the replacement hospital, either at the time of
211.24 construction of the initial building or as the result of future expansion, will not exceed 70
211.25 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

211.26 (11) the relocation of licensed hospital beds from an existing state facility operated by
211.27 the commissioner of human services to a new or existing facility, building, or complex
211.28 operated by the commissioner of human services; from one regional treatment center site
211.29 to another; or from one building or site to a new or existing building or site on the same
211.30 campus;

211.31 (12) the construction or relocation of hospital beds operated by a hospital having a
211.32 statutory obligation to provide hospital and medical services for the indigent that does not
211.33 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27

212.1 beds, of which 12 serve mental health needs, may be transferred from Hennepin County
212.2 Medical Center to Regions Hospital under this clause;

212.3 (13) a construction project involving the addition of up to 31 new beds in an existing
212.4 nonfederal hospital in Beltrami County;

212.5 (14) a construction project involving the addition of up to eight new beds in an existing
212.6 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

212.7 (15) a construction project involving the addition of 20 new hospital beds in an existing
212.8 hospital in Carver County serving the southwest suburban metropolitan area;

212.9 (16) a project for the construction or relocation of up to 20 hospital beds for the operation
212.10 of up to two psychiatric facilities or units for children provided that the operation of the
212.11 facilities or units have received the approval of the commissioner of human services;

212.12 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation
212.13 services in an existing hospital in Itasca County;

212.14 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County
212.15 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for
212.16 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another
212.17 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

212.18 (19) a critical access hospital established under section 144.1483, clause (9), and section
212.19 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that
212.20 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,
212.21 to the extent that the critical access hospital does not seek to exceed the maximum number
212.22 of beds permitted such hospital under federal law;

212.23 (20) notwithstanding section 144.552, a project for the construction of a new hospital
212.24 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

212.25 (i) the project, including each hospital or health system that will own or control the entity
212.26 that will hold the new hospital license, is approved by a resolution of the Maple Grove City
212.27 Council as of March 1, 2006;

212.28 (ii) the entity that will hold the new hospital license will be owned or controlled by one
212.29 or more not-for-profit hospitals or health systems that have previously submitted a plan or
212.30 plans for a project in Maple Grove as required under section 144.552, and the plan or plans
212.31 have been found to be in the public interest by the commissioner of health as of April 1,
212.32 2005;

213.1 (iii) the new hospital's initial inpatient services must include, but are not limited to,
213.2 medical and surgical services, obstetrical and gynecological services, intensive care services,
213.3 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health
213.4 services, and emergency room services;

213.5 (iv) the new hospital:

213.6 (A) will have the ability to provide and staff sufficient new beds to meet the growing
213.7 needs of the Maple Grove service area and the surrounding communities currently being
213.8 served by the hospital or health system that will own or control the entity that will hold the
213.9 new hospital license;

213.10 (B) will provide uncompensated care;

213.11 (C) will provide mental health services, including inpatient beds;

213.12 (D) will be a site for workforce development for a broad spectrum of health-care-related
213.13 occupations and have a commitment to providing clinical training programs for physicians
213.14 and other health care providers;

213.15 (E) will demonstrate a commitment to quality care and patient safety;

213.16 (F) will have an electronic medical records system, including physician order entry;

213.17 (G) will provide a broad range of senior services;

213.18 (H) will provide emergency medical services that will coordinate care with regional
213.19 providers of trauma services and licensed emergency ambulance services in order to enhance
213.20 the continuity of care for emergency medical patients; and

213.21 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond
213.22 the control of the entity holding the new hospital license; and

213.23 (v) as of 30 days following submission of a written plan, the commissioner of health
213.24 has not determined that the hospitals or health systems that will own or control the entity
213.25 that will hold the new hospital license are unable to meet the criteria of this clause;

213.26 (21) a project approved under section 144.553;

213.27 (22) a project for the construction of a hospital with up to 25 beds in Cass County within
213.28 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder
213.29 is approved by the Cass County Board;

214.1 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity
214.2 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing
214.3 a separately licensed 13-bed skilled nursing facility;

214.4 (24) notwithstanding section 144.552, a project for the construction and expansion of a
214.5 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients
214.6 who are under 21 years of age on the date of admission. The commissioner conducted a
214.7 public interest review of the mental health needs of Minnesota and the Twin Cities
214.8 metropolitan area in 2008. No further public interest review shall be conducted for the
214.9 construction or expansion project under this clause;

214.10 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the
214.11 commissioner finds the project is in the public interest after the public interest review
214.12 conducted under section 144.552 is complete;

214.13 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city
214.14 of Maple Grove, exclusively for patients who are under 21 years of age on the date of
214.15 admission, if the commissioner finds the project is in the public interest after the public
214.16 interest review conducted under section 144.552 is complete;

214.17 (ii) this project shall serve patients in the continuing care benefit program under section
214.18 256.9693. The project may also serve patients not in the continuing care benefit program;
214.19 and

214.20 (iii) if the project ceases to participate in the continuing care benefit program, the
214.21 commissioner must complete a subsequent public interest review under section 144.552. If
214.22 the project is found not to be in the public interest, the license must be terminated six months
214.23 from the date of that finding. If the commissioner of human services terminates the contract
214.24 without cause or reduces per diem payment rates for patients under the continuing care
214.25 benefit program below the rates in effect for services provided on December 31, 2015, the
214.26 project may cease to participate in the continuing care benefit program and continue to
214.27 operate without a subsequent public interest review;

214.28 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital
214.29 in Hennepin County that is exclusively for patients who are under 21 years of age on the
214.30 date of admission; ~~or~~

214.31 (28) a project to add 55 licensed beds in an existing safety net, level I trauma center
214.32 hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which
214.33 15 beds are to be used for inpatient mental health and 40 are to be used for other services.
214.34 In addition, five unlicensed observation mental health beds shall be added~~.~~;

215.1 (29) notwithstanding section 144.552, a project to add 45 licensed beds in an existing
215.2 safety net, level I trauma center hospital in Ramsey County as designated under section
215.3 383A.91, subdivision 5. The commissioner conducted a public interest review of the
215.4 construction and expansion of this hospital in 2018. No further public interest review shall
215.5 be conducted for the project under this clause; or

215.6 (30) the addition of licensed beds in a hospital or hospital corporate system to primarily
215.7 provide mental health services or substance use disorder services. In order to add beds under
215.8 this clause, a hospital must have an emergency department and must not be a hospital that
215.9 solely provides treatment to adults for mental illnesses or substance use disorders. Beds
215.10 added under this clause must be available to serve medical assistance and MinnesotaCare
215.11 enrollees. Notwithstanding section 144.552, public interest review shall not be required for
215.12 an addition of beds under this clause.

215.13 **EFFECTIVE DATE.** (a) Paragraph (b), clause (29), is effective the day following final
215.14 enactment, contingent upon:

215.15 (1) the addition of the 15 inpatient mental health beds specified in paragraph (b), clause
215.16 (28), to the Ramsey County level I trauma center's bed capacity;

215.17 (2) five of the 45 additional beds authorized in paragraph (b), clause (29), being
215.18 designated for use for inpatient mental health and added to the hospital's bed capacity before
215.19 the remaining 40 beds authorized under that clause are added; and

215.20 (3) the Ramsey County level I trauma center's agreement to not participate in the Revenue
215.21 Recapture Act under Minnesota Statutes, chapter 270, and Minnesota Statutes, section
215.22 270C.41.

215.23 (b) The amendment to paragraph (b), clause (8), and paragraph (b), clause (30), are
215.24 effective the day following final enactment.

215.25 Sec. 50. Minnesota Statutes 2020, section 144.551, is amended by adding a subdivision
215.26 to read:

215.27 Subd. 5. **Monitoring.** The commissioner shall monitor the implementation of exceptions
215.28 under this section. Each hospital or hospital corporate system granted an exception under
215.29 this section shall submit to the commissioner each year a report on how the hospital or
215.30 hospital corporate system continues to satisfy the conditions on which the exception was
215.31 granted.

216.1 Sec. 51. Minnesota Statutes 2020, section 144.555, is amended to read:

216.2 **144.555 ~~HOSPITAL~~ FACILITY OR CAMPUS CLOSINGS, RELOCATING**
216.3 **SERVICES, OR CEASING TO OFFER CERTAIN SERVICES; PATIENT**
216.4 **RELOCATIONS.**

216.5 Subdivision 1. **Notice of closing or curtailing ~~service~~ operations; facilities other than**
216.6 **hospitals.** If a facility licensed under sections 144.50 to 144.56, other than a hospital,
216.7 voluntarily plans to cease operations or to curtail operations to the extent that patients or
216.8 residents must be relocated, the controlling persons of the facility must notify the
216.9 commissioner of health at least 90 days before the scheduled cessation or curtailment. The
216.10 commissioner shall cooperate with the controlling persons and advise them about relocating
216.11 the patients or residents.

216.12 Subd. 1a. **Notice of closing, curtailing operations, relocating services, or ceasing to**
216.13 **offer certain services; hospitals.** (a) The controlling persons of a hospital licensed under
216.14 sections 144.50 to 144.56 or a hospital campus must notify the commissioner of health at
216.15 least nine months before a scheduled action if the hospital or hospital campus voluntarily
216.16 plans to:

216.17 (1) cease operations;

216.18 (2) curtail operations to the extent that patients must be relocated;

216.19 (3) relocate the provision of health services to another hospital or another hospital
216.20 campus; or

216.21 (4) cease offering maternity care and newborn care services, intensive care unit services,
216.22 inpatient mental health services, or inpatient substance use disorder treatment services.

216.23 (b) The commissioner shall cooperate with the controlling persons and advise them
216.24 about relocating the patients. The controlling persons of the hospital or hospital campus
216.25 must comply with section 144.556.

216.26 Subd. 1b. **Public hearing.** Upon receiving notice under subdivision 1a, the commissioner
216.27 shall conduct a public hearing on the scheduled cessation of operations, curtailment of
216.28 operations, relocation of health services, or cessation in offering health services. The
216.29 commissioner must provide adequate public notice of the hearing in a time and manner
216.30 determined by the commissioner. The public hearing must be held in the community where
216.31 the hospital or hospital campus is located at least six months before the scheduled cessation
216.32 or curtailment of operations, relocation of health services, or cessation in offering health

217.1 services. The controlling persons of the hospital or hospital campus must participate in the
217.2 public hearing. The public hearing must include:

217.3 (1) an explanation by the controlling persons of the reasons for ceasing or curtailing
217.4 operations, relocating health services, or ceasing to offer any of the listed health services;

217.5 (2) a description of the actions that controlling persons will take to ensure that residents
217.6 in the hospital's or campus's service area have continued access to the health services being
217.7 eliminated, curtailed, or relocated;

217.8 (3) an opportunity for public testimony on the scheduled cessation or curtailment of
217.9 operations, relocation of health services, or cessation in offering any of the listed health
217.10 services, and on the hospital's or campus's plan to ensure continued access to those health
217.11 services being eliminated, curtailed, or relocated; and

217.12 (4) an opportunity for the controlling persons to respond to questions from interested
217.13 persons.

217.14 Subd. 2. **Penalty.** Failure to notify the commissioner under subdivision 1 or 1a or failure
217.15 to participate in a public hearing under subdivision 1b may result in issuance of a correction
217.16 order under section 144.653, subdivision 5.

217.17 Sec. 52. **[144.556] RIGHT OF FIRST REFUSAL FOR HOSPITAL OR HOSPITAL**
217.18 **CAMPUS.**

217.19 Subdivision 1. **Prerequisite before sale, conveyance, or ceasing operations of hospital**
217.20 **or hospital campus.** The controlling persons of a hospital licensed under sections 144.50
217.21 to 144.56 shall not sell or convey the hospital or a campus of the hospital, offer to sell or
217.22 convey the hospital or hospital campus, or voluntarily cease operations of the hospital or
217.23 hospital campus unless the controlling persons have first made a good faith offer to sell or
217.24 convey the hospital or hospital campus to the home rule charter or statutory city, county,
217.25 town, or hospital district in which the hospital or hospital campus is located.

217.26 Subd. 2. **Offer.** The offer to sell or convey the hospital or hospital campus must be at a
217.27 price that does not exceed the current fair market value of the hospital or hospital campus.
217.28 A party to whom an offer is made under subdivision 1 must accept or decline the offer
217.29 within 60 days after receipt. If the party fails to respond within 60 days after receipt, the
217.30 offer is deemed declined.

218.1 Sec. 53. Minnesota Statutes 2020, section 144.9501, subdivision 17, is amended to read:

218.2 Subd. 17. **Lead hazard reduction.** "Lead hazard reduction" means abatement or interim
218.3 controls undertaken to make a residence, child care facility, school, ~~or~~ playground, or other
218.4 location where lead hazards are identified lead-safe by complying with the lead standards
218.5 and methods adopted under section 144.9508.

218.6 Sec. 54. Minnesota Statutes 2020, section 144.9502, subdivision 3, is amended to read:

218.7 Subd. 3. **Reports of blood lead analysis required.** (a) Every hospital, medical clinic,
218.8 medical laboratory, other facility, or individual performing blood lead analysis shall report
218.9 the results after the analysis of each specimen analyzed, for both capillary and venous
218.10 specimens, and epidemiologic information required in this section to the commissioner of
218.11 health, within the time frames set forth in clauses (1) and (2):

218.12 (1) within two working days by telephone, fax, or electronic transmission as prescribed
218.13 by the commissioner, with written or electronic confirmation within one month as prescribed
218.14 by the commissioner, for a venous blood lead level equal to or greater than 15 micrograms
218.15 of lead per deciliter of whole blood; or

218.16 (2) within one month in writing or by electronic transmission as prescribed by the
218.17 commissioner, for any capillary result or for a venous blood lead level less than 15
218.18 micrograms of lead per deciliter of whole blood.

218.19 (b) If a blood lead analysis is performed outside of Minnesota and the facility performing
218.20 the analysis does not report the blood lead analysis results and epidemiological information
218.21 required in this section to the commissioner, the provider who collected the blood specimen
218.22 must satisfy the reporting requirements of this section. For purposes of this section, "provider"
218.23 has the meaning given in section 62D.02, subdivision 9.

218.24 (c) The commissioner shall coordinate with hospitals, medical clinics, medical
218.25 laboratories, and other facilities performing blood lead analysis to develop a universal
218.26 reporting form and mechanism.

218.27 Sec. 55. Minnesota Statutes 2020, section 144.9504, subdivision 2, is amended to read:

218.28 Subd. 2. **Lead risk assessment.** (a) Notwithstanding section 144.9501, subdivision 6a,
218.29 for purposes of this subdivision, "child" means an individual under 18 years of age.

218.30 (b) An assessing agency shall conduct a lead risk assessment of a residence, residential
218.31 or commercial child care facility, playground, school, or other location where lead hazards

219.1 are suspected according to the venous blood lead level and time frame set forth in clauses
219.2 (1) to (4) for purposes of secondary prevention:

219.3 (1) within 48 hours of a child or pregnant female in the residence, residential or
219.4 commercial child care facility, playground, school, or other location where lead hazards are
219.5 suspected being identified to the agency as having a venous blood lead level equal to or
219.6 greater than 60 micrograms of lead per deciliter of whole blood;

219.7 (2) within five working days of a child or pregnant female in the residence, residential
219.8 or commercial child care facility, playground, school, or other location where lead hazards
219.9 are suspected being identified to the agency as having a venous blood lead level equal to
219.10 or greater than 45 micrograms of lead per deciliter of whole blood;

219.11 ~~(3) within ten working days of a child in the residence being identified to the agency as~~
219.12 ~~having a venous blood lead level equal to or greater than 15 micrograms of lead per deciliter~~
219.13 ~~of whole blood; or~~

219.14 ~~(4)~~ (3) within ten working days of a child or pregnant female in the residence, residential
219.15 or commercial child care facility, playground, school, or other location where lead hazards
219.16 are suspected being identified to the agency as having a venous blood lead level equal to
219.17 or greater than ten micrograms of lead per deciliter of whole blood~~.~~; or

219.18 (4) within 20 working days of a child or pregnant female in the residence, residential or
219.19 commercial child care facility, playground, school, or other location where lead hazards are
219.20 suspected being identified to the agency as having a venous blood lead level equal to or
219.21 greater than five micrograms per deciliter of whole blood.

219.22 An assessing agency may refer investigations at sites other than the child's or pregnant
219.23 female's residence to the commissioner.

219.24 ~~(b)~~ (c) Within the limits of available local, state, and federal appropriations, an assessing
219.25 agency may also conduct a lead risk assessment for children with any elevated blood lead
219.26 level.

219.27 ~~(c)~~ (d) In a building with two or more dwelling units, an assessing agency shall assess
219.28 the individual unit in which the conditions of this section are met and shall inspect all
219.29 common areas accessible to a child. If a child visits one or more other sites such as another
219.30 residence, or a residential or commercial child care facility, playground, or school, the
219.31 assessing agency shall also inspect the other sites. The assessing agency shall have one
219.32 additional day added to the time frame set forth in this subdivision to complete the lead risk
219.33 assessment for each additional site.

~~(d)~~ (e) Within the limits of appropriations, the assessing agency shall identify the known addresses for the previous 12 months of the child or pregnant female with venous blood lead levels of at least 15 micrograms per deciliter for the child or at least ten micrograms per deciliter for the pregnant female; notify the property owners, landlords, and tenants at those addresses that an elevated blood lead level was found in a person who resided at the property; and give them primary prevention information. Within the limits of appropriations, the assessing agency may perform a risk assessment and issue corrective orders in the properties, if it is likely that the previous address contributed to the child's or pregnant female's blood lead level. The assessing agency shall provide the notice required by this subdivision without identifying the child or pregnant female with the elevated blood lead level. The assessing agency is not required to obtain the consent of the child's parent or guardian or the consent of the pregnant female for purposes of this subdivision. This information shall be classified as private data on individuals as defined under section 13.02, subdivision 12.

~~(e)~~ (f) The assessing agency shall conduct the lead risk assessment according to rules adopted by the commissioner under section 144.9508. An assessing agency shall have lead risk assessments performed by lead risk assessors licensed by the commissioner according to rules adopted under section 144.9508. If a property owner refuses to allow a lead risk assessment, the assessing agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead risk assessment set forth in this subdivision no longer applies. A lead risk assessor or assessing agency may observe the performance of lead hazard reduction in progress and shall enforce the provisions of this section under section 144.9509. Deteriorated painted surfaces, bare soil, and dust must be tested with appropriate analytical equipment to determine the lead content, except that deteriorated painted surfaces or bare soil need not be tested if the property owner agrees to engage in lead hazard reduction on those surfaces. The lead content of drinking water must be measured if another probable source of lead exposure is not identified. Within a standard metropolitan statistical area, an assessing agency may order lead hazard reduction of bare soil without measuring the lead content of the bare soil if the property is in a census tract in which soil sampling has been performed according to rules established by the commissioner and at least 25 percent of the soil samples contain lead concentrations above the standard in section 144.9508.

~~(f)~~ (g) Each assessing agency shall establish an administrative appeal procedure which allows a property owner to contest the nature and conditions of any lead order issued by the assessing agency. Assessing agencies must consider appeals that propose lower cost

221.1 methods that make the residence lead safe. The commissioner shall use the authority and
221.2 appeal procedure granted under sections 144.989 to 144.993.

221.3 ~~(g)~~ (h) Sections 144.9501 to 144.9512 neither authorize nor prohibit an assessing agency
221.4 from charging a property owner for the cost of a lead risk assessment.

221.5 Sec. 56. Minnesota Statutes 2020, section 144.9504, subdivision 5, is amended to read:

221.6 Subd. 5. **Lead orders.** (a) An assessing agency, after conducting a lead risk assessment,
221.7 shall order a property owner to perform lead hazard reduction on all lead sources that exceed
221.8 a standard adopted according to section 144.9508. If lead risk assessments and lead orders
221.9 are conducted at times when weather or soil conditions do not permit the lead risk assessment
221.10 or lead hazard reduction, external surfaces and soil lead shall be assessed, and lead orders
221.11 complied with, if necessary, at the first opportunity that weather and soil conditions allow.

221.12 (b) If, after conducting a lead risk assessment, an assessing agency determines that the
221.13 property owner's lead hazard originated from another source location, the assessing agency
221.14 may order the responsible person of the source location to:

221.15 (1) perform lead hazard reduction at the site where the assessing agency conducted the
221.16 lead risk assessment; and

221.17 (2) remediate the conditions at the source location that allowed the lead hazard, pollutant,
221.18 or contaminant to migrate from the source location.

221.19 (c) For purposes of this subdivision, "pollutant or contaminant" has the meaning given
221.20 in section 115B.02, subdivision 13, and "responsible person" has the meaning given in
221.21 section 115B.03.

221.22 ~~(b)~~ (d) If the paint standard under section 144.9508 is violated, but the paint is intact,
221.23 the assessing agency shall not order the paint to be removed unless the intact paint is a
221.24 known source of actual lead exposure to a specific person. Before the assessing agency may
221.25 order the intact paint to be removed, a reasonable effort must be made to protect the child
221.26 and preserve the intact paint by the use of guards or other protective devices and methods.

221.27 ~~(c)~~ (e) Whenever windows and doors or other components covered with deteriorated
221.28 lead-based paint have sound substrate or are not rotting, those components should be repaired,
221.29 sent out for stripping or planed down to remove deteriorated lead-based paint, or covered
221.30 with protective guards instead of being replaced, provided that such an activity is the least
221.31 cost method. However, a property owner who has been ordered to perform lead hazard
221.32 reduction may choose any method to address deteriorated lead-based paint on windows,

222.1 doors, or other components, provided that the method is approved in rules adopted under
222.2 section 144.9508 and that it is appropriate to the specific property.

222.3 ~~(d)~~ (f) Lead orders must require that any source of damage, such as leaking roofs,
222.4 plumbing, and windows, be repaired or replaced, as needed, to prevent damage to
222.5 lead-containing interior surfaces.

222.6 ~~(e)~~ (g) The assessing agency is not required to pay for lead hazard reduction. The
222.7 assessing agency shall enforce the lead orders issued to a property owner under this section.

222.8 Sec. 57. Minnesota Statutes 2020, section 144G.08, subdivision 7, as amended by Laws
222.9 2020, Seventh Special Session chapter 1, article 6, section 5, is amended to read:

222.10 Subd. 7. **Assisted living facility.** "Assisted living facility" means ~~a facility that~~ an
222.11 establishment where an operating person or legal entity, either directly or through contract,
222.12 business relationship, or common ownership with another person or entity, provides sleeping
222.13 accommodations and assisted living services to one or more adults in the facility. Assisted
222.14 living facility includes assisted living facility with dementia care, and does not include:

222.15 (1) emergency shelter, transitional housing, or any other residential units serving
222.16 exclusively or primarily homeless individuals, as defined under section 116L.361;

222.17 (2) a nursing home licensed under chapter 144A;

222.18 (3) a hospital, certified boarding care, or supervised living facility licensed under sections
222.19 144.50 to 144.56;

222.20 (4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts
222.21 9520.0500 to 9520.0670, or under chapter 245D or 245G;

222.22 (5) services and residential settings licensed under chapter 245A, including adult foster
222.23 care and services and settings governed under the standards in chapter 245D;

222.24 (6) a private home in which the residents are related by kinship, law, or affinity with the
222.25 provider of services;

222.26 (7) a duly organized condominium, cooperative, and common interest community, or
222.27 owners' association of the condominium, cooperative, and common interest community
222.28 where at least 80 percent of the units that comprise the condominium, cooperative, or
222.29 common interest community are occupied by individuals who are the owners, members, or
222.30 shareholders of the units;

222.31 (8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593;

(9) a setting offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing;

(10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services;

(11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q;

(12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56;

(13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011;

~~(14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b);~~ or

~~(15)~~ (14) any establishment that exclusively or primarily serves as a shelter or temporary shelter for victims of domestic or any other form of violence.

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

Sec. 58. Minnesota Statutes 2020, section 144G.54, subdivision 3, is amended to read:

Subd. 3. **Appeals process.** (a) The Office of Administrative Hearings must conduct an expedited hearing using the procedures in Minnesota Rules, parts 1400.8505 to 1400.8612, as soon as practicable under this section, but in no event later than 14 calendar days after the office receives the request, unless the parties agree otherwise or the chief administrative law judge deems the timing to be unreasonable, given the complexity of the issues presented.

(b) The hearing must be held at the facility where the resident lives, unless holding the hearing at that location is impractical, the parties agree to hold the hearing at a different location, or the chief administrative law judge grants a party's request to appear at another location or by telephone or interactive video.

224.1 (c) The hearing is not a formal contested case proceeding conducted according to the
224.2 procedures in Minnesota Rules, parts 1400.5010 to 1400.8400, except when determined
224.3 necessary by the chief administrative law judge.

224.4 (d) Parties may but are not required to be represented by counsel. The appearance of a
224.5 party without counsel does not constitute the unauthorized practice of law.

224.6 (e) The hearing shall be limited to the amount of time necessary for the participants to
224.7 expeditiously present the facts about the proposed termination. The administrative law judge
224.8 shall issue a recommendation to the commissioner as soon as practicable, but in no event
224.9 later than ten business days after the hearing.

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

224.11 Sec. 59. Minnesota Statutes 2020, section 144G.84, is amended to read:

224.12 **144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA.**

224.13 (a) In addition to the minimum services required in section 144G.41, an assisted living
224.14 facility with dementia care must also provide the following services:

224.15 (1) assistance with activities of daily living that address the needs of each resident with
224.16 dementia due to cognitive or physical limitations. These services must meet or be in addition
224.17 to the requirements in the licensing rules for the facility. Services must be provided in a
224.18 person-centered manner that promotes resident choice, dignity, and sustains the resident's
224.19 abilities;

224.20 (2) nonpharmacological practices that are person-centered and evidence-informed;

224.21 (3) services to prepare and educate persons living with dementia and their legal and
224.22 designated representatives about transitions in care and ensuring complete, timely
224.23 communication between, across, and within settings; and

224.24 (4) services that provide residents with choices for meaningful engagement with other
224.25 facility residents and the broader community.

224.26 (b) Each resident must be evaluated for activities according to the licensing rules of the
224.27 facility. In addition, the evaluation must address the following:

224.28 (1) past and current interests;

224.29 (2) current abilities and skills;

224.30 (3) emotional and social needs and patterns;

224.31 (4) physical abilities and limitations;

225.1 (5) adaptations necessary for the resident to participate; and

225.2 (6) identification of activities for behavioral interventions.

225.3 (c) An individualized activity plan must be developed for each resident based on their
225.4 activity evaluation. The plan must reflect the resident's activity preferences and needs.

225.5 (d) A selection of daily structured and non-structured activities must be provided and
225.6 included on the resident's activity service or care plan as appropriate. Daily activity options
225.7 based on resident evaluation may include but are not limited to:

225.8 (1) occupation or chore related tasks;

225.9 (2) scheduled and planned events such as entertainment or outings;

225.10 (3) spontaneous activities for enjoyment or those that may help defuse a behavior;

225.11 (4) one-to-one activities that encourage positive relationships between residents and
225.12 staff such as telling a life story, reminiscing, or playing music;

225.13 (5) spiritual, creative, and intellectual activities;

225.14 (6) sensory stimulation activities;

225.15 (7) physical activities that enhance or maintain a resident's ability to ambulate or move;
225.16 and

225.17 (8) a resident's individualized activity plan for regular outdoor ~~activities~~ activity.

225.18 (e) Behavioral symptoms that negatively impact the resident and others in the assisted
225.19 living facility with dementia care must be evaluated and included on the service or care
225.20 plan. The staff must initiate and coordinate outside consultation or acute care when indicated.

225.21 (f) Support must be offered to family and other significant relationships on a regularly
225.22 scheduled basis but not less than quarterly.

225.23 (g) ~~Access to secured outdoor space and walkways that allow residents to enter and~~
225.24 ~~return without staff assistance must be provided.~~ Existing housing with services
225.25 establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted
225.26 living facility license must provide residents with regular access to outdoor space. A licensee
225.27 with new construction on or after August 1, 2021, or a new licensee that was not previously
225.28 registered under chapter 144D prior to August 1, 2021, must provide regular access to
225.29 secured outdoor space on the premises of the facility. A resident's access to outdoor space
225.30 must be in accordance with the resident's documented care plan.

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

226.1 Sec. 60. **[145.87] HOME VISITING FOR PREGNANT WOMEN AND FAMILIES**
226.2 **WITH YOUNG CHILDREN.**

226.3 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section
226.4 and have the meanings given them.

226.5 (b) "Evidence-based home visiting program" means a program that:

226.6 (1) is based on a clear, consistent program or model that is research-based and grounded
226.7 in relevant, empirically based knowledge;

226.8 (2) is linked to program-determined outcomes and is associated with a national
226.9 organization, institution of higher education, or national or state public health institute;

226.10 (3) has comprehensive home visitation standards that ensure high-quality service delivery
226.11 and continuous quality improvement;

226.12 (4) has demonstrated significant, sustained positive outcomes; and

226.13 (5) either:

226.14 (i) has been evaluated using rigorous randomized controlled research designs and the
226.15 evaluation results have been published in a peer-reviewed journal; or

226.16 (ii) is based on quasi-experimental research using two or more separate, comparable
226.17 client samples.

226.18 (c) "Evidence-informed home visiting program" means a program that:

226.19 (1) has data or evidence demonstrating effectiveness at achieving positive outcomes for
226.20 pregnant women and young children; and

226.21 (2) either:

226.22 (i) has an active evaluation of the program; or

226.23 (ii) has a plan and timeline for an active evaluation of the program to be conducted.

226.24 (d) "Health equity" means every individual has a fair opportunity to attain the individual's
226.25 full health potential and no individual is disadvantaged from achieving this potential.

226.26 (e) "Promising practice home visiting program" means a program that has shown
226.27 improvement toward achieving positive outcomes for pregnant women or young children.

226.28 Subd. 2. **Grants for home visiting programs.** (a) The commissioner of health shall
226.29 award grants to community health boards, nonprofit organizations, and tribal nations to start
226.30 up or expand voluntary home visiting programs serving pregnant women and families with

227.1 young children. Home visiting programs supported under this section shall provide voluntary
227.2 home visits by early childhood professionals or health professionals, including but not
227.3 limited to nurses, social workers, early childhood educators, and trained paraprofessionals.
227.4 Grant money shall be used to:

227.5 (1) establish or expand evidence-based, evidence-informed, or promising practice home
227.6 visiting programs that address health equity and utilize community-driven health strategies;

227.7 (2) serve families with young children or pregnant women who have high needs or are
227.8 high-risk, including but not limited to a family with low income, a parent or pregnant woman
227.9 with a mental illness or a substance use disorder, or a parent or pregnant woman experiencing
227.10 housing instability or domestic abuse; and

227.11 (3) improve program outcomes in two or more of the following areas:

227.12 (i) maternal and newborn health;

227.13 (ii) school readiness and achievement;

227.14 (iii) family economic self-sufficiency;

227.15 (iv) coordination and referral for other community resources and supports;

227.16 (v) reduction in child injuries, abuse, or neglect; or

227.17 (vi) reduction in crime or domestic violence.

227.18 (b) Grants awarded to evidence-informed and promising practice home visiting programs
227.19 must include money to evaluate program outcomes for up to four of the areas listed in
227.20 paragraph (a), clause (3).

227.21 Subd. 3. **Grant prioritization.** (a) In awarding grants, the commissioner shall give
227.22 priority to community health boards, nonprofit organizations, and tribal nations seeking to
227.23 expand home visiting services with community or regional partnerships.

227.24 (b) The commissioner shall allocate at least 75 percent of the grant money awarded each
227.25 grant cycle to evidence-based home visiting programs that address health equity and up to
227.26 25 percent of the grant money awarded each grant cycle to evidence-informed or promising
227.27 practice home visiting programs that address health equity and utilize community-driven
227.28 health strategies.

227.29 Subd. 4. **Administrative costs.** The commissioner may use up to seven percent of the
227.30 annual appropriation under this section to provide training and technical assistance and to
227.31 administer and evaluate the program. The commissioner may contract for training,

228.1 capacity-building support for grantees or potential grantees, technical assistance, and
228.2 evaluation support.

228.3 Subd. 5. **Use of state general fund appropriations.** Appropriations dedicated to
228.4 establishing or expanding evidence-based home visiting programs shall, for grants awarded
228.5 on or after July 1, 2021, be awarded according to this section. This section shall not govern
228.6 grant awards of federal funds for home visiting programs and shall not govern grant awards
228.7 using state general fund appropriations dedicated to establishing or expanding nurse-family
228.8 partnership home visiting programs.

228.9 Sec. 61. Minnesota Statutes 2020, section 145.893, subdivision 1, is amended to read:

228.10 Subdivision 1. **~~Vouchers~~ Food benefits.** An eligible individual shall receive ~~vouchers~~
228.11 food benefits for the purchase of specified nutritional supplements in type and quantity
228.12 approved by the commissioner. Alternate forms of delivery may be developed by the
228.13 commissioner in appropriate cases.

228.14 Sec. 62. Minnesota Statutes 2020, section 145.894, is amended to read:

228.15 **145.894 STATE COMMISSIONER OF HEALTH; DUTIES, RESPONSIBILITIES.**

228.16 The commissioner of health shall:

228.17 (1) develop a comprehensive state plan for the delivery of nutritional supplements to
228.18 pregnant and lactating women, infants, and children;

228.19 (2) contract with existing local public or private nonprofit organizations for the
228.20 administration of the nutritional supplement program;

228.21 (3) develop and implement a public education program promoting the provisions of
228.22 sections 145.891 to 145.897, and provide for the delivery of individual and family nutrition
228.23 education and counseling at project sites. The education programs must include a campaign
228.24 to promote breast feeding;

228.25 (4) develop in cooperation with other agencies and vendors a uniform state ~~voucher~~ food
228.26 benefit system for the delivery of nutritional supplements;

228.27 (5) authorize local health agencies to issue ~~vouchers bimonthly~~ food benefits trimonthly
228.28 to some or all eligible individuals served by the agency, provided the agency demonstrates
228.29 that the federal minimum requirements for providing nutrition education will continue to
228.30 be met and that the quality of nutrition education and health services provided by the agency
228.31 will not be adversely impacted;

229.1 (6) investigate and implement a system to reduce the cost of nutritional supplements
229.2 and maintain ongoing negotiations with nonparticipating manufacturers and suppliers to
229.3 maximize cost savings;

229.4 (7) develop, analyze, and evaluate the health aspects of the nutritional supplement
229.5 program and establish nutritional guidelines for the program;

229.6 (8) apply for, administer, and annually expend at least 99 percent of available federal
229.7 or private funds;

229.8 (9) aggressively market services to eligible individuals by conducting ongoing outreach
229.9 activities and by coordinating with and providing marketing materials and technical assistance
229.10 to local human services and community service agencies and nonprofit service providers;

229.11 (10) determine, on July 1 of each year, the number of pregnant women participating in
229.12 each special supplemental food program for women, infants, and children (WIC) ~~and, in~~
229.13 ~~1986, 1987, and 1988, at the commissioner's discretion, designate a different food program~~
229.14 ~~deliverer if the current deliverer fails to increase the participation of pregnant women in the~~
229.15 ~~program by at least ten percent over the previous year's participation rate~~;

229.16 (11) promulgate all rules necessary to carry out the provisions of sections 145.891 to
229.17 145.897; and

229.18 (12) ensure that any state appropriation to supplement the federal program is spent
229.19 consistent with federal requirements.

229.20 Sec. 63. Minnesota Statutes 2020, section 145.897, is amended to read:

229.21 **145.897 ~~VOUCHERS~~ FOOD BENEFITS.**

229.22 ~~Vouchers~~ Food benefits issued pursuant to sections 145.891 to 145.897 shall be only
229.23 for the purchase of those foods determined by the ~~commissioner~~ United States Department
229.24 of Agriculture to be desirable nutritional supplements for pregnant and lactating women,
229.25 infants and children. ~~These foods shall include, but not be limited to, iron fortified infant~~
229.26 ~~formula, vegetable or fruit juices, cereal, milk, cheese, and eggs.~~

229.27 Sec. 64. Minnesota Statutes 2020, section 145.899, is amended to read:

229.28 **145.899 WIC ~~VOUCHERS~~ FOOD BENEFITS FOR ORGANICS.**

229.29 ~~Vouchers~~ Food benefits for the special supplemental nutrition program for women,
229.30 infants, and children (WIC) may be used to purchase cost-neutral organic WIC allowable
229.31 food. The commissioner of health shall regularly evaluate the list of WIC allowable food

230.1 in accordance with federal requirements and shall add to the list any organic WIC allowable
230.2 foods determined to be cost-neutral.

230.3 Sec. 65. Minnesota Statutes 2020, section 145.901, subdivision 2, is amended to read:

230.4 Subd. 2. **Access to data.** (a) The commissioner of health has access to medical data as
230.5 defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined
230.6 in section 13.83, subdivision 1, and health records created, maintained, or stored by providers
230.7 ~~as defined in section 144.291, subdivision 2, paragraph (i),~~ without the consent of the subject
230.8 of the data, and without the consent of the parent, spouse, other guardian, or legal
230.9 representative of the subject of the data, when the subject of the data is a woman who died
230.10 during a pregnancy or within 12 months of a fetal death, a live birth, or other termination
230.11 of a pregnancy.

230.12 The commissioner has access only to medical data and health records related to deaths
230.13 that occur on or after July 1, 2000, including the names of the providers, clinics, or other
230.14 health services such as family home visiting programs; the women, infants, and children
230.15 (WIC) program; prescription monitoring programs; and behavioral health services, where
230.16 care was received before, during, or related to the pregnancy or death. The commissioner
230.17 has access to records maintained by a medical examiner, a coroner, or hospitals or to hospital
230.18 discharge data, for the purpose of providing the name and location of any pre-pregnancy,
230.19 prenatal, or other care received by the subject of the data up to one year after the end of the
230.20 pregnancy.

230.21 (b) The provider or responsible authority that creates, maintains, or stores the data shall
230.22 furnish the data upon the request of the commissioner. The provider or responsible authority
230.23 may charge a fee for providing the data, not to exceed the actual cost of retrieving and
230.24 duplicating the data.

230.25 (c) The commissioner shall make a good faith reasonable effort to notify the parent,
230.26 spouse, other guardian, or legal representative of the subject of the data before collecting
230.27 data on the subject. For purposes of this paragraph, "reasonable effort" means one notice
230.28 is sent by certified mail to the last known address of the parent, spouse, guardian, or legal
230.29 representative informing the recipient of the data collection and offering a public health
230.30 nurse support visit if desired.

230.31 (d) The commissioner does not have access to coroner or medical examiner data that
230.32 are part of an active investigation as described in section 13.83.

231.1 (e) The commissioner may request and receive from a coroner or medical examiner the
231.2 name of the health care provider that provided prenatal, postpartum, or other health services
231.3 to the subject of the data.

231.4 (f) The commissioner may access Department of Human Services data to identify sources
231.5 of care and services to assist with the evaluation of welfare systems, including housing, to
231.6 reduce preventable maternal deaths.

231.7 (g) The commissioner may request and receive law enforcement reports or incident
231.8 reports related to the subject of the data.

231.9 Sec. 66. Minnesota Statutes 2020, section 145.901, subdivision 4, is amended to read:

231.10 Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source
231.11 records under subdivision 2, including identifying information on individual providers, data
231.12 subjects, or their children, and data derived by the commissioner under subdivision 3 for
231.13 the purpose of carrying out maternal death studies, are classified as confidential data on
231.14 individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3,
231.15 and 13.10, subdivision 1, paragraph (a).

231.16 (b) Information classified under paragraph (a) shall not be subject to discovery or
231.17 introduction into evidence in any administrative, civil, or criminal proceeding. Such
231.18 information otherwise available from an original source shall not be immune from discovery
231.19 or barred from introduction into evidence merely because it was utilized by the commissioner
231.20 in carrying out maternal death studies.

231.21 (c) Summary data on maternal death studies created by the commissioner, which does
231.22 not identify individual data subjects or individual providers, shall be public in accordance
231.23 with section 13.05, subdivision 7.

231.24 (d) Data provided by the commissioner of human services to the commissioner of health
231.25 under this section retain the same classification the data held when retained by the
231.26 commissioner of human services, as required under section 13.03, subdivision 4, paragraph
231.27 (c).

231.28 Sec. 67. Minnesota Statutes 2020, section 152.01, subdivision 23, is amended to read:

231.29 Subd. 23. **Analog.** (a) Except as provided in paragraph (b), "analog" means a substance,
231.30 the chemical structure of which is substantially similar to the chemical structure of a
231.31 controlled substance in Schedule I or II:

232.1 (1) that has a stimulant, depressant, or hallucinogenic effect on the central nervous system
232.2 that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic
232.3 effect on the central nervous system of a controlled substance in Schedule I or II; or

232.4 (2) with respect to a particular person, if the person represents or intends that the substance
232.5 have a stimulant, depressant, or hallucinogenic effect on the central nervous system that is
232.6 substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect
232.7 on the central nervous system of a controlled substance in Schedule I or II.

232.8 (b) "Analog" does not include:

232.9 (1) a controlled substance;

232.10 (2) any substance for which there is an approved new drug application under the Federal
232.11 Food, Drug, and Cosmetic Act; ~~or~~

232.12 (3) with respect to a particular person, any substance, if an exemption is in effect for
232.13 investigational use, for that person, as provided by United States Code, title 21, section 355,
232.14 and the person is registered as a controlled substance researcher as required under section
232.15 152.12, subdivision 3, to the extent conduct with respect to the substance is pursuant to the
232.16 exemption and registration; or

232.17 (4) marijuana or tetrahydrocannabinols naturally contained in a plant of the genus
232.18 cannabis or in the resinous extractives of the plant.

232.19 **EFFECTIVE DATE.** This section is effective August 1, 2021, and applies to crimes
232.20 committed on or after that date.

232.21 Sec. 68. Minnesota Statutes 2020, section 152.02, subdivision 2, is amended to read:

232.22 Subd. 2. **Schedule I.** (a) Schedule I consists of the substances listed in this subdivision.

232.23 (b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the
232.24 following substances, including their analogs, isomers, esters, ethers, salts, and salts of
232.25 isomers, esters, and ethers, whenever the existence of the analogs, isomers, esters, ethers,
232.26 and salts is possible:

232.27 (1) acetylmethadol;

232.28 (2) allylprodine;

232.29 (3) alphacetylmethadol (except levo-alphacetylmethadol, also known as levomethadyl
232.30 acetate);

232.31 (4) alphameprodine;

233.1 (5) alphamethadol;

233.2 (6) alpha-methylfentanyl benzethidine;

233.3 (7) betacetylmethadol;

233.4 (8) betameprodine;

233.5 (9) betamethadol;

233.6 (10) betaprodine;

233.7 (11) clonitazene;

233.8 (12) dextromoramide;

233.9 (13) diampromide;

233.10 (14) diethyliambutene;

233.11 (15) difenoxin;

233.12 (16) dimenoxadol;

233.13 (17) dimepheptanol;

233.14 (18) dimethyliambutene;

233.15 (19) dioxaphetyl butyrate;

233.16 (20) dipipanone;

233.17 (21) ethylmethylthiambutene;

233.18 (22) etonitazene;

233.19 (23) etoxeridine;

233.20 (24) furethidine;

233.21 (25) hydroxypethidine;

233.22 (26) ketobemidone;

233.23 (27) levomoramide;

233.24 (28) levophenacylmorphan;

233.25 (29) 3-methylfentanyl;

233.26 (30) acetyl-alpha-methylfentanyl;

233.27 (31) alpha-methylthiofentanyl;

234.1 (32) benzylfentanyl beta-hydroxyfentanyl;

234.2 (33) beta-hydroxy-3-methylfentanyl;

234.3 (34) 3-methylthiofentanyl;

234.4 (35) thenylfentanyl;

234.5 (36) thiofentanyl;

234.6 (37) para-fluorofentanyl;

234.7 (38) morpheridine;

234.8 (39) 1-methyl-4-phenyl-4-propionoxypiperidine;

234.9 (40) noracymethadol;

234.10 (41) norlevorphanol;

234.11 (42) normethadone;

234.12 (43) norpipanone;

234.13 (44) 1-(2-phenylethyl)-4-phenyl-4-acetoxypiperidine (PEPAP);

234.14 (45) phenadoxone;

234.15 (46) phenampromide;

234.16 (47) phenomorphan;

234.17 (48) phenoperidine;

234.18 (49) piritramide;

234.19 (50) proheptazine;

234.20 (51) properidine;

234.21 (52) propiram;

234.22 (53) racemoramide;

234.23 (54) tilidine;

234.24 (55) trimeperidine;

234.25 (56) N-(1-Phenethylpiperidin-4-yl)-N-phenylacetamide (acetyl fentanyl);

234.26 (57) 3,4-dichloro-N-[(1R,2R)-2-(dimethylamino)cyclohexyl]-N-
234.27 methylbenzamide(U47700);

235.1 (58) N-phenyl-N-[1-(2-phenylethyl)piperidin-4-yl]furan-2-carboxamide(furanylfentanyl);

235.2 (59) 4-(4-bromophenyl)-4-dimethylamino-1-phenethylcyclohexanol (bromadol);

235.3 (60) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide (Cycloproprl
235.4 fentanyl);

235.5 (61) N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide) (butyryl fentanyl);

235.6 (62) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine) (MT-45);

235.7 (63) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide (cyclopentyl
235.8 fentanyl);

235.9 (64) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide (isobutyryl fentanyl);

235.10 (65) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide (valeryl fentanyl);

235.11 (66) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide
235.12 (para-chloroisobutyryl fentanyl);

235.13 (67) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-fluorobutyryl
235.14 fentanyl);

235.15 (68) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide
235.16 (para-methoxybutyryl fentanyl);

235.17 (69) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide (ocfentanil);

235.18 (70) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (4-fluoroisobutyryl
235.19 fentanyl or para-fluoroisobutyryl fentanyl);

235.20 (71) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide (acryl fentanyl or
235.21 acryloylfentanyl);

235.22 (72) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide (methoxyacetyl
235.23 fentanyl);

235.24 (73) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide (ortho-fluorofentanyl
235.25 or 2-fluorofentanyl);

235.26 (74) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide
235.27 (tetrahydrofuranyl fentanyl); and

235.28 (75) Fentanyl-related substances, their isomers, esters, ethers, salts and salts of isomers,
235.29 esters and ethers, meaning any substance not otherwise listed under another federal
235.30 Administration Controlled Substance Code Number or not otherwise listed in this section,

236.1 and for which no exemption or approval is in effect under section 505 of the Federal Food,
236.2 Drug, and Cosmetic Act, United States Code , title 21, section 355, that is structurally related
236.3 to fentanyl by one or more of the following modifications:

236.4 (i) replacement of the phenyl portion of the phenethyl group by any monocycle, whether
236.5 or not further substituted in or on the monocycle;

236.6 (ii) substitution in or on the phenethyl group with alkyl, alkenyl, alkoxyl, hydroxyl, halo,
236.7 haloalkyl, amino, or nitro groups;

236.8 (iii) substitution in or on the piperidine ring with alkyl, alkenyl, alkoxyl, ester, ether,
236.9 hydroxyl, halo, haloalkyl, amino, or nitro groups;

236.10 (iv) replacement of the aniline ring with any aromatic monocycle whether or not further
236.11 substituted in or on the aromatic monocycle; or

236.12 (v) replacement of the N-propionyl group by another acyl group.

236.13 (c) Opium derivatives. Any of the following substances, their analogs, salts, isomers,
236.14 and salts of isomers, unless specifically excepted or unless listed in another schedule,
236.15 whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

236.16 (1) acetorphine;

236.17 (2) acetyldihydrocodeine;

236.18 (3) benzylmorphine;

236.19 (4) codeine methylbromide;

236.20 (5) codeine-n-oxide;

236.21 (6) cyprenorphine;

236.22 (7) desomorphine;

236.23 (8) dihydromorphine;

236.24 (9) drotebanol;

236.25 (10) etorphine;

236.26 (11) heroin;

236.27 (12) hydromorphinol;

236.28 (13) methyldesorphine;

236.29 (14) methyldihydromorphine;

237.1 (15) morphine methylbromide;

237.2 (16) morphine methylsulfonate;

237.3 (17) morphine-n-oxide;

237.4 (18) myrophine;

237.5 (19) nicocodeine;

237.6 (20) nicomorphine;

237.7 (21) normorphine;

237.8 (22) pholcodine; and

237.9 (23) thebacon.

237.10 (d) Hallucinogens. Any material, compound, mixture or preparation which contains any
237.11 quantity of the following substances, their analogs, salts, isomers (whether optical, positional,
237.12 or geometric), and salts of isomers, unless specifically excepted or unless listed in another
237.13 schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is
237.14 possible:

237.15 (1) methylenedioxy amphetamine;

237.16 (2) methylenedioxymethamphetamine;

237.17 (3) methylenedioxy-N-ethylamphetamine (MDEA);

237.18 (4) n-hydroxy-methylenedioxyamphetamine;

237.19 (5) 4-bromo-2,5-dimethoxyamphetamine (DOB);

237.20 (6) 2,5-dimethoxyamphetamine (2,5-DMA);

237.21 (7) 4-methoxyamphetamine;

237.22 (8) 5-methoxy-3, 4-methylenedioxyamphetamine;

237.23 (9) alpha-ethyltryptamine;

237.24 (10) bufotenine;

237.25 (11) diethyltryptamine;

237.26 (12) dimethyltryptamine;

237.27 (13) 3,4,5-trimethoxyamphetamine;

237.28 (14) 4-methyl-2, 5-dimethoxyamphetamine (DOM);

238.1 (15) ibogaine;

238.2 (16) lysergic acid diethylamide (LSD);

238.3 (17) mescaline;

238.4 (18) parahexyl;

238.5 (19) N-ethyl-3-piperidyl benzilate;

238.6 (20) N-methyl-3-piperidyl benzilate;

238.7 (21) psilocybin;

238.8 (22) psilocyn;

238.9 (23) tenocyclidine (TPCP or TCP);

238.10 (24) N-ethyl-1-phenyl-cyclohexylamine (PCE);

238.11 (25) 1-(1-phenylcyclohexyl) pyrrolidine (PCPy);

238.12 (26) 1-[1-(2-thienyl)cyclohexyl]-pyrrolidine (TCPy);

238.13 (27) 4-chloro-2,5-dimethoxyamphetamine (DOC);

238.14 (28) 4-ethyl-2,5-dimethoxyamphetamine (DOET);

238.15 (29) 4-iodo-2,5-dimethoxyamphetamine (DOI);

238.16 (30) 4-bromo-2,5-dimethoxyphenethylamine (2C-B);

238.17 (31) 4-chloro-2,5-dimethoxyphenethylamine (2C-C);

238.18 (32) 4-methyl-2,5-dimethoxyphenethylamine (2C-D);

238.19 (33) 4-ethyl-2,5-dimethoxyphenethylamine (2C-E);

238.20 (34) 4-iodo-2,5-dimethoxyphenethylamine (2C-I);

238.21 (35) 4-propyl-2,5-dimethoxyphenethylamine (2C-P);

238.22 (36) 4-isopropylthio-2,5-dimethoxyphenethylamine (2C-T-4);

238.23 (37) 4-propylthio-2,5-dimethoxyphenethylamine (2C-T-7);

238.24 (38) 2-(8-bromo-2,3,6,7-tetrahydrofuro [2,3-f][1]benzofuran-4-yl)ethanamine
238.25 (2-CB-FLY);

238.26 (39) bromo-benzodifuranyl-isopropylamine (Bromo-DragonFLY);

238.27 (40) alpha-methyltryptamine (AMT);

239.1 (41) N,N-diisopropyltryptamine (DiPT);

239.2 (42) 4-acetoxy-N,N-dimethyltryptamine (4-AcO-DMT);

239.3 (43) 4-acetoxy-N,N-diethyltryptamine (4-AcO-DET);

239.4 (44) 4-hydroxy-N-methyl-N-propyltryptamine (4-HO-MPT);

239.5 (45) 4-hydroxy-N,N-dipropyltryptamine (4-HO-DPT);

239.6 (46) 4-hydroxy-N,N-diallyltryptamine (4-HO-DALT);

239.7 (47) 4-hydroxy-N,N-diisopropyltryptamine (4-HO-DiPT);

239.8 (48) 5-methoxy-N,N-diisopropyltryptamine (5-MeO-DiPT);

239.9 (49) 5-methoxy-α-methyltryptamine (5-MeO-AMT);

239.10 (50) 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT);

239.11 (51) 5-methylthio-N,N-dimethyltryptamine (5-MeS-DMT);

239.12 (52) 5-methoxy-N-methyl-N-isopropyltryptamine (5-MeO-MiPT);

239.13 (53) 5-methoxy-α-ethyltryptamine (5-MeO-AET);

239.14 (54) 5-methoxy-N,N-dipropyltryptamine (5-MeO-DPT);

239.15 (55) 5-methoxy-N,N-diethyltryptamine (5-MeO-DET);

239.16 (56) 5-methoxy-N,N-diallyltryptamine (5-MeO-DALT);

239.17 (57) methoxetamine (MXE);

239.18 (58) 5-iodo-2-aminoindane (5-IAI);

239.19 (59) 5,6-methylenedioxy-2-aminoindane (MDAI);

239.20 (60) 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe);

239.21 (61) 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe);

239.22 (62) 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe);

239.23 (63) 2-(2,5-Dimethoxyphenyl)ethanamine (2C-H);

239.24 (64) 2-(4-Ethylthio-2,5-dimethoxyphenyl)ethanamine (2C-T-2);

239.25 (65) N,N-Dipropyltryptamine (DPT);

239.26 (66) 3-[1-(Piperidin-1-yl)cyclohexyl]phenol (3-HO-PCP);

239.27 (67) N-ethyl-1-(3-methoxyphenyl)cyclohexanamine (3-MeO-PCE);

240.1 (68) 4-[1-(3-methoxyphenyl)cyclohexyl]morpholine (3-MeO-PCMo);

240.2 (69) 1-[1-(4-methoxyphenyl)cyclohexyl]-piperidine (methoxydine, 4-MeO-PCP);

240.3 (70) 2-(2-Chlorophenyl)-2-(ethylamino)cyclohexan-1-one (N-Ethylnorketamine,
240.4 ethketamine, NENK);

240.5 (71) methylenedioxy-N,N-dimethylamphetamine (MDDMA);

240.6 (72) 3-(2-Ethyl(methyl)aminoethyl)-1H-indol-4-yl (4-AcO-MET); and

240.7 (73) 2-Phenyl-2-(methylamino)cyclohexanone (deschloroketamine).

240.8 (e) Peyote. All parts of the plant presently classified botanically as Lophophora williamsii
240.9 Lemaire, whether growing or not, the seeds thereof, any extract from any part of the plant,
240.10 and every compound, manufacture, salts, derivative, mixture, or preparation of the plant,
240.11 its seeds or extracts. The listing of peyote as a controlled substance in Schedule I does not
240.12 apply to the nondrug use of peyote in bona fide religious ceremonies of the American Indian
240.13 Church, and members of the American Indian Church are exempt from registration. Any
240.14 person who manufactures peyote for or distributes peyote to the American Indian Church,
240.15 however, is required to obtain federal registration annually and to comply with all other
240.16 requirements of law.

240.17 (f) Central nervous system depressants. Unless specifically excepted or unless listed in
240.18 another schedule, any material compound, mixture, or preparation which contains any
240.19 quantity of the following substances, their analogs, salts, isomers, and salts of isomers
240.20 whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

240.21 (1) mecloqualone;

240.22 (2) methaqualone;

240.23 (3) gamma-hydroxybutyric acid (GHB), including its esters and ethers;

240.24 (4) flunitrazepam;

240.25 (5) 2-(2-Methoxyphenyl)-2-(methylamino)cyclohexanone (2-MeO-2-deschloroketamine,
240.26 methoxyketamine);

240.27 (6) tianeptine;

240.28 (7) clonazolam;

240.29 (8) etizolam;

240.30 (9) flubromazolam; and

241.1 (10) flubromazepam.

241.2 (g) Stimulants. Unless specifically excepted or unless listed in another schedule, any
241.3 material compound, mixture, or preparation which contains any quantity of the following
241.4 substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the
241.5 analogs, salts, isomers, and salts of isomers is possible:

241.6 (1) aminorex;

241.7 (2) cathinone;

241.8 (3) fenethylline;

241.9 (4) methcathinone;

241.10 (5) methylaminorex;

241.11 (6) N,N-dimethylamphetamine;

241.12 (7) N-benzylpiperazine (BZP);

241.13 (8) methylmethcathinone (mephedrone);

241.14 (9) 3,4-methylenedioxy-N-methylcathinone (methylone);

241.15 (10) methoxymethcathinone (methedrone);

241.16 (11) methylenedioxypyrovalerone (MDPV);

241.17 (12) 3-fluoro-N-methylcathinone (3-FMC);

241.18 (13) methylethcathinone (MEC);

241.19 (14) 1-benzofuran-6-ylpropan-2-amine (6-APB);

241.20 (15) dimethylmethcathinone (DMMC);

241.21 (16) fluoroamphetamine;

241.22 (17) fluoromethamphetamine;

241.23 (18) α-methylaminobutyrophenone (MABP or buphedrone);

241.24 (19) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one (butylone);

241.25 (20) 2-(methylamino)-1-(4-methylphenyl)butan-1-one (4-MEMABP or BZ-6378);

241.26 (21) 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl) pentan-1-one (naphthylpyrovalerone or
241.27 naphyrone);

241.28 (22) (alpha-pyrrolidinopentiophenone (alpha-PVP);

242.1 (23) (RS)-1-(4-methylphenyl)-2-(1-pyrrolidinyl)-1-hexanone (4-Me-PHP or MPHP);

242.2 (24) 2-(1-pyrrolidinyl)-hexanophenone (Alpha-PHP);

242.3 (25) 4-methyl-N-ethylcathinone (4-MEC);

242.4 (26) 4-methyl-alpha-pyrrolidinopropiophenone (4-MePPP);

242.5 (27) 2-(methylamino)-1-phenylpentan-1-one (pentedrone);

242.6 (28) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one (pentylone);

242.7 (29) 4-fluoro-N-methylcathinone (4-FMC);

242.8 (30) 3,4-methylenedioxy-N-ethylcathinone (ethylone);

242.9 (31) alpha-pyrrolidinobutiophenone (α-PBP);

242.10 (32) 5-(2-Aminopropyl)-2,3-dihydrobenzofuran (5-APDB);

242.11 (33) 1-phenyl-2-(1-pyrrolidinyl)-1-heptanone (PV8);

242.12 (34) 6-(2-Aminopropyl)-2,3-dihydrobenzofuran (6-APDB);

242.13 (35) 4-methyl-alpha-ethylaminopentiophenone (4-MEAPP);

242.14 (36) 4'-chloro-alpha-pyrrolidinopropiophenone (4'-chloro-PPP);

242.15 (37) 1-(1,3-Benzodioxol-5-yl)-2-(dimethylamino)butan-1-one (dibutylone, bk-DMBDB);

242.16 (38) 1-(3-chlorophenyl) piperazine (meta-chlorophenylpiperazine or mCPP);

242.17 (39) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one (N-ethylpentylone, ephylone);
242.18 and

242.19 (40) any other substance, except bupropion or compounds listed under a different
242.20 schedule, that is structurally derived from 2-aminopropan-1-one by substitution at the
242.21 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the
242.22 compound is further modified in any of the following ways:

242.23 (i) by substitution in the ring system to any extent with alkyl, alkylenedioxy, alkoxy,
242.24 haloalkyl, hydroxyl, or halide substituents, whether or not further substituted in the ring
242.25 system by one or more other univalent substituents;

242.26 (ii) by substitution at the 3-position with an acyclic alkyl substituent;

242.27 (iii) by substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or
242.28 methoxybenzyl groups; or

242.29 (iv) by inclusion of the 2-amino nitrogen atom in a cyclic structure.

243.1 (h) ~~Marijuana,~~ Synthetic tetrahydrocannabinols~~,~~ and synthetic cannabinoids. Unless
243.2 specifically excepted or unless listed in another schedule, any ~~natural or~~ synthetic material,
243.3 compound, mixture, or preparation that contains any quantity of the following substances,
243.4 their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever
243.5 the existence of the isomers, esters, ethers, or salts is possible:

243.6 ~~(1) marijuana;~~

243.7 ~~(2)~~ (1) synthetic tetrahydrocannabinols ~~naturally contained in a plant of the genus~~
243.8 ~~Cannabis,~~ that are the synthetic equivalents of the substances contained in the cannabis
243.9 plant or in the resinous extractives of the plant, or synthetic substances with similar chemical
243.10 structure and pharmacological activity to those substances contained in the plant or resinous
243.11 extract, including, but not limited to, 1 cis or trans tetrahydrocannabinol, 6 cis or trans
243.12 tetrahydrocannabinol, and 3,4 cis or trans tetrahydrocannabinol;

243.13 ~~(3)~~ (2) synthetic cannabinoids, including the following substances:

243.14 (i) Naphthoylindoles, which are any compounds containing a 3-(1-napthoyl)indole
243.15 structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl,
243.16 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
243.17 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any
243.18 extent and whether or not substituted in the naphthyl ring to any extent. Examples of
243.19 naphthoylindoles include, but are not limited to:

243.20 (A) 1-Pentyl-3-(1-naphthoyl)indole (JWH-018 and AM-678);

243.21 (B) 1-Butyl-3-(1-naphthoyl)indole (JWH-073);

243.22 (C) 1-Pentyl-3-(4-methoxy-1-naphthoyl)indole (JWH-081);

243.23 (D) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole (JWH-200);

243.24 (E) 1-Propyl-2-methyl-3-(1-naphthoyl)indole (JWH-015);

243.25 (F) 1-Hexyl-3-(1-naphthoyl)indole (JWH-019);

243.26 (G) 1-Pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);

243.27 (H) 1-Pentyl-3-(4-ethyl-1-naphthoyl)indole (JWH-210);

243.28 (I) 1-Pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);

243.29 (J) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM-2201).

243.30 (ii) Napthylmethylindoles, which are any compounds containing a
243.31 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the

244.1 indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl,
244.2 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further
244.3 substituted in the indole ring to any extent and whether or not substituted in the naphthyl
244.4 ring to any extent. Examples of naphthylmethylindoles include, but are not limited to:

244.5 (A) 1-Pentyl-1H-indol-3-yl-(1-naphthyl)methane (JWH-175);

244.6 (B) 1-Pentyl-1H-indol-3-yl-(4-methyl-1-naphthyl)methane (JWH-184).

244.7 (iii) Naphthoylpyrroles, which are any compounds containing a 3-(1-naphthoyl)pyrrole
244.8 structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl,
244.9 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
244.10 2-(4-morpholinyl)ethyl group whether or not further substituted in the pyrrole ring to any
244.11 extent, whether or not substituted in the naphthyl ring to any extent. Examples of
244.12 naphthoylpyrroles include, but are not limited to,
244.13 (5-(2-fluorophenyl)-1-pentylpyrrol-3-yl)-naphthalen-1-ylmethanone (JWH-307).

244.14 (iv) Naphthylmethylindenes, which are any compounds containing a naphthylideneindene
244.15 structure with substitution at the 3-position of the indene ring by an alkyl, haloalkyl, alkenyl,
244.16 cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
244.17 2-(4-morpholinyl)ethyl group whether or not further substituted in the indene ring to any
244.18 extent, whether or not substituted in the naphthyl ring to any extent. Examples of
244.19 naphthylemethylindenes include, but are not limited to,
244.20 E-1-[1-(1-naphthalenylmethylene)-1H-inden-3-yl]pentane (JWH-176).

244.21 (v) Phenylacetylindoles, which are any compounds containing a 3-phenylacetylindole
244.22 structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl,
244.23 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
244.24 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any
244.25 extent, whether or not substituted in the phenyl ring to any extent. Examples of
244.26 phenylacetylindoles include, but are not limited to:

244.27 (A) 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole (RCS-8);

244.28 (B) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);

244.29 (C) 1-pentyl-3-(2-methylphenylacetyl)indole (JWH-251);

244.30 (D) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).

244.31 (vi) Cyclohexylphenols, which are compounds containing a
244.32 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic
244.33 ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl,

245.1 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not substituted
245.2 in the cyclohexyl ring to any extent. Examples of cyclohexylphenols include, but are not
245.3 limited to:

245.4 (A) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP 47,497);

245.5 (B) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol
245.6 (Cannabicyclohexanol or CP 47,497 C8 homologue);

245.7 (C) 5-(1,1-dimethylheptyl)-2-[(1R,2R)-5-hydroxy-2-(3-hydroxypropyl)cyclohexyl]
245.8 -phenol (CP 55,940).

245.9 (vii) Benzoylindoles, which are any compounds containing a 3-(benzoyl)indole structure
245.10 with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl,
245.11 cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
245.12 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any
245.13 extent and whether or not substituted in the phenyl ring to any extent. Examples of
245.14 benzoylindoles include, but are not limited to:

245.15 (A) 1-Pentyl-3-(4-methoxybenzoyl)indole (RCS-4);

245.16 (B) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM-694);

245.17 (C) (4-methoxyphenyl-[2-methyl-1-(2-(4-morpholinyl)ethyl)indol-3-yl]methanone (WIN
245.18 48,098 or Pravadoline).

245.19 (viii) Others specifically named:

245.20 (A) (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)
245.21 -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (HU-210);

245.22 (B) (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)
245.23 -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (Dexanabinol or HU-211);

245.24 (C) 2,3-dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de]
245.25 -1,4-benzoxazin-6-yl-1-naphthalenylmethanone (WIN 55,212-2);

245.26 (D) (1-pentylindol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone (UR-144);

245.27 (E) (1-(5-fluoropentyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone
245.28 (XLR-11);

245.29 (F) 1-pentyl-N-tricyclo[3.3.1.13,7]dec-1-yl-1H-indazole-3-carboxamide
245.30 (AKB-48(APINACA));

246.1 (G) N-((3s,5s,7s)-adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide
246.2 (5-Fluoro-AKB-48);

246.3 (H) 1-pentyl-8-quinolinyl ester-1H-indole-3-carboxylic acid (PB-22);

246.4 (I) 8-quinolinyl ester-1-(5-fluoropentyl)-1H-indole-3-carboxylic acid (5-Fluoro PB-22);

246.5 (J) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-pentyl-1H-indazole- 3-carboxamide
246.6 (AB-PINACA);

246.7 (K) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(4-fluorophenyl)methyl]-
246.8 1H-indazole-3-carboxamide (AB-FUBINACA);

246.9 (L) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-(cyclohexylmethyl)-1H-
246.10 indazole-3-carboxamide(AB-CHMINACA);

246.11 (M) (S)-methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3- methylbutanoate
246.12 (5-fluoro-AMB);

246.13 (N) [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl) methanone (THJ-2201);

246.14 (O) (1-(5-fluoropentyl)-1H-benzo[d]imidazol-2-yl)(naphthalen-1-yl)methanone)
246.15 (FUBIMINA);

246.16 (P) (7-methoxy-1-(2-morpholinoethyl)-N-((1S,2S,4R)-1,3,3-trimethylbicyclo
246.17 [2.2.1]heptan-2-yl)-1H-indole-3-carboxamide (MN-25 or UR-12);

246.18 (Q) (S)-N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)
246.19 -1H-indole-3-carboxamide (5-fluoro-ABICA);

246.20 (R) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)
246.21 -1H-indole-3-carboxamide;

246.22 (S) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)
246.23 -1H-indazole-3-carboxamide;

246.24 (T) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido) -3,3-dimethylbutanoate;

246.25 (U) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1(cyclohexylmethyl)-1
246.26 H-indazole-3-carboxamide (MAB-CHMINACA);

246.27 (V) N-(1-Amino-3,3-dimethyl-1-oxo-2-butanyl)-1-pentyl-1H-indazole-3-carboxamide
246.28 (ADB-PINACA);

246.29 (W) methyl (1-(4-fluorobenzyl)-1H-indazole-3-carbonyl)-L-valinate (FUB-AMB);

247.1 (X) N-[(1S)-2-amino-2-oxo-1-(phenylmethyl)ethyl]-1-(cyclohexylmethyl)-1H-Indazole-
247.2 3-carboxamide. (APP-CHMINACA);

247.3 (Y) quinolin-8-yl 1-(4-fluorobenzyl)-1H-indole-3-carboxylate (FUB-PB-22); and

247.4 (Z) methyl N-[1-(cyclohexylmethyl)-1H-indole-3-carbonyl]valinate (MMB-CHMICA).

247.5 (ix) Additional substances specifically named:

247.6 (A) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1
247.7 H-pyrrolo[2,3-B]pyridine-3-carboxamide (5F-CUMYL-P7AICA);

247.8 (B) 1-(4-cyanobutyl)-N-(2- phenylpropan-2-yl)-1 H-indazole-3-carboxamide
247.9 (4-CN-Cumyl-Butinaca);

247.10 (C) naphthalen-1-yl-1-(5-fluoropentyl)-1-H-indole-3-carboxylate (NM2201; CBL2201);

247.11 (D) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1
247.12 H-indazole-3-carboxamide (5F-ABPINACA);

247.13 (E) methyl-2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate
247.14 (MDMB CHMICA);

247.15 (F) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate
247.16 (5F-ADB; 5F-MDMB-PINACA); and

247.17 (G) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)
247.18 1H-indazole-3-carboxamide (ADB-FUBINACA).

247.19 (i) A controlled substance analog, to the extent that it is implicitly or explicitly intended
247.20 for human consumption.

247.21 **EFFECTIVE DATE.** This section is effective August 1, 2021, and applies to crimes
247.22 committed on or after that date.

247.23 Sec. 69. Minnesota Statutes 2020, section 152.02, subdivision 3, is amended to read:

247.24 Subd. 3. **Schedule II.** (a) Schedule II consists of the substances listed in this subdivision.

247.25 (b) Unless specifically excepted or unless listed in another schedule, any of the following
247.26 substances whether produced directly or indirectly by extraction from substances of vegetable
247.27 origin or independently by means of chemical synthesis, or by a combination of extraction
247.28 and chemical synthesis:

247.29 (1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or
247.30 opiate.

248.1 (i) Excluding:

248.2 (A) apomorphine;

248.3 (B) thebaine-derived butorphanol;

248.4 (C) dextrophan;

248.5 (D) nalbuphine;

248.6 (E) nalmefene;

248.7 (F) naloxegol;

248.8 (G) naloxone;

248.9 (H) naltrexone; and

248.10 (I) their respective salts;

248.11 (ii) but including the following:

248.12 (A) opium, in all forms and extracts;

248.13 (B) codeine;

248.14 (C) dihydroetorphine;

248.15 (D) ethylmorphine;

248.16 (E) etorphine hydrochloride;

248.17 (F) hydrocodone;

248.18 (G) hydromorphone;

248.19 (H) metopon;

248.20 (I) morphine;

248.21 (J) oxycodone;

248.22 (K) oxymorphone;

248.23 (L) thebaine;

248.24 (M) oripavine;

248.25 (2) any salt, compound, derivative, or preparation thereof which is chemically equivalent
248.26 or identical with any of the substances referred to in clause (1), except that these substances
248.27 shall not include the isoquinoline alkaloids of opium;

248.28 (3) opium poppy and poppy straw;

249.1 (4) coca leaves and any salt, cocaine compound, derivative, or preparation of coca leaves
249.2 (including cocaine and ecgonine and their salts, isomers, derivatives, and salts of isomers
249.3 and derivatives), and any salt, compound, derivative, or preparation thereof which is
249.4 chemically equivalent or identical with any of these substances, except that the substances
249.5 shall not include decocainized coca leaves or extraction of coca leaves, which extractions
249.6 do not contain cocaine or ecgonine;

249.7 (5) concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid,
249.8 or powder form which contains the phenanthrene alkaloids of the opium poppy).

249.9 (c) Any of the following opiates, including their isomers, esters, ethers, salts, and salts
249.10 of isomers, esters and ethers, unless specifically excepted, or unless listed in another schedule,
249.11 whenever the existence of such isomers, esters, ethers and salts is possible within the specific
249.12 chemical designation:

249.13 (1) alfentanil;

249.14 (2) alphaprodine;

249.15 (3) anileridine;

249.16 (4) bezitramide;

249.17 (5) bulk dextropropoxyphene (nondosage forms);

249.18 (6) carfentanil;

249.19 (7) dihydrocodeine;

249.20 (8) dihydromorphinone;

249.21 (9) diphenoxylate;

249.22 (10) fentanyl;

249.23 (11) isomethadone;

249.24 (12) levo-alpha-acetylmethadol (LAAM);

249.25 (13) levomethorphan;

249.26 (14) levorphanol;

249.27 (15) metazocine;

249.28 (16) methadone;

249.29 (17) methadone - intermediate, 4-cyano-2-dimethylamino-4, 4-diphenylbutane;

250.1 (18) moramide - intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic
250.2 acid;

250.3 (19) pethidine;

250.4 (20) pethidine - intermediate - a, 4-cyano-1-methyl-4-phenylpiperidine;

250.5 (21) pethidine - intermediate - b, ethyl-4-phenylpiperidine-4-carboxylate;

250.6 (22) pethidine - intermediate - c, 1-methyl-4-phenylpiperidine-4-carboxylic acid;

250.7 (23) phenazocine;

250.8 (24) piminodine;

250.9 (25) racemethorphan;

250.10 (26) racemorphan;

250.11 (27) remifentanil;

250.12 (28) sufentanil;

250.13 (29) tapentadol;

250.14 (30) 4-Anilino-N-phenethylpiperidine.

250.15 (d) Unless specifically excepted or unless listed in another schedule, any material,
250.16 compound, mixture, or preparation which contains any quantity of the following substances
250.17 having a stimulant effect on the central nervous system:

250.18 (1) amphetamine, its salts, optical isomers, and salts of its optical isomers;

250.19 (2) methamphetamine, its salts, isomers, and salts of its isomers;

250.20 (3) phenmetrazine and its salts;

250.21 (4) methylphenidate;

250.22 (5) lisdexamfetamine.

250.23 (e) Unless specifically excepted or unless listed in another schedule, any material,
250.24 compound, mixture, or preparation which contains any quantity of the following substances
250.25 having a depressant effect on the central nervous system, including its salts, isomers, and
250.26 salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible
250.27 within the specific chemical designation:

250.28 (1) amobarbital;

250.29 (2) glutethimide;

251.1 (3) secobarbital;

251.2 (4) pentobarbital;

251.3 (5) phencyclidine;

251.4 (6) phencyclidine immediate precursors:

251.5 (i) 1-phenylcyclohexylamine;

251.6 (ii) 1-piperidinocyclohexanecarbonitrile;

251.7 (7) phenylacetone.

251.8 (f) Cannabis and cannabinoids:

251.9 (1) nabilone;

251.10 (2) unless specifically excepted or unless listed in another schedule, any natural material,
251.11 compound, mixture, or preparation that contains any quantity of the following substances,
251.12 their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever
251.13 the existence of the isomers, esters, ethers, or salts is possible:

251.14 (i) marijuana; and

251.15 (ii) tetrahydrocannabinols naturally contained in a plant of the genus cannabis or in the
251.16 resinous extractives of the plant; and

251.17 ~~(2)~~ (3) dronabinol [(-)-delta-9-trans-tetrahydrocannabinol (delta-9-THC)] in an oral
251.18 solution in a drug product approved for marketing by the United States Food and Drug
251.19 Administration.

251.20 **EFFECTIVE DATE.** This section is effective August 1, 2021, and applies to crimes
251.21 committed on or after that date.

251.22 Sec. 70. Minnesota Statutes 2020, section 152.11, subdivision 1a, is amended to read:

251.23 Subd. 1a. **Prescription requirements for Schedule II controlled substances.** Except
251.24 as allowed under section 152.29, no person may dispense a controlled substance included
251.25 in Schedule II of section 152.02 without a prescription issued by a doctor of medicine, a
251.26 doctor of osteopathic medicine licensed to practice medicine, a doctor of dental surgery, a
251.27 doctor of dental medicine, a doctor of podiatry, or a doctor of veterinary medicine, lawfully
251.28 licensed to prescribe in this state or by a practitioner licensed to prescribe controlled
251.29 substances by the state in which the prescription is issued, and having a current federal Drug
251.30 Enforcement Administration registration number. The prescription must either be printed
251.31 or written in ink and contain the handwritten signature of the prescriber or be transmitted

252.1 electronically or by facsimile as permitted under subdivision 1. Provided that in emergency
252.2 situations, as authorized by federal law, such drug may be dispensed upon oral prescription
252.3 reduced promptly to writing and filed by the pharmacist. Such prescriptions shall be retained
252.4 in conformity with section 152.101. No prescription for a Schedule II substance may be
252.5 refilled.

252.6 Sec. 71. Minnesota Statutes 2020, section 152.11, is amended by adding a subdivision to
252.7 read:

252.8 Subd. 5. **Exception.** References in this section to Schedule II controlled substances do
252.9 not extend to marijuana or tetrahydrocannabinols.

252.10 Sec. 72. Minnesota Statutes 2020, section 152.12, is amended by adding a subdivision to
252.11 read:

252.12 Subd. 6. **Exception.** References in this section to Schedule II controlled substances do
252.13 not extend to marijuana or tetrahydrocannabinols.

252.14 Sec. 73. Minnesota Statutes 2020, section 152.125, subdivision 3, is amended to read:

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

252.16 (1) a physician's treatment of an individual for chemical dependency resulting from the
252.17 use of controlled substances in Schedules II to V of section 152.02;

252.18 (2) the prescription or administration of controlled substances in Schedules II to V of
252.19 section 152.02 to an individual whom the physician knows to be using the controlled
252.20 substances for nontherapeutic purposes;

252.21 (3) the prescription or administration of controlled substances in Schedules II to V of
252.22 section 152.02 for the purpose of terminating the life of an individual having intractable
252.23 pain; ~~or~~

252.24 (4) the prescription or administration of a controlled substance in Schedules II to V of
252.25 section 152.02 that is not a controlled substance approved by the United States Food and
252.26 Drug Administration for pain relief; or

252.27 (5) the administration of medical cannabis under sections 152.22 to 152.37.

253.1 Sec. 74. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
253.2 read:

253.3 Subd. 5c. **Hemp processor.** "Hemp processor" means a person or business licensed by
253.4 the commissioner of agriculture under chapter 18K to convert raw hemp into a product.

253.5 Sec. 75. Minnesota Statutes 2020, section 152.22, subdivision 6, is amended to read:

253.6 Subd. 6. **Medical cannabis.** (a) "Medical cannabis" means any species of the genus
253.7 cannabis plant, or any mixture or preparation of them, including whole plant extracts and
253.8 resins, and is delivered in the form of:

253.9 (1) liquid, including, but not limited to, oil;

253.10 (2) pill;

253.11 (3) vaporized delivery method with use of liquid or oil ~~but which does not require the~~
253.12 ~~use of dried leaves or plant form; or~~;

253.13 (4) combustion with use of dried raw cannabis; or

253.14 ~~(4)~~ (5) any other method~~, excluding smoking,~~ approved by the commissioner.

253.15 (b) This definition includes any part of the genus cannabis plant prior to being processed
253.16 into a form allowed under paragraph (a), that is possessed by a person while that person is
253.17 engaged in employment duties necessary to carry out a requirement under sections 152.22
253.18 to 152.37 for a registered manufacturer or a laboratory under contract with a registered
253.19 manufacturer. This definition also includes any hemp acquired by a manufacturer by a hemp
253.20 grower as permitted under section 152.29, subdivision 1, paragraph (b).

253.21 **EFFECTIVE DATE.** This section is effective the earlier of (1) March 1, 2022, or (2)
253.22 a date, as determined by the commissioner of health, by which (i) the rules adopted or
253.23 amended under Minnesota Statutes, section 152.26, paragraph (b), are in effect and (ii) the
253.24 independent laboratories under contract with the manufacturers have the necessary procedures
253.25 and equipment in place to perform the required testing of dried raw cannabis. If this section
253.26 is effective before March 1, 2022, the commissioner shall provide notice of that effective
253.27 date to the public.

253.28 Sec. 76. Minnesota Statutes 2020, section 152.22, subdivision 11, is amended to read:

253.29 Subd. 11. **Registered designated caregiver.** "Registered designated caregiver" means
253.30 a person who:

253.31 (1) is at least 18 years old;

254.1 (2) does not have a conviction for a disqualifying felony offense;

254.2 (3) has been approved by the commissioner to assist a patient who ~~has been identified~~
254.3 ~~by a health care practitioner as developmentally or physically disabled and therefore~~ requires
254.4 assistance in administering medical cannabis or obtaining medical cannabis from a
254.5 distribution facility ~~due to the disability~~; and

254.6 (4) is authorized by the commissioner to assist the patient with the use of medical
254.7 cannabis.

254.8 Sec. 77. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
254.9 read:

254.10 Subd. 13a. **Tribal medical cannabis program.** "Tribal medical cannabis program"
254.11 means a medical cannabis program operated by a federally recognized Indian Tribe located
254.12 within the state that has been recognized by the commissioner of health in accordance with
254.13 section 152.25, subdivision 5.

254.14 Sec. 78. Minnesota Statutes 2020, section 152.23, is amended to read:

254.15 **152.23 LIMITATIONS.**

254.16 (a) Nothing in sections 152.22 to 152.37 permits any person to engage in and does not
254.17 prevent the imposition of any civil, criminal, or other penalties for:

254.18 (1) undertaking any task under the influence of medical cannabis that would constitute
254.19 negligence or professional malpractice;

254.20 (2) possessing or engaging in the use of medical cannabis:

254.21 (i) on a school bus or van;

254.22 (ii) on the grounds of any preschool or primary or secondary school;

254.23 (iii) in any correctional facility; or

254.24 (iv) on the grounds of any child care facility or home day care;

254.25 (3) vaporizing or combusting medical cannabis pursuant to section 152.22, subdivision
254.26 6:

254.27 (i) on any form of public transportation;

254.28 (ii) where the vapor would be inhaled by a nonpatient minor child or where the smoke
254.29 would be inhaled by a minor child; or

255.1 (iii) in any public place, including any indoor or outdoor area used by or open to the
255.2 general public or a place of employment as defined under section 144.413, subdivision 1b;
255.3 and

255.4 (4) operating, navigating, or being in actual physical control of any motor vehicle,
255.5 aircraft, train, or motorboat, or working on transportation property, equipment, or facilities
255.6 while under the influence of medical cannabis.

255.7 (b) Nothing in sections 152.22 to 152.37 require the medical assistance and
255.8 MinnesotaCare programs to reimburse an enrollee or a provider for costs associated with
255.9 the medical use of cannabis. Medical assistance and MinnesotaCare shall continue to provide
255.10 coverage for all services related to treatment of an enrollee's qualifying medical condition
255.11 if the service is covered under chapter 256B or 256L.

255.12 Sec. 79. Minnesota Statutes 2020, section 152.25, is amended by adding a subdivision to
255.13 read:

255.14 Subd. 5. **Tribal medical cannabis programs.** Upon the request of an Indian Tribe
255.15 operating a Tribal medical cannabis program, the commissioner shall determine if the
255.16 standards for the Tribal medical cannabis program meet or exceed the standards required
255.17 under sections 152.22 to 152.37 in terms of qualifying for the medical cannabis program,
255.18 allowable forms of medical cannabis, production and distribution requirements, product
255.19 safety and testing, and security measures. If the commissioner determines that the Tribal
255.20 medical cannabis program meets or exceeds the standards in sections 152.22 to 152.37, the
255.21 commissioner shall recognize the Tribal medical cannabis program and shall post the Tribal
255.22 medical cannabis programs that have been recognized by the commissioner on the
255.23 Department of Health's website.

255.24 Sec. 80. Minnesota Statutes 2020, section 152.26, is amended to read:

255.25 **152.26 RULEMAKING.**

255.26 (a) The commissioner may adopt rules to implement sections 152.22 to 152.37. Rules
255.27 for which notice is published in the State Register before January 1, 2015, may be adopted
255.28 using the process in section 14.389.

255.29 (b) The commissioner may adopt or amend rules, using the procedure in section 14.386,
255.30 paragraph (a), to implement the addition of dried raw cannabis as an allowable form of
255.31 medical cannabis under section 152.22, subdivision 6, paragraph (a), clause (4). Section
255.32 14.386, paragraph (b), does not apply to these rules.

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

256.2 Sec. 81. Minnesota Statutes 2020, section 152.27, subdivision 3, is amended to read:

256.3 Subd. 3. **Patient application.** (a) The commissioner shall develop a patient application
256.4 for enrollment into the registry program. The application shall be available to the patient
256.5 and given to health care practitioners in the state who are eligible to serve as health care
256.6 practitioners. The application must include:

256.7 (1) the name, mailing address, and date of birth of the patient;

256.8 (2) the name, mailing address, and telephone number of the patient's health care
256.9 practitioner;

256.10 (3) the name, mailing address, and date of birth of the patient's designated caregiver, if
256.11 any, or the patient's parent, legal guardian, or spouse if the parent, legal guardian, or spouse
256.12 will be acting as a caregiver;

256.13 (4) a copy of the certification from the patient's health care practitioner that is dated
256.14 within 90 days prior to submitting the application ~~which~~ that certifies that the patient has
256.15 been diagnosed with a qualifying medical condition ~~and, if applicable, that, in the health~~
256.16 ~~care practitioner's medical opinion, the patient is developmentally or physically disabled~~
256.17 ~~and, as a result of that disability, the patient requires assistance in administering medical~~
256.18 ~~cannabis or obtaining medical cannabis from a distribution facility~~; and

256.19 (5) all other signed affidavits and enrollment forms required by the commissioner under
256.20 sections 152.22 to 152.37, including, but not limited to, the disclosure form required under
256.21 paragraph (c).

256.22 (b) The commissioner shall require a patient to resubmit a copy of the certification from
256.23 the patient's health care practitioner on a yearly basis and shall require that the recertification
256.24 be dated within 90 days of submission.

256.25 (c) The commissioner shall develop a disclosure form and require, as a condition of
256.26 enrollment, all patients to sign a copy of the disclosure. The disclosure must include:

256.27 (1) a statement that, notwithstanding any law to the contrary, the commissioner, or an
256.28 employee of any state agency, may not be held civilly or criminally liable for any injury,
256.29 loss of property, personal injury, or death caused by any act or omission while acting within
256.30 the scope of office or employment under sections 152.22 to 152.37; and

(2) the patient's acknowledgment that enrollment in the patient registry program is conditional on the patient's agreement to meet all of the requirements of sections 152.22 to 152.37.

Sec. 82. Minnesota Statutes 2020, section 152.27, subdivision 4, is amended to read:

Subd. 4. **Registered designated caregiver.** (a) The commissioner shall register a designated caregiver for a patient if ~~the patient's health care practitioner has certified that the patient, in the health care practitioner's medical opinion, is developmentally or physically disabled and, as a result of that disability,~~ the patient requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility and the caregiver has agreed, in writing, to be the patient's designated caregiver. As a condition of registration as a designated caregiver, the commissioner shall require the person to:

(1) be at least 18 years of age;

(2) agree to only possess the patient's medical cannabis for purposes of assisting the patient; and

(3) agree that if the application is approved, the person will not be a registered designated caregiver for more than ~~one patient, unless the~~ six registered patients at one time. Patients who reside in the same residence shall count as one patient.

(b) The commissioner shall conduct a criminal background check on the designated caregiver prior to registration to ensure that the person does not have a conviction for a disqualifying felony offense. Any cost of the background check shall be paid by the person seeking registration as a designated caregiver. A designated caregiver must have the criminal background check renewed every two years.

(c) Nothing in sections 152.22 to 152.37 shall be construed to prevent a person registered as a designated caregiver from also being enrolled in the registry program as a patient and possessing and using medical cannabis as a patient.

Sec. 83. Minnesota Statutes 2020, section 152.27, subdivision 6, is amended to read:

Subd. 6. **Patient enrollment.** (a) After receipt of a patient's application, application fees, and signed disclosure, the commissioner shall enroll the patient in the registry program and issue the patient and patient's registered designated caregiver or parent, legal guardian, or spouse, if applicable, a registry verification. The commissioner shall approve or deny a patient's application for participation in the registry program within 30 days after the commissioner receives the patient's application and application fee. ~~The commissioner may~~

~~approve applications up to 60 days after the receipt of a patient's application and application fees until January 1, 2016.~~ A patient's enrollment in the registry program shall only be denied if the patient:

(1) does not have certification from a health care practitioner that the patient has been diagnosed with a qualifying medical condition;

(2) has not signed and returned the disclosure form required under subdivision 3, paragraph (c), to the commissioner;

(3) does not provide the information required; or

~~(4) has previously been removed from the registry program for violations of section 152.30 or 152.33; or~~

~~(5)~~ (4) provides false information.

(b) The commissioner shall give written notice to a patient of the reason for denying enrollment in the registry program.

(c) Denial of enrollment into the registry program is considered a final decision of the commissioner and is subject to judicial review under the Administrative Procedure Act pursuant to chapter 14.

(d) A patient's enrollment in the registry program may only be revoked upon the death of the patient or if a patient violates a requirement under section 152.30 or 152.33. If a patient's enrollment in the registry program has been revoked due to a violation of section 152.30 or 152.33, the patient may reapply for enrollment 12 months from the date the patient's enrollment was revoked. The commissioner shall process the application in accordance with this section.

(e) The commissioner shall develop a registry verification to provide to the patient, the health care practitioner identified in the patient's application, and to the manufacturer. The registry verification shall include:

(1) the patient's name and date of birth;

(2) the patient registry number assigned to the patient; and

(3) the name and date of birth of the patient's registered designated caregiver, if any, or the name of the patient's parent, legal guardian, or spouse if the parent, legal guardian, or spouse will be acting as a caregiver.

259.1 (f) The commissioner shall not deny a patient's application for participation in the registry
259.2 program or revoke a patient's enrollment in the registry program solely because the patient
259.3 is also enrolled in a Tribal medical cannabis program.

259.4 Sec. 84. Minnesota Statutes 2020, section 152.28, subdivision 1, is amended to read:

259.5 Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in
259.6 the registry program, a health care practitioner shall:

259.7 (1) determine, in the health care practitioner's medical judgment, whether a patient suffers
259.8 from a qualifying medical condition, and, if so determined, provide the patient with a
259.9 certification of that diagnosis;

259.10 (2) ~~determine whether a patient is developmentally or physically disabled and, as a result~~
259.11 ~~of that disability, the patient requires assistance in administering medical cannabis or~~
259.12 ~~obtaining medical cannabis from a distribution facility, and, if so determined, include that~~
259.13 ~~determination on the patient's certification of diagnosis;~~

259.14 ~~(3)~~ advise patients, registered designated caregivers, and parents, legal guardians, or
259.15 spouses who are acting as caregivers of the existence of any nonprofit patient support groups
259.16 or organizations;

259.17 ~~(4)~~ (3) provide explanatory information from the commissioner to patients with qualifying
259.18 medical conditions, including disclosure to all patients about the experimental nature of
259.19 therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the
259.20 proposed treatment; the application and other materials from the commissioner; and provide
259.21 patients with the Tennessen warning as required by section 13.04, subdivision 2; and

259.22 ~~(5)~~ (4) agree to continue treatment of the patient's qualifying medical condition and
259.23 report medical findings to the commissioner.

259.24 (b) Upon notification from the commissioner of the patient's enrollment in the registry
259.25 program, the health care practitioner shall:

259.26 (1) participate in the patient registry reporting system under the guidance and supervision
259.27 of the commissioner;

259.28 (2) report health records of the patient throughout the ongoing treatment of the patient
259.29 to the commissioner in a manner determined by the commissioner and in accordance with
259.30 subdivision 2;

259.31 (3) determine, on a yearly basis, if the patient continues to suffer from a qualifying
259.32 medical condition and, if so, issue the patient a new certification of that diagnosis; and

260.1 (4) otherwise comply with all requirements developed by the commissioner.

260.2 (c) A health care practitioner may conduct a patient assessment to issue a recertification
260.3 as required under paragraph (b), clause (3), via telemedicine as defined under section
260.4 62A.671, subdivision 9.

260.5 (d) Nothing in this section requires a health care practitioner to participate in the registry
260.6 program.

260.7 Sec. 85. Minnesota Statutes 2020, section 152.29, subdivision 1, is amended to read:

260.8 Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer may operate eight
260.9 distribution facilities, which may include the manufacturer's single location for cultivation,
260.10 harvesting, manufacturing, packaging, and processing but is not required to include that
260.11 location. The commissioner shall designate the geographical service areas to be served by
260.12 each manufacturer based on geographical need throughout the state to improve patient
260.13 access. A manufacturer shall not have more than two distribution facilities in each
260.14 geographical service area assigned to the manufacturer by the commissioner. A manufacturer
260.15 shall operate only one location where all cultivation, harvesting, manufacturing, packaging,
260.16 and processing of medical cannabis shall be conducted. This location may be one of the
260.17 manufacturer's distribution facility sites. The additional distribution facilities may dispense
260.18 medical cannabis and medical cannabis products but may not contain any medical cannabis
260.19 in a form other than those forms allowed under section 152.22, subdivision 6, and the
260.20 manufacturer shall not conduct any cultivation, harvesting, manufacturing, packaging, or
260.21 processing at the other distribution facility sites. Any distribution facility operated by the
260.22 manufacturer is subject to all of the requirements applying to the manufacturer under sections
260.23 152.22 to 152.37, including, but not limited to, security and distribution requirements.

260.24 (b) A manufacturer may acquire hemp grown in this state from a hemp grower, and may
260.25 acquire hemp products produced by a hemp processor. A manufacturer may manufacture
260.26 or process hemp and hemp products into an allowable form of medical cannabis under
260.27 section 152.22, subdivision 6. Hemp and hemp products acquired by a manufacturer under
260.28 this paragraph ~~is~~ are subject to the same quality control program, security and testing
260.29 requirements, and other requirements that apply to medical cannabis under sections 152.22
260.30 to 152.37 and Minnesota Rules, chapter 4770.

260.31 (c) A medical cannabis manufacturer shall contract with a laboratory approved by the
260.32 commissioner, subject to any additional requirements set by the commissioner, for purposes
260.33 of testing medical cannabis manufactured or hemp or hemp products acquired by the medical
260.34 cannabis manufacturer as to content, contamination, and consistency to verify the medical

261.1 cannabis meets the requirements of section 152.22, subdivision 6. The cost of laboratory
261.2 testing shall be paid by the manufacturer.

261.3 (d) The operating documents of a manufacturer must include:

261.4 (1) procedures for the oversight of the manufacturer and procedures to ensure accurate
261.5 record keeping;

261.6 (2) procedures for the implementation of appropriate security measures to deter and
261.7 prevent the theft of medical cannabis and unauthorized entrance into areas containing medical
261.8 cannabis; and

261.9 (3) procedures for the delivery and transportation of hemp between hemp growers and
261.10 manufacturers and for the delivery and transportation of hemp products between hemp
261.11 processors and manufacturers.

261.12 (e) A manufacturer shall implement security requirements, including requirements for
261.13 the delivery and transportation of hemp and hemp products, protection of each location by
261.14 a fully operational security alarm system, facility access controls, perimeter intrusion
261.15 detection systems, and a personnel identification system.

261.16 (f) A manufacturer shall not share office space with, refer patients to a health care
261.17 practitioner, or have any financial relationship with a health care practitioner.

261.18 (g) A manufacturer shall not permit any person to consume medical cannabis on the
261.19 property of the manufacturer.

261.20 (h) A manufacturer is subject to reasonable inspection by the commissioner.

261.21 (i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is not
261.22 subject to the Board of Pharmacy licensure or regulatory requirements under chapter 151.

261.23 (j) A medical cannabis manufacturer may not employ any person who is under 21 years
261.24 of age or who has been convicted of a disqualifying felony offense. An employee of a
261.25 medical cannabis manufacturer must submit a completed criminal history records check
261.26 consent form, a full set of classifiable fingerprints, and the required fees for submission to
261.27 the Bureau of Criminal Apprehension before an employee may begin working with the
261.28 manufacturer. The bureau must conduct a Minnesota criminal history records check and
261.29 the superintendent is authorized to exchange the fingerprints with the Federal Bureau of
261.30 Investigation to obtain the applicant's national criminal history record information. The
261.31 bureau shall return the results of the Minnesota and federal criminal history records checks
261.32 to the commissioner.

262.1 (k) A manufacturer may not operate in any location, whether for distribution or
262.2 cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a
262.3 public or private school existing before the date of the manufacturer's registration with the
262.4 commissioner.

262.5 (l) A manufacturer shall comply with reasonable restrictions set by the commissioner
262.6 relating to signage, marketing, display, and advertising of medical cannabis.

262.7 (m) Before a manufacturer acquires hemp from a hemp grower or hemp products from
262.8 a hemp processor, the manufacturer must verify that the hemp grower or hemp processor
262.9 has a valid license issued by the commissioner of agriculture under chapter 18K.

262.10 (n) Until a state-centralized, seed-to-sale system is implemented that can track a specific
262.11 medical cannabis plant from cultivation through testing and point of sale, the commissioner
262.12 shall conduct at least one unannounced inspection per year of each manufacturer that includes
262.13 inspection of:

262.14 (1) business operations;

262.15 (2) physical locations of the manufacturer's manufacturing facility and distribution
262.16 facilities;

262.17 (3) financial information and inventory documentation, including laboratory testing
262.18 results; and

262.19 (4) physical and electronic security alarm systems.

262.20 Sec. 86. Minnesota Statutes 2020, section 152.29, subdivision 3, is amended to read:

262.21 Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees
262.22 licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval
262.23 for the distribution of medical cannabis to a patient. A manufacturer may transport medical
262.24 cannabis or medical cannabis products that have been cultivated, harvested, manufactured,
262.25 packaged, and processed by that manufacturer to another registered manufacturer for the
262.26 other manufacturer to distribute.

262.27 (b) A manufacturer may distribute medical cannabis products, whether or not the products
262.28 have been manufactured by that manufacturer.

262.29 (c) Prior to distribution of any medical cannabis, the manufacturer shall:

262.30 (1) verify that the manufacturer has received the registry verification from the
262.31 commissioner for that individual patient;

263.1 (2) verify that the person requesting the distribution of medical cannabis is the patient,
263.2 the patient's registered designated caregiver, or the patient's parent, legal guardian, or spouse
263.3 listed in the registry verification using the procedures described in section 152.11, subdivision
263.4 2d;

263.5 (3) assign a tracking number to any medical cannabis distributed from the manufacturer;

263.6 (4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to
263.7 chapter 151 has consulted with the patient to determine the proper dosage for the individual
263.8 patient after reviewing the ranges of chemical compositions of the medical cannabis and
263.9 the ranges of proper dosages reported by the commissioner. For purposes of this clause, a
263.10 consultation may be conducted remotely ~~using a~~ <u>by secure</u> videoconference<u>, telephone, or</u>
263.11 <u>other remote means</u>, so long as the employee providing the consultation is able to confirm
263.12 the identity of the patient~~, the consultation occurs while the patient is at a distribution facility,~~
263.13 and the consultation adheres to patient privacy requirements that apply to health care services
263.14 delivered through telemedicine<u>. A pharmacist consultation under this clause is not required</u>
263.15 <u>when a manufacturer is distributing medical cannabis to a patient according to a</u>
263.16 <u>patient-specific dosage plan established with that manufacturer and is not modifying the</u>
263.17 <u>dosage or product being distributed under that plan and the medical cannabis is distributed</u>
263.18 <u>by a pharmacy technician</u>;

263.19 (5) properly package medical cannabis in compliance with the United States Poison
263.20 Prevention Packing Act regarding child-resistant packaging and exemptions for packaging
263.21 for elderly patients, and label distributed medical cannabis with a list of all active ingredients
263.22 and individually identifying information, including:

263.23 (i) the patient's name and date of birth;

263.24 (ii) the name and date of birth of the patient's registered designated caregiver or, if listed
263.25 on the registry verification, the name of the patient's parent or legal guardian, if applicable;

263.26 (iii) the patient's registry identification number;

263.27 (iv) the chemical composition of the medical cannabis; and

263.28 (v) the dosage; and

263.29 (6) ensure that the medical cannabis distributed contains a maximum of a 90-day supply
263.30 of the dosage determined for that patient.

263.31 (d) A manufacturer shall require any employee of the manufacturer who is transporting
263.32 medical cannabis or medical cannabis products to a distribution facility or to another

264.1 registered manufacturer to carry identification showing that the person is an employee of
264.2 the manufacturer.

264.3 (e) A manufacturer shall distribute medical cannabis in dried raw cannabis form only
264.4 to a patient age 21 or older, or to the registered designated caregiver, parent, legal guardian,
264.5 or spouse of a patient age 21 or older.

264.6 **EFFECTIVE DATE.** Paragraph (e) is effective the earlier of (1) March 1, 2022, or (2)
264.7 a date, as determined by the commissioner of health, by which (i) the rules adopted or
264.8 amended under Minnesota Statutes, section 152.26, paragraph (b), are in effect and (ii) the
264.9 independent laboratories under contract with the manufacturers have the necessary procedures
264.10 and equipment in place to perform the required testing of dried raw cannabis. If this section
264.11 is effective before March 1, 2022, the commissioner shall provide notice of that effective
264.12 date to the public.

264.13 Sec. 87. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to
264.14 read:

264.15 Subd. 3b. **Distribution to recipient in a motor vehicle.** A manufacturer may distribute
264.16 medical cannabis to a patient, registered designated caregiver, or parent, legal guardian, or
264.17 spouse of a patient who is at the distribution facility but remains in a motor vehicle, provided:

264.18 (1) distribution facility staff receive payment and distribute medical cannabis in a
264.19 designated zone that is as close as feasible to the front door of the distribution facility;

264.20 (2) the manufacturer ensures that the receipt of payment and distribution of medical
264.21 cannabis are visually recorded by a closed-circuit television surveillance camera at the
264.22 distribution facility and provides any other necessary security safeguards;

264.23 (3) the manufacturer does not store medical cannabis outside a restricted access area at
264.24 the distribution facility, and distribution facility staff transport medical cannabis from a
264.25 restricted access area at the distribution facility to the designated zone for distribution only
264.26 after confirming that the patient, designated caregiver, or parent, guardian, or spouse has
264.27 arrived in the designated zone;

264.28 (4) the payment and distribution of medical cannabis take place only after a pharmacist
264.29 consultation takes place, if required under subdivision 3, paragraph (c), clause (4);

264.30 (5) immediately following distribution of medical cannabis, distribution facility staff
264.31 enter the transaction in the state medical cannabis registry information technology database;
264.32 and

265.1 (6) immediately following distribution of medical cannabis, distribution facility staff
265.2 take the payment received into the distribution facility.

265.3 Sec. 88. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to
265.4 read:

265.5 Subd. 3c. **Disposal of medical cannabis plant root balls.** Notwithstanding Minnesota
265.6 Rules, part 4770.1200, subpart 2, item C, a manufacturer is not required to grind root balls
265.7 of medical cannabis plants or incorporate them with a greater quantity of nonconsumable
265.8 solid waste before transporting root balls to another location for disposal. For purposes of
265.9 this subdivision, "root ball" means a compact mass of roots formed by a plant and any
265.10 attached growing medium.

265.11 Sec. 89. Minnesota Statutes 2020, section 152.31, is amended to read:

265.12 **152.31 DATA PRACTICES.**

265.13 (a) Government data in patient files maintained by the commissioner and the health care
265.14 practitioner, and data submitted to or by a medical cannabis manufacturer, are private data
265.15 on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in
265.16 section 13.02, subdivision 9, but may be used for purposes of complying with chapter 13
265.17 and complying with a request from the legislative auditor or the state auditor in the
265.18 performance of official duties. The provisions of section 13.05, subdivision 11, apply to a
265.19 registration agreement entered between the commissioner and a medical cannabis
265.20 manufacturer under section 152.25.

265.21 (b) Not public data maintained by the commissioner may not be used for any purpose
265.22 not provided for in sections 152.22 to 152.37, and may not be combined or linked in any
265.23 manner with any other list, dataset, or database.

265.24 (c) The commissioner may execute data sharing arrangements with the commissioner
265.25 of agriculture to verify licensing, inspection, and compliance information related to hemp
265.26 growers and hemp processors under chapter 18K.

265.27 Sec. 90. Minnesota Statutes 2020, section 152.32, subdivision 3, is amended to read:

265.28 Subd. 3. **Discrimination prohibited.** (a) No school or landlord may refuse to enroll or
265.29 lease to and may not otherwise penalize a person solely for the person's status as a patient
265.30 enrolled in the registry program under sections 152.22 to 152.37, unless failing to do so
265.31 would violate federal law or regulations or cause the school or landlord to lose a monetary
265.32 or licensing-related benefit under federal law or regulations.

266.1 (b) For the purposes of medical care, including organ transplants, a registry program
266.2 enrollee's use of medical cannabis under sections 152.22 to 152.37 is considered the
266.3 equivalent of the authorized use of any other medication used at the discretion of a physician
266.4 or advanced practice registered nurse and does not constitute the use of an illicit substance
266.5 or otherwise disqualify a patient from needed medical care.

266.6 (c) Unless a failure to do so would violate federal law or regulations or cause an employer
266.7 to lose a monetary or licensing-related benefit under federal law or regulations, an employer
266.8 may not discriminate against a person in hiring, termination, or any term or condition of
266.9 employment, or otherwise penalize a person, if the discrimination is based upon either of
266.10 the following:

266.11 (1) the person's status as a patient enrolled in the registry program under sections 152.22
266.12 to 152.37; or

266.13 (2) a patient's positive drug test for cannabis components or metabolites, unless the
266.14 patient used, possessed, or was impaired by medical cannabis on the premises of the place
266.15 of employment or during the hours of employment.

266.16 (d) An employee who is required to undergo employer drug testing pursuant to section
266.17 181.953 may present verification of enrollment in the patient registry as part of the employee's
266.18 explanation under section 181.953, subdivision 6.

266.19 (e) A person shall not be denied custody of a minor child or visitation rights or parenting
266.20 time with a minor child solely based on the person's status as a patient enrolled in the registry
266.21 program under sections 152.22 to 152.37. There shall be no presumption of neglect or child
266.22 endangerment for conduct allowed under sections 152.22 to 152.37, unless the person's
266.23 behavior is such that it creates an unreasonable danger to the safety of the minor as
266.24 established by clear and convincing evidence.

266.25 (f) This subdivision applies to any person enrolled in a Tribal medical cannabis program
266.26 to the same extent as if the person was enrolled in the registry program under sections 152.22
266.27 to 152.37.

266.28 Sec. 91. Minnesota Statutes 2020, section 171.07, is amended by adding a subdivision to
266.29 read:

266.30 Subd. 3b. **Identification card for homeless youth.** (a) A homeless youth, as defined in
266.31 section 256K.45, subdivision 1a, who meets the requirements of this subdivision may obtain
266.32 a noncompliant identification card, notwithstanding section 171.06, subdivision 3.

266.33 (b) An applicant under this subdivision must:

267.1 (1) provide the applicant's full name, date of birth, and sex;

267.2 (2) provide the applicant's height in feet and inches, weight in pounds, and eye color;

267.3 (3) submit a certified copy of a birth certificate issued by a government bureau of vital
267.4 statistics or equivalent agency in the applicant's state of birth, which must bear the raised
267.5 or authorized seal of the issuing government entity; and

267.6 (4) submit a statement verifying that the applicant is a homeless youth who resides in
267.7 Minnesota that is signed by:

267.8 (i) an employee of a human services agency receiving public funding to provide services
267.9 to homeless youth, runaway youth, youth with mental illness, or youth with substance use
267.10 disorders; or

267.11 (ii) staff at a school who provide services to homeless youth or a school social worker.

267.12 (c) For a noncompliant identification card under this subdivision:

267.13 (1) the commissioner must not impose a fee, surcharge, or filing fee under section 171.06,
267.14 subdivision 2; and

267.15 (2) a driver's license agent must not impose a filing fee under section 171.061, subdivision
267.16 4.

267.17 (d) Minnesota Rules, parts 7410.0400 and 7410.0410, or successor rules, do not apply
267.18 for an identification card under this subdivision.

267.19 **EFFECTIVE DATE.** This section is effective the day following final enactment for
267.20 application and issuance of Minnesota identification cards on and after January 1, 2022.

267.21 Sec. 92. Minnesota Statutes 2020, section 256.98, subdivision 1, is amended to read:

267.22 Subdivision 1. **Wrongfully obtaining assistance.** (a) A person who commits any of the
267.23 following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897,
267.24 the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program
267.25 formerly codified in sections 256.72 to 256.871, chapter 256B, 256D, 256I, 256J, 256K, or
267.26 256L, child care assistance programs, and emergency assistance programs under section
267.27 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses
267.28 (1) to (5):

267.29 (1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a
267.30 willfully false statement or representation, by intentional concealment of any material fact,
267.31 or by impersonation or other fraudulent device, assistance or the continued receipt of

268.1 assistance, to include child care assistance or ~~vouchers~~ food benefits produced according
268.2 to sections 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365,
268.3 256.94, and 256L.01 to 256L.15, to which the person is not entitled or assistance greater
268.4 than that to which the person is entitled;

268.5 (2) knowingly aids or abets in buying or in any way disposing of the property of a
268.6 recipient or applicant of assistance without the consent of the county agency; or

268.7 (3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments
268.8 to which the individual is not entitled as a provider of subsidized child care, or by furnishing
268.9 or concurring in a willfully false claim for child care assistance.

268.10 (b) The continued receipt of assistance to which the person is not entitled or greater than
268.11 that to which the person is entitled as a result of any of the acts, failure to act, or concealment
268.12 described in this subdivision shall be deemed to be continuing offenses from the date that
268.13 the first act or failure to act occurred.

268.14 Sec. 93. Minnesota Statutes 2020, section 256B.0625, subdivision 52, is amended to read:

268.15 Subd. 52. **Lead risk assessments.** (a) Effective October 1, 2007, or six months after
268.16 federal approval, whichever is later, medical assistance covers lead risk assessments provided
268.17 by a lead risk assessor who is licensed by the commissioner of health under section 144.9505
268.18 and employed by an assessing agency as defined in section 144.9501. Medical assistance
268.19 covers a onetime on-site investigation of a recipient's home or primary residence to determine
268.20 the existence of lead so long as the recipient is under the age of 21 and has a venous blood
268.21 lead level specified in section 144.9504, subdivision 2, paragraph ~~(a)~~ (b).

268.22 (b) Medical assistance reimbursement covers the lead risk assessor's time to complete
268.23 the following activities:

268.24 (1) gathering samples;

268.25 (2) interviewing family members;

268.26 (3) gathering data, including meter readings; and

268.27 (4) providing a report with the results of the investigation and options for reducing
268.28 lead-based paint hazards.

268.29 Medical assistance coverage of lead risk assessment does not include testing of
268.30 environmental substances such as water, paint, or soil or any other laboratory services.
268.31 Medical assistance coverage of lead risk assessments is not included in the capitated services

269.1 for children enrolled in health plans through the prepaid medical assistance program and
269.2 the MinnesotaCare program.

269.3 (c) Payment for lead risk assessment must be cost-based and must meet the criteria for
269.4 federal financial participation under the Medicaid program. The rate must be based on
269.5 allowable expenditures from cost information gathered. Under section 144.9507, subdivision
269.6 5, federal medical assistance funds may not replace existing funding for lead-related activities.
269.7 The nonfederal share of costs for services provided under this subdivision must be from
269.8 state or local funds and is the responsibility of the agency providing the risk assessment.
269.9 When the risk assessment is conducted by the commissioner of health, the state share must
269.10 be from appropriations to the commissioner of health for this purpose. Eligible expenditures
269.11 for the nonfederal share of costs may not be made from federal funds or funds used to match
269.12 other federal funds. Any federal disallowances are the responsibility of the agency providing
269.13 risk assessment services.

269.14 Sec. 94. Minnesota Statutes 2020, section 326.71, subdivision 4, is amended to read:

269.15 Subd. 4. **Asbestos-related work.** "Asbestos-related work" means the enclosure, removal,
269.16 or encapsulation of asbestos-containing material in a quantity that meets or exceeds 260
269.17 linear feet of friable asbestos-containing material on pipes, 160 square feet of friable
269.18 asbestos-containing material on other facility components, or, if linear feet or square feet
269.19 cannot be measured, a total of 35 cubic feet of friable asbestos-containing material on or
269.20 off all facility components in one facility. In the case of single or multifamily residences,
269.21 "asbestos-related work" also means the enclosure, removal, or encapsulation of greater than
269.22 ten but less than 260 linear feet of friable asbestos-containing material on pipes, greater
269.23 than six but less than 160 square feet of friable asbestos-containing material on other facility
269.24 components, or, if linear feet or square feet cannot be measured, greater than one cubic foot
269.25 but less than 35 cubic feet of friable asbestos-containing material on or off all facility
269.26 components in one facility. ~~This provision excludes asbestos-containing floor tiles and~~
269.27 ~~sheeting, roofing materials, siding, and all ceilings with asbestos-containing material in~~
269.28 ~~single family residences and buildings with no more than four dwelling units.~~
269.29 Asbestos-related work includes asbestos abatement area preparation; enclosure, removal,
269.30 or encapsulation operations; and an air quality monitoring specified in rule to assure that
269.31 the abatement and adjacent areas are not contaminated with asbestos fibers during the project
269.32 and after completion.

269.33 For purposes of this subdivision, the quantity of ~~asbestos containing~~ asbestos-containing
269.34 material applies separately for every project.

Sec. 95. Minnesota Statutes 2020, section 326.75, subdivision 1, is amended to read:

Subdivision 1. **Licensing fee.** A person required to be licensed under section 326.72 shall, before receipt of the license and before causing asbestos-related work to be performed, pay the commissioner an annual license fee of ~~$100~~ $105.

Sec. 96. Minnesota Statutes 2020, section 326.75, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** An individual required to be certified as an asbestos worker or asbestos site supervisor under section 326.73, subdivision 1, shall pay the commissioner a certification fee of ~~$50~~ $52.50 before the issuance of the certificate. ~~The commissioner may establish by rule fees required before the issuance of~~ An individual required to be certified as an asbestos inspector, asbestos management planner, and asbestos project designer ~~certificates required~~ under section 326.73, subdivisions 2, 3, and 4, shall pay the commissioner a certification fee of $105 before the issuance of the certificate.

Sec. 97. Minnesota Statutes 2020, section 326.75, subdivision 3, is amended to read:

Subd. 3. **Permit fee.** Five calendar days before beginning asbestos-related work, a person shall pay a project permit fee to the commissioner equal to ~~one~~ two percent of the total costs of the asbestos-related work. For asbestos-related work performed in single or multifamily residences, of greater than ten but less than 260 linear feet of asbestos-containing material on pipes, or greater than six but less than 160 square feet of asbestos-containing material on other facility components, a person shall pay a project permit fee of $35 to the commissioner.

Sec. 98. Laws 2020, Seventh Special Session chapter 1, article 6, section 12, subdivision 4, is amended to read:

Subd. 4. **Housing with services establishment registration; conversion to an assisted living facility license.** (a) Housing with services establishments registered under chapter 144D, providing home care services according to chapter 144A to at least one resident, and intending to provide assisted living services on or after August 1, 2021, must submit an application for an assisted living facility license in accordance with section 144G.12 no later than June 1, 2021. The commissioner shall consider the application in accordance with section ~~144G.16~~ 144G.15.

(b) Notwithstanding the housing with services contract requirements identified in section 144D.04, any existing housing with services establishment registered under chapter 144D that does not intend to convert its registration to an assisted living facility license under this

271.1 chapter must provide written notice to its residents at least 60 days before the expiration of
271.2 its registration, or no later than May 31, 2021, whichever is earlier. The notice must:

271.3 (1) state that the housing with services establishment does not intend to convert to an
271.4 assisted living facility;

271.5 (2) include the date when the housing with services establishment will no longer provide
271.6 housing with services;

271.7 (3) include the name, e-mail address, and phone number of the individual associated
271.8 with the housing with services establishment that the recipient of home care services may
271.9 contact to discuss the notice;

271.10 (4) include the contact information consisting of the phone number, e-mail address,
271.11 mailing address, and website for the Office of Ombudsman for Long-Term Care and the
271.12 Office of Ombudsman for Mental Health and Developmental Disabilities; and

271.13 (5) for residents who receive home and community-based waiver services under section
271.14 256B.49 and chapter 256S, also be provided to the resident's case manager at the same time
271.15 that it is provided to the resident.

271.16 (c) A housing with services registrant that obtains an assisted living facility license, but
271.17 does so under a different business name as a result of reincorporation, and continues to
271.18 provide services to the recipient, is not subject to the 60-day notice required under paragraph
271.19 (b). However, the provider must otherwise provide notice to the recipient as required under
271.20 sections 144D.04 and 144D.045, as applicable, and section 144D.09.

271.21 (d) All registered housing with services establishments providing assisted living under
271.22 sections 144G.01 to 144G.07 prior to August 1, 2021, must have an assisted living facility
271.23 license under this chapter.

271.24 (e) Effective August 1, 2021, any housing with services establishment registered under
271.25 chapter 144D that has not converted its registration to an assisted living facility license
271.26 under this chapter is prohibited from providing assisted living services.

271.27 **EFFECTIVE DATE.** This section is effective retroactively from December 17, 2020.

271.28 Sec. 99. **ADDITIONAL MEMBER TO COVID-19 VACCINE ALLOCATION**
271.29 **ADVISORY GROUP.**

271.30 The commissioner of health shall appoint an individual who is an expert on vaccine
271.31 disinformation to the state COVID-19 Vaccine Allocation Advisory Group no later than
271.32 ....

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

272.2 Sec. 100. **FEDERAL SCHEDULE I EXEMPTION APPLICATION FOR MEDICAL**
272.3 **USE OF CANNABIS.**

272.4 By September 1, 2021, the commissioner of health shall apply to the Drug Enforcement
272.5 Administration's Office of Diversion Control for an exception under Code of Federal
272.6 Regulations, title 21, section 1307.03, and request formal written acknowledgment that the
272.7 listing of marijuana, marijuana extract, and tetrahydrocannabinols as controlled substances
272.8 in federal Schedule I does not apply to the protected activities in Minnesota Statutes, section
272.9 152.32, subdivision 2, pursuant to the medical cannabis program established under Minnesota
272.10 Statutes, sections 152.22 to 152.37. The application shall include the presumption in
272.11 Minnesota Statutes, section 152.32, subdivision 1.

272.12 Sec. 101. **MENTAL HEALTH CULTURAL COMMUNITY CONTINUING**
272.13 **EDUCATION GRANT PROGRAM.**

272.14 The commissioner of health shall develop a grant program, in consultation with the
272.15 relevant mental health licensing boards, to provide for the continuing education necessary
272.16 for social workers, marriage and family therapists, psychologists, and professional clinical
272.17 counselors who are members of communities of color or underrepresented communities,
272.18 as defined in Minnesota Statutes, section 148E.010, subdivision 20, and who work for
272.19 community mental health providers, to become supervisors for individuals pursuing licensure
272.20 in mental health professions.

272.21 Sec. 102. **RECOMMENDATIONS; EXPANDED ACCESS TO DATA FROM**
272.22 **ALL-PAYER CLAIMS DATABASE.**

272.23 The commissioner of health shall develop recommendations to expand access to data
272.24 in the all-payer claims database under Minnesota Statutes, section 62U.04, to additional
272.25 outside entities for public health or research purposes. In the recommendations, the
272.26 commissioner must address an application process for outside entities to access the data,
272.27 how the department will exercise ongoing oversight over data use by outside entities,
272.28 purposes for which the data may be used by outside entities, establishment of a data access
272.29 committee to advise the department on selecting outside entities that may access the data,
272.30 and steps outside entities must take to protect data held by those entities from unauthorized
272.31 use. Following development of these recommendations, an outside entity that accesses data
272.32 in compliance with these recommendations may publish results that identify hospitals,
272.33 clinics, and medical practices so long as no individual health professionals are identified

273.1 and the commissioner finds the data to be accurate, valid, and suitable for publication for
273.2 such use. The commissioner shall submit these recommendations by December 15, 2021,
273.3 to the chairs and ranking minority members of the legislative committees with jurisdiction
273.4 over health policy and civil law.

273.5 Sec. 103. **SKIN LIGHTENING PRODUCTS PUBLIC AWARENESS AND**
273.6 **EDUCATION GRANT PROGRAM.**

273.7 Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a
273.8 grant program for the purpose of increasing public awareness and education on the health
273.9 dangers associated with using skin lightening creams and products that contain mercury
273.10 that are manufactured in other countries and brought into this country and sold illegally
273.11 online or in stores.

273.12 Subd. 2. **Grants authorized.** The commissioner shall award grants through a request
273.13 for proposal process to community-based, nonprofit organizations that serve ethnic
273.14 communities and that focus on public health outreach to Black, Indigenous, and people of
273.15 color communities on the issue of skin lightening products and chemical exposure from
273.16 these products. Priority in awarding grants shall be given to organizations that have
273.17 historically provided services to ethnic communities on the skin lightening and chemical
273.18 exposure issue for the past three years.

273.19 Subd. 3. **Grant allocation.** (a) Grantees must use the funds to conduct public awareness
273.20 and education activities that are culturally specific and community-based and focus on:

273.21 (1) the dangers of exposure to mercury through dermal absorption, inhalation,
273.22 hand-to-mouth contact, and through contact with individuals who have used these skin
273.23 lightening products;

273.24 (2) the signs and symptoms of mercury poisoning;

273.25 (3) the health effects of mercury poisoning, including the permanent effects on the central
273.26 nervous system and kidneys;

273.27 (4) the dangers of using these products or being exposed to these products during
273.28 pregnancy and breastfeeding to the mother and to the infant;

273.29 (5) knowing how to identify products that contain mercury; and

273.30 (6) proper disposal of the product if the product contains mercury.

273.31 (b) The grant application must include:

273.32 (1) a description of the purpose or project for which the grant funds will be used;

274.1 (2) a description of the objectives, a work plan, and a timeline for implementation; and

274.2 (3) the community or group the grant proposes to focus on.

274.3 Sec. 104. **TRAUMA-INFORMED GUN VIOLENCE REDUCTION; PILOT**
274.4 **PROGRAM.**

274.5 Subdivision 1. **Pilot program.** (a) The commissioner of health shall establish a pilot
274.6 program to aid in the reduction of trauma resulting from gun violence and address the root
274.7 causes of gun violence by making the following resources available to professionals and
274.8 organizations in health care, public health, mental health, social service, law enforcement,
274.9 and victim advocacy and other professionals who are most likely to encounter individuals
274.10 who have been victims, witnesses, or perpetrators of gun violence occurring in a community,
274.11 or in a domestic or other setting:

274.12 (1) training on recognizing trauma as both a result and a cause of gun violence;

274.13 (2) developing skills to address the effects of trauma on individuals and family members;

274.14 (3) investments in community-based organizations to enable high-quality, targeted
274.15 services to individuals in need. This may include resources for additional training, hiring
274.16 of specialized staff needed to address trauma-related issues, management information
274.17 systems to facilitate data collection, and expansion of existing programming;

274.18 (4) replication and expansion of effective community-based gun violence prevention
274.19 initiatives, such as Project Life, the Minneapolis Group Violence Intervention initiative, to
274.20 connect at-risk individuals to mental health services, job readiness programs, and employment
274.21 opportunities; and

274.22 (5) education campaigns and outreach materials to educate communities, organizations,
274.23 and the public about the relationship between trauma and gun violence.

274.24 (b) The pilot program shall address the traumatic effects of gun violence exposure using
274.25 a holistic treatment modality.

274.26 Subd. 2. **Program guidelines and protocols.** (a) The commissioner, with advice from
274.27 an advisory panel knowledgeable about gun violence and its traumatic impact, shall develop
274.28 protocols and program guidelines that address resources and training to be used by
274.29 professionals who encounter individuals who have perpetrated or been impacted by gun
274.30 violence. Educational, training, and outreach material must be culturally appropriate for the
274.31 community and provided in multiple languages for those with limited English language
274.32 proficiency. The materials developed must address necessary responses by local, state, and

275.1 other governmental entities tasked with addressing gun violence. The protocols must include
275.2 a method of informing affected communities and local governments representing those
275.3 communities on effective strategies to target community, domestic, and other forms of gun
275.4 violence.

275.5 (b) The commissioner may enter into contractual agreements with community-based
275.6 organizations or experts in the field to perform any of the activities under this section.

275.7 Subd. 3. **Report.** By November 15, 2021, the commissioner shall submit a report on the
275.8 progress of the pilot program to the chairs and ranking minority members of the committees
275.9 with jurisdiction over health and public safety.

275.10 Sec. 105. **REVISOR INSTRUCTION.**

275.11 The revisor of statutes shall amend the section headnote for Minnesota Statutes, section
275.12 62J.63, to read "HEALTH CARE PURCHASING AND PERFORMANCE
275.13 MEASUREMENT."

275.14 Sec. 106. **REPEALER.**

275.15 Minnesota Statutes 2020, sections 62J.63, subdivision 3; 144.0721, subdivision 1;
275.16 144.0722; 144.0724, subdivision 10; and 144.693, are repealed.

275.17 **ARTICLE 4**

275.18 **HEALTH-RELATED LICENSING BOARDS**

275.19 Section 1. Minnesota Statutes 2020, section 148.90, subdivision 2, is amended to read:

275.20 Subd. 2. **Members.** (a) The members of the board shall:

275.21 (1) be appointed by the governor;

275.22 (2) be residents of the state;

275.23 (3) serve for not more than two consecutive terms;

275.24 (4) designate the officers of the board; and

275.25 (5) administer oaths pertaining to the business of the board.

275.26 (b) A public member of the board shall represent the public interest and shall not:

275.27 (1) be a psychologist or have engaged in the practice of psychology;

275.28 (2) be an applicant or former applicant for licensure;

276.1 (3) be a member of another health profession and be licensed by a health-related licensing
276.2 board as defined under section 214.01, subdivision 2; the commissioner of health; or licensed,
276.3 certified, or registered by another jurisdiction;

276.4 (4) be a member of a household that includes a psychologist; or

276.5 (5) have conflicts of interest or the appearance of conflicts with duties as a board member.

276.6 (c) At the time of their appointments, at least two members of the board must reside
276.7 outside of the seven-county metropolitan area.

276.8 (d) At the time of their appointments, at least two members of the board must be members
276.9 of:

276.10 (1) a community of color; or

276.11 (2) an underrepresented community, defined as a group that is not represented in the
276.12 majority with respect to race, ethnicity, national origin, sexual orientation, gender identity,
276.13 or physical ability.

276.14 Sec. 2. Minnesota Statutes 2020, section 148.911, is amended to read:

276.15 **148.911 CONTINUING EDUCATION.**

276.16 (a) Upon application for license renewal, a licensee shall provide the board with
276.17 satisfactory evidence that the licensee has completed continuing education requirements
276.18 established by the board. Continuing education programs shall be approved under section
276.19 148.905, subdivision 1, clause (10). The board shall establish by rule the number of
276.20 continuing education training hours required each year and may specify subject or skills
276.21 areas that the licensee shall address.

276.22 (b) At least four of the required continuing education hours must be on increasing the
276.23 knowledge, understanding, self-awareness, and practice skills to competently address the
276.24 psychological needs of individuals from diverse socioeconomic and cultural backgrounds.
276.25 Topics include but are not limited to:

276.26 (1) understanding culture, its functions, and strengths that exist in varied cultures;

276.27 (2) understanding clients' cultures and differences among and between cultural groups;

276.28 (3) understanding the nature of social diversity and oppression;

276.29 (4) understanding cultural humility; and

276.30 (5) understanding human diversity, meaning individual client differences that are
276.31 associated with the client's cultural group, including race, ethnicity, national origin, religious

277.1 affiliation, language, age, gender, gender identity, physical and mental capabilities, sexual
277.2 orientation, and socioeconomic status.

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

277.4 Sec. 3. Minnesota Statutes 2020, section 148B.30, subdivision 1, is amended to read:

277.5 Subdivision 1. **Creation.** (a) There is created a Board of Marriage and Family Therapy
277.6 that consists of seven members appointed by the governor. Four members shall be licensed,
277.7 practicing marriage and family therapists, each of whom shall for at least five years
277.8 immediately preceding appointment, have been actively engaged as a marriage and family
277.9 therapist, rendering professional services in marriage and family therapy. One member shall
277.10 be engaged in the professional teaching and research of marriage and family therapy. Two
277.11 members shall be representatives of the general public who have no direct affiliation with
277.12 the practice of marriage and family therapy. All members shall have been a resident of the
277.13 state two years preceding their appointment. Of the first board members appointed, three
277.14 shall continue in office for two years, two members for three years, and two members,
277.15 including the chair, for terms of four years respectively. Their successors shall be appointed
277.16 for terms of four years each, except that a person chosen to fill a vacancy shall be appointed
277.17 only for the unexpired term of the board member whom the newly appointed member
277.18 succeeds. Upon the expiration of a board member's term of office, the board member shall
277.19 continue to serve until a successor is appointed and qualified.

277.20 (b) At the time of their appointments, at least two members must reside outside of the
277.21 seven-county metropolitan area.

277.22 (c) At the time of their appointments, at least two members must be members of:

277.23 (1) a community of color; or

277.24 (2) an underrepresented community, defined as a group that is not represented in the
277.25 majority with respect to race, ethnicity, national origin, sexual orientation, gender identity,
277.26 or physical ability.

277.27 Sec. 4. Minnesota Statutes 2020, section 148B.31, is amended to read:

277.28 **148B.31 DUTIES OF THE BOARD.**

277.29 (a) The board shall:

277.30 (1) adopt and enforce rules for marriage and family therapy licensing, which shall be
277.31 designed to protect the public;

278.1 (2) develop by rule appropriate techniques, including examinations and other methods,
278.2 for determining whether applicants and licensees are qualified under sections 148B.29 to
278.3 148B.392;

278.4 (3) issue licenses to individuals who are qualified under sections 148B.29 to 148B.392;

278.5 (4) establish and implement procedures designed to assure that licensed marriage and
278.6 family therapists will comply with the board's rules;

278.7 (5) study and investigate the practice of marriage and family therapy within the state in
278.8 order to improve the standards imposed for the licensing of marriage and family therapists
278.9 and to improve the procedures and methods used for enforcement of the board's standards;

278.10 (6) formulate and implement a code of ethics for all licensed marriage and family
278.11 therapists; and

278.12 (7) establish continuing education requirements for marriage and family therapists.

278.13 (b) At least four of the 40 continuing education training hours required under Minnesota
278.14 Rules, part 5300.0320, subpart 2, must be on increasing the knowledge, understanding,
278.15 self-awareness, and practice skills that enable a marriage and family therapist to serve clients
278.16 from diverse socioeconomic and cultural backgrounds. Topics include but are not limited
278.17 to:

278.18 (1) understanding culture, its functions, and strengths that exist in varied cultures;

278.19 (2) understanding clients' cultures and differences among and between cultural groups;

278.20 (3) understanding the nature of social diversity and oppression; and

278.21 (4) understanding cultural humility.

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

278.23 Sec. 5. Minnesota Statutes 2020, section 148B.51, is amended to read:

278.24 **148B.51 BOARD OF BEHAVIORAL HEALTH AND THERAPY.**

278.25 (a) The Board of Behavioral Health and Therapy consists of 13 members appointed by
278.26 the governor. Five of the members shall be professional counselors licensed or eligible for
278.27 licensure under sections 148B.50 to 148B.593. Five of the members shall be alcohol and
278.28 drug counselors licensed under chapter 148F. Three of the members shall be public members
278.29 as defined in section 214.02. The board shall annually elect from its membership a chair
278.30 and vice-chair. The board shall appoint and employ an executive director who is not a
278.31 member of the board. The employment of the executive director shall be subject to the terms

279.1 described in section 214.04, subdivision 2a. Chapter 214 applies to the Board of Behavioral
279.2 Health and Therapy unless superseded by sections 148B.50 to 148B.593.

279.3 (b) At the time of their appointments, at least three members must reside outside of the
279.4 seven-county metropolitan area.

279.5 (c) At the time of their appointments, at least three members must be members of:

279.6 (1) a community of color; or

279.7 (2) an underrepresented community, defined as a group that is not represented in the
279.8 majority with respect to race, ethnicity, national origin, sexual orientation, gender identity,
279.9 or physical ability.

279.10 Sec. 6. Minnesota Statutes 2020, section 148B.54, subdivision 2, is amended to read:

279.11 Subd. 2. **Continuing education.** (a) At the completion of the first four years of licensure,
279.12 a licensee must provide evidence satisfactory to the board of completion of 12 additional
279.13 postgraduate semester credit hours or its equivalent in counseling as determined by the
279.14 board, except that no licensee shall be required to show evidence of greater than 60 semester
279.15 hours or its equivalent. In addition to completing the requisite graduate coursework, each
279.16 licensee shall also complete in the first four years of licensure a minimum of 40 hours of
279.17 continuing education activities approved by the board under Minnesota Rules, part 2150.2540.
279.18 Graduate credit hours successfully completed in the first four years of licensure may be
279.19 applied to both the graduate credit requirement and to the requirement for 40 hours of
279.20 continuing education activities. A licensee may receive 15 continuing education hours per
279.21 semester credit hour or ten continuing education hours per quarter credit hour. Thereafter,
279.22 at the time of renewal, each licensee shall provide evidence satisfactory to the board that
279.23 the licensee has completed during each two-year period at least the equivalent of 40 clock
279.24 hours of professional postdegree continuing education in programs approved by the board
279.25 and continues to be qualified to practice under sections 148B.50 to 148B.593.

279.26 (b) At least four of the required 40 continuing education clock hours must be on increasing
279.27 the knowledge, understanding, self-awareness, and practice skills that enable a licensed
279.28 professional counselor and licensed professional clinical counselor to serve clients from
279.29 diverse socioeconomic and cultural backgrounds. Topics include but are not limited to:

279.30 (1) understanding culture, culture's functions, and strengths that exist in varied cultures;

279.31 (2) understanding clients' cultures and differences among and between cultural groups;

279.32 (3) understanding the nature of social diversity and oppression; and

280.1 (4) understanding cultural humility.

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

280.3 Sec. 7. Minnesota Statutes 2020, section 148E.010, is amended by adding a subdivision
280.4 to read:

280.5 Subd. 7f. **Cultural responsiveness.** "Cultural responsiveness" means increasing the
280.6 knowledge, understanding, self-awareness, and practice skills that enable a social worker
280.7 to serve clients from diverse socioeconomic and cultural backgrounds including:

280.8 (1) understanding culture, its functions, and strengths that exist in varied cultures;

280.9 (2) understanding clients' cultures and differences among and between cultural groups;

280.10 (3) understanding the nature of social diversity and oppression; and

280.11 (4) understanding cultural humility.

280.12 Sec. 8. Minnesota Statutes 2020, section 148E.130, subdivision 1, is amended to read:

280.13 Subdivision 1. **Total clock hours required.** (a) A licensee must complete 40 hours of
280.14 continuing education for each two-year renewal term. At the time of license renewal, a
280.15 licensee must provide evidence satisfactory to the board that the licensee has completed the
280.16 required continuing education hours during the previous renewal term. Of the total clock
280.17 hours required:

280.18 (1) all licensees must complete:

280.19 (i) two hours in social work ethics as defined in section 148E.010; and

280.20 (ii) four hours in cultural responsiveness;

280.21 (2) licensed independent clinical social workers must complete 12 clock hours in one
280.22 or more of the clinical content areas specified in section 148E.055, subdivision 5, paragraph
280.23 (a), clause (2);

280.24 (3) licensees providing licensing supervision according to sections 148E.100 to 148E.125,
280.25 must complete six clock hours in supervision as defined in section 148E.010; and

280.26 (4) no more than half of the required clock hours may be completed via continuing
280.27 education independent learning as defined in section 148E.010.

280.28 (b) If the licensee's renewal term is prorated to be less or more than 24 months, the total
280.29 number of required clock hours is prorated proportionately.

281.1 Sec. 9. Minnesota Statutes 2020, section 148E.130, is amended by adding a subdivision
281.2 to read:

281.3 Subd. 1b. **New content clock hours required effective July 1, 2021.** (a) The content
281.4 clock hours in subdivision 1, paragraph (a), clause (1), item (ii), apply to all new licenses
281.5 issued effective July 1, 2021, under section 148E.055.

281.6 (b) Any licensee issued a license prior to July 1, 2021, under section 148E.055 must
281.7 comply with the clock hours in subdivision 1, including the content clock hours in subdivision
281.8 1, paragraph (a), clause (1), item (ii), at the first two-year renewal term after July 1, 2021.

281.9 Sec. 10. Minnesota Statutes 2020, section 156.12, subdivision 2, is amended to read:

281.10 Subd. 2. **Authorized activities.** No provision of this chapter shall be construed to prohibit:

281.11 (a) a person from rendering necessary gratuitous assistance in the treatment of any animal
281.12 when the assistance does not amount to prescribing, testing for, or diagnosing, operating,
281.13 or vaccinating and when the attendance of a licensed veterinarian cannot be procured;

281.14 (b) a person who is a regular student in an accredited or approved college of veterinary
281.15 medicine from performing duties or actions assigned by instructors or preceptors or working
281.16 under the direct supervision of a licensed veterinarian;

281.17 (c) a veterinarian regularly licensed in another jurisdiction from consulting with a licensed
281.18 veterinarian in this state;

281.19 (d) the owner of an animal and the owner's regular employee from caring for and
281.20 administering to the animal belonging to the owner, except where the ownership of the
281.21 animal was transferred for purposes of circumventing this chapter;

281.22 (e) veterinarians who are in compliance with subdivision 6 and who are employed by
281.23 the University of Minnesota from performing their duties with the College of Veterinary
281.24 Medicine, College of Agriculture, Agricultural Experiment Station, Agricultural Extension
281.25 Service, Medical School, School of Public Health, or other unit within the university; or a
281.26 person from lecturing or giving instructions or demonstrations at the university or in
281.27 connection with a continuing education course or seminar to veterinarians or pathologists
281.28 at the University of Minnesota Veterinary Diagnostic Laboratory;

281.29 (f) any person from selling or applying any pesticide, insecticide or herbicide;

281.30 (g) any person from engaging in bona fide scientific research or investigations which
281.31 reasonably requires experimentation involving animals;

282.1 (h) any employee of a licensed veterinarian from performing duties other than diagnosis,
282.2 prescription or surgical correction under the direction and supervision of the veterinarian,
282.3 who shall be responsible for the performance of the employee;

282.4 (i) a graduate of a foreign college of veterinary medicine from working under the direct
282.5 personal instruction, control, or supervision of a veterinarian faculty member of the College
282.6 of Veterinary Medicine, University of Minnesota in order to complete the requirements
282.7 necessary to obtain an ECFVG or PAVE certificate;

282.8 (j) a licensed chiropractor registered under section 148.01, subdivision 1a, from practicing
282.9 animal chiropractic.; or

282.10 (k) a person certified by the Emergency Medical Services Regulatory Board under
282.11 chapter 144E from providing emergency medical care to a police dog wounded in the line
282.12 of duty.

282.13 Sec. 11. **MENTAL HEALTH PROFESSIONAL LICENSING SUPERVISION.**

282.14 (a) The Board of Psychology, the Board of Marriage and Family Therapy, the Board of
282.15 Social Work, and the Board of Behavioral Health and Therapy must convene to develop
282.16 recommendations for:

282.17 (1) providing certification of individuals across multiple mental health professions who
282.18 may serve as supervisors;

282.19 (2) adopting a single, common supervision certificate for all mental health professional
282.20 education programs;

282.21 (3) determining ways for internship hours to be counted toward licensure in mental
282.22 health professions; and

282.23 (4) determining ways for practicum hours to count toward supervisory experience.

282.24 (b) No later than February 1, 2023, the commissioners must submit a written report to
282.25 the members of the legislative committees with jurisdiction over health and human services
282.26 on the recommendations developed under paragraph (a).

282.27 **ARTICLE 5**

282.28 **PRESCRIPTION DRUGS**

282.29 Section 1. **[62J.841] DEFINITIONS.**

282.30 Subdivision 1. **Scope.** For purposes of sections 62J.841 to 62J.845, the following
282.31 definitions apply.

283.1 Subd. 2. **Consumer Price Index.** "Consumer Price Index" means the Consumer Price
283.2 Index, Annual Average, for All Urban Consumers, CPI-U: U.S. City Average, All Items,
283.3 reported by the United States Department of Labor, Bureau of Labor Statistics, or its
283.4 successor or, if the index is discontinued, an equivalent index reported by a federal authority
283.5 or, if no such index is reported, "Consumer Price Index" means a comparable index chosen
283.6 by the Bureau of Labor Statistics.

283.7 Subd. 3. **Generic or off-patent drug.** "Generic or off-patent drug" means any prescription
283.8 drug for which any exclusive marketing rights granted under the Federal Food, Drug, and
283.9 Cosmetic Act, section 351 of the federal Public Health Service Act, and federal patent law
283.10 have expired, including any drug-device combination product for the delivery of a generic
283.11 drug.

283.12 Subd. 4. **Manufacturer.** "Manufacturer" has the meaning provided in section 151.01,
283.13 subdivision 14a.

283.14 Subd. 5. **Prescription drug.** "Prescription drug" means a drug for human use subject
283.15 to United States Code, title 21, section 353(b)(1).

283.16 Subd. 6. **Wholesale acquisition cost.** "Wholesale acquisition cost" has the meaning
283.17 provided in United States Code, title 42, section 1395w-3a.

283.18 Subd. 7. **Wholesale distributor.** "Wholesale distributor" has the meaning provided in
283.19 section 151.441, subdivision 14.

283.20 Sec. 2. **[62J.842] EXCESSIVE PRICE INCREASES PROHIBITED.**

283.21 Subdivision 1. **Prohibition.** No manufacturer shall impose, or cause to be imposed, an
283.22 excessive price increase, whether directly or through a wholesale distributor, pharmacy, or
283.23 similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or
283.24 delivered to any consumer in the state.

283.25 Subd. 2. **Excessive price increase.** A price increase is excessive for purposes of this
283.26 section when:

283.27 (1) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds:

283.28 (i) 15 percent of the wholesale acquisition cost over the immediately preceding calendar
283.29 year; or

283.30 (ii) 40 percent of the wholesale acquisition cost over the immediately preceding three
283.31 calendar years; and

284.1 (2) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds
284.2 $30 for:

284.3 (i) a 30-day supply of the drug; or

284.4 (ii) a course of treatment lasting less than 30 days.

284.5 Subd. 3. **Exemption.** It is not a violation of this section for a wholesale distributor or
284.6 pharmacy to increase the price of a generic or off-patent drug if the price increase is directly
284.7 attributable to additional costs for the drug imposed on the wholesale distributor or pharmacy
284.8 by the manufacturer of the drug.

284.9 Sec. 3. **[62J.843] REGISTERED AGENT AND OFFICE WITHIN THE STATE.**

284.10 Any manufacturer that sells, distributes, delivers, or offers for sale any generic or
284.11 off-patent drug in the state is required to maintain a registered agent and office within the
284.12 state.

284.13 Sec. 4. **[62J.844] ENFORCEMENT.**

284.14 Subdivision 1. **Notification.** The commissioner of management and budget and any
284.15 other state agency that provides or purchases a pharmacy benefit except the Department of
284.16 Human Services, and any entity under contract with a state agency to provide a pharmacy
284.17 benefit other than an entity under contract with the Department of Human Services, shall
284.18 notify the manufacturer of a generic or off-patent drug, the attorney general, and the Board
284.19 of Pharmacy of any price increase that is in violation of section 62J.842.

284.20 Subd. 2. **Submission of drug cost statement and other information by manufacturer;**
284.21 **investigation by attorney general.** (a) Within 45 days of receiving a notice under subdivision
284.22 1, the manufacturer of the generic or off-patent drug shall submit a drug cost statement to
284.23 the attorney general. The statement must:

284.24 (1) itemize the cost components related to production of the drug;

284.25 (2) identify the circumstances and timing of any increase in materials or manufacturing
284.26 costs that caused any increase during the preceding calendar year, or preceding three calendar
284.27 years as applicable, in the price of the drug; and

284.28 (3) provide any other information that the manufacturer believes to be relevant to a
284.29 determination of whether a violation of section 62J.842 has occurred.

284.30 (b) The attorney general may investigate whether a violation of section 62J.842 has
284.31 occurred, is occurring, or is about to occur, in accordance with section 8.31, subdivision 2.

285.1 Subd. 3. **Petition to court.** (a) On petition of the attorney general, a court may issue an
285.2 order:

285.3 (1) compelling the manufacturer of a generic or off-patent drug to:

285.4 (i) provide the drug cost statement required under subdivision 2, paragraph (a); and

285.5 (ii) answer interrogatories, produce records or documents, or be examined under oath,
285.6 as required by the attorney general under subdivision 2, paragraph (b);

285.7 (2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including issuing
285.8 an order requiring that drug prices be restored to levels that comply with section 62J.842;

285.9 (3) requiring the manufacturer to provide an accounting to the attorney general of all
285.10 revenues resulting from a violation of section 62J.842;

285.11 (4) requiring the manufacturer to repay to all consumers, including any third-party payers,
285.12 any money acquired as a result of a price increase that violates section 62J.842;

285.13 (5) notwithstanding section 16A.151, requiring that all revenues generated from a
285.14 violation of section 62J.842 be remitted to the state and deposited into a special fund, to be
285.15 used for initiatives to reduce the cost to consumers of acquiring prescription drugs, if a
285.16 manufacturer is unable to determine the individual transactions necessary to provide the
285.17 repayments described in clause (4);

285.18 (6) imposing a civil penalty of up to $10,000 per day for each violation of section 62J.842;

285.19 (7) providing for the attorney general's recovery of its costs and disbursements incurred
285.20 in bringing an action against a manufacturer found in violation of section 62J.842, including
285.21 the costs of investigation and reasonable attorney's fees; and

285.22 (8) providing any other appropriate relief, including any other equitable relief as
285.23 determined by the court.

285.24 (b) For purposes of paragraph (a), clause (6), every individual transaction in violation
285.25 of section 62J.842 shall be considered a separate violation.

285.26 Subd. 4. **Private right of action.** Any action brought pursuant to section 8.31, subdivision
285.27 3a, by a person injured by a violation of this section is for the benefit of the public.

286.1 Sec. 5. **[62J.845] PROHIBITION ON WITHDRAWAL OF GENERIC OR**
286.2 **OFF-PATENT DRUGS FOR SALE.**

286.3 Subdivision 1. **Prohibition.** A manufacturer of a generic or off-patent drug is prohibited
286.4 from withdrawing that drug from sale or distribution within this state for the purpose of
286.5 avoiding the prohibition on excessive price increases under section 62J.842.

286.6 Subd. 2. **Notice to board and attorney general.** Any manufacturer that intends to
286.7 withdraw a generic or off-patent drug from sale or distribution within the state shall provide
286.8 a written notice of withdrawal to the Board of Pharmacy and the attorney general, at least
286.9 180 days prior to the withdrawal.

286.10 Subd. 3. **Financial penalty.** The attorney general shall assess a penalty of $500,000 on
286.11 any manufacturer of a generic or off-patent drug that it determines has failed to comply
286.12 with the requirements of this section.

286.13 Sec. 6. **[62J.846] SEVERABILITY.**

286.14 If any provision of sections 62J.841 to 62J.845 or the application thereof to any person
286.15 or circumstance is held invalid for any reason in a court of competent jurisdiction, the
286.16 invalidity does not affect other provisions or any other application of sections 62J.841 to
286.17 62J.845 that can be given effect without the invalid provision or application.

286.18 Sec. 7. Minnesota Statutes 2020, section 62Q.81, is amended by adding a subdivision to
286.19 read:

286.20 Subd. 6. **Prescription drug benefits.** (a) A health plan company that offers individual
286.21 health plans must ensure that no fewer than 25 percent of the individual health plans the
286.22 company offers in each geographic area that the health plan company services at each level
286.23 of coverage described in subdivision 1, paragraph (b), clause (3), applies a predeductible,
286.24 flat-dollar amount co-payment structure to the entire drug benefit, including all tiers.

286.25 (b) A health plan company that offers small group health plans must ensure that no fewer
286.26 than 25 percent of small group health plans the company offers in each geographic area that
286.27 the health plan company services at each level of coverage described in subdivision 1,
286.28 paragraph (b), clause (3), applies a predeductible, flat-dollar amount co-payment structure
286.29 to the entire drug benefit, including all tiers.

286.30 (c) The highest allowable co-payment for the highest cost drug tier for health plans
286.31 offered pursuant to this subdivision must be no greater than 1/12 of the plan's out-of-pocket
286.32 maximum for an individual.

287.1 (d) The flat-dollar amount co-payment tier structure for prescription drugs under this
287.2 subdivision must be graduated and proportionate.

287.3 (e) All individual and small group health plans offered pursuant to this subdivision must
287.4 be:

287.5 (1) clearly and appropriately named to aid the purchaser in the selection process;

287.6 (2) marketed in the same manner as other health plans offered by the health plan company;
287.7 and

287.8 (3) offered for purchase to any individual or small group.

287.9 (f) This subdivision does not apply to catastrophic plans, grandfathered plans, large
287.10 group health plans, health savings accounts (HSAs), qualified high deductible health benefit
287.11 plans, limited health benefit plans, or short-term limited-duration health insurance policies.

287.12 (g) Health plan companies must meet the requirements in this subdivision separately for
287.13 plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

287.14 **EFFECTIVE DATE.** This section is effective January 1, 2022, and applies to individual
287.15 and small group health plans offered, issued, or renewed on or after that date.

287.16 Sec. 8. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND**
287.17 **MANAGEMENT.**

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

287.20 (b) "Drug" has the meaning given in section 151.01, subdivision 5.

287.21 (c) "Enrollee contract term" means the 12-month term during which benefits associated
287.22 with health plan company products are in effect. For managed care plans and county-based
287.23 purchasing plans under section 256B.69 and chapter 256L, enrollee contract term means a
287.24 single calendar quarter.

287.25 (d) "Formulary" means a list of prescription drugs that have been developed by clinical
287.26 and pharmacy experts and represents the health plan company's medically appropriate and
287.27 cost-effective prescription drugs approved for use.

287.28 (e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and
287.29 includes an entity that performs pharmacy benefits management for the health plan company.

287.30 (f) "Pharmacy benefits management" means the administration or management of
287.31 prescription drug benefits provided by the health plan company for the benefit of its enrollees

288.1 and may include but is not limited to procurement of prescription drugs, clinical formulary
288.2 development and management services, claims processing, and rebate contracting and
288.3 administration.

288.4 (g) "Prescription" has the meaning given in section 151.01, subdivision 16a.

288.5 Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides
288.6 prescription drug benefit coverage and uses a formulary must make its formulary and related
288.7 benefit information available by electronic means and, upon request, in writing at least 30
288.8 days prior to annual renewal dates.

288.9 (b) Formularies must be organized and disclosed consistent with the most recent version
288.10 of the United States Pharmacopeia's Model Guidelines.

288.11 (c) For each item or category of items on the formulary, the specific enrollee benefit
288.12 terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

288.13 Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan
288.14 company may, at any time during the enrollee's contract term:

288.15 (1) expand its formulary by adding drugs to the formulary;

288.16 (2) reduce co-payments or coinsurance; or

288.17 (3) move a drug to a benefit category that reduces an enrollee's cost.

288.18 (b) A health plan company may remove a brand name drug from its formulary or place
288.19 a brand name drug in a benefit category that increases an enrollee's cost only upon the
288.20 addition to the formulary of a generic or multisource brand name drug rated as therapeutically
288.21 equivalent according to the Food and Drug Administration (FDA) Orange Book or a biologic
288.22 drug rated as interchangeable according to the FDA Purple Book at a lower cost to the
288.23 enrollee and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

288.24 (c) A health plan company may change utilization review requirements or move drugs
288.25 to a benefit category that increases an enrollee's cost during the enrollee's contract term
288.26 upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided
288.27 that these changes do not apply to enrollees who are currently taking the drugs affected by
288.28 these changes for the duration of the enrollee's contract term.

288.29 (d) A health plan company may remove any drugs from its formulary that have been
288.30 deemed unsafe by the FDA; that have been withdrawn by either the FDA or the product
288.31 manufacturer; or when an independent source of research, clinical guidelines, or

289.1 evidence-based standards has issued drug-specific warnings or recommended changes in
289.2 drug usage.

289.3 Subd. 4. **Exclusion.** This section does not apply to health coverage provided through
289.4 the State Employee Group Insurance Plan (SEGIP) under chapter 43A.

289.5 Sec. 9. **[62W.0751] ALTERNATIVE BIOLOGICAL PRODUCTS.**

289.6 Subdivision 1. **Definitions.** (a) For the purposes of this section, the following definitions
289.7 have the meanings given.

289.8 (b) "Biological product" has the meaning given in section 151.01, subdivision 40.

289.9 (c) "Biosimilar" or "biosimilar product" has the meaning given in section 151.01,
289.10 subdivision 43.

289.11 (d) "Interchangeable biological product" has the meaning given in section 151.01,
289.12 subdivision 41.

289.13 (e) "Reference biological product" has the meaning given in section 151.01, subdivision
289.14 44.

289.15 Subd. 2. **Pharmacy and provider choice related to dispensing reference biological**
289.16 **products, interchangeable biological products, or biosimilar products.** (a) A pharmacy
289.17 benefit manager or health carrier must not require or demonstrate a preference for a pharmacy
289.18 or health care provider to prescribe or dispense a single biological product for which there
289.19 is a United States Food and Drug Administration-approved biosimilar or interchangeable
289.20 biological product relative to a reference biological product, except as provided in paragraph
289.21 (b).

289.22 (b) If a pharmacy benefit manager or health carrier elects coverage of a product listed
289.23 in paragraph (a), it must also elect equivalent coverage for at least three reference, biosimilar,
289.24 or interchangeable biological products, or the total number of products that have been
289.25 approved by the United States Food and Drug Administration relative to the reference
289.26 product if less than three, for which the wholesale acquisition cost is less than the wholesale
289.27 acquisition cost of the product listed in paragraph (a).

289.28 (c) A pharmacy benefit manager or health carrier must not impose limits on access to a
289.29 product required to be covered under paragraph (b) that are more restrictive than limits
289.30 imposed on access to a product listed in paragraph (a), or that otherwise have the same
289.31 effect as giving preferred status to a product listed in paragraph (a) over the product required
289.32 to be covered under paragraph (b).

290.1 (d) This section does not apply to coverage provided through a public health care program
290.2 under chapter 256B or 256L, or health plan coverage through the State Employee Group
290.3 Insurance Plan (SEGIP) under chapter 43A.

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

290.5 Sec. 10. Minnesota Statutes 2020, section 62W.11, is amended to read:

290.6 **62W.11 GAG CLAUSE PROHIBITION.**

290.7 (a) No contract between a pharmacy benefit manager or health carrier and a pharmacy
290.8 or pharmacist shall prohibit, restrict, or penalize a pharmacy or pharmacist from disclosing
290.9 to an enrollee any health care information that the pharmacy or pharmacist deems appropriate
290.10 regarding the nature of treatment; the risks or alternatives; the availability of alternative
290.11 therapies, consultations, or tests; the decision of utilization reviewers or similar persons to
290.12 authorize or deny services; the process that is used to authorize or deny health care services
290.13 or benefits; or information on financial incentives and structures used by the health carrier
290.14 or pharmacy benefit manager.

290.15 (b) A pharmacy or pharmacist must provide to an enrollee information regarding the
290.16 enrollee's total cost for each prescription drug dispensed where part or all of the cost of the
290.17 prescription is being paid or reimbursed by the employer-sponsored plan or by a health
290.18 carrier or pharmacy benefit manager, in accordance with section 151.214, subdivision 1.

290.19 (c) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or
290.20 pharmacy from discussing information regarding the total cost for pharmacy services for a
290.21 prescription drug, including the patient's co-payment amount ~~and~~, the pharmacy's own usual
290.22 and customary price ~~of~~ for the prescription drug, the pharmacy's acquisition cost for the
290.23 prescription drug, and the amount the pharmacy is being reimbursed by the pharmacy benefit
290.24 manager or health carrier for the prescription drug.

290.25 (d) A pharmacy benefit manager must not prohibit a pharmacist or pharmacy from
290.26 discussing with a health carrier the amount the pharmacy is being paid or reimbursed for a
290.27 prescription drug by the pharmacy benefit manager or the pharmacy's acquisition cost for
290.28 a prescription drug.

290.29 ~~(d)~~ (e) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or
290.30 pharmacy from discussing the availability of any therapeutically equivalent alternative
290.31 prescription drugs or alternative methods for purchasing the prescription drug, including
290.32 but not limited to paying out-of-pocket the pharmacy's usual and customary price when that

291.1 amount is less expensive to the enrollee than the amount the enrollee is required to pay for
291.2 the prescription drug under the enrollee's health plan.

291.3 Sec. 11. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to
291.4 read:

291.5 Subd. 43. **Biosimilar product.** "Biosimilar" or "interchangeable biological product"
291.6 means a biological product that the United States Food and Drug Administration has licensed,
291.7 and determined to be "biosimilar" under United States Code, title 42, section 262(i)(2).

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

291.9 Sec. 12. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to
291.10 read:

291.11 Subd. 44. **Reference biological product.** "Reference biological product" means the
291.12 single biological product for which the United States Food and Drug Administration has
291.13 approved an initial biological product license application, against which other biological
291.14 products are evaluated for licensure as biosimilar products or interchangeable biological
291.15 products.

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

291.17 Sec. 13. Minnesota Statutes 2020, section 151.071, subdivision 1, is amended to read:

291.18 Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee,
291.19 registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do
291.20 one or more of the following:

291.21 (1) deny the issuance of a license or registration;

291.22 (2) refuse to renew a license or registration;

291.23 (3) revoke the license or registration;

291.24 (4) suspend the license or registration;

291.25 (5) impose limitations, conditions, or both on the license or registration, including but
291.26 not limited to: the limitation of practice to designated settings; the limitation of the scope
291.27 of practice within designated settings; the imposition of retraining or rehabilitation
291.28 requirements; the requirement of practice under supervision; the requirement of participation
291.29 in a diversion program such as that established pursuant to section 214.31 or the conditioning

292.1 of continued practice on demonstration of knowledge or skills by appropriate examination
292.2 or other review of skill and competence;

292.3 (6) impose a civil penalty not exceeding $10,000 for each separate violation, except that
292.4 a civil penalty not exceeding $25,000 may be imposed for each separate violation of section
292.5 62J.842, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant
292.6 of any economic advantage gained by reason of the violation, to discourage similar violations
292.7 by the licensee or registrant or any other licensee or registrant, or to reimburse the board
292.8 for the cost of the investigation and proceeding, including but not limited to, fees paid for
292.9 services provided by the Office of Administrative Hearings, legal and investigative services
292.10 provided by the Office of the Attorney General, court reporters, witnesses, reproduction of
292.11 records, board members' per diem compensation, board staff time, and travel costs and
292.12 expenses incurred by board staff and board members; and

292.13 (7) reprimand the licensee or registrant.

292.14 Sec. 14. Minnesota Statutes 2020, section 151.071, subdivision 2, is amended to read:

292.15 Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is
292.16 grounds for disciplinary action:

292.17 (1) failure to demonstrate the qualifications or satisfy the requirements for a license or
292.18 registration contained in this chapter or the rules of the board. The burden of proof is on
292.19 the applicant to demonstrate such qualifications or satisfaction of such requirements;

292.20 (2) obtaining a license by fraud or by misleading the board in any way during the
292.21 application process or obtaining a license by cheating, or attempting to subvert the licensing
292.22 examination process. Conduct that subverts or attempts to subvert the licensing examination
292.23 process includes, but is not limited to: (i) conduct that violates the security of the examination
292.24 materials, such as removing examination materials from the examination room or having
292.25 unauthorized possession of any portion of a future, current, or previously administered
292.26 licensing examination; (ii) conduct that violates the standard of test administration, such as
292.27 communicating with another examinee during administration of the examination, copying
292.28 another examinee's answers, permitting another examinee to copy one's answers, or
292.29 possessing unauthorized materials; or (iii) impersonating an examinee or permitting an
292.30 impersonator to take the examination on one's own behalf;

292.31 (3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist
292.32 or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration,
292.33 conviction of a felony reasonably related to the practice of pharmacy. Conviction as used

293.1 in this subdivision includes a conviction of an offense that if committed in this state would
293.2 be deemed a felony without regard to its designation elsewhere, or a criminal proceeding
293.3 where a finding or verdict of guilt is made or returned but the adjudication of guilt is either
293.4 withheld or not entered thereon. The board may delay the issuance of a new license or
293.5 registration if the applicant has been charged with a felony until the matter has been
293.6 adjudicated;

293.7 (4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner
293.8 or applicant is convicted of a felony reasonably related to the operation of the facility. The
293.9 board may delay the issuance of a new license or registration if the owner or applicant has
293.10 been charged with a felony until the matter has been adjudicated;

293.11 (5) for a controlled substance researcher, conviction of a felony reasonably related to
293.12 controlled substances or to the practice of the researcher's profession. The board may delay
293.13 the issuance of a registration if the applicant has been charged with a felony until the matter
293.14 has been adjudicated;

293.15 (6) disciplinary action taken by another state or by one of this state's health licensing
293.16 agencies:

293.17 (i) revocation, suspension, restriction, limitation, or other disciplinary action against a
293.18 license or registration in another state or jurisdiction, failure to report to the board that
293.19 charges or allegations regarding the person's license or registration have been brought in
293.20 another state or jurisdiction, or having been refused a license or registration by any other
293.21 state or jurisdiction. The board may delay the issuance of a new license or registration if an
293.22 investigation or disciplinary action is pending in another state or jurisdiction until the
293.23 investigation or action has been dismissed or otherwise resolved; and

293.24 (ii) revocation, suspension, restriction, limitation, or other disciplinary action against a
293.25 license or registration issued by another of this state's health licensing agencies, failure to
293.26 report to the board that charges regarding the person's license or registration have been
293.27 brought by another of this state's health licensing agencies, or having been refused a license
293.28 or registration by another of this state's health licensing agencies. The board may delay the
293.29 issuance of a new license or registration if a disciplinary action is pending before another
293.30 of this state's health licensing agencies until the action has been dismissed or otherwise
293.31 resolved;

293.32 (7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of
293.33 any order of the board, of any of the provisions of this chapter or any rules of the board or

294.1 violation of any federal, state, or local law or rule reasonably pertaining to the practice of
294.2 pharmacy;

294.3 (8) for a facility, other than a pharmacy, licensed by the board, violations of any order
294.4 of the board, of any of the provisions of this chapter or the rules of the board or violation
294.5 of any federal, state, or local law relating to the operation of the facility;

294.6 (9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the
294.7 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of
294.8 a patient; or pharmacy practice that is professionally incompetent, in that it may create
294.9 unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of
294.10 actual injury need not be established;

294.11 (10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it
294.12 is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy
294.13 technician or pharmacist intern if that person is performing duties allowed by this chapter
294.14 or the rules of the board;

294.15 (11) for an individual licensed or registered by the board, adjudication as mentally ill
294.16 or developmentally disabled, or as a chemically dependent person, a person dangerous to
294.17 the public, a sexually dangerous person, or a person who has a sexual psychopathic
294.18 personality, by a court of competent jurisdiction, within or without this state. Such
294.19 adjudication shall automatically suspend a license for the duration thereof unless the board
294.20 orders otherwise;

294.21 (12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified
294.22 in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in
294.23 board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist
294.24 intern or performing duties specifically reserved for pharmacists under this chapter or the
294.25 rules of the board;

294.26 (13) for a pharmacy, operation of the pharmacy without a pharmacist present and on
294.27 duty except as allowed by a variance approved by the board;

294.28 (14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety
294.29 to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
294.30 of material or as a result of any mental or physical condition, including deterioration through
294.31 the aging process or loss of motor skills. In the case of registered pharmacy technicians,
294.32 pharmacist interns, or controlled substance researchers, the inability to carry out duties
294.33 allowed under this chapter or the rules of the board with reasonable skill and safety to
294.34 patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type

295.1 of material or as a result of any mental or physical condition, including deterioration through
295.2 the aging process or loss of motor skills;

295.3 (15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas
295.4 dispenser, or controlled substance researcher, revealing a privileged communication from
295.5 or relating to a patient except when otherwise required or permitted by law;

295.6 (16) for a pharmacist or pharmacy, improper management of patient records, including
295.7 failure to maintain adequate patient records, to comply with a patient's request made pursuant
295.8 to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

295.9 (17) fee splitting, including without limitation:

295.10 (i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate,
295.11 kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

295.12 (ii) referring a patient to any health care provider as defined in sections 144.291 to
295.13 144.298 in which the licensee or registrant has a financial or economic interest as defined
295.14 in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the
295.15 licensee's or registrant's financial or economic interest in accordance with section 144.6521;
295.16 and

295.17 (iii) any arrangement through which a pharmacy, in which the prescribing practitioner
295.18 does not have a significant ownership interest, fills a prescription drug order and the
295.19 prescribing practitioner is involved in any manner, directly or indirectly, in setting the price
295.20 for the filled prescription that is charged to the patient, the patient's insurer or pharmacy
295.21 benefit manager, or other person paying for the prescription or, in the case of veterinary
295.22 patients, the price for the filled prescription that is charged to the client or other person
295.23 paying for the prescription, except that a veterinarian and a pharmacy may enter into such
295.24 an arrangement provided that the client or other person paying for the prescription is notified,
295.25 in writing and with each prescription dispensed, about the arrangement, unless such
295.26 arrangement involves pharmacy services provided for livestock, poultry, and agricultural
295.27 production systems, in which case client notification would not be required;

295.28 (18) engaging in abusive or fraudulent billing practices, including violations of the
295.29 federal Medicare and Medicaid laws or state medical assistance laws or rules;

295.30 (19) engaging in conduct with a patient that is sexual or may reasonably be interpreted
295.31 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
295.32 to a patient;

296.1 (20) failure to make reports as required by section 151.072 or to cooperate with an
296.2 investigation of the board as required by section 151.074;

296.3 (21) knowingly providing false or misleading information that is directly related to the
296.4 care of a patient unless done for an accepted therapeutic purpose such as the dispensing and
296.5 administration of a placebo;

296.6 (22) aiding suicide or aiding attempted suicide in violation of section 609.215 as
296.7 established by any of the following:

296.8 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
296.9 of section 609.215, subdivision 1 or 2;

296.10 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
296.11 issued under section 609.215, subdivision 4;

296.12 (iii) a copy of the record of a judgment assessing damages under section 609.215,
296.13 subdivision 5; or

296.14 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
296.15 The board must investigate any complaint of a violation of section 609.215, subdivision 1
296.16 or 2;

296.17 (23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For
296.18 a pharmacist intern, pharmacy technician, or controlled substance researcher, performing
296.19 duties permitted to such individuals by this chapter or the rules of the board under a lapsed
296.20 or nonrenewed registration. For a facility required to be licensed under this chapter, operation
296.21 of the facility under a lapsed or nonrenewed license or registration; ~~and~~

296.22 (24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge
296.23 from the health professionals services program for reasons other than the satisfactory
296.24 completion of the program~~.~~; and

296.25 (25) for a manufacturer, a violation of section 62J.842 or section 62J.845.

296.26 Sec. 15. **[151.335] DELIVERY THROUGH COMMON CARRIER; COMPLIANCE**
296.27 **WITH TEMPERATURE REQUIREMENTS.**

296.28 In addition to complying with the requirements of Minnesota Rules, part 6800.3000, a
296.29 mail order or specialty pharmacy that employs the United States Postal Service or other
296.30 common carrier to deliver a filled prescription directly to a patient must ensure that the drug
296.31 is delivered in compliance with temperature requirements established by the manufacturer
296.32 of the drug. The pharmacy must develop written policies and procedures that are consistent

297.1 with United States Pharmacopeia, chapters 1079 and 1118, and with nationally recognized
297.2 standards issued by standard-setting or accreditation organizations recognized by the board
297.3 through guidance. The policies and procedures must be provided to the board upon request.

297.4 Sec. 16. Minnesota Statutes 2020, section 151.555, subdivision 1, is amended to read:

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

297.7 (b) "Central repository" means a wholesale distributor that meets the requirements under
297.8 subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this
297.9 section.

297.10 (c) "Distribute" means to deliver, other than by administering or dispensing.

297.11 (d) "Donor" means:

297.12 (1) a health care facility as defined in this subdivision;

297.13 (2) a skilled nursing facility licensed under chapter 144A;

297.14 (3) an assisted living facility registered under chapter 144D where there is centralized
297.15 storage of drugs and 24-hour on-site licensed nursing coverage provided seven days a week;

297.16 (4) a pharmacy licensed under section 151.19, and located either in the state or outside
297.17 the state;

297.18 (5) a drug wholesaler licensed under section 151.47;

297.19 (6) a drug manufacturer licensed under section 151.252; or

297.20 (7) an individual at least 18 years of age, provided that the drug or medical supply that
297.21 is donated was obtained legally and meets the requirements of this section for donation.

297.22 (e) "Drug" means any prescription drug that has been approved for medical use in the
297.23 United States, is listed in the United States Pharmacopoeia or National Formulary, and
297.24 meets the criteria established under this section for donation; or any over-the-counter
297.25 medication that meets the criteria established under this section for donation. This definition
297.26 includes cancer drugs and antirejection drugs, but does not include controlled substances,
297.27 as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed
297.28 to a patient registered with the drug's manufacturer in accordance with federal Food and
297.29 Drug Administration requirements.

297.30 (f) "Health care facility" means:

298.1 (1) a physician's office or health care clinic where licensed practitioners provide health
298.2 care to patients;

298.3 (2) a hospital licensed under section 144.50;

298.4 (3) a pharmacy licensed under section 151.19 and located in Minnesota; or

298.5 (4) a nonprofit community clinic, including a federally qualified health center; a rural
298.6 health clinic; public health clinic; or other community clinic that provides health care utilizing
298.7 a sliding fee scale to patients who are low-income, uninsured, or underinsured.

298.8 (g) "Local repository" means a health care facility that elects to accept donated drugs
298.9 and medical supplies and meets the requirements of subdivision 4.

298.10 (h) "Medical supplies" or "supplies" means any prescription and nonprescription medical
298.11 supplies needed to administer a prescription drug.

298.12 (i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is
298.13 sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or
298.14 unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose
298.15 packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules,
298.16 part 6800.3750.

298.17 (j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that
298.18 it does not include a veterinarian.

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

298.20 Sec. 17. Minnesota Statutes 2020, section 151.555, subdivision 7, is amended to read:

298.21 Subd. 7. **Standards and procedures for inspecting and storing donated prescription**
298.22 **drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or
298.23 under contract with the central repository or a local repository shall inspect all donated
298.24 prescription drugs and supplies before the drug or supply is dispensed to determine, to the
298.25 extent reasonably possible in the professional judgment of the pharmacist or practitioner,
298.26 that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe
298.27 and suitable for dispensing, has not been subject to a recall, and meets the requirements for
298.28 donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an
298.29 inspection record stating that the requirements for donation have been met. If a local
298.30 repository receives drugs and supplies from the central repository, the local repository does
298.31 not need to reinspect the drugs and supplies.

299.1 (b) The central repository and local repositories shall store donated drugs and supplies
299.2 in a secure storage area under environmental conditions appropriate for the drug or supply
299.3 being stored. Donated drugs and supplies may not be stored with nondonated inventory. ~~If~~
299.4 ~~donated drugs or supplies are not inspected immediately upon receipt, a repository must~~
299.5 ~~quarantine the donated drugs or supplies separately from all dispensing stock until the~~
299.6 ~~donated drugs or supplies have been inspected and (1) approved for dispensing under the~~
299.7 ~~program; (2) disposed of pursuant to paragraph (c); or (3) returned to the donor pursuant to~~
299.8 ~~paragraph (d).~~

299.9 (c) The central repository and local repositories shall dispose of all prescription drugs
299.10 and medical supplies that are not suitable for donation in compliance with applicable federal
299.11 and state statutes, regulations, and rules concerning hazardous waste.

299.12 (d) In the event that controlled substances or prescription drugs that can only be dispensed
299.13 to a patient registered with the drug's manufacturer are shipped or delivered to a central or
299.14 local repository for donation, the shipment delivery must be documented by the repository
299.15 and returned immediately to the donor or the donor's representative that provided the drugs.

299.16 (e) Each repository must develop drug and medical supply recall policies and procedures.
299.17 If a repository receives a recall notification, the repository shall destroy all of the drug or
299.18 medical supply in its inventory that is the subject of the recall and complete a record of
299.19 destruction form in accordance with paragraph (f). If a drug or medical supply that is the
299.20 subject of a Class I or Class II recall has been dispensed, the repository shall immediately
299.21 notify the recipient of the recalled drug or medical supply. A drug that potentially is subject
299.22 to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug
299.23 is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

299.24 (f) A record of destruction of donated drugs and supplies that are not dispensed under
299.25 subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation
299.26 shall be maintained by the repository for at least ~~five~~ <u>two</u> years. For each drug or supply
299.27 destroyed, the record shall include the following information:

299.28 (1) the date of destruction;

299.29 (2) the name, strength, and quantity of the drug destroyed; and

299.30 (3) the name of the person or firm that destroyed the drug.

299.31 <u>**EFFECTIVE DATE.** This section is effective the day following final enactment.</u>

300.1 Sec. 18. Minnesota Statutes 2020, section 151.555, subdivision 11, is amended to read:

300.2 Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed
300.3 for the administration of this program shall be utilized by the participants of the program
300.4 and shall be available on the board's website:

300.5 (1) intake application form described under subdivision 5;

300.6 (2) local repository participation form described under subdivision 4;

300.7 (3) local repository withdrawal form described under subdivision 4;

300.8 (4) drug repository donor form described under subdivision 6;

300.9 (5) record of destruction form described under subdivision 7; and

300.10 (6) drug repository recipient form described under subdivision 8.

300.11 (b) All records, including drug inventory, inspection, and disposal of donated prescription
300.12 drugs and medical supplies, must be maintained by a repository for a minimum of ~~five~~ two
300.13 years. Records required as part of this program must be maintained pursuant to all applicable
300.14 practice acts.

300.15 (c) Data collected by the drug repository program from all local repositories shall be
300.16 submitted quarterly or upon request to the central repository. Data collected may consist of
300.17 the information, records, and forms required to be collected under this section.

300.18 (d) The central repository shall submit reports to the board as required by the contract
300.19 or upon request of the board.

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

300.21 Sec. 19. Minnesota Statutes 2020, section 151.555, is amended by adding a subdivision
300.22 to read:

300.23 Subd. 14. **Cooperation.** The central repository, as approved by the Board of Pharmacy,
300.24 may enter into an agreement with another state that has an established drug repository or
300.25 drug donation program if the other state's program includes regulations to ensure the purity,
300.26 integrity, and safety of the drugs and supplies donated, to permit the central repository to
300.27 offer to another state program inventory that is not needed by a Minnesota resident and to
300.28 accept inventory from another state program to be distributed to local repositories and
300.29 dispensed to Minnesota residents in accordance with this program.

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

301.1 Sec. 20. Minnesota Statutes 2020, section 256B.69, subdivision 6, is amended to read:

301.2 Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the
301.3 health care coordination for eligible individuals. Demonstration providers:

301.4 (1) shall authorize and arrange for the provision of all needed health services including
301.5 but not limited to the full range of services listed in sections 256B.02, subdivision 8, and
301.6 256B.0625 in order to ensure appropriate health care is delivered to enrollees.
301.7 Notwithstanding section 256B.0621, demonstration providers that provide nursing home
301.8 and community-based services under this section shall provide relocation service coordination
301.9 to enrolled persons age 65 and over;

301.10 (2) shall accept the prospective, per capita payment from the commissioner in return for
301.11 the provision of comprehensive and coordinated health care services for eligible individuals
301.12 enrolled in the program;

301.13 (3) may contract with other health care and social service practitioners to provide services
301.14 to enrollees; and

301.15 (4) shall institute recipient grievance procedures according to the method established
301.16 by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved
301.17 through this process shall be appealable to the commissioner as provided in subdivision 11.

301.18 (b) Demonstration providers must comply with the standards for claims settlement under
301.19 section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and
301.20 social service practitioners to provide services to enrollees. A demonstration provider must
301.21 pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b),
301.22 within 30 business days of the date of acceptance of the claim.

301.23 (c) Managed care plans and county-based purchasing plans must comply with section
301.24 62Q.83.

301.25 Sec. 21. **STUDY OF PHARMACY AND PROVIDER CHOICE OF BIOLOGICAL**
301.26 **PRODUCTS.**

301.27 The commissioner of health, within the limits of existing resources, shall analyze the
301.28 effect of Minnesota Statutes, section 62W.0751, on the net price for different payors of
301.29 biological products, interchangeable biological products, and biosimilar products. The
301.30 commissioner of health shall report findings to the chairs and ranking minority members
301.31 of the legislative committees with jurisdiction over health and human services policy and
301.32 finance, and insurance, by December 15, 2023.

302.1 Sec. 22. **STUDY OF TEMPERATURE MONITORING.**

302.2 The Board of Pharmacy shall conduct a study to determine the appropriateness and
302.3 feasibility of requiring mail order and specialty pharmacies to enclose in each medication's
302.4 packaging a method by which the patient can easily detect improper storage or temperature
302.5 variations that may have occurred during the delivery of a medication. The board shall
302.6 report the results of the study by January 15, 2022, to the chairs and ranking minority
302.7 members of the legislative committees with jurisdiction over health finance and policy.

302.8 **ARTICLE 6**

302.9 **HEALTH INSURANCE**

302.10 Section 1. Minnesota Statutes 2020, section 62A.04, subdivision 2, is amended to read:

302.11 Subd. 2. **Required provisions.** Except as provided in subdivision 4 each such policy
302.12 delivered or issued for delivery to any person in this state shall contain the provisions
302.13 specified in this subdivision in the words in which the same appear in this section. The
302.14 insurer may, at its option, substitute for one or more of such provisions corresponding
302.15 provisions of different wording approved by the commissioner which are in each instance
302.16 not less favorable in any respect to the insured or the beneficiary. Such provisions shall be
302.17 preceded individually by the caption appearing in this subdivision or, at the option of the
302.18 insurer, by such appropriate individual or group captions or subcaptions as the commissioner
302.19 may approve.

302.20 (1) A provision as follows:

302.21 ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the
302.22 attached papers, if any, constitutes the entire contract of insurance. No change in this policy
302.23 shall be valid until approved by an executive officer of the insurer and unless such approval
302.24 be endorsed hereon or attached hereto. No agent has authority to change this policy or to
302.25 waive any of its provisions.

302.26 (2) A provision as follows:

302.27 TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of
302.28 this policy no misstatements, except fraudulent misstatements, made by the applicant in the
302.29 application for such policy shall be used to void the policy or to deny a claim for loss incurred
302.30 or disability (as defined in the policy) commencing after the expiration of such two year
302.31 period.

303.1 The foregoing policy provision shall not be so construed as to affect any legal requirement
303.2 for avoidance of a policy or denial of a claim during such initial two year period, nor to
303.3 limit the application of clauses (1), (2), (3), (4) and (5), in the event of misstatement with
303.4 respect to age or occupation or other insurance. A policy which the insured has the right to
303.5 continue in force subject to its terms by the timely payment of premium (1) until at least
303.6 age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date
303.7 of issue, may contain in lieu of the foregoing the following provisions (from which the
303.8 clause in parentheses may be omitted at the insurer's option) under the caption
303.9 "INCONTESTABLE":

303.10 After this policy has been in force for a period of two years during the lifetime of the
303.11 insured (excluding any period during which the insured is disabled), it shall become
303.12 incontestable as to the statements contained in the application.

303.13 (b) No claim for loss incurred or disability (as defined in the policy) commencing after
303.14 two years from the date of issue of this policy shall be reduced or denied on the ground that
303.15 a disease or physical condition not excluded from coverage by name or specific description
303.16 effective on the date of loss had existed prior to the effective date of coverage of this policy.

303.17 (3)(a) Except as required for qualified health plans sold through MNsure to individuals
303.18 receiving advance payments of the premium tax credit, a provision as follows:

303.19 GRACE PERIOD: A grace period of ..... (insert a number not less than "7" for weekly
303.20 premium policies, "10" for monthly premium policies and "31" for all other policies) days
303.21 will be granted for the payment of each premium falling due after the first premium, during
303.22 which grace period the policy shall continue in force.

303.23 A policy which contains a cancellation provision may add, at the end of the above
303.24 provision,

303.25 subject to the right of the insurer to cancel in accordance with the cancellation provision
303.26 hereof.

303.27 A policy in which the insurer reserves the right to refuse any renewal shall have, at the
303.28 beginning of the above provision,

303.29 Unless not less than five days prior to the premium due date the insurer has delivered
303.30 to the insured or has mailed to the insured's last address as shown by the records of the
303.31 insurer written notice of its intention not to renew this policy beyond the period for which
303.32 the premium has been accepted.

304.1 (b) For ~~qualified~~ individual and small group health plans ~~sold through MNsure to~~
304.2 ~~individuals receiving advance payments of the premium tax credit~~, a grace period provision
304.3 must be included that complies with ~~the Affordable Care Act and is no less restrictive than~~
304.4 ~~the grace period required by the Affordable Care Act~~ section 62A.65, subdivision 2a.

304.5 (4) A provision as follows:

304.6 REINSTATEMENT: If any renewal premium be not paid within the time granted the
304.7 insured for payment, a subsequent acceptance of premium by the insurer or by any agent
304.8 duly authorized by the insurer to accept such premium, without requiring in connection
304.9 therewith an application for reinstatement, shall reinstate the policy. If the insurer or such
304.10 agent requires an application for reinstatement and issues a conditional receipt for the
304.11 premium tendered, the policy will be reinstated upon approval of such application by the
304.12 insurer or, lacking such approval, upon the forty-fifth day following the date of such
304.13 conditional receipt unless the insurer has previously notified the insured in writing of its
304.14 disapproval of such application. For health plans described in section 62A.011, subdivision
304.15 3, clause (10), an insurer must accept payment of a renewal premium and reinstate the
304.16 policy, if the insured applies for reinstatement no later than 60 days after the due date for
304.17 the premium payment, unless:

304.18 (1) the insured has in the interim left the state or the insurer's service area; or

304.19 (2) the insured has applied for reinstatement on two or more prior occasions.

304.20 The reinstated policy shall cover only loss resulting from such accidental injury as may
304.21 be sustained after the date of reinstatement and loss due to such sickness as may begin more
304.22 than ten days after such date. In all other respects the insured and insurer shall have the
304.23 same rights thereunder as they had under the policy immediately before the due date of the
304.24 defaulted premium, subject to any provisions endorsed hereon or attached hereto in
304.25 connection with the reinstatement. Any premium accepted in connection with a reinstatement
304.26 shall be applied to a period for which premium has not been previously paid, but not to any
304.27 period more than 60 days prior to the date of reinstatement. The last sentence of the above
304.28 provision may be omitted from any policy which the insured has the right to continue in
304.29 force subject to its terms by the timely payment of premiums (1) until at least age 50, or,
304.30 (2) in the case of a policy issued after age 44, for at least five years from its date of issue.

304.31 (5) A provision as follows:

304.32 NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20
304.33 days after the occurrence or commencement of any loss covered by the policy, or as soon
304.34 thereafter as is reasonably possible. Notice given by or on behalf of the insured or the

305.1 beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate
305.2 for the purpose), or to any authorized agent of the insurer, with information sufficient to
305.3 identify the insured, shall be deemed notice to the insurer.

305.4 In a policy providing a loss-of-time benefit which may be payable for at least two years,
305.5 an insurer may at its option insert the following between the first and second sentences of
305.6 the above provision:

305.7 Subject to the qualifications set forth below, if the insured suffers loss of time on account
305.8 of disability for which indemnity may be payable for at least two years, the insured shall,
305.9 at least once in every six months after having given notice of claim, give to the insurer
305.10 notice of continuance of said disability, except in the event of legal incapacity. The period
305.11 of six months following any filing of proof by the insured or any payment by the insurer
305.12 on account of such claim or any denial of liability in whole or in part by the insurer shall
305.13 be excluded in applying this provision. Delay in the giving of such notice shall not impair
305.14 the insured's right to any indemnity which would otherwise have accrued during the period
305.15 of six months preceding the date on which such notice is actually given.

305.16 (6) A provision as follows:

305.17 CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the
305.18 claimant such forms as are usually furnished by it for filing proofs of loss. If such forms
305.19 are not furnished within 15 days after the giving of such notice the claimant shall be deemed
305.20 to have complied with the requirements of this policy as to proof of loss upon submitting,
305.21 within the time fixed in the policy for filing proofs of loss, written proof covering the
305.22 occurrence, the character and the extent of the loss for which claim is made.

305.23 (7) A provision as follows:

305.24 PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said
305.25 office in case of claim for loss for which this policy provides any periodic payment contingent
305.26 upon continuing loss within 90 days after the termination of the period for which the insurer
305.27 is liable and in case of claim for any other loss within 90 days after the date of such loss.
305.28 Failure to furnish such proof within the time required shall not invalidate nor reduce any
305.29 claim if it was not reasonably possible to give proof within such time, provided such proof
305.30 is furnished as soon as reasonably possible and in no event, except in the absence of legal
305.31 capacity, later than one year from the time proof is otherwise required.

305.32 (8) A provision as follows:

306.1 TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss
306.2 other than loss for which this policy provides periodic payment will be paid immediately
306.3 upon receipt of due written proof of such loss. Subject to due written proof of loss, all
306.4 accrued indemnities for loss for which this policy provides periodic payment will be paid
306.5 ..... (insert period for payment which must not be less frequently than monthly) and any
306.6 balance remaining unpaid upon the termination of liability will be paid immediately upon
306.7 receipt of due written proof.

306.8 (9) A provision as follows:

306.9 PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with
306.10 the beneficiary designation and the provisions respecting such payment which may be
306.11 prescribed herein and effective at the time of payment. If no such designation or provision
306.12 is then effective, such indemnity shall be payable to the estate of the insured. Any other
306.13 accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid
306.14 either to such beneficiary or to such estate. All other indemnities will be payable to the
306.15 insured.

306.16 The following provisions, or either of them, may be included with the foregoing provision
306.17 at the option of the insurer:

306.18 If any indemnity of this policy shall be payable to the estate of the insured, or to an
306.19 insured or beneficiary who is a minor or otherwise not competent to give a valid release,
306.20 the insurer may pay such indemnity, up to an amount not exceeding $..... (insert an amount
306.21 which shall not exceed $1,000), to any relative by blood or connection by marriage of the
306.22 insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any
306.23 payment made by the insurer in good faith pursuant to this provision shall fully discharge
306.24 the insurer to the extent of such payment.

306.25 Subject to any written direction of the insured in the application or otherwise all or a
306.26 portion of any indemnities provided by this policy on account of hospital, nursing, medical,
306.27 or surgical services may, at the insurer's option and unless the insured requests otherwise
306.28 in writing not later than the time of filing proofs of such loss, be paid directly to the hospital
306.29 or person rendering such services; but it is not required that the service be rendered by a
306.30 particular hospital or person.

306.31 (10) A provision as follows:

306.32 PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall
306.33 have the right and opportunity to examine the person of the insured when and as often as it

307.1 may reasonably require during the pendency of a claim hereunder and to make an autopsy
307.2 in case of death where it is not forbidden by law.

307.3 (11) A provision as follows:

307.4 LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this
307.5 policy prior to the expiration of 60 days after written proof of loss has been furnished in
307.6 accordance with the requirements of this policy. No such action shall be brought after the
307.7 expiration of three years after the time written proof of loss is required to be furnished.

307.8 (12) A provision as follows:

307.9 CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation
307.10 of beneficiary, the right to change of beneficiary is reserved to the insured and the consent
307.11 of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this
307.12 policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.
307.13 The first clause of this provision, relating to the irrevocable designation of beneficiary, may
307.14 be omitted at the insurer's option.

307.15 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
307.16 sold, issued, or renewed on or after that date.

307.17 Sec. 2. Minnesota Statutes 2020, section 62A.10, is amended by adding a subdivision to
307.18 read:

307.19 Subd. 5. **Prohibition on waiting periods that exceed 90 days.** (a) For purposes of this
307.20 subdivision, "waiting period" means the period that must pass before coverage becomes
307.21 effective for an individual who is otherwise eligible to enroll under the terms of a group
307.22 health plan.

307.23 (b) A health carrier offering a group health plan must not apply a waiting period that
307.24 exceeds 90 days, with exceptions for the circumstances described in paragraphs (c) to (e).
307.25 A health carrier does not violate this subdivision solely because an individual is permitted
307.26 to take additional time to elect coverage beyond the end of the 90-day waiting period.

307.27 (c) If a group health plan conditions eligibility on an employee working full time or
307.28 regularly having a specified number of service hours per period, and the plan is unable to
307.29 determine whether a newly hired employee is full time or reasonably expected to regularly
307.30 work the specific number of hours per period, the plan may take a reasonable period of
307.31 time, not to exceed 12 months beginning on any date between the employee's start date and
307.32 the first day of the first calendar month after the employee's start date, to determine whether
307.33 the employee meets the plan's eligibility condition.

308.1 (d) If a group health plan conditions eligibility on an employee having completed a
308.2 cumulative number of service hours, the cumulative hours-of-service requirement must not
308.3 exceed 1,200 hours.

308.4 (e) An orientation period may be added to the 90-day waiting period if the orientation
308.5 period is one month or less. The one-month period is determined by adding one calendar
308.6 month and subtracting one calendar day, measured from an employee's start date in a position
308.7 that is otherwise eligible for coverage.

308.8 (f) A group health plan may treat an employee whose employment has terminated and
308.9 is later rehired as newly eligible upon rehire and require the rehired employee to meet the
308.10 plan's eligibility criteria and waiting period again, if doing so is reasonable under the
308.11 circumstances. Treating an employee as rehired is reasonable if the employee has a break
308.12 in service of at least 13 weeks, or at least 26 weeks if the employer is an educational
308.13 institution.

308.14 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
308.15 sold, issued, or renewed on or after that date.

308.16 Sec. 3. Minnesota Statutes 2020, section 62A.15, is amended by adding a subdivision to
308.17 read:

308.18 Subd. 3c. **Mental health services.** All benefits provided by a policy or contract referred
308.19 to in subdivision 1 relating to expenses incurred for mental health treatment or services
308.20 provided by a mental health professional must also include treatment and services provided
308.21 by a clinical trainee to the extent that the services and treatment are within the scope of
308.22 practice of the clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5,
308.23 item C. This subdivision is intended to provide equal payment of benefits for mental health
308.24 treatment and services provided by a mental health professional, as defined in Minnesota
308.25 Rules, part 9505.0371, subpart 5, item A, or a clinical trainee and is not intended to change
308.26 or add to the benefits provided for in those policies or contracts.

308.27 **EFFECTIVE DATE.** This section is effective January 1, 2022, and applies to policies
308.28 and contracts offered, issued, or renewed on or after that date.

308.29 Sec. 4. Minnesota Statutes 2020, section 62A.15, subdivision 4, is amended to read:

308.30 Subd. 4. **Denial of benefits.** (a) No carrier referred to in subdivision 1 may, in the
308.31 payment of claims to employees in this state, deny benefits payable for services covered by
308.32 the policy or contract if the services are lawfully performed by a licensed chiropractor,

309.1 licensed optometrist, a registered nurse meeting the requirements of subdivision 3a, ~~or~~ a
309.2 licensed acupuncture practitioner, or a mental health clinical trainee.

309.3 (b) When carriers referred to in subdivision 1 make claim determinations concerning
309.4 the appropriateness, quality, or utilization of chiropractic health care for Minnesotans, any
309.5 of these determinations that are made by health care professionals must be made by, or
309.6 under the direction of, or subject to the review of licensed doctors of chiropractic.

309.7 (c) When a carrier referred to in subdivision 1 makes a denial of payment claim
309.8 determination concerning the appropriateness, quality, or utilization of acupuncture services
309.9 for individuals in this state performed by a licensed acupuncture practitioner, a denial of
309.10 payment claim determination that is made by a health professional must be made by, under
309.11 the direction of, or subject to the review of a licensed acupuncture practitioner.

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

309.13 Sec. 5. Minnesota Statutes 2020, section 62A.65, subdivision 1, is amended to read:

309.14 Subdivision 1. **Applicability.** No health carrier, as defined in section 62A.011, shall
309.15 offer, sell, issue, or renew any individual health plan, as defined in section 62A.011, to a
309.16 Minnesota resident except in compliance with this section. ~~This section does not apply to~~
309.17 ~~the Comprehensive Health Association established in section 62E.10.~~ A health carrier must
309.18 only offer, sell, issue, or renew individual health plans on a guaranteed issue basis and at a
309.19 premium rate that does not vary based on the health status of the individual.

309.20 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
309.21 sold, issued, or renewed on or after that date.

309.22 Sec. 6. Minnesota Statutes 2020, section 62A.65, is amended by adding a subdivision to
309.23 read:

309.24 Subd. 2a. **Grace period for nonpayment of premium.** (a) Notwithstanding any other
309.25 law to the contrary, an individual health plan may be canceled for nonpayment of premiums,
309.26 but must include a grace period as described in this subdivision.

309.27 (b) The grace period must be three consecutive months. During the grace period, the
309.28 health carrier must:

309.29 (1) pay all claims for services that would have been covered if the premium had been
309.30 paid, which are provided to the enrollee during the first month of the grace period, and may
309.31 pend claims for services provided to an enrollee in the second and third months of the grace
309.32 period; and

310.1 (2) notify health care providers of the possibility of denied claims when an enrollee is
310.2 in the second and third month of the grace period.

310.3 (c) In order to stop a cancellation, an enrollee must pay all outstanding premiums before
310.4 the end of the grace period.

310.5 (d) If a health plan is canceled under this subdivision, the final day of the enrollment is
310.6 the last day of the first month of the three-month grace period.

310.7 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
310.8 sold, issued, or renewed on or after that date.

310.9 Sec. 7. Minnesota Statutes 2020, section 62D.095, subdivision 2, is amended to read:

310.10 Subd. 2. **Co-payments.** A health maintenance contract may impose a co-payment and
310.11 coinsurance consistent with the provisions of the Affordable Care Act as defined under
310.12 section 62A.011, subdivision 1a state and federal law.

310.13 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
310.14 sold, issued, or renewed on or after that date.

310.15 Sec. 8. Minnesota Statutes 2020, section 62D.095, subdivision 3, is amended to read:

310.16 Subd. 3. **Deductibles.** A health maintenance contract may impose a deductible consistent
310.17 with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision
310.18 1a state and federal law.

310.19 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
310.20 sold, issued, or renewed on or after that date.

310.21 Sec. 9. Minnesota Statutes 2020, section 62D.095, subdivision 4, is amended to read:

310.22 Subd. 4. **Annual out-of-pocket maximums.** A health maintenance contract may impose
310.23 an annual out-of-pocket maximum consistent with the provisions of the Affordable Care
310.24 Act as defined under section 62A.011, subdivision 1a section 62Q.677, subdivision 6a.

310.25 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
310.26 sold, issued, or renewed on or after that date.

310.27 Sec. 10. Minnesota Statutes 2020, section 62D.095, subdivision 5, is amended to read:

310.28 Subd. 5. **Exceptions.** No co-payments or deductibles may be imposed on preventive
310.29 health care items and services consistent with the provisions of the Affordable Care Act as

311.1 ~~defined under section 62A.011, subdivision 1a~~, as defined in section 62Q.46, subdivision
311.2 1.

311.3 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
311.4 sold, issued, or renewed on or after that date.

311.5 Sec. 11. Minnesota Statutes 2020, section 62Q.01, subdivision 2a, is amended to read:

311.6 Subd. 2a. **Dependent child to the limiting age.** "Dependent child to the limiting age"
311.7 or "dependent children to the limiting age" means those individuals who are eligible and
311.8 covered as a dependent child under the terms of a health plan who have not yet attained 26
311.9 years of age. A health plan company must not deny or restrict eligibility for a dependent
311.10 child to the limiting age based on financial dependency, residency, marital status, or student
311.11 status. For coverage under plans offered by the Minnesota Comprehensive Health
311.12 Association, dependent to the limiting age means dependent as defined in section 62A.302,
311.13 subdivision 3. Notwithstanding the provisions in this subdivision, a health plan may include:

311.14 (1) eligibility requirements regarding the absence of other health plan coverage ~~as~~
311.15 ~~permitted by the Affordable Care Act~~ for grandfathered plan coverage; or

311.16 (2) an age greater than 26 in its policy, contract, or certificate of coverage.

311.17 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
311.18 sold, issued, or renewed on or after that date.

311.19 Sec. 12. **[62Q.097] REQUIREMENTS FOR TIMELY PROVIDER**
311.20 **CREDENTIALING.**

311.21 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

311.22 (b) "Clean application for provider credentialing" or "clean application" means an
311.23 application for provider credentialing submitted by a health care provider to a health plan
311.24 company that is complete, is in the format required by the health plan company, and includes
311.25 all information and substantiation required by the health plan company and does not require
311.26 evaluation of any identified potential quality or safety concern.

311.27 (c) "Provider credentialing" means the process undertaken by a health plan company to
311.28 evaluate and approve a health care provider's education, training, residency, licenses,
311.29 certifications, and history of significant quality or safety concerns in order to approve the
311.30 health care provider to provide health care services to patients at a clinic or facility.

312.1 Subd. 2. **Time limit for credentialing determination.** A health plan company that
312.2 receives an application for provider credentialing must:

312.3 (1) if the application is determined to be a clean application for provider credentialing
312.4 and if the health care provider submitting the application or the clinic or facility at which
312.5 the health care provider provides services requests the information, affirm that the health
312.6 care provider's application is a clean application and notify the health care provider or clinic
312.7 or facility of the date by which the health plan company will make a determination on the
312.8 health care provider's application;

312.9 (2) if the application is determined not to be a clean application, inform the health care
312.10 provider of the application's deficiencies or missing information or substantiation within
312.11 three business days after the health plan company determines the application is not a clean
312.12 application; and

312.13 (3) make a determination on the health care provider's clean application within 45 days
312.14 after receiving the clean application unless the health plan company identifies a substantive
312.15 quality or safety concern in the course of provider credentialing that requires further
312.16 investigation. Upon notice to the health care provider, clinic, or facility, the health plan
312.17 company is allowed 30 additional days to investigate any quality or safety concerns.

312.18 **EFFECTIVE DATE; APPLICATION.** This section applies to applications for provider
312.19 credentialing submitted to a health plan company on or after January 1, 2022.

312.20 Sec. 13. Minnesota Statutes 2020, section 62Q.46, is amended to read:

312.21 **62Q.46 PREVENTIVE ITEMS AND SERVICES.**

312.22 Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and
312.23 services" ~~has the meaning specified in the Affordable Care Act~~ means the items and services
312.24 categorized as preventive under subdivision 1a.

312.25 (b) A health plan company must provide coverage for preventive items and services at
312.26 a participating provider without imposing cost-sharing requirements, including a deductible,
312.27 coinsurance, or co-payment. Nothing in this section prohibits a health plan company that
312.28 has a network of providers from excluding coverage or imposing cost-sharing requirements
312.29 for preventive items or services that are delivered by an out-of-network provider.

312.30 (c) A health plan company is not required to provide coverage for any items or services
312.31 specified in any recommendation or guideline described in paragraph (a) if the
312.32 recommendation or guideline is no longer included as a preventive item or service as defined
312.33 in paragraph (a). Annually, a health plan company must determine whether any additional

313.1 items or services must be covered without cost-sharing requirements or whether any items
313.2 or services are no longer required to be covered.

313.3 (d) Nothing in this section prevents a health plan company from using reasonable medical
313.4 management techniques to determine the frequency, method, treatment, or setting for a
313.5 preventive item or service to the extent not specified in the recommendation or guideline.

313.6 (e) This section does not apply to grandfathered plans.

313.7 (f) This section does not apply to plans offered by the Minnesota Comprehensive Health
313.8 Association.

313.9 Subd. 1a. **Preventive items and services.** The commissioner of commerce must provide
313.10 health plan companies with information regarding which items and services must be
313.11 categorized as preventive.

313.12 Subd. 2. **Coverage for office visits in conjunction with preventive items and**
313.13 **services.** (a) A health plan company may impose cost-sharing requirements with respect to
313.14 an office visit if a preventive item or service is billed separately or is tracked separately as
313.15 individual encounter data from the office visit.

313.16 (b) A health plan company must not impose cost-sharing requirements with respect to
313.17 an office visit if a preventive item or service is not billed separately or is not tracked
313.18 separately as individual encounter data from the office visit and the primary purpose of the
313.19 office visit is the delivery of the preventive item or service.

313.20 (c) A health plan company may impose cost-sharing requirements with respect to an
313.21 office visit if a preventive item or service is not billed separately or is not tracked separately
313.22 as individual encounter data from the office visit and the primary purpose of the office visit
313.23 is not the delivery of the preventive item or service.

313.24 Subd. 3. **Additional services not prohibited.** Nothing in this section prohibits a health
313.25 plan company from providing coverage for preventive items and services in addition to
313.26 those specified in ~~the Affordable Care Act~~ subdivision 1a, or from denying coverage for
313.27 preventive items and services that are not recommended as preventive items and services
313.28 under ~~the Affordable Care Act~~ subdivision 1a. A health plan company may impose
313.29 cost-sharing requirements for a treatment not described in ~~the Affordable Care Act~~
313.30 subdivision 1a even if the treatment results from a preventive item or service described in
313.31 ~~the Affordable Care Act~~ subdivision 1a.

313.32 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
313.33 sold, issued, or renewed on or after that date.

314.1 Sec. 14. **[62Q.472] SCREENING AND TESTING FOR OPIOIDS.**

314.2 (a) A health plan company shall not place a lifetime or annual limit on screenings and
314.3 urinalysis testing for opioids for an enrollee in an inpatient or outpatient substance use
314.4 disorder treatment program when ordered by a health care provider and performed by an
314.5 accredited clinical laboratory. A health plan company is not prohibited from conducting a
314.6 medical necessity review when screenings or urinalysis testing for an enrollee exceeds 24
314.7 tests in any 12-month period.

314.8 (b) This section does not apply to managed care plans or county-based purchasing plans
314.9 when the plan is providing coverage to public health care program enrollees under chapter
314.10 256B or 256L.

314.11 **EFFECTIVE DATE.** This section is effective January 1, 2022, and applies to health
314.12 plans offered, issued, or renewed on or after that date.

314.13 Sec. 15. **[62Q.521] COVERAGE OF CONTRACEPTIVES AND CONTRACEPTIVE**
314.14 **SERVICES.**

314.15 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

314.16 (b) "Closely held for-profit entity" means an entity that:

314.17 (1) is not a nonprofit entity;

314.18 (2) has more than 50 percent of the value of its ownership interest owned directly or
314.19 indirectly by five or fewer individuals, or has an ownership structure that is substantially
314.20 similar; and

314.21 (3) has no publicly traded ownership interest, having any class of common equity
314.22 securities required to be registered under United States Code, title 15, section 781.

314.23 For purposes of this paragraph:

314.24 (i) ownership interests owned by a corporation, partnership, estate, or trust are considered
314.25 owned proportionately by that entity's shareholders, partners, or beneficiaries;

314.26 (ii) ownership interests owned by a nonprofit entity are considered owned by a single
314.27 owner;

314.28 (iii) ownership interests owned by an individual are considered owned, directly or
314.29 indirectly, by or for the individual's family. For purposes of this item, "family" means
314.30 brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal
314.31 descendants; and

315.1 (iv) if an individual or entity holds an option to purchase an ownership interest, the
315.2 individual or entity is considered to be the owner of those ownership interests.

315.3 (c) "Contraceptive" means a drug, device, or other product approved by the Food and
315.4 Drug Administration to prevent unintended pregnancy.

315.5 (d) "Contraceptive service" means consultation, examination, procedure, and medical
315.6 service related to the prevention of unintended pregnancy. This includes but is not limited
315.7 to voluntary sterilization procedures, patient education, counseling on contraceptives, and
315.8 follow-up services related to contraceptives or contraceptive services, management of side
315.9 effects, counseling for continued adherence, and device insertion or removal.

315.10 (e) "Eligible organization" means an organization that opposes providing coverage for
315.11 some or all contraceptives or contraceptive services on account of religious objections and
315.12 that is:

315.13 (1) organized as a nonprofit entity and holds itself as a religious employer; or

315.14 (2) organized and operates as a closely held for-profit entity, and the organization's
315.15 highest governing body has adopted, under the organization's applicable rules of governance
315.16 and consistent with state law, a resolution or similar action establishing that it objects to
315.17 covering some or all contraceptives or contraceptive services on account of the owners'
315.18 sincerely held religious beliefs.

315.19 (f) "Medical necessity" includes but is not limited to considerations such as severity of
315.20 side effects, difference in permanence and reversibility of a contraceptive or contraceptive
315.21 service, and ability to adhere to the appropriate use of the contraceptive method or service,
315.22 as determined by the attending provider.

315.23 (g) "Religious employer" means an organization that is organized and operates as a
315.24 nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal
315.25 Revenue Code of 1986, as amended.

315.26 (h) "Therapeutic equivalent version" means a drug, device, or product that can be expected
315.27 to have the same clinical effect and safety profile when administered to a patient under the
315.28 conditions specified in the labeling, and that:

315.29 (1) is approved as safe and effective;

315.30 (2) is a pharmaceutical equivalent, (i) containing identical amounts of the same active
315.31 drug ingredient in the same dosage form and route of administration, and (ii) meeting
315.32 compendial or other applicable standards of strength, quality, purity, and identity;

316.1 (3) is bioequivalent in that:

316.2 (i) the drug, device, or product does not present a known or potential bioequivalence
316.3 problem and meets an acceptable in vitro standard; or

316.4 (ii) if the drug, device, or product does present a known or potential bioequivalence
316.5 problem, it is shown to meet an appropriate bioequivalence standard;

316.6 (4) is adequately labeled; and

316.7 (5) is manufactured in compliance with current manufacturing practice regulations.

316.8 Subd. 2. **Required coverage; cost-sharing prohibited.** (a) A health plan must provide
316.9 coverage for all prescription contraceptives and contraceptive services.

316.10 (b) A health plan company must not impose cost-sharing requirements, including co-pays,
316.11 deductibles, or co-insurance, for contraceptives or contraceptive services.

316.12 (c) Notwithstanding paragraph (b), a health plan that is a high-deductible health plan in
316.13 conjunction with a health savings account must include cost-sharing for contraceptives and
316.14 contraceptive services at the minimum level necessary to preserve the enrollee's ability to
316.15 make tax exempt contributions and withdrawals from the health savings account, as provided
316.16 by section 223 of the Internal Revenue Code of 1986, as amended.

316.17 (d) A health plan company must not impose any referral requirements, restrictions, or
316.18 delays for contraceptives or contraceptive services.

316.19 (e) If more than one therapeutic equivalent version of a contraceptive is approved by
316.20 the FDA, a health plan must cover at least one therapeutic equivalent version, but is not
316.21 required to cover all therapeutic equivalent versions.

316.22 (f) For each health plan, a health plan company must list the contraceptives and
316.23 contraceptive services that are covered without cost-sharing in a manner that is easily
316.24 accessible to enrollees, health care providers, and representatives of health care providers.
316.25 The list for each health plan must be promptly updated to reflect changes to the coverage.

316.26 (g) If an enrollee's attending provider recommends a particular contraceptive or
316.27 contraceptive service based on a determination of medical necessity for that enrollee, the
316.28 health plan must cover that contraceptive or contraceptive service without cost-sharing. The
316.29 health plan company issuing the health plan must defer to the attending provider's
316.30 determination that the particular contraceptive or contraceptive service is medically necessary
316.31 for the enrollee.

317.1 Subd. 3. **Religious employers; exempt.** (a) A religious employer is not required to cover
317.2 contraceptives or contraceptive services if the employer has religious objections to the
317.3 coverage. A religious employer that chooses not to provide coverage for some or all
317.4 contraceptives and contraceptive services must notify employees as part of the hiring process
317.5 and all employees at least 30 days before:

317.6 (1) an employee enrolls in the health plan; or

317.7 (2) the effective date of the health plan, whichever occurs first.

317.8 (b) If the religious employer provides coverage for some contraceptives or contraceptive
317.9 services, the notice must provide a list of the contraceptives or contraceptive services the
317.10 employer refuses to cover.

317.11 Subd. 4. **Accommodation for eligible organizations.** (a) A health plan established or
317.12 maintained by an eligible organization complies with the requirements of subdivision 2 to
317.13 provide coverage of contraceptives and contraceptive services if the eligible organization
317.14 provides notice to any health plan company the eligible organization contracts with that it
317.15 is an eligible organization and that the eligible organization has a religious objection to
317.16 coverage for all or a subset of contraceptives or contraceptive services.

317.17 (b) The notice from an eligible organization to a health plan company under paragraph
317.18 (a) must include the name of the eligible organization, a statement that it objects to coverage
317.19 for some or all of contraceptives or contraceptive services, including a list of the contraceptive
317.20 services the eligible organization objects to, if applicable, and the health plan name. The
317.21 notice must be executed by a person authorized to provide notice on behalf of the eligible
317.22 organization.

317.23 (c) An eligible organization must provide a copy of the notice under paragraph (b) to
317.24 prospective employees as part of the hiring process and to all employees at least 30 days
317.25 before:

317.26 (1) an employee enrolls in the health plan; or

317.27 (2) the effective date of the health plan, whichever occurs first.

317.28 (d) A health plan company that receives a copy of the notice under paragraph (a) with
317.29 respect to a health plan established or maintained by an eligible organization must:

317.30 (1) expressly exclude coverage for some or all contraceptives or contraceptive services
317.31 from the health plan and provide separate payments for any contraceptive or contraceptive
317.32 service required to be covered under subdivision 2 for enrollees as long as the enrollee
317.33 remains enrolled in the health plan; or

318.1 (2) arrange for an issuer or other entity to provide payments for contraceptive services
318.2 for plan participants and beneficiaries without imposing any cost-sharing requirements, or
318.3 imposing a premium fee or other charge, or any portion thereof directly or indirectly, on
318.4 the eligible organization, the group health plan, or plan participants or beneficiaries.

318.5 (e) The health plan company must not impose any cost-sharing requirements, including
318.6 co-pays, deductibles, or co-insurance, or directly or indirectly impose any premium, fee, or
318.7 other charge for contraceptive services or contraceptives on the eligible organization, health
318.8 plan, or enrollee.

318.9 (f) On January 1, 2022, and every year thereafter a health plan company must notify the
318.10 commissioner, in a manner to be determined by the commissioner, regarding the number
318.11 of eligible organizations granted an accommodation under this subdivision.

318.12 **EFFECTIVE DATE.** This section is effective January 1, 2022, and applies to coverage
318.13 offered, sold, issued, or renewed on or after that date.

318.14 Sec. 16. **[62Q.522] COVERAGE FOR PRESCRIPTION CONTRACEPTIVES;**
318.15 **SUPPLY REQUIREMENTS.**

318.16 Subdivision 1. **Scope of coverage.** Except as otherwise provided in section 62Q.521,
318.17 subdivision 3, all health plans that provide prescription coverage must comply with the
318.18 requirements of this section.

318.19 Subd. 2. **Definition.** For purposes of this section, "prescription contraceptive" means
318.20 any drug or device that requires a prescription and is approved by the Food and Drug
318.21 Administration to prevent pregnancy. Prescription contraceptive does not include an
318.22 emergency contraceptive drug that prevents pregnancy when administered after sexual
318.23 contact.

318.24 Subd. 3. **Required coverage.** (a) Health plan coverage for a prescription contraceptive
318.25 must provide a 12-month supply for any prescription contraceptive, regardless of whether
318.26 the enrollee was covered by the health plan at the time of the first dispensing.

318.27 (b) The prescribing health care provider must determine the appropriate number of
318.28 months to prescribe the prescription contraceptives for, up to 12 months.

318.29 **EFFECTIVE DATE.** This section is effective January 1, 2022, and applies to coverage
318.30 offered, sold, issued, or renewed on or after that date.

319.1 Sec. 17. Minnesota Statutes 2020, section 62Q.677, is amended by adding a subdivision
319.2 to read:

319.3 Subd. 6a. **Out-of-pocket annual maximum.** By October of each year, the commissioner
319.4 of commerce must determine the maximum annual out-of-pocket limits applicable to
319.5 individual health plans and small group health plans.

319.6 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
319.7 sold, issued, or renewed on or after that date.

319.8 Sec. 18. Minnesota Statutes 2020, section 62Q.81, is amended to read:

319.9 **62Q.81 ESSENTIAL HEALTH BENEFIT PACKAGE REQUIREMENTS.**

319.10 Subdivision 1. **Essential health benefits package.** (a) Health plan companies offering
319.11 individual and small group health plans must include the essential health benefits package
319.12 ~~required under section 1302(a) of the Affordable Care Act and as~~ described in this
319.13 subdivision.

319.14 (b) The essential health benefits package means insurance coverage that:

319.15 (1) provides the essential health benefits ~~as outlined in the Affordable Care Act~~ described
319.16 in subdivision 4;

319.17 (2) limits cost-sharing for ~~such~~ the coverage ~~in accordance with the Affordable Care~~
319.18 ~~Act~~, as described in subdivision 2; and

319.19 (3) ~~subject to subdivision 3,~~ provides bronze, silver, gold, or platinum level of coverage
319.20 ~~in accordance with the Affordable Care Act~~, as described in subdivision 3.

319.21 Subd. 2. **Cost-sharing; coverage for enrollees under the age of 21.** (a) Cost-sharing
319.22 includes (1) deductibles, coinsurance, co-payments, or similar charges, and (2) qualified
319.23 medical expenses, as defined in section 223(d)(2) of the Internal Revenue Code of 1986,
319.24 as amended. Cost-sharing does not include premiums, balance billing from non-network
319.25 providers, or spending for noncovered services.

319.26 (b) Cost-sharing per year for individual health plans is limited to the amount allowed
319.27 under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, as amended, increased
319.28 by an amount equal to the product of that amount and the premium adjustment percentage.
319.29 The premium adjustment percentage is the percentage that the average per capita premium
319.30 for health insurance coverage in the United States for the preceding calendar year exceeds
319.31 the average per capita premium for 2017. If the amount of the increase is not a multiple of
319.32 $50, the increases must be rounded to the next lowest multiple of $50.

320.1 (c) Cost-sharing per year for small group health plans is limited to twice the amount
320.2 allowed under paragraph (b).

320.3 (d) If a health plan company offers health plans in any level of coverage ~~specified under~~
320.4 ~~section 1302(d) of the Affordable Care Act, as~~ described in subdivision ~~1, paragraph (b),~~
320.5 ~~clause (3)~~ 3, the health plan company shall also offer coverage in that level to individuals
320.6 who have not attained 21 years of age as of the beginning of a policy year.

320.7 Subd. 3. **Levels of coverage; alternative compliance for catastrophic plans.** (a) A
320.8 health plan in the bronze level must provide a level of coverage designed to provide benefits
320.9 that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided
320.10 under the plan.

320.11 (b) A health plan in the silver level must provide a level of coverage designed to provide
320.12 benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits
320.13 provided under the plan.

320.14 (c) A health plan in the gold level must provide a level of coverage designed to provide
320.15 benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits
320.16 provided under the plan.

320.17 (d) A health plan in the platinum level must provide a level of coverage designed to
320.18 provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of
320.19 the benefits provided under the plan.

320.20 (e) A health plan company that does not provide an individual or small group health
320.21 plan in the bronze, silver, gold, or platinum level of coverage~~, as described in subdivision~~
320.22 ~~1, paragraph (b), clause (3), shall be treated as meeting~~ meets the requirements of this section
320.23 ~~1302(d) of the Affordable Care Act~~ with respect to any ~~policy~~ plan year if the health plan
320.24 company provides a catastrophic plan that meets the following requirements ~~of section~~
320.25 ~~1302(e) of the Affordable Care Act.~~:

320.26 (1) enrollment in the health plan is limited only to individuals that:

320.27 (i) have not attained age 30 before the beginning of the plan year;

320.28 (ii) are unable to access affordable coverage; or

320.29 (iii) are experiencing a hardship in reference to the individual's capability to access
320.30 coverage; and

320.31 (2) the health plan provides:

321.1 (i) essential health benefits, except that the plan does not provide benefits for any plan
321.2 year until the individual has incurred cost-sharing expenses in an amount equal to the
321.3 limitation in effect under subdivision 2; and

321.4 (ii) coverage for at least three primary care visits.

321.5 Subd. 4. **Essential health benefits; definition.** (a) For purposes of this section, "essential
321.6 health benefits" has the meaning given under section 1302(b) of the Affordable Care Act
321.7 and includes means:

321.8 (1) ambulatory patient services;

321.9 (2) emergency services;

321.10 (3) hospitalization;

321.11 (4) laboratory services;

321.12 (5) maternity and newborn care;

321.13 (6) mental health and substance use disorder services, including behavioral health
321.14 treatment;

321.15 (7) pediatric services, including oral and vision care;

321.16 (8) prescription drugs;

321.17 (9) preventive and wellness services and chronic disease management;

321.18 (10) rehabilitative and habilitative services and devices; and

321.19 (11) additional essential health benefits included in the EHB-benchmark plan, as defined
321.20 under the Affordable Care Act health plan described in paragraph (c).

321.21 (b) If a service provider does not have a contractual relationship with the health plan to
321.22 provide services, emergency services must be provided without imposing any prior
321.23 authorization requirement or limitation on coverage that is more restrictive than the
321.24 requirements or limitations that apply to emergency services received from providers who
321.25 have a contractual relationship with the health plan. If services are provided out-of-network,
321.26 the cost-sharing must be equivalent to services provided in-network.

321.27 (c) The scope of essential health benefits under paragraph (a) must be equal to the scope
321.28 of benefits provided under a typical employer plan.

321.29 (d) Essential health benefits must:

322.1 (1) reflect an appropriate balance among the categories to ensure benefits are not unduly
322.2 weighted toward any category;

322.3 (2) not make coverage decisions, determine reimbursement rates, establish incentive
322.4 programs, or design benefits in a manner that discriminates against individuals on the basis
322.5 of age, disability, or expected length of life;

322.6 (3) account for the health care needs of diverse segments of the population, including
322.7 women, children, persons with disabilities, and other groups; and

322.8 (4) ensure that health benefits established as essential are not subject to denial against
322.9 the individual's wishes on the basis of the individual's age or expected length of life or of
322.10 the individual's present or predicted disability, degree of medical dependency, or quality of
322.11 life.

322.12 Subd. 5. **Exception.** This section does not apply to a dental plan ~~described in section~~
322.13 ~~1311(d)(2)(B)(ii) of the Affordable Care Act~~ that is limited in scope and provides pediatric
322.14 dental benefits.

322.15 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
322.16 sold, issued, or renewed on or after that date.

322.17 Sec. 19. Minnesota Statutes 2020, section 256B.0625, subdivision 10, is amended to read:

322.18 Subd. 10. **Laboratory ~~and~~, x-ray, and opioid screening services.** (a) Medical assistance
322.19 covers laboratory and x-ray services.

322.20 (b) Medical assistance covers screening and urinalysis tests for opioids without lifetime
322.21 or annual limits.

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

322.23 Sec. 20. Minnesota Statutes 2020, section 256B.0625, subdivision 13, is amended to read:

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

322.30 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
322.31 unless authorized by the commissioner or as provided in paragraph (h).

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

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

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

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

323.15 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
323.16 a licensed practitioner or by a licensed pharmacist who meets standards established by the
323.17 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
323.18 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
323.19 with documented vitamin deficiencies, vitamins for children under the age of seven and
323.20 pregnant or nursing women, and any other over-the-counter drug identified by the
323.21 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
323.22 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
323.23 disorders, and this determination shall not be subject to the requirements of chapter 14. A
323.24 pharmacist may prescribe over-the-counter medications as provided under this paragraph
323.25 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
323.26 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
323.27 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
323.28 and make referrals as needed to other health care professionals.

323.29 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
323.30 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
323.31 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
323.32 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
323.33 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
323.34 individuals, medical assistance may cover drugs from the drug classes listed in United States

324.1 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
324.2 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
324.3 not be covered.

324.4 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
324.5 Program and dispensed by 340B covered entities and ambulatory pharmacies under common
324.6 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired
324.7 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

324.8 (g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal
324.9 contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section
324.10 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a
324.11 licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists
324.12 used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed
324.13 pharmacist in accordance with section 151.37, subdivision 16.

324.14 (h) Medical assistance coverage for a prescription contraceptive must provide a 12-month
324.15 supply for any prescription contraceptive. The prescribing health care provider must
324.16 determine the appropriate number of months to prescribe the prescription contraceptives,
324.17 up to 12 months. For the purposes of this paragraph, "prescription contraceptive" means
324.18 any drug or device that requires a prescription and is approved by the Food and Drug
324.19 Administration to prevent pregnancy. Prescription contraceptive does not include an
324.20 emergency contraceptive drug approved to prevent pregnancy when administered after
324.21 sexual contact.

324.22 **EFFECTIVE DATE.** This section applies to medical assistance and MinnesotaCare
324.23 coverage effective January 1, 2022.

324.24 Sec. 21. **COMMISSIONER OF COMMERCE; DETERMINATION OF**
324.25 **PREVENTIVE ITEMS AND SERVICES.**

324.26 The commissioner of commerce must determine the items and services that are preventive
324.27 under Minnesota Statutes, section 62Q.46, subdivision 1a. Items and services that are
324.28 preventive must include:

324.29 (1) evidence-based items or services that have in effect a rating of A or B pursuant to
324.30 the recommendations of the United States Preventive Services Task Force in effect January
324.31 1, 2021, and with respect to the individual involved;

324.32 (2) immunizations for routine use in children, adolescents, and adults that have in effect
324.33 a recommendation from the Advisory Committee on Immunization Practices of the Centers

325.1 for Disease Control and Prevention with respect to the individual involved. For the purposes
325.2 of this clause, a recommendation from the Advisory Committee on Immunization Practices
325.3 of the Centers for Disease Control and Prevention is considered in effect after it has been
325.4 adopted by the Director of the Centers for Disease Control and Prevention and a
325.5 recommendation is considered to be for routine use if it is listed on the Immunization
325.6 Schedules of the Centers for Disease Control and Prevention;

325.7 (3) with respect to infants, children, and adolescents, evidence-informed preventive care
325.8 and screenings provided for in comprehensive guidelines supported by the Health Resources
325.9 and Services Administration; and

325.10 (4) with respect to women, additional preventive care and screenings not described in
325.11 clause (1), as provided for in comprehensive guidelines supported by the Health Resources
325.12 and Services Administration.

325.13 **ARTICLE 7**

325.14 **TELEHEALTH**

325.15 Section 1. **[62A.673] COVERAGE OF SERVICES PROVIDED THROUGH**
325.16 **TELEHEALTH.**

325.17 Subdivision 1. **Citation.** This section may be cited as the "Minnesota Telehealth Act."

325.18 Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this
325.19 subdivision have the meanings given.

325.20 (b) "Distant site" means a site at which a health care provider is located while providing
325.21 health care services or consultations by means of telehealth.

325.22 (c) "Health care provider" means a health care professional who is licensed or registered
325.23 by the state to perform health care services within the provider's scope of practice and in
325.24 accordance with state law. A health care provider includes a mental health professional as
325.25 defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; a mental health
325.26 practitioner as defined under section 245.462, subdivision 17, or 245.4871, subdivision 26;
325.27 a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor
325.28 under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision
325.29 8.

325.30 (d) "Health carrier" has the meaning given in section 62A.011, subdivision 2.

325.31 (e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan
325.32 includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental

326.1 plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed
326.2 to pay benefits directly to the policy holder.

326.3 (f) "Originating site" means a site at which a patient is located at the time health care
326.4 services are provided to the patient by means of telehealth. For purposes of store-and-forward
326.5 transfer, the originating site also means the location at which a health care provider transfers
326.6 or transmits information to the distant site.

326.7 (g) "Store-and-forward transfer" means the asynchronous electronic transfer of a patient's
326.8 medical information or data from an originating site to a distant site for the purposes of
326.9 diagnostic and therapeutic assistance in the care of a patient.

326.10 (h) "Telehealth" means the delivery of health care services or consultations through the
326.11 use of real-time, two-way interactive audio and visual or audio-only communications to
326.12 provide or support health care delivery and facilitate the assessment, diagnosis, consultation,
326.13 treatment, education, and care management of a patient's health care. Telehealth includes
326.14 the application of secure video conferencing, store-and-forward transfers, and synchronous
326.15 interactions between a patient located at an originating site and a health care provider located
326.16 at a distant site. Telehealth includes audio-only communication between a health care
326.17 provider and a patient if the communication is a scheduled appointment and the standard
326.18 of care for the service can be met through the use of audio-only communication. Telehealth
326.19 does not include communication between health care providers or between a health care
326.20 provider and a patient that consists solely of an e-mail or facsimile transmission. Telehealth
326.21 does not include communication between health care providers that consists solely of a
326.22 telephone conversation.

326.23 (i) "Telemonitoring services" means the remote monitoring of clinical data related to
326.24 the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits
326.25 the data electronically to a health care provider for analysis. Telemonitoring is intended to
326.26 collect an enrollee's health-related data for the purpose of assisting a health care provider
326.27 in assessing and monitoring the enrollee's medical condition or status.

326.28 Subd. 3. **Coverage of telehealth.** (a) A health plan sold, issued, or renewed by a health
326.29 carrier in Minnesota must (1) cover benefits delivered through telehealth in the same manner
326.30 as any other benefits covered under the health plan, and (2) comply with this section.

326.31 (b) Coverage for services delivered through telehealth must not be limited on the basis
326.32 of geography, location, or distance for travel.

326.33 (c) A health carrier must not create a separate provider network or provide incentives
326.34 to enrollees to use a separate provider network to deliver services through telehealth that

327.1 does not include network providers who provide in-person care to patients for the same
327.2 service.

327.3 (d) A health carrier may require a deductible, co-payment, or coinsurance payment for
327.4 a health care service provided through telehealth, provided that the deductible, co-payment,
327.5 or coinsurance payment is not in addition to, and does not exceed, the deductible, co-payment,
327.6 or coinsurance applicable for the same service provided through in-person contact.

327.7 (e) Nothing in this section:

327.8 (1) requires a health carrier to provide coverage for services that are not medically
327.9 necessary or are not covered under the enrollee's health plan; or

327.10 (2) prohibits a health carrier from:

327.11 (i) establishing criteria that a health care provider must meet to demonstrate the safety
327.12 or efficacy of delivering a particular service through telehealth for which the health carrier
327.13 does not already reimburse other health care providers for delivering the service through
327.14 telehealth;

327.15 (ii) establishing reasonable medical management techniques, provided the criteria or
327.16 techniques are not unduly burdensome or unreasonable for the particular service; or

327.17 (iii) requiring documentation or billing practices designed to protect the health carrier
327.18 or patient from fraudulent claims, provided the practices are not unduly burdensome or
327.19 unreasonable for the particular service.

327.20 (f) Nothing in this section requires the use of telehealth when a health care provider
327.21 determines that the delivery of a health care service through telehealth is not appropriate or
327.22 when an enrollee chooses not to receive a health care service through telehealth.

327.23 Subd. 4. **Parity between telehealth and in-person services.** (a) A health carrier must
327.24 not restrict or deny coverage of a health care service that is covered under a health plan
327.25 solely:

327.26 (1) because the health care service provided by the health care provider through telehealth
327.27 is not provided through in-person contact; or

327.28 (2) based on the communication technology or application used to deliver the health
327.29 care service through telehealth, provided the technology or application complies with this
327.30 section and is appropriate for the particular service.

328.1 (b) Prior authorization may be required for health care services delivered through
328.2 telehealth only if prior authorization is required before the delivery of the same service
328.3 through in-person contact.

328.4 (c) A health carrier may require a utilization review for services delivered through
328.5 telehealth, provided the utilization review is conducted in the same manner and uses the
328.6 same clinical review criteria as a utilization review for the same services delivered through
328.7 in-person contact.

328.8 Subd. 5. **Reimbursement for services delivered through telehealth.** (a) A health carrier
328.9 must reimburse the health care provider for services delivered through telehealth on the
328.10 same basis and at the same rate as the health carrier would apply to those services if the
328.11 services had been delivered by the health care provider through in-person contact.

328.12 (b) A health carrier must not deny or limit reimbursement based solely on a health care
328.13 provider delivering the service or consultation through telehealth instead of through in-person
328.14 contact.

328.15 (c) A health carrier must not deny or limit reimbursement based solely on the technology
328.16 and equipment used by the health care provider to deliver the health care service or
328.17 consultation through telehealth, provided the technology and equipment used by the provider
328.18 meets the requirements of this section and is appropriate for the particular service.

328.19 Subd. 6. **Telehealth equipment.** (a) A health carrier must not require a health care
328.20 provider to use specific telecommunications technology and equipment as a condition of
328.21 coverage under this section, provided the health care provider uses telecommunications
328.22 technology and equipment that complies with current industry interoperable standards and
328.23 complies with standards required under the federal Health Insurance Portability and
328.24 Accountability Act of 1996, Public Law 104-191, and regulations promulgated under that
328.25 Act, unless authorized under this section.

328.26 (b) A health carrier must provide coverage for health care services delivered through
328.27 telehealth by means of the use of audio-only telephone communication if the communication
328.28 is a scheduled appointment and the standard of care for that particular service can be met
328.29 through the use of audio-only communication.

328.30 Subd. 7. **Telemonitoring services.** A health carrier must provide coverage for
328.31 telemonitoring services if:

328.32 (1) the telemonitoring service is medically appropriate based on the enrollee's medical
328.33 condition or status;

(2) the enrollee is cognitively and physically capable of operating the monitoring device or equipment, or the enrollee has a caregiver who is willing and able to assist with the monitoring device or equipment; and

(3) the enrollee resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

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

Sec. 2. Minnesota Statutes 2020, section 147.033, is amended to read:

147.033 PRACTICE OF ~~TELEMEDICINE~~ TELEHEALTH.

Subdivision 1. **Definition.** For the purposes of this section, ~~"telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way interactive audio, and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, that facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.~~ "telehealth" has the meaning given in section 62A.673, subdivision 2, paragraph (h).

Subd. 2. **Physician-patient relationship.** A physician-patient relationship may be established through ~~telemedicine~~ telehealth.

Subd. 3. **Standards of practice and conduct.** A physician providing health care services by ~~telemedicine~~ telehealth in this state shall be held to the same standards of practice and conduct as provided in this chapter for in-person health care services.

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

Sec. 3. Minnesota Statutes 2020, section 151.37, subdivision 2, is amended to read:

Subd. 2. **Prescribing and filing.** (a) A licensed practitioner in the course of professional practice only, may prescribe, administer, and dispense a legend drug, and may cause the same to be administered by a nurse, a physician assistant, or medical student or resident under the practitioner's direction and supervision, and may cause a person who is an appropriately certified, registered, or licensed health care professional to prescribe, dispense,

330.1 and administer the same within the expressed legal scope of the person's practice as defined
330.2 in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference
330.3 to a specific patient, by directing a licensed dietitian or licensed nutritionist, pursuant to
330.4 section 148.634; a nurse, pursuant to section 148.235, subdivisions 8 and 9; physician
330.5 assistant; medical student or resident; or pharmacist according to section 151.01, subdivision
330.6 27, to adhere to a particular practice guideline or protocol when treating patients whose
330.7 condition falls within such guideline or protocol, and when such guideline or protocol
330.8 specifies the circumstances under which the legend drug is to be prescribed and administered.
330.9 An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic
330.10 order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug.
330.11 This paragraph applies to a physician assistant only if the physician assistant meets the
330.12 requirements of ~~section 147A.18~~ <u>sections 147A.02 and 147A.09</u>.

330.13 (b) The commissioner of health, if a licensed practitioner, or a person designated by the
330.14 commissioner who is a licensed practitioner, may prescribe a legend drug to an individual
330.15 or by protocol for mass dispensing purposes where the commissioner finds that the conditions
330.16 triggering section 144.4197 or 144.4198, subdivision 2, paragraph (b), exist. The
330.17 commissioner, if a licensed practitioner, or a designated licensed practitioner, may prescribe,
330.18 dispense, or administer a legend drug or other substance listed in subdivision 10 to control
330.19 tuberculosis and other communicable diseases. The commissioner may modify state drug
330.20 labeling requirements, and medical screening criteria and documentation, where time is
330.21 critical and limited labeling and screening are most likely to ensure legend drugs reach the
330.22 maximum number of persons in a timely fashion so as to reduce morbidity and mortality.

330.23 (c) A licensed practitioner that dispenses for profit a legend drug that is to be administered
330.24 orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the
330.25 practitioner's licensing board a statement indicating that the practitioner dispenses legend
330.26 drugs for profit, the general circumstances under which the practitioner dispenses for profit,
330.27 and the types of legend drugs generally dispensed. It is unlawful to dispense legend drugs
330.28 for profit after July 31, 1990, unless the statement has been filed with the appropriate
330.29 licensing board. For purposes of this paragraph, "profit" means (1) any amount received by
330.30 the practitioner in excess of the acquisition cost of a legend drug for legend drugs that are
330.31 purchased in prepackaged form, or (2) any amount received by the practitioner in excess
330.32 of the acquisition cost of a legend drug plus the cost of making the drug available if the
330.33 legend drug requires compounding, packaging, or other treatment. The statement filed under
330.34 this paragraph is public data under section 13.03. This paragraph does not apply to a licensed
330.35 doctor of veterinary medicine or a registered pharmacist. Any person other than a licensed

331.1 practitioner with the authority to prescribe, dispense, and administer a legend drug under
331.2 paragraph (a) shall not dispense for profit. To dispense for profit does not include dispensing
331.3 by a community health clinic when the profit from dispensing is used to meet operating
331.4 expenses.

331.5 (d) A prescription drug order for the following drugs is not valid, unless it can be
331.6 established that the prescription drug order was based on a documented patient evaluation,
331.7 including an examination, adequate to establish a diagnosis and identify underlying conditions
331.8 and contraindications to treatment:

331.9 (1) controlled substance drugs listed in section 152.02, subdivisions 3 to 5;

331.10 (2) drugs defined by the Board of Pharmacy as controlled substances under section
331.11 152.02, subdivisions 7, 8, and 12;

331.12 (3) muscle relaxants;

331.13 (4) centrally acting analgesics with opioid activity;

331.14 (5) drugs containing butalbital; or

331.15 (6) phosphodiesterase type 5 inhibitors when used to treat erectile dysfunction.

331.16 ~~For purposes of prescribing drugs listed in clause (6), the requirement for a documented~~
331.17 ~~patient evaluation, including an examination, may be met through the use of telemedicine,~~
331.18 ~~as defined in section 147.033, subdivision 1.~~

331.19 (e) For the purposes of paragraph (d), the requirement for an examination shall be met
331.20 if:

331.21 (1) an in-person examination has been completed in any of the following circumstances:

331.22 ~~(1)~~ (i) the prescribing practitioner examines the patient at the time the prescription or
331.23 drug order is issued;

331.24 ~~(2)~~ (ii) the prescribing practitioner has performed a prior examination of the patient;

331.25 ~~(3)~~ (iii) another prescribing practitioner practicing within the same group or clinic as
331.26 the prescribing practitioner has examined the patient;

331.27 ~~(4)~~ (iv) a consulting practitioner to whom the prescribing practitioner has referred the
331.28 patient has examined the patient; or

331.29 ~~(5)~~ (v) the referring practitioner has performed an examination in the case of a consultant
331.30 practitioner issuing a prescription or drug order when providing services by means of
331.31 telemedicine~~.~~; or

332.1 (2) the prescription order is for a drug listed in paragraph (d), clause (6), or for medication
332.2 assisted therapy for a substance use disorder, and the prescribing practitioner has completed
332.3 an examination of the patient via telehealth as defined in section 62A.673, subdivision 2,
332.4 paragraph (h).

332.5 (f) Nothing in paragraph (d) or (e) prohibits a licensed practitioner from prescribing a
332.6 drug through the use of a guideline or protocol pursuant to paragraph (a).

332.7 (g) Nothing in this chapter prohibits a licensed practitioner from issuing a prescription
332.8 or dispensing a legend drug in accordance with the Expedited Partner Therapy in the
332.9 Management of Sexually Transmitted Diseases guidance document issued by the United
332.10 States Centers for Disease Control.

332.11 (h) Nothing in paragraph (d) or (e) limits prescription, administration, or dispensing of
332.12 legend drugs through a public health clinic or other distribution mechanism approved by
332.13 the commissioner of health or a community health board in order to prevent, mitigate, or
332.14 treat a pandemic illness, infectious disease outbreak, or intentional or accidental release of
332.15 a biological, chemical, or radiological agent.

332.16 (i) No pharmacist employed by, under contract to, or working for a pharmacy located
332.17 within the state and licensed under section 151.19, subdivision 1, may dispense a legend
332.18 drug based on a prescription that the pharmacist knows, or would reasonably be expected
332.19 to know, is not valid under paragraph (d).

332.20 (j) No pharmacist employed by, under contract to, or working for a pharmacy located
332.21 outside the state and licensed under section 151.19, subdivision 1, may dispense a legend
332.22 drug to a resident of this state based on a prescription that the pharmacist knows, or would
332.23 reasonably be expected to know, is not valid under paragraph (d).

332.24 (k) Nothing in this chapter prohibits the commissioner of health, if a licensed practitioner,
332.25 or, if not a licensed practitioner, a designee of the commissioner who is a licensed
332.26 practitioner, from prescribing legend drugs for field-delivered therapy in the treatment of
332.27 a communicable disease according to the Centers For Disease Control and Prevention Partner
332.28 Services Guidelines.

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

332.30 Sec. 4. Minnesota Statutes 2020, section 245G.01, subdivision 13, is amended to read:

332.31 Subd. 13. **Face-to-face.** "Face-to-face" means two-way, real-time, interactive ~~and visual~~
332.32 communication between a client and a treatment service provider and includes services
332.33 delivered in person or via ~~telemedicine~~ telehealth with priority being given to interactive

333.1 audio and visual communication, if available. Meetings required by section 245G.22,
333.2 subdivision 4, must be conducted by interactive video and visual communication.

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

333.6 Sec. 5. Minnesota Statutes 2020, section 245G.01, subdivision 26, is amended to read:

333.7 Subd. 26. ~~**Telemedicine**~~ **Telehealth.** ~~"Telemedicine"~~ "Telehealth" means the delivery
333.8 of a substance use disorder treatment service while the client is at an originating site and
333.9 the ~~licensed~~ health care provider is at a distant site via telehealth as defined in section
333.10 256B.0625, subdivision 3b, and as specified in section 254B.05, subdivision 5, paragraph
333.11 (f).

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

333.13 Sec. 6. Minnesota Statutes 2020, section 245G.06, subdivision 1, is amended to read:

333.14 Subdivision 1. **General.** Each client must have a person-centered individual treatment
333.15 plan developed by an alcohol and drug counselor within ten days from the day of service
333.16 initiation for a residential program and within five calendar days on which a treatment
333.17 session has been provided from the day of service initiation for a client in a nonresidential
333.18 program. Opioid treatment programs must complete the individual treatment plan within
333.19 21 days from the day of service initiation. The individual treatment plan must be signed by
333.20 the client and the alcohol and drug counselor and document the client's involvement in the
333.21 development of the plan. The individual treatment plan is developed upon the qualified staff
333.22 member's dated signature. Treatment planning must include ongoing assessment of client
333.23 needs. An individual treatment plan must be updated based on new information gathered
333.24 about the client's condition, the client's level of participation, and on whether methods
333.25 identified have the intended effect. A change to the plan must be signed by the client and
333.26 the alcohol and drug counselor. If the client chooses to have family or others involved in
333.27 treatment services, the client's individual treatment plan must include how the family or
333.28 others will be involved in the client's treatment. If a client is receiving treatment services
333.29 or an assessment via telehealth and the license holder documents the reason the client's
333.30 signature cannot be obtained, the alcohol and drug counselor may document the client's
333.31 verbal approval or electronic written approval of the treatment plan or change to the treatment
333.32 plan in lieu of the client's signature.

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

334.1 Sec. 7. Minnesota Statutes 2020, section 254A.19, subdivision 5, is amended to read:

334.2 Subd. 5. **Assessment via ~~telemedicine~~ telehealth.** Notwithstanding Minnesota Rules,
334.3 part 9530.6615, subpart 3, item A, a chemical use assessment may be conducted via
334.4 ~~telemedicine~~ telehealth as defined in section 256B.0625, subdivision 3b.

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

334.8 Sec. 8. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

334.9 Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance
334.10 use disorder services and service enhancements funded under this chapter.

334.11 (b) Eligible substance use disorder treatment services include:

334.12 (1) outpatient treatment services that are licensed according to sections 245G.01 to
334.13 245G.17, or applicable tribal license;

334.14 (2) comprehensive assessments provided according to sections 245.4863, paragraph (a),
334.15 and 245G.05;

334.16 (3) care coordination services provided according to section 245G.07, subdivision 1,
334.17 paragraph (a), clause (5);

334.18 (4) peer recovery support services provided according to section 245G.07, subdivision
334.19 2, clause (8);

334.20 (5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management
334.21 services provided according to chapter 245F;

334.22 (6) medication-assisted therapy services that are licensed according to sections 245G.01
334.23 to 245G.17 and 245G.22, or applicable tribal license;

334.24 (7) medication-assisted therapy plus enhanced treatment services that meet the
334.25 requirements of clause (6) and provide nine hours of clinical services each week;

334.26 (8) high, medium, and low intensity residential treatment services that are licensed
334.27 according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which
334.28 provide, respectively, 30, 15, and five hours of clinical services each week;

334.29 (9) hospital-based treatment services that are licensed according to sections 245G.01 to
334.30 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to
334.31 144.56;

335.1 (10) adolescent treatment programs that are licensed as outpatient treatment programs
335.2 according to sections 245G.01 to 245G.18 or as residential treatment programs according
335.3 to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or
335.4 applicable tribal license;

335.5 (11) high-intensity residential treatment services that are licensed according to sections
335.6 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of
335.7 clinical services each week provided by a state-operated vendor or to clients who have been
335.8 civilly committed to the commissioner, present the most complex and difficult care needs,
335.9 and are a potential threat to the community; and

335.10 (12) room and board facilities that meet the requirements of subdivision 1a.

335.11 (c) The commissioner shall establish higher rates for programs that meet the requirements
335.12 of paragraph (b) and one of the following additional requirements:

335.13 (1) programs that serve parents with their children if the program:

335.14 (i) provides on-site child care during the hours of treatment activity that:

335.15 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
335.16 9503; or

335.17 (B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph
335.18 (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

335.19 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
335.20 licensed under chapter 245A as:

335.21 (A) a child care center under Minnesota Rules, chapter 9503; or

335.22 (B) a family child care home under Minnesota Rules, chapter 9502;

335.23 (2) culturally specific programs as defined in section 254B.01, subdivision 4a, or
335.24 programs or subprograms serving special populations, if the program or subprogram meets
335.25 the following requirements:

335.26 (i) is designed to address the unique needs of individuals who share a common language,
335.27 racial, ethnic, or social background;

335.28 (ii) is governed with significant input from individuals of that specific background; and

335.29 (iii) employs individuals to provide individual or group therapy, at least 50 percent of
335.30 whom are of that specific background, except when the common social background of the
335.31 individuals served is a traumatic brain injury or cognitive disability and the program employs

336.1 treatment staff who have the necessary professional training, as approved by the
336.2 commissioner, to serve clients with the specific disabilities that the program is designed to
336.3 serve;

336.4 (3) programs that offer medical services delivered by appropriately credentialed health
336.5 care staff in an amount equal to two hours per client per week if the medical needs of the
336.6 client and the nature and provision of any medical services provided are documented in the
336.7 client file; and

336.8 (4) programs that offer services to individuals with co-occurring mental health and
336.9 chemical dependency problems if:

336.10 (i) the program meets the co-occurring requirements in section 245G.20;

336.11 (ii) 25 percent of the counseling staff are licensed mental health professionals, as defined
336.12 in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates
336.13 under the supervision of a licensed alcohol and drug counselor supervisor and licensed
336.14 mental health professional, except that no more than 50 percent of the mental health staff
336.15 may be students or licensing candidates with time documented to be directly related to
336.16 provisions of co-occurring services;

336.17 (iii) clients scoring positive on a standardized mental health screen receive a mental
336.18 health diagnostic assessment within ten days of admission;

336.19 (iv) the program has standards for multidisciplinary case review that include a monthly
336.20 review for each client that, at a minimum, includes a licensed mental health professional
336.21 and licensed alcohol and drug counselor, and their involvement in the review is documented;

336.22 (v) family education is offered that addresses mental health and substance abuse disorders
336.23 and the interaction between the two; and

336.24 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
336.25 training annually.

336.26 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program
336.27 that provides arrangements for off-site child care must maintain current documentation at
336.28 the chemical dependency facility of the child care provider's current licensure to provide
336.29 child care services. Programs that provide child care according to paragraph (c), clause (1),
336.30 must be deemed in compliance with the licensing requirements in section 245G.19.

336.31 (e) Adolescent residential programs that meet the requirements of Minnesota Rules,
336.32 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
336.33 in paragraph (c), clause (4), items (i) to (iv).

337.1 (f) Subject to federal approval, chemical dependency services that are otherwise covered
337.2 as direct face-to-face services may be provided via ~~two-way interactive video~~ telehealth as
337.3 defined in section 256B.0625, subdivision 3b. The use of ~~two-way interactive video~~ telehealth
337.4 to deliver services must be medically appropriate to the condition and needs of the person
337.5 being served. Reimbursement shall be at the same rates and under the same conditions that
337.6 would otherwise apply to direct face-to-face services. ~~The interactive video equipment and~~
337.7 ~~connection must comply with Medicare standards in effect at the time the service is provided.~~

337.8 (g) For the purpose of reimbursement under this section, substance use disorder treatment
337.9 services provided in a group setting without a group participant maximum or maximum
337.10 client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one.
337.11 At least one of the attending staff must meet the qualifications as established under this
337.12 chapter for the type of treatment service provided. A recovery peer may not be included as
337.13 part of the staff ratio.

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

337.17 Sec. 9. Minnesota Statutes 2020, section 256B.0621, subdivision 10, is amended to read:

337.18 Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case
337.19 management under this subdivision. Case managers may bill according to the following
337.20 criteria:

337.21 (1) for relocation targeted case management, case managers may bill for direct case
337.22 management activities, including face-to-face contact, telephone contact, and interactive
337.23 video contact ~~according to section 256B.0924, subdivision 4a~~, in the lesser of:

337.24 (i) 180 days preceding an eligible recipient's discharge from an institution; or

337.25 (ii) the limits and conditions which apply to federal Medicaid funding for this service;

337.26 (2) for home care targeted case management, case managers may bill for direct case
337.27 management activities, including face-to-face and telephone contacts; and

337.28 (3) billings for targeted case management services under this subdivision shall not
337.29 duplicate payments made under other program authorities for the same purpose.

337.30 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
337.31 of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **~~Telemedicine~~ Telehealth services.** (a) Medical assistance covers medically necessary services and consultations delivered by a ~~licensed~~ health care provider ~~via telemedicine~~ through telehealth in the same manner as if the service or consultation was delivered ~~in person~~ through in-person contact. ~~Coverage is limited to three telemedicine services per enrollee per calendar week, except as provided in paragraph (f). Telemedicine~~ Services or consultations delivered through telehealth shall be paid at the full allowable rate.

(b) The commissioner ~~shall~~ may establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service ~~via telemedicine~~ through telehealth. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide ~~via telemedicine~~ through telehealth;

(2) has written policies and procedures specific to ~~telemedicine~~ services delivered through telehealth that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the ~~telemedicine~~ service is ~~rendered~~ delivered through telehealth;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to ~~telemedicine~~ delivering services through telehealth.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service ~~provided by telemedicine~~ delivered through telehealth to a medical assistance enrollee. Health care service records for services ~~provided by telemedicine~~ delivered through telehealth must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service ~~provided by telemedicine~~ delivered through telehealth;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the ~~licensed~~ health care provider's basis for determining that ~~telemedicine~~ telehealth is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission ~~of~~ used to deliver the ~~telemedicine~~ service through telehealth and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's ~~telemedicine~~ consultation with another physician through telehealth, the written opinion from the consulting physician providing the ~~telemedicine~~ telehealth consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) For purposes of this subdivision, unless otherwise covered under this chapter~~, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.~~:

(1) "telehealth" means the delivery of health care services or consultations through the use of real-time, two-way interactive audio and visual or audio-only communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward transfers, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Unless interactive visual and audio communication is specifically required, telehealth includes audio-only communication between a health care provider and a patient, if the communication is a scheduled appointment with the health care provider and the standard of care for the service can be met through the use of audio-only communication. Telehealth does not include communication between health care providers, or communication between a health care provider and a patient that consists solely of an e-mail or facsimile transmission;

~~(e) For purposes of this section, "licensed~~ (2) "health care provider" means a ~~licensed~~ health care provider ~~under section 62A.671, subdivision 6~~ as defined under section 62A.673, a community paramedic as defined under section 144E.001, subdivision 5f, ~~or a mental~~

340.1 health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision
340.2 26, working under the general supervision of a mental health professional, and a community
340.3 health worker who meets the criteria under subdivision 49, paragraph (a); "health care
340.4 provider" is defined under section 62A.671, subdivision 3;, a mental health certified peer
340.5 specialist under section 256B.0615, subdivision 5, a mental health certified family peer
340.6 specialist under section 256B.0616, subdivision 5, a mental health rehabilitation worker
340.7 under section 256B.0623, subdivision 5, paragraph (a), clause (4), and paragraph (b), a
340.8 mental health behavioral aide under section 256B.0943, subdivision 7, paragraph (b), clause
340.9 (3), a treatment coordinator under section 245G.11, subdivision 7, an alcohol and drug
340.10 counselor under section 245G.11, subdivision 5, a recovery peer under section 245G.11,
340.11 subdivision 8, and a mental health case manager under section 245.462, subdivision 4; and

340.12 (3) "originating site" is defined under section 62A.671, subdivision 7, "distant site," and
340.13 "store-and-forward transfer" have the meanings given in section 62A.673, subdivision 2.

340.14 (f) The limit on coverage of three telemedicine services per enrollee per calendar week
340.15 does not apply if:

340.16 (1) the telemedicine services provided by the licensed health care provider are for the
340.17 treatment and control of tuberculosis; and

340.18 (2) the services are provided in a manner consistent with the recommendations and best
340.19 practices specified by the Centers for Disease Control and Prevention and the commissioner
340.20 of health.

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

340.24 Sec. 11. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
340.25 to read:

340.26 Subd. 3h. **Telemonitoring services.** (a) Medical assistance covers telemonitoring services
340.27 if a recipient:

340.28 (1) has been diagnosed and is receiving services for at least one of the following chronic
340.29 conditions: hypertension, cancer, congestive heart failure, chronic obstructive pulmonary
340.30 disease, asthma, or diabetes;

340.31 (2) requires at least five times per week monitoring to manage the chronic condition, as
340.32 ordered by the recipient's health care provider;

341.1 (3) has had two or more emergency room or inpatient hospitalization stays within the
341.2 last 12 months due to the chronic condition or the recipient's health care provider has
341.3 identified that telemonitoring services would likely prevent the recipient's admission or
341.4 readmission to a hospital, emergency room, or nursing facility;

341.5 (4) is cognitively and physically capable of operating the monitoring device or equipment,
341.6 or the recipient has a caregiver who is willing and able to assist with the monitoring device
341.7 or equipment; and

341.8 (5) resides in a setting that is suitable for telemonitoring and not in a setting that has
341.9 health care staff on site.

341.10 (b) For purposes of this subdivision, "telemonitoring services" means the remote
341.11 monitoring of data related to a recipient's vital signs or biometric data by a monitoring
341.12 device or equipment that transmits the data electronically to a provider for analysis. The
341.13 assessment and monitoring of the health data transmitted by telemonitoring must be
341.14 performed by one of the following licensed health care professionals: physician, podiatrist,
341.15 registered nurse, advanced practice registered nurse, physician assistant, respiratory therapist,
341.16 or licensed professional working under the supervision of a medical director.

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

341.18 Sec. 12. Minnesota Statutes 2020, section 256B.0625, subdivision 13h, is amended to
341.19 read:

341.20 Subd. 13h. **Medication therapy management services.** (a) Medical assistance covers
341.21 medication therapy management services for a recipient taking prescriptions to treat or
341.22 prevent one or more chronic medical conditions. For purposes of this subdivision,
341.23 "medication therapy management" means the provision of the following pharmaceutical
341.24 care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's
341.25 medications:

341.26 (1) performing or obtaining necessary assessments of the patient's health status;

341.27 (2) formulating a medication treatment plan, which may include prescribing medications
341.28 or products in accordance with section 151.37, subdivision 14, 15, or 16;

341.29 (3) monitoring and evaluating the patient's response to therapy, including safety and
341.30 effectiveness;

341.31 (4) performing a comprehensive medication review to identify, resolve, and prevent
341.32 medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued by the Board of Pharmacy of the state in which the medication therapy management service is being performed;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements; and

~~(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, including long-term care settings, group homes, and facilities providing assisted living services, but excluding skilled nursing facilities; and~~

~~(4)~~ (3) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance providers. The commissioner may also establish ~~contact requirements between the pharmacist and recipient, including limiting~~ limits on the number of reimbursable consultations per recipient.

(d) ~~If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide The~~ Medication therapy management services may be provided

via ~~two-way interactive video~~ telehealth as defined in subdivision 3b and may be delivered into a patient's residence. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b)~~, and must be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3). The patient must also be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3). Services provided under this paragraph may not be transmitted into the patient's residence~~.

~~(e) Medication therapy management services may be delivered into a patient's residence via secure interactive video if the medication therapy management services are performed electronically during a covered home care visit by an enrolled provider. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b) and must be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3).~~

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

Sec. 13. Minnesota Statutes 2020, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 20b with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

344.1 (1) at least a face-to-face contact, or a contact by interactive video that meets the
344.2 requirements of subdivision 20b, with the adult or the adult's legal representative or a contact
344.3 by interactive video that meets the requirements of subdivision 20b; or

344.4 (2) at least a telephone contact with the adult or the adult's legal representative and
344.5 document a face-to-face contact or a contact by interactive video that meets the requirements
344.6 of subdivision 20b with the adult or the adult's legal representative within the preceding
344.7 two months.

344.8 (d) Payment for mental health case management provided by county or state staff shall
344.9 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph
344.10 (b), with separate rates calculated for child welfare and mental health, and within mental
344.11 health, separate rates for children and adults.

344.12 (e) Payment for mental health case management provided by Indian health services or
344.13 by agencies operated by Indian tribes may be made according to this section or other relevant
344.14 federally approved rate setting methodology.

344.15 (f) Payment for mental health case management provided by vendors who contract with
344.16 a county or Indian tribe shall be based on a monthly rate negotiated by the host county or
344.17 tribe. The negotiated rate must not exceed the rate charged by the vendor for the same
344.18 service to other payers. If the service is provided by a team of contracted vendors, the county
344.19 or tribe may negotiate a team rate with a vendor who is a member of the team. The team
344.20 shall determine how to distribute the rate among its members. No reimbursement received
344.21 by contracted vendors shall be returned to the county or tribe, except to reimburse the county
344.22 or tribe for advance funding provided by the county or tribe to the vendor.

344.23 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
344.24 and county or state staff, the costs for county or state staff participation in the team shall be
344.25 included in the rate for county-provided services. In this case, the contracted vendor, the
344.26 tribal agency, and the county may each receive separate payment for services provided by
344.27 each entity in the same month. In order to prevent duplication of services, each entity must
344.28 document, in the recipient's file, the need for team case management and a description of
344.29 the roles of the team members.

344.30 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
344.31 mental health case management shall be provided by the recipient's county of responsibility,
344.32 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
344.33 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal
344.34 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state

345.1 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
345.2 the recipient's county of responsibility.

345.3 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
345.4 and MinnesotaCare include mental health case management. When the service is provided
345.5 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
345.6 share.

345.7 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
345.8 that does not meet the reporting or other requirements of this section. The county of
345.9 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,
345.10 is responsible for any federal disallowances. The county or tribe may share this responsibility
345.11 with its contracted vendors.

345.12 (k) The commissioner shall set aside a portion of the federal funds earned for county
345.13 expenditures under this section to repay the special revenue maximization account under
345.14 section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

345.15 (1) the costs of developing and implementing this section; and

345.16 (2) programming the information systems.

345.17 (l) Payments to counties and tribal agencies for case management expenditures under
345.18 this section shall only be made from federal earnings from services provided under this
345.19 section. When this service is paid by the state without a federal share through fee-for-service,
345.20 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
345.21 shall include the federal earnings, the state share, and the county share.

345.22 (m) Case management services under this subdivision do not include therapy, treatment,
345.23 legal, or outreach services.

345.24 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
345.25 and the recipient's institutional care is paid by medical assistance, payment for case
345.26 management services under this subdivision is limited to the lesser of:

345.27 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
345.28 than six months in a calendar year; or

345.29 (2) the limits and conditions which apply to federal Medicaid funding for this service.

345.30 (o) Payment for case management services under this subdivision shall not duplicate
345.31 payments made under other program authorities for the same purpose.

(p) If the recipient is receiving care in a hospital, nursing facility, or residential setting licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week, mental health targeted case management services must actively support identification of community alternatives for the recipient and discharge planning.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 14. Minnesota Statutes 2020, section 256B.0625, subdivision 20b, is amended to read:

Subd. 20b. ~~**Mental health**~~ **Targeted case management face-to-face contact through interactive video.** ~~(a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment if:~~

~~(1) the person receiving targeted case management services is residing in:~~

~~(i) a hospital;~~

~~(ii) a nursing facility; or~~

~~(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;~~

~~(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;~~

~~(3) the use of interactive video is approved as part of the person's written personal service or case plan, taking into consideration the person's vulnerability and active personal relationships; and~~

~~(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contact.~~ (a) Minimum required face-to-face contacts for targeted case management may be provided through interactive video if interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian and the case management provider.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner ~~shall~~ may establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of ~~delivering the service~~ meeting the minimum face-to-face contact requirements for targeted case management via interactive video. ~~The attestation may include that the case management provider has:~~

~~(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;~~

~~(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;~~

~~(3) established protocols addressing how and when to discontinue interactive video services; and~~

~~(4) established a quality assurance process related to interactive video services.~~

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video for the purpose of face-to-face contact:

(1) the time the ~~service~~ contact began and the time the ~~service~~ contact ended, including an a.m. and p.m. designation;

(2) the basis for determining that interactive video is an appropriate and effective means for ~~delivering the service to~~ contacting the person receiving targeted case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized; and

(4) the location of the originating site and the distant site~~; and~~.

~~(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).~~

(e) Interactive video must not be used to meet minimum face-to-face contact requirements for children who are in out-of-home placement or receiving case management services for child protection reasons.

(f) For the purposes of this section, "interactive video" means real-time, two-way interactive audio and visual communications.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 15. Minnesota Statutes 2020, section 256B.0625, subdivision 46, is amended to read:

Subd. 46. **Mental health ~~telemedicine~~ telehealth.** ~~Effective January 1, 2006, and~~ Subject to federal approval, mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via ~~two-way interactive video~~ telehealth as defined in subdivision 3b. Use of ~~two-way interactive video~~ telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the service. ~~The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.~~

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

Sec. 16. Minnesota Statutes 2020, section 256B.0911, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) Until additional requirements apply under paragraph (b), "long-term care consultation services" means:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations for and referrals to cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) ~~face-to-face~~ long-term care consultation assessments conducted according to subdivision 3a, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) determination of home and community-based waiver and other service eligibility as required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on a long-term care consultation assessment and community support plan development, appropriate referrals to obtain necessary diagnostic

349.1 information, and including an eligibility determination for consumer-directed community
349.2 supports;

349.3 (7) providing recommendations for institutional placement when there are no
349.4 cost-effective community services available;

349.5 (8) providing access to assistance to transition people back to community settings after
349.6 institutional admission;

349.7 (9) providing information about competitive employment, with or without supports, for
349.8 school-age youth and working-age adults and referrals to the Disability Hub and Disability
349.9 Benefits 101 to ensure that an informed choice about competitive employment can be made.
349.10 For the purposes of this subdivision, "competitive employment" means work in the
349.11 competitive labor market that is performed on a full-time or part-time basis in an integrated
349.12 setting, and for which an individual is compensated at or above the minimum wage, but not
349.13 less than the customary wage and level of benefits paid by the employer for the same or
349.14 similar work performed by individuals without disabilities;

349.15 (10) providing information about independent living to ensure that an informed choice
349.16 about independent living can be made; and

349.17 (11) providing information about self-directed services and supports, including
349.18 self-directed funding options, to ensure that an informed choice about self-directed options
349.19 can be made.

349.20 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c,
349.21 and 3a, "long-term care consultation services" also means:

349.22 (1) service eligibility determination for the following state plan services:

349.23 (i) personal care assistance services under section 256B.0625, subdivisions 19a and 19c;

349.24 (ii) consumer support grants under section 256.476; or

349.25 (iii) community first services and supports under section 256B.85;

349.26 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
349.27 gaining access to:

349.28 (i) relocation targeted case management services available under section 256B.0621,
349.29 subdivision 2, clause (4);

349.30 (ii) case management services targeted to vulnerable adults or developmental disabilities
349.31 under section 256B.0924; and

350.1 (iii) case management services targeted to people with developmental disabilities under
350.2 Minnesota Rules, part 9525.0016;

350.3 (3) determination of eligibility for semi-independent living services under section
350.4 252.275; and

350.5 (4) obtaining necessary diagnostic information to determine eligibility under clauses (2)
350.6 and (3).

350.7 (c) "Long-term care options counseling" means the services provided by sections 256.01,
350.8 subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and
350.9 follow up once a long-term care consultation assessment has been completed.

350.10 (d) "Minnesota health care programs" means the medical assistance program under this
350.11 chapter and the alternative care program under section 256B.0913.

350.12 (e) "Lead agencies" means counties administering or tribes and health plans under
350.13 contract with the commissioner to administer long-term care consultation services.

350.14 (f) "Person-centered planning" is a process that includes the active participation of a
350.15 person in the planning of the person's services, including in making meaningful and informed
350.16 choices about the person's own goals, talents, and objectives, as well as making meaningful
350.17 and informed choices about the services the person receives, the settings in which the person
350.18 receives the services, and the setting in which the person lives.

350.19 (g) "Informed choice" means a voluntary choice of services, settings, living arrangement,
350.20 and work by a person from all available service and setting options based on accurate and
350.21 complete information concerning all available service and setting options and concerning
350.22 the person's own preferences, abilities, goals, and objectives. In order for a person to make
350.23 an informed choice, all available options must be developed and presented to the person in
350.24 a way the person can understand to empower the person to make fully informed choices.

350.25 (h) "Available service and setting options" or "available options," with respect to the
350.26 home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49,
350.27 means all services and settings defined under the waiver plan for which a waiver applicant
350.28 or waiver participant is eligible.

350.29 (i) "Independent living" means living in a setting that is not controlled by a provider.

350.30 Sec. 17. Minnesota Statutes 2020, section 256B.0911, subdivision 3a, is amended to read:

350.31 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
350.32 planning, or other assistance intended to support community-based living, including persons

351.1 who need assessment in order to determine waiver or alternative care program eligibility,
351.2 must be visited by a long-term care consultation team within 20 calendar days after the date
351.3 on which an assessment was requested or recommended. Upon statewide implementation
351.4 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
351.5 requesting personal care assistance services. The commissioner shall provide at least a
351.6 90-day notice to lead agencies prior to the effective date of this requirement. ~~Face-to-face~~
351.7 Assessments must be conducted according to paragraphs (b) to ~~(i)~~ (q).

351.8 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
351.9 assessors to conduct the assessment. For a person with complex health care needs, a public
351.10 health or registered nurse from the team must be consulted.

351.11 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
351.12 be used to complete a comprehensive, conversation-based, person-centered assessment.
351.13 The assessment must include the health, psychological, functional, environmental, and
351.14 social needs of the individual necessary to develop a person-centered community support
351.15 plan that meets the individual's needs and preferences.

351.16 (d) Except as provided in paragraph (q), the assessment must be conducted by a certified
351.17 assessor in a face-to-face conversational interview with the person being assessed. The
351.18 person's legal representative must provide input during the assessment process and may do
351.19 so remotely if requested. At the request of the person, other individuals may participate in
351.20 the assessment to provide information on the needs, strengths, and preferences of the person
351.21 necessary to develop a community support plan that ensures the person's health and safety.
351.22 Except for legal representatives or family members invited by the person, persons
351.23 participating in the assessment may not be a provider of service or have any financial interest
351.24 in the provision of services. For persons who are to be assessed for elderly waiver customized
351.25 living or adult day services under chapter 256S, with the permission of the person being
351.26 assessed or the person's designated or legal representative, the client's current or proposed
351.27 provider of services may submit a copy of the provider's nursing assessment or written
351.28 report outlining its recommendations regarding the client's care needs. The person conducting
351.29 the assessment must notify the provider of the date by which this information is to be
351.30 submitted. This information shall be provided to the person conducting the assessment prior
351.31 to the assessment. For a person who is to be assessed for waiver services under section
351.32 256B.092 or 256B.49, with the permission of the person being assessed or the person's
351.33 designated legal representative, the person's current provider of services may submit a
351.34 written report outlining recommendations regarding the person's care needs the person
351.35 completed in consultation with someone who is known to the person and has interaction

352.1 with the person on a regular basis. The provider must submit the report at least 60 days
352.2 before the end of the person's current service agreement. The certified assessor must consider
352.3 the content of the submitted report prior to finalizing the person's assessment or reassessment.

352.4 (e) The certified assessor and the individual responsible for developing the coordinated
352.5 service and support plan must complete the community support plan and the coordinated
352.6 service and support plan no more than 60 calendar days from the assessment visit. The
352.7 person or the person's legal representative must be provided with a written community
352.8 support plan within the timelines established by the commissioner, regardless of whether
352.9 the person is eligible for Minnesota health care programs.

352.10 (f) For a person being assessed for elderly waiver services under chapter 256S, a provider
352.11 who submitted information under paragraph (d) shall receive the final written community
352.12 support plan when available and the Residential Services Workbook.

352.13 (g) The written community support plan must include:

352.14 (1) a summary of assessed needs as defined in paragraphs (c) and (d);

352.15 (2) the individual's options and choices to meet identified needs, including:

352.16 (i) all available options for case management services and providers;

352.17 (ii) all available options for employment services, settings, and providers;

352.18 (iii) all available options for living arrangements;

352.19 (iv) all available options for self-directed services and supports, including self-directed
352.20 budget options; and

352.21 (v) service provided in a non-disability-specific setting;

352.22 (3) identification of health and safety risks and how those risks will be addressed,
352.23 including personal risk management strategies;

352.24 (4) referral information; and

352.25 (5) informal caregiver supports, if applicable.

352.26 For a person determined eligible for state plan home care under subdivision 1a, paragraph
352.27 (b), clause (1), the person or person's representative must also receive a copy of the home
352.28 care service plan developed by the certified assessor.

352.29 (h) A person may request assistance in identifying community supports without
352.30 participating in a complete assessment. Upon a request for assistance identifying community
352.31 support, the person must be transferred or referred to long-term care options counseling

353.1 services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for
353.2 telephone assistance and follow up.

353.3 (i) The person has the right to make the final decision:

353.4 (1) between institutional placement and community placement after the recommendations
353.5 have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

353.6 (2) between community placement in a setting controlled by a provider and living
353.7 independently in a setting not controlled by a provider;

353.8 (3) between day services and employment services; and

353.9 (4) regarding available options for self-directed services and supports, including
353.10 self-directed funding options.

353.11 (j) The lead agency must give the person receiving long-term care consultation services
353.12 or the person's legal representative, materials, and forms supplied by the commissioner
353.13 containing the following information:

353.14 (1) written recommendations for community-based services and consumer-directed
353.15 options;

353.16 (2) documentation that the most cost-effective alternatives available were offered to the
353.17 individual. For purposes of this clause, "cost-effective" means community services and
353.18 living arrangements that cost the same as or less than institutional care. For an individual
353.19 found to meet eligibility criteria for home and community-based service programs under
353.20 chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally
353.21 approved waiver plan for each program;

353.22 (3) the need for and purpose of preadmission screening conducted by long-term care
353.23 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
353.24 nursing facility placement. If the individual selects nursing facility placement, the lead
353.25 agency shall forward information needed to complete the level of care determinations and
353.26 screening for developmental disability and mental illness collected during the assessment
353.27 to the long-term care options counselor using forms provided by the commissioner;

353.28 (4) the role of long-term care consultation assessment and support planning in eligibility
353.29 determination for waiver and alternative care programs, and state plan home care, case
353.30 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
353.31 and (b);

353.32 (5) information about Minnesota health care programs;

354.1 (6) the person's freedom to accept or reject the recommendations of the team;

354.2 (7) the person's right to confidentiality under the Minnesota Government Data Practices
354.3 Act, chapter 13;

354.4 (8) the certified assessor's decision regarding the person's need for institutional level of
354.5 care as determined under criteria established in subdivision 4e and the certified assessor's
354.6 decision regarding eligibility for all services and programs as defined in subdivision 1a,
354.7 paragraphs (a), clause (6), and (b);

354.8 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
354.9 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
354.10 (8), and (b), and incorporating the decision regarding the need for institutional level of care
354.11 or the lead agency's final decisions regarding public programs eligibility according to section
354.12 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
354.13 to the person and must visually point out where in the document the right to appeal is stated;
354.14 and

354.15 (10) documentation that available options for employment services, independent living,
354.16 and self-directed services and supports were described to the individual.

354.17 (k) ~~Face-to-face~~ Assessment completed as part of an eligibility determination for multiple
354.18 programs for the alternative care, elderly waiver, developmental disabilities, community
354.19 access for disability inclusion, community alternative care, and brain injury waiver programs
354.20 under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish
354.21 service eligibility for no more than 60 calendar days after the date of assessment.

354.22 (l) The effective eligibility start date for programs in paragraph (k) can never be prior
354.23 to the date of assessment. If an assessment was completed more than 60 days before the
354.24 effective waiver or alternative care program eligibility start date, assessment and support
354.25 plan information must be updated and documented in the department's Medicaid Management
354.26 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
354.27 state plan services, the effective date of eligibility for programs included in paragraph (k)
354.28 cannot be prior to the date the most recent updated assessment is completed.

354.29 (m) If an eligibility update is completed within 90 days of the previous ~~face-to-face~~
354.30 assessment and documented in the department's Medicaid Management Information System
354.31 (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date
354.32 of the previous ~~face-to-face~~ assessment when all other eligibility requirements are met.

355.1 (n) At the time of reassessment, the certified assessor shall assess each person receiving
355.2 waiver residential supports and services currently residing in a community residential setting,
355.3 licensed adult foster care home that is either not the primary residence of the license holder
355.4 or in which the license holder is not the primary caregiver, family adult foster care residence,
355.5 customized living setting, or supervised living facility to determine if that person would
355.6 prefer to be served in a community-living setting as defined in section 256B.49, subdivision
355.7 23, in a setting not controlled by a provider, or to receive integrated community supports
355.8 as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified
355.9 assessor shall offer the person, through a person-centered planning process, the option to
355.10 receive alternative housing and service options.

355.11 (o) At the time of reassessment, the certified assessor shall assess each person receiving
355.12 waiver day services to determine if that person would prefer to receive employment services
355.13 as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified
355.14 assessor shall describe to the person through a person-centered planning process the option
355.15 to receive employment services.

355.16 (p) At the time of reassessment, the certified assessor shall assess each person receiving
355.17 non-self-directed waiver services to determine if that person would prefer an available
355.18 service and setting option that would permit self-directed services and supports. The certified
355.19 assessor shall describe to the person through a person-centered planning process the option
355.20 to receive self-directed services and supports.

355.21 (q) All assessments performed according to this subdivision must be face-to-face unless
355.22 the assessment is a reassessment meeting the requirements of this paragraph. Subject to
355.23 federal approval, remote reassessments conducted by interactive video or telephone may
355.24 substitute for face-to-face reassessments for services provided by alternative care under
355.25 section 256B.0913, the elderly waiver under chapter 256S, the developmental disabilities
355.26 waiver under section 256B.092, and the community access for disability inclusion,
355.27 community alternative care, and brain injury waiver programs under section 256B.49.
355.28 Remote reassessments may be substituted for two consecutive reassessments if followed
355.29 by a face-to-face reassessment. A remote reassessment is permitted only if the person being
355.30 reassessed, the person's legal representative, and the lead agency case manager all agree
355.31 that there is no change in the person's condition, there is no need for a change in service,
355.32 and that a remote reassessment is appropriate. The person being reassessed, or the person's
355.33 legal representative, has the right to refuse a remote reassessment at any time. During a
355.34 remote reassessment, if the certified assessor determines in the assessor's sole judgment
355.35 that a remote reassessment is inappropriate, the certified assessor shall suspend the remote

356.1 reassessment and schedule a face-to-face reassessment to complete the reassessment. All
356.2 other requirements of a face-to-face reassessment apply to a remote reassessment.

356.3 Sec. 18. Minnesota Statutes 2020, section 256B.0911, subdivision 3f, is amended to read:

356.4 Subd. 3f. **Long-term care reassessments and community support plan updates.** (a)
356.5 Prior to a ~~face-to-face~~ reassessment, the certified assessor must review the person's most
356.6 recent assessment. Reassessments must be tailored using the professional judgment of the
356.7 assessor to the person's known needs, strengths, preferences, and circumstances.
356.8 Reassessments provide information to support the person's informed choice and opportunities
356.9 to express choice regarding activities that contribute to quality of life, as well as information
356.10 and opportunity to identify goals related to desired employment, community activities, and
356.11 preferred living environment. Reassessments require a review of the most recent assessment,
356.12 review of the current coordinated service and support plan's effectiveness, monitoring of
356.13 services, and the development of an updated person-centered community support plan.
356.14 Reassessments must verify continued eligibility, offer alternatives as warranted, and provide
356.15 an opportunity for quality assurance of service delivery. ~~Face-to-face~~ Reassessments must
356.16 be conducted annually or as required by federal and state laws and rules. For reassessments,
356.17 the certified assessor and the individual responsible for developing the coordinated service
356.18 and support plan must ensure the continuity of care for the person receiving services and
356.19 complete the updated community support plan and the updated coordinated service and
356.20 support plan no more than 60 days from the reassessment visit.

356.21 (b) The commissioner shall develop mechanisms for providers and case managers to
356.22 share information with the assessor to facilitate a reassessment and support planning process
356.23 tailored to the person's current needs and preferences.

356.24 Sec. 19. Minnesota Statutes 2020, section 256B.0911, subdivision 4d, is amended to read:

356.25 Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the
356.26 policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness
356.27 are served in the most integrated setting appropriate to their needs and have the necessary
356.28 information to make informed choices about home and community-based service options.

356.29 (b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing
356.30 facility must be screened prior to admission according to the requirements outlined in section
356.31 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as
356.32 required under section 256.975, subdivision 7.

357.1 (c) Individuals under 65 years of age who are admitted to nursing facilities with only a
357.2 telephone screening must receive a face-to-face assessment from the long-term care
357.3 consultation team member of the county in which the facility is located or from the recipient's
357.4 county case manager within the timeline established by the commissioner, based on review
357.5 of data.

357.6 (d) At the face-to-face assessment, the long-term care consultation team member or
357.7 county case manager must perform the activities required under subdivision 3b.

357.8 (e) For individuals under 21 years of age, a screening interview which recommends
357.9 nursing facility admission must be face-to-face and approved by the commissioner before
357.10 the individual is admitted to the nursing facility.

357.11 (f) In the event that an individual under 65 years of age is admitted to a nursing facility
357.12 on an emergency basis, the Senior LinkAge Line must be notified of the admission on the
357.13 next working day, and a face-to-face assessment as described in paragraph (c) must be
357.14 conducted within the timeline established by the commissioner, based on review of data.

357.15 (g) At the face-to-face assessment, the long-term care consultation team member or the
357.16 case manager must present information about home and community-based options, including
357.17 consumer-directed options, so the individual can make informed choices. If the individual
357.18 chooses home and community-based services, the long-term care consultation team member
357.19 or case manager must complete a written relocation plan within 20 working days of the
357.20 visit. The plan shall describe the services needed to move out of the facility and a time line
357.21 for the move which is designed to ensure a smooth transition to the individual's home and
357.22 community.

357.23 (h) An individual under 65 years of age residing in a nursing facility shall receive a
357.24 ~~face-to-face assessment~~ reassessment at least every 12 months to review the person's service
357.25 choices and available alternatives unless the individual indicates, in writing, that annual
357.26 visits are not desired. In this case, the individual must receive a ~~face-to-face assessment~~
357.27 reassessment at least once every 36 months for the same purposes. A remote reassessment
357.28 is permitted only if the person being reassessed, the person's legal representative, and the
357.29 lead agency case manager all agree that there is no change in the person's condition, there
357.30 is no need for a change in service, and that a remote reassessment is appropriate. The person
357.31 being reassessed, or the person's legal representative, has the right to refuse a remote
357.32 reassessment at any time. During a remote reassessment, if the certified assessor determines
357.33 in the assessor's sole judgment that a remote reassessment is inappropriate, the certified
357.34 assessor shall suspend the remote reassessment and schedule a face-to-face reassessment

358.1 <u>to complete the reassessment. All other requirements of a face-to-face reassessment apply</u>
358.2 <u>to a remote reassessment.</u>

358.3 (i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county
358.4 agencies directly for ~~face-to-face~~ assessments for individuals under 65 years of age who
358.5 are being considered for placement or residing in a nursing facility.

358.6 (j) Funding for preadmission screening follow-up shall be provided to the Disability
358.7 Hub for the under-60 population by the Department of Human Services to cover options
358.8 counseling salaries and expenses to provide the services described in subdivisions 7a to 7c.
358.9 The Disability Hub shall employ, or contract with other agencies to employ, within the
358.10 limits of available funding, sufficient personnel to provide preadmission screening follow-up
358.11 services and shall seek to maximize federal funding for the service as provided under section
358.12 256.01, subdivision 2, paragraph (aa).

358.13 Sec. 20. Minnesota Statutes 2020, section 256B.0924, subdivision 6, is amended to read:

358.14 Subd. 6. **Payment for targeted case management.** (a) Medical assistance and
358.15 MinnesotaCare payment for targeted case management shall be made on a monthly basis.
358.16 In order to receive payment for an eligible adult, the provider must document at least one
358.17 contact per month and not more than two consecutive months without a face-to-face contact
358.18 <u>or a contact by interactive video that meets the requirements of section 256B.0625,</u>
358.19 <u>subdivision 20b,</u> with the adult or the adult's legal representative, family, primary caregiver,
358.20 or other relevant persons identified as necessary to the development or implementation of
358.21 the goals of the personal service plan.

358.22 (b) Payment for targeted case management provided by county staff under this subdivision
358.23 shall be based on the monthly rate methodology under section 256B.094, subdivision 6,
358.24 paragraph (b), calculated as one combined average rate together with adult mental health
358.25 case management under section 256B.0625, subdivision 20, except for calendar year 2002.
358.26 In calendar year 2002, the rate for case management under this section shall be the same as
358.27 the rate for adult mental health case management in effect as of December 31, 2001. Billing
358.28 and payment must identify the recipient's primary population group to allow tracking of
358.29 revenues.

358.30 (c) Payment for targeted case management provided by county-contracted vendors shall
358.31 be based on a monthly rate negotiated by the host county. The negotiated rate must not
358.32 exceed the rate charged by the vendor for the same service to other payers. If the service is
358.33 provided by a team of contracted vendors, the county may negotiate a team rate with a
358.34 vendor who is a member of the team. The team shall determine how to distribute the rate

359.1 among its members. No reimbursement received by contracted vendors shall be returned
359.2 to the county, except to reimburse the county for advance funding provided by the county
359.3 to the vendor.

359.4 (d) If the service is provided by a team that includes contracted vendors and county staff,
359.5 the costs for county staff participation on the team shall be included in the rate for
359.6 county-provided services. In this case, the contracted vendor and the county may each
359.7 receive separate payment for services provided by each entity in the same month. In order
359.8 to prevent duplication of services, the county must document, in the recipient's file, the need
359.9 for team targeted case management and a description of the different roles of the team
359.10 members.

359.11 (e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
359.12 targeted case management shall be provided by the recipient's county of responsibility, as
359.13 defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
359.14 used to match other federal funds.

359.15 (f) The commissioner may suspend, reduce, or terminate reimbursement to a provider
359.16 that does not meet the reporting or other requirements of this section. The county of
359.17 responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal
359.18 disallowances. The county may share this responsibility with its contracted vendors.

359.19 (g) The commissioner shall set aside five percent of the federal funds received under
359.20 this section for use in reimbursing the state for costs of developing and implementing this
359.21 section.

359.22 (h) Payments to counties for targeted case management expenditures under this section
359.23 shall only be made from federal earnings from services provided under this section. Payments
359.24 to contracted vendors shall include both the federal earnings and the county share.

359.25 (i) Notwithstanding section 256B.041, county payments for the cost of case management
359.26 services provided by county staff shall not be made to the commissioner of management
359.27 and budget. For the purposes of targeted case management services provided by county
359.28 staff under this section, the centralized disbursement of payments to counties under section
359.29 256B.041 consists only of federal earnings from services provided under this section.

359.30 (j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
359.31 and the recipient's institutional care is paid by medical assistance, payment for targeted case
359.32 management services under this subdivision is limited to the lesser of:

359.33 (1) the last 180 days of the recipient's residency in that facility; or

360.1 (2) the limits and conditions which apply to federal Medicaid funding for this service.

360.2 (k) Payment for targeted case management services under this subdivision shall not
360.3 duplicate payments made under other program authorities for the same purpose.

360.4 (l) Any growth in targeted case management services and cost increases under this
360.5 section shall be the responsibility of the counties.

360.6 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
360.7 of human services shall notify the revisor of statutes when federal approval is obtained.

360.8 Sec. 21. Minnesota Statutes 2020, section 256B.094, subdivision 6, is amended to read:

360.9 Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical
360.10 assistance reimbursement for services under this section shall be made on a monthly basis.
360.11 Payment is based on face-to-face, interactive video, or telephone contacts between the case
360.12 manager and the client, client's family, primary caregiver, legal representative, or other
360.13 relevant person identified as necessary to the development or implementation of the goals
360.14 of the individual service plan regarding the status of the client, the individual service plan,
360.15 or the goals for the client. These contacts must meet the minimum standards in clauses (1)
360.16 and (2):

360.17 (1) there must be a face-to-face contact, or a contact by interactive video that meets the
360.18 requirements of section 256B.0625, subdivision 20b, at least once a month except as provided
360.19 in clause (2); and

360.20 (2) for a client placed outside of the county of financial responsibility, or a client served
360.21 by tribal social services placed outside the reservation, in an excluded time facility under
360.22 section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of
360.23 Children, section 260.93, and the placement in either case is more than 60 miles beyond
360.24 the county or reservation boundaries, there must be at least one contact per month and not
360.25 more than two consecutive months without a face-to-face contact.

360.26 Face-to-face contacts under this paragraph may be conducted using interactive video for
360.27 up to two consecutive contacts following each in-person contact.

360.28 (b) Except as provided under paragraph (c), the payment rate is established using time
360.29 study data on activities of provider service staff and reports required under sections 245.482
360.30 and 256.01, subdivision 2, paragraph (p).

361.1 (c) Payments for tribes may be made according to section 256B.0625 or other relevant
361.2 federally approved rate setting methodology for child welfare targeted case management
361.3 provided by Indian health services and facilities operated by a tribe or tribal organization.

361.4 (d) Payment for case management provided by county or tribal social services contracted
361.5 vendors shall be based on a monthly rate negotiated by the host county or tribal social
361.6 services. The negotiated rate must not exceed the rate charged by the vendor for the same
361.7 service to other payers. If the service is provided by a team of contracted vendors, the county
361.8 or tribal social services may negotiate a team rate with a vendor who is a member of the
361.9 team. The team shall determine how to distribute the rate among its members. No
361.10 reimbursement received by contracted vendors shall be returned to the county or tribal social
361.11 services, except to reimburse the county or tribal social services for advance funding provided
361.12 by the county or tribal social services to the vendor.

361.13 (e) If the service is provided by a team that includes contracted vendors and county or
361.14 tribal social services staff, the costs for county or tribal social services staff participation in
361.15 the team shall be included in the rate for county or tribal social services provided services.
361.16 In this case, the contracted vendor and the county or tribal social services may each receive
361.17 separate payment for services provided by each entity in the same month. To prevent
361.18 duplication of services, each entity must document, in the recipient's file, the need for team
361.19 case management and a description of the roles and services of the team members.

361.20 (f) Separate payment rates may be established for different groups of providers to
361.21 maximize reimbursement as determined by the commissioner. The payment rate will be
361.22 reviewed annually and revised periodically to be consistent with the most recent time study
361.23 and other data. Payment for services will be made upon submission of a valid claim and
361.24 verification of proper documentation described in subdivision 7. Federal administrative
361.25 revenue earned through the time study, or under paragraph (c), shall be distributed according
361.26 to earnings, to counties, reservations, or groups of counties or reservations which have the
361.27 same payment rate under this subdivision, and to the group of counties or reservations which
361.28 are not certified providers under section 256F.10. The commissioner shall modify the
361.29 requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to
361.30 accomplish this.

361.31 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
361.32 of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2020, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only ~~face-to-face~~ assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

(d) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

Sec. 23. Minnesota Statutes 2020, section 256J.09, subdivision 3, is amended to read:

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

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

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

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

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

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

363.1 ~~(4)~~ (6) explain the information that will be verified during the application process by
363.2 the county agency as provided in section 256J.32;

363.3 ~~(5)~~ (7) inform a person about the county agency's average application processing time
363.4 and explain how the application will be processed under subdivision 5;

363.5 ~~(6)~~ (8) explain how to contact the county agency if a person's application information
363.6 changes and how to withdraw the application;

363.7 ~~(7)~~ (9) inform a person that the next step in the application process is an interview and
363.8 what a person must do if the application is approved including, but not limited to, attending
363.9 orientation under section 256J.45 and complying with employment and training services
363.10 requirements in sections 256J.515 to 256J.57;

363.11 ~~(8)~~ (10) inform the person that ~~the~~ an interview must be conducted. The interview may
363.12 be conducted face-to-face in the county office or at a location mutually agreed upon, through
363.13 Internet telepresence, or ~~at a location mutually agreed upon~~ by telephone;

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

363.16 ~~(10)~~ (11) explain the child care and transportation services that are available under
363.17 paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

363.18 ~~(11)~~ (12) identify any language barriers and arrange for translation assistance during
363.19 appointments, including, but not limited to, screening under subdivision 3a, orientation
363.20 under section 256J.45, and assessment under section 256J.521.

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

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

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

364.3 Sec. 24. Minnesota Statutes 2020, section 256J.45, subdivision 1, is amended to read:

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

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

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

364.10 The county agency must inform caregivers who are not exempt under clause (1) or (2) that
364.11 failure to attend the orientation is considered an occurrence of noncompliance with program
364.12 requirements, and will result in the imposition of a sanction under section 256J.46. If the
364.13 client complies with the orientation requirement prior to the first day of the month in which
364.14 the grant reduction is proposed to occur, the orientation sanction shall be lifted.

364.15 Sec. 25. Minnesota Statutes 2020, section 256S.05, subdivision 2, is amended to read:

364.16 Subd. 2. **Nursing facility level of care determination required.** Notwithstanding other
364.17 assessments identified in section 144.0724, subdivision 4, only ~~face-to-face~~ assessments
364.18 conducted according to section 256B.0911, subdivisions 3, 3a, and 3b, that result in a nursing
364.19 facility level of care determination at initial and subsequent assessments shall be accepted
364.20 for purposes of a participant's initial and ongoing participation in the elderly waiver and a
364.21 service provider's access to service payments under this chapter.

364.22 Sec. 26. **STUDY OF TELEHEALTH.**

364.23 (a) The commissioner of health, in consultation with the commissioners of human services
364.24 and commerce, shall study the impact of telehealth payment methodologies and expansion
364.25 under the Minnesota Telehealth Act on the coverage and provision of health care services
364.26 under public health care programs and private health insurance. The study shall review and
364.27 make recommendations related to:

364.28 (1) the impact of telehealth payment methodologies and expansion on access to health
364.29 care services, quality of care, and value-based payments and innovation in care delivery;

365.1 (2) the short-term and long-term impacts of telehealth payment methodologies and
365.2 expansion in reducing health care disparities and providing equitable access for underserved
365.3 communities;

365.4 (3) the use of audio-only communication in supporting equitable access to health care
365.5 services, including behavioral health services for the elderly, rural communities, and
365.6 communities of color, and eliminating barriers for vulnerable and underserved populations;

365.7 (4) whether there is evidence to suggest that increased access to telehealth improves
365.8 health outcomes and, if so, for which services and populations; and

365.9 (5) the effect of payment parity on public and private health care costs, health care
365.10 premiums, and health outcomes.

365.11 (b) When conducting the study, the commissioner shall consult with stakeholders and
365.12 communities impacted by telehealth payment and expansion. The commissioner,
365.13 notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, may use data available
365.14 under that section to conduct the study. The commissioner shall report findings to the chairs
365.15 and ranking minority members of the legislative committees with jurisdiction over health
365.16 care policy and finance and commerce, by February 15, 2023.

365.17 Sec. 27. **EXPIRATION DATE.**

365.18 (a) Sections 1 to 15, 20, and 21 expire July 1, 2023.

365.19 (b) Notwithstanding paragraph (a), the definition of "originating site" in Minnesota
365.20 Statutes, section 256B.0625, subdivision 3b, paragraph (d), clause (3), shall not expire.

365.21 Sec. 28. **REVISOR INSTRUCTION.**

365.22 The revisor of statutes shall substitute the term "telemedicine" with "telehealth" whenever
365.23 the term appears in Minnesota Statutes and substitute Minnesota Statutes, section 62A.673,
365.24 whenever references to Minnesota Statutes, sections 62A.67, 62A.671, and 62A.672, appear
365.25 in Minnesota Statutes.

365.26 Sec. 29. **REPEALER.**

365.27 (a) Minnesota Statutes 2020, sections 62A.67; 62A.671; and 62A.672, are repealed
365.28 January 1, 2022, and are revived and reenacted July 1, 2023.

365.29 (b) Minnesota Statutes 2020, sections 256B.0596; and 256B.0924, subdivision 4a, are
365.30 repealed upon federal approval and are revived and reenacted July 1, 2023. The commissioner
365.31 of human services shall notify the revisor of statutes when federal approval is obtained.

366.1 **ARTICLE 8**

366.2 **ECONOMIC SUPPORTS**

366.3 Section 1. Minnesota Statutes 2020, section 119B.011, subdivision 15, is amended to read:

366.4 Subd. 15. **Income.** "Income" means earned income as defined under section 256P.01,
366.5 subdivision 3, unearned income as defined under section 256P.01, subdivision 8, and public
366.6 assistance cash benefits, including the Minnesota family investment program, diversionary
366.7 work program, work benefit, Minnesota supplemental aid, general assistance, refugee cash
366.8 assistance, at-home infant child care subsidy payments, and child support and maintenance
366.9 distributed to ~~the~~ a family under section 256.741, subdivision 2a, and nonrecurring income
366.10 over $60 per quarter unless earmarked and used for the purpose for which it was intended.
366.11 The following are deducted from income: funds used to pay for health insurance premiums
366.12 for family members, and child or spousal support paid to or on behalf of a person or persons
366.13 who live outside of the household. Income sources that are not included in this subdivision
366.14 and section 256P.06, subdivision 3, are not counted as income.

366.15 **EFFECTIVE DATE.** This section is effective March 1, 2023.

366.16 Sec. 2. Minnesota Statutes 2020, section 119B.025, subdivision 4, is amended to read:

366.17 Subd. 4. **Changes in eligibility.** (a) The county shall process a change in eligibility
366.18 factors according to paragraphs (b) to (g).

366.19 (b) A family is subject to the reporting requirements in section 256P.07, subdivision 6.

366.20 (c) If a family reports a change or a change is known to the agency before the family's
366.21 regularly scheduled redetermination, the county must act on the change. The commissioner
366.22 shall establish standards for verifying a change.

366.23 (d) A change in income occurs on the day the participant received the first payment
366.24 reflecting the change in income.

366.25 (e) During a family's 12-month eligibility period, if the family's income increases and
366.26 remains at or below 85 percent of the state median income, adjusted for family size, there
366.27 is no change to the family's eligibility. The county shall not request verification of the
366.28 change. The co-payment fee shall not increase during the remaining portion of the family's
366.29 12-month eligibility period.

366.30 (f) During a family's 12-month eligibility period, if the family's income increases and
366.31 exceeds 85 percent of the state median income, adjusted for family size, the family is not
366.32 eligible for child care assistance. The family must be given 15 calendar days to provide

367.1 verification of the change. If the required verification is not returned or confirms ineligibility,
367.2 the family's eligibility ends following a subsequent 15-day adverse action notice.

367.3 (g) Notwithstanding Minnesota Rules, parts 3400.0040, subpart 3, and 3400.0170,
367.4 subpart 1, if an applicant or participant reports that employment ended, the agency may
367.5 accept a signed statement from the applicant or participant as verification that employment
367.6 ended.

367.7 **EFFECTIVE DATE.** This section is effective March 1, 2023.

367.8 Sec. 3. Minnesota Statutes 2020, section 256D.03, is amended by adding a subdivision to
367.9 read:

367.10 Subd. 2b. **Budgeting and reporting.** County agencies shall determine eligibility and
367.11 calculate benefit amounts for general assistance according to the provisions in sections
367.12 256P.06, 256P.07, 256P.09, and 256P.10.

367.13 **EFFECTIVE DATE.** This section is effective March 1, 2023.

367.14 Sec. 4. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision
367.15 to read:

367.16 Subd. 20. **SNAP employment and training.** The commissioner shall implement a
367.17 Supplemental Nutrition Assistance Program (SNAP) employment and training program
367.18 that meets the SNAP employment and training participation requirements of the United
367.19 States Department of Agriculture governed by Code of Federal Regulations, title 7, section
367.20 273.7. The commissioner shall operate a SNAP employment and training program in which
367.21 SNAP recipients elect to participate. In order to receive SNAP assistance beyond the time
367.22 limit, unless residing in an area covered by a time-limit waiver governed by Code of Federal
367.23 Regulations, title 7, section 273.24, nonexempt SNAP recipients who do not meet federal
367.24 SNAP work requirements must participate in an employment and training program. In
367.25 addition to county and tribal agencies that administer SNAP, the commissioner may contract
367.26 with third-party providers for SNAP employment and training services.

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

367.28 Sec. 5. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision
367.29 to read:

367.30 Subd. 21. **County and tribal agency duties.** County or tribal agencies that administer
367.31 SNAP shall inform adult SNAP recipients about employment and training services and

368.1 providers in the recipient's area. County or tribal agencies that administer SNAP may elect
368.2 to subcontract with a public or private entity approved by the commissioner to provide
368.3 SNAP employment and training services.

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

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

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

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

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

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

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

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

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

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

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

368.25 Sec. 7. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision
368.26 to read:

368.27 Subd. 23. **Recipient duties.** Unless residing in an area covered by a time-limit waiver,
368.28 nonexempt SNAP recipients must meet federal SNAP work requirements to receive SNAP
368.29 assistance beyond the time limit.

368.30 **EFFECTIVE DATE.** This section is effective August 1, 2021.

369.1 Sec. 8. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision
369.2 to read:

369.3 Subd. 24. **Program funding.** (a) The United States Department of Agriculture annually
369.4 allocates SNAP employment and training funds to the commissioner of human services for
369.5 the operation of the SNAP employment and training program.

369.6 (b) The United States Department of Agriculture authorizes the disbursement of SNAP
369.7 employment and training reimbursement funds to the commissioner of human services for
369.8 the operation of the SNAP employment and training program.

369.9 (c) Except for funds allocated for state program development and administrative purposes
369.10 or designated by the United States Department of Agriculture for a specific project, the
369.11 commissioner of human services shall disburse money allocated for federal SNAP
369.12 employment and training to counties and tribes that administer SNAP based on a formula
369.13 determined by the commissioner that includes but is not limited to the county's or tribe's
369.14 proportion of adult SNAP recipients as compared to the statewide total.

369.15 (d) The commissioner of human services shall disburse federal funds that the
369.16 commissioner receives as reimbursement for SNAP employment and training costs to the
369.17 state agency, county, tribe, or contracted agency that incurred the costs being reimbursed.

369.18 (e) The commissioner of human services may reallocate unexpended money disbursed
369.19 under this section to county, tribal, or contracted agencies that demonstrate a need for
369.20 additional funds.

369.21 **EFFECTIVE DATE.** This section is effective August 1, 2021.

369.22 Sec. 9. Minnesota Statutes 2020, section 256D.0515, is amended to read:

369.23 **256D.0515 ASSET LIMITATIONS FOR SUPPLEMENTAL NUTRITION**
369.24 **ASSISTANCE PROGRAM HOUSEHOLDS.**

369.25 All Supplemental Nutrition Assistance Program (SNAP) households must be determined
369.26 eligible for the benefit discussed under section 256.029. SNAP households must demonstrate
369.27 that their gross income is equal to or less than ~~165~~ 200 percent of the federal poverty
369.28 guidelines for the same family size.

369.29 Sec. 10. Minnesota Statutes 2020, section 256D.0516, subdivision 2, is amended to read:

369.30 Subd. 2. **SNAP reporting requirements.** The commissioner of human services shall
369.31 implement simplified reporting as permitted under the Food and Nutrition Act of 2008, as

370.1 amended, and the SNAP regulations in Code of Federal Regulations, title 7, part 273. SNAP
370.2 benefit recipient households required to report periodically shall not be required to report
370.3 more often than one time every six months. ~~This provision shall not apply to households~~
370.4 ~~receiving food benefits under the Minnesota family investment program waiver.~~

370.5 **EFFECTIVE DATE.** This section is effective March 1, 2023.

370.6 Sec. 11. Minnesota Statutes 2020, section 256E.34, subdivision 1, is amended to read:

370.7 Subdivision 1. **Distribution of appropriation.** The commissioner must distribute funds
370.8 appropriated to the commissioner by law for that purpose to Hunger Solutions, a statewide
370.9 association of food shelves organized as a nonprofit corporation as defined under section
370.10 501(c)(3) of the Internal Revenue Code of 1986, to distribute to qualifying food shelves. A
370.11 food shelf qualifies under this section if:

370.12 (1) it is a nonprofit corporation, or is affiliated with a nonprofit corporation, as defined
370.13 in section 501(c)(3) of the Internal Revenue Code of 1986 or a federally recognized tribal
370.14 nation;

370.15 (2) it distributes standard food orders without charge to needy individuals. The standard
370.16 food order must consist of at least a two-day supply or six pounds per person of nutritionally
370.17 balanced food items;

370.18 (3) it does not limit food distributions to individuals of a particular religious affiliation,
370.19 race, or other criteria unrelated to need or to requirements necessary to administration of a
370.20 fair and orderly distribution system;

370.21 (4) it does not use the money received or the food distribution program to foster or
370.22 advance religious or political views; and

370.23 (5) it has a stable address and directly serves individuals.

370.24 Sec. 12. Minnesota Statutes 2020, section 256I.03, subdivision 13, is amended to read:

370.25 Subd. 13. **Prospective budgeting.** "Prospective budgeting" ~~means estimating the amount~~
370.26 ~~of monthly income a person will have in the payment month~~ has the meaning given in
370.27 section 256P.01, subdivision 9.

370.28 **EFFECTIVE DATE.** This section is effective March 1, 2023.

Sec. 13. Minnesota Statutes 2020, section 256I.06, subdivision 6, is amended to read:

Subd. 6. **Reports.** Recipients must report changes in circumstances according to section 256P.07 ~~that affect eligibility or housing support payment amounts, other than changes in earned income, within ten days of the change~~. Recipients with countable earned income must complete a household report form at least once every six months according to section 256P.10. ~~If the report form is not received before the end of the month in which it is due, the county agency must terminate eligibility for housing support payments. The termination shall be effective on the first day of the month following the month in which the report was due. If a complete report is received within the month eligibility was terminated, the individual is considered to have continued an application for housing support payment effective the first day of the month the eligibility was terminated.~~

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 14. Minnesota Statutes 2020, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the room and board rate for that same month. The housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

~~(b) For an individual with earned income under paragraph (a), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.~~

~~(c)~~ (b) For an individual who receives housing support payments under section 256I.04, subdivision 1, paragraph (c), the amount of the housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident.

EFFECTIVE DATE. This section is effective March 1, 2023.

Sec. 15. Minnesota Statutes 2020, section 256J.08, subdivision 15, is amended to read:

Subd. 15. **Countable income.** "Countable income" means earned and unearned income that is ~~not excluded under section 256J.21, subdivision 2~~ described in section 256P.06, subdivision 3, or disregarded under section 256J.21, subdivision 3, or section 256P.03.

372.1 **EFFECTIVE DATE.** This section is effective August 1, 2021.

372.2 Sec. 16. Minnesota Statutes 2020, section 256J.08, subdivision 71, is amended to read:

372.3 Subd. 71. **Prospective budgeting.** "Prospective budgeting" means a method of
372.4 determining the amount of the assistance payment in which the budget month and payment
372.5 month are the same has the meaning given in section 256P.01, subdivision 9.

372.6 **EFFECTIVE DATE.** This section is effective March 1, 2023.

372.7 Sec. 17. Minnesota Statutes 2020, section 256J.08, subdivision 79, is amended to read:

372.8 Subd. 79. **Recurring income.** "Recurring income" means a form of income which is:

372.9 (1) received periodically, and may be received irregularly when receipt can be anticipated
372.10 even though the date of receipt cannot be predicted; and

372.11 (2) from the same source or of the same type that is received and budgeted in a
372.12 prospective month and is received in one or both of the first two retrospective months.

372.13 **EFFECTIVE DATE.** This section is effective March 1, 2023.

372.14 Sec. 18. Minnesota Statutes 2020, section 256J.10, is amended to read:

372.15 **256J.10 MFIP ELIGIBILITY REQUIREMENTS.**

372.16 To be eligible for MFIP, applicants must meet the general eligibility requirements in
372.17 sections 256J.11 to 256J.15, the property limitations in section 256P.02, and the income
372.18 limitations in section sections 256J.21 and 256P.06.

372.19 **EFFECTIVE DATE.** This section is effective August 1, 2021.

372.20 Sec. 19. Minnesota Statutes 2020, section 256J.21, subdivision 3, is amended to read:

372.21 Subd. 3. **Initial income test.** The agency shall determine initial eligibility by considering
372.22 all earned and unearned income that is not excluded under subdivision 2 as defined in section
372.23 256P.06. To be eligible for MFIP, the assistance unit's countable income minus the earned
372.24 income disregards in paragraph (a) and section 256P.03 must be below the family wage
372.25 level according to section 256J.24, subdivision 7, for that size assistance unit.

372.26 (a) The initial eligibility determination must disregard the following items:

372.27 (1) the earned income disregard as determined in section 256P.03;

373.1 (2) dependent care costs must be deducted from gross earned income for the actual
373.2 amount paid for dependent care up to a maximum of $200 per month for each child less
373.3 than two years of age, and $175 per month for each child two years of age and older;

373.4 (3) all payments made according to a court order for spousal support or the support of
373.5 children not living in the assistance unit's household shall be disregarded from the income
373.6 of the person with the legal obligation to pay support; and

373.7 (4) an allocation for the unmet need of an ineligible spouse or an ineligible child under
373.8 the age of 21 for whom the caregiver is financially responsible and who lives with the
373.9 caregiver according to section 256J.36.

373.10 (b) ~~After initial eligibility is established,~~ The income test is for a six-month period. The
373.11 assistance payment calculation is based on ~~the monthly income test~~ prospective budgeting
373.12 according to section 256P.09.

373.13 **EFFECTIVE DATE.** This section is effective August 1, 2021, except for the
373.14 amendments in subdivision 3, paragraph (b), which are effective March 1, 2023.

373.15 Sec. 20. Minnesota Statutes 2020, section 256J.21, subdivision 4, is amended to read:

373.16 Subd. 4. **~~Monthly~~ Income test and determination of assistance payment.** ~~The county~~
373.17 ~~agency shall determine ongoing eligibility and the assistance payment amount according~~
373.18 ~~to the monthly income test.~~ To be eligible for MFIP, the result of the computations in
373.19 paragraphs (a) to (e) applied to prospective budgeting must be at least $1.

373.20 (a) Apply an income disregard as defined in section 256P.03, to gross earnings and
373.21 subtract this amount from the family wage level. If the difference is equal to or greater than
373.22 the MFIP transitional standard, the assistance payment is equal to the MFIP transitional
373.23 standard. If the difference is less than the MFIP transitional standard, the assistance payment
373.24 is equal to the difference. The earned income disregard in this paragraph must be deducted
373.25 every month there is earned income.

373.26 (b) All payments made according to a court order for spousal support or the support of
373.27 children not living in the assistance unit's household must be disregarded from the income
373.28 of the person with the legal obligation to pay support.

373.29 (c) An allocation for the unmet need of an ineligible spouse or an ineligible child under
373.30 the age of 21 for whom the caregiver is financially responsible and who lives with the
373.31 caregiver must be made according to section 256J.36.

374.1 (d) Subtract unearned income dollar for dollar from the MFIP transitional standard to
374.2 determine the assistance payment amount.

374.3 (e) When income is both earned and unearned, the amount of the assistance payment
374.4 must be determined by first treating gross earned income as specified in paragraph (a). After
374.5 determining the amount of the assistance payment under paragraph (a), unearned income
374.6 must be subtracted from that amount dollar for dollar to determine the assistance payment
374.7 amount.

374.8 ~~(f) When the monthly income is greater than the MFIP transitional standard after~~
374.9 ~~deductions and the income will only exceed the standard for one month, the county agency~~
374.10 ~~must suspend the assistance payment for the payment month.~~

374.11 **EFFECTIVE DATE.** This section is effective March 1, 2023.

374.12 Sec. 21. Minnesota Statutes 2020, section 256J.21, subdivision 5, is amended to read:

374.13 Subd. 5. **Distribution of income.** (a) The income of all members of the assistance unit
374.14 must be counted. Income may also be deemed from ineligible persons to the assistance unit.
374.15 Income must be attributed to the person who earns it or to the assistance unit according to
374.16 paragraphs ~~(a) to~~ (b) and (c).

374.17 ~~(a) Funds distributed from a trust, whether from the principal holdings or sale of trust~~
374.18 ~~property or from the interest and other earnings of the trust holdings, must be considered~~
374.19 ~~income when the income is legally available to an applicant or participant. Trusts are~~
374.20 ~~presumed legally available unless an applicant or participant can document that the trust is~~
374.21 ~~not legally available.~~

374.22 (b) Income from jointly owned property must be divided equally among property owners
374.23 unless the terms of ownership provide for a different distribution.

374.24 (c) Deductions are not allowed from the gross income of a financially responsible
374.25 household member or by the members of an assistance unit to meet a current or prior debt.

374.26 **EFFECTIVE DATE.** This section is effective August 1, 2021.

374.27 Sec. 22. Minnesota Statutes 2020, section 256J.24, subdivision 5, is amended to read:

374.28 Subd. 5. **MFIP transitional standard.** (a) The MFIP transitional standard is based on
374.29 the number of persons in the assistance unit eligible for both food and cash assistance. The
374.30 amount of the transitional standard is published annually by the Department of Human
374.31 Services.

(b) The amount of the MFIP cash assistance portion of the transitional standard is increased $100 per month per household. This increase shall be reflected in the MFIP cash assistance portion of the transitional standard published annually by the commissioner.

(c) On October 1 of each year, the commissioner of human services shall adjust the cash assistance portion under paragraph (a) for inflation based on the CPI-U for the prior calendar year.

EFFECTIVE DATE. This section is effective for the fiscal year beginning on July 1, 2021.

Sec. 23. Minnesota Statutes 2020, section 256J.30, subdivision 8, is amended to read:

Subd. 8. **Late MFIP household report forms.** (a) Paragraphs (b) to (e) apply to the reporting requirements in subdivision 7.

(b) When the county agency receives an incomplete MFIP household report form, the county agency must immediately ~~return the incomplete form and clearly state what the caregiver must do for the form to be complete~~ contact the caregiver by phone or in writing to acquire the necessary information to complete the form.

(c) The automated eligibility system must send a notice of proposed termination of assistance to the assistance unit if a complete MFIP household report form is not received by a county agency. The automated notice must be mailed to the caregiver by approximately the 16th of the month. When a caregiver submits an incomplete form on or after the date a notice of proposed termination has been sent, the termination is valid unless the caregiver submits a complete form before the end of the month.

(d) An assistance unit required to submit an MFIP household report form is considered to have continued its application for assistance if a complete MFIP household report form is received within a calendar month after the month in which the form was due and assistance shall be paid for the period beginning with the first day of that calendar month.

(e) A county agency must allow good cause exemptions from the reporting requirements under subdivision 5 when any of the following factors cause a caregiver to fail to provide the county agency with a completed MFIP household report form before the end of the month in which the form is due:

(1) an employer delays completion of employment verification;

(2) a county agency does not help a caregiver complete the MFIP household report form when the caregiver asks for help;

(3) a caregiver does not receive an MFIP household report form due to mistake on the part of the department or the county agency or due to a reported change in address;

(4) a caregiver is ill, or physically or mentally incapacitated; or

(5) some other circumstance occurs that a caregiver could not avoid with reasonable care which prevents the caregiver from providing a completed MFIP household report form before the end of the month in which the form is due.

Sec. 24. Minnesota Statutes 2020, section 256J.33, subdivision 1, is amended to read:

Subdivision 1. **Determination of eligibility.** (a) A county agency must determine MFIP eligibility prospectively ~~for a payment month~~ based on ~~retrospectively~~ assessing income and the county agency's best estimate of the circumstances that will exist in the payment month.

~~Except as described in section 256J.34, subdivision 1, when prospective eligibility exists,~~ (b) A county agency must calculate the amount of the assistance payment using ~~retrospective~~ prospective budgeting. To determine MFIP eligibility and the assistance payment amount, a county agency must apply countable income, described in ~~section~~ sections 256P.06 and 256J.37, subdivisions 3 to ~~10~~ 9, received by members of an assistance unit or by other persons whose income is counted for the assistance unit, described under sections ~~256J.21 and~~ 256J.37, subdivisions 1 to 2, and 256P.06, subdivision 1.

(c) This income must be applied to the MFIP standard of need or family wage level subject to this section and sections 256J.34 to 256J.36. Countable income received ~~in a calendar month and not otherwise excluded under section 256J.21, subdivision 2,~~ must be applied to the needs of an assistance unit.

(d) An assistance unit is not eligible when the countable income equals or exceeds the MFIP standard of need or the family wage level for the assistance unit.

EFFECTIVE DATE. Paragraph (a) is effective March 1, 2023. Paragraph (b) is effective March 1, 2023, except the amendment striking section 256J.21 and inserting section 256P.06 is effective August 1, 2021. Paragraph (c) is effective August 1, 2021, except the amendment striking "in a calendar month" is effective March 1, 2023. Paragraph (d) is effective March 1, 2023.

Sec. 25. Minnesota Statutes 2020, section 256J.33, subdivision 2, is amended to read:

Subd. 2. **Prospective eligibility.** An agency must determine whether the eligibility requirements that pertain to an assistance unit, including those in sections 256J.11 to 256J.15

377.1 and 256P.02, will be met prospectively for the payment ~~month~~ period. ~~Except for the~~
377.2 ~~provisions in section 256J.34, subdivision 1,~~ The income test will be applied ~~retrospectively~~
377.3 prospectively.

377.4 **EFFECTIVE DATE.** This section is effective March 1, 2023.

377.5 Sec. 26. Minnesota Statutes 2020, section 256J.33, subdivision 4, is amended to read:

377.6 Subd. 4. **Monthly income test.** A county agency must apply the monthly income test
377.7 retrospectively for each month of MFIP eligibility. An assistance unit is not eligible when
377.8 the countable income equals or exceeds the MFIP standard of need or the family wage level
377.9 for the assistance unit. The income applied against the monthly income test must include:

377.10 (1) gross earned income from employment as described in chapter 256P, prior to
377.11 mandatory payroll deductions, voluntary payroll deductions, wage authorizations, and after
377.12 the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36~~,~~
377.13 ~~unless the employment income is specifically excluded under section 256J.21, subdivision~~
377.14 ~~2~~;

377.15 (2) gross earned income from self-employment less deductions for self-employment
377.16 expenses in section 256J.37, subdivision 5, but prior to any reductions for personal or
377.17 business state and federal income taxes, personal FICA, personal health and life insurance,
377.18 and after the disregards in section 256J.21, subdivision 4, and the allocations in section
377.19 256J.36;

377.20 (3) unearned income as described in section 256P.06, subdivision 3, after deductions
377.21 for allowable expenses in section 256J.37, subdivision 9, and allocations in section 256J.36~~,~~
377.22 ~~unless the income has been specifically excluded in section 256J.21, subdivision 2~~;

377.23 (4) gross earned income from employment as determined under clause (1) which is
377.24 received by a member of an assistance unit who is a minor child or minor caregiver and
377.25 less than a half-time student;

377.26 (5) child support received by an assistance unit, excluded under ~~section 256J.21,~~
377.27 ~~subdivision 2, clause (49), or~~ section 256P.06, subdivision 3, clause (2), item (xvi);

377.28 (6) spousal support received by an assistance unit;

377.29 (7) the income of a parent when that parent is not included in the assistance unit;

377.30 (8) the income of an eligible relative and spouse who seek to be included in the assistance
377.31 unit; and

377.32 (9) the unearned income of a minor child included in the assistance unit.

378.1 **EFFECTIVE DATE.** This section is effective August 1, 2021.

378.2 Sec. 27. Minnesota Statutes 2020, section 256J.37, subdivision 1, is amended to read:

378.3 Subdivision 1. **Deemed income from ineligible assistance unit members.** The income
378.4 of ineligible assistance unit members, except individuals identified in section 256J.24,
378.5 subdivision 3, paragraph (a), clause (1), must be deemed after allowing the following
378.6 disregards:

378.7 (1) an earned income disregard as determined under section 256P.03;

378.8 (2) all payments made by the ineligible person according to a court order for spousal
378.9 support or the support of children not living in the assistance unit's household; and

378.10 (3) an amount for the unmet needs of the ineligible persons who live in the household
378.11 who, if eligible, would be assistance unit members under section 256J.24, subdivision 2 or
378.12 4, paragraph (b). This amount is equal to the difference between the MFIP transitional
378.13 standard when the ineligible persons are included in the assistance unit and the MFIP
378.14 transitional standard when the ineligible persons are not included in the assistance unit.

378.15 **EFFECTIVE DATE.** This section is effective August 1, 2021.

378.16 Sec. 28. Minnesota Statutes 2020, section 256J.37, subdivision 1b, is amended to read:

378.17 Subd. 1b. **Deemed income from parents of minor caregivers.** In households where
378.18 minor caregivers live with a parent or parents or a stepparent who do not receive MFIP for
378.19 themselves or their minor children, the income of the parents or a stepparent must be deemed
378.20 after allowing the following disregards:

378.21 (1) income of the parents equal to 200 percent of the federal poverty guideline for a
378.22 family size not including the minor parent and the minor parent's child in the household
378.23 ~~according to section 256J.21, subdivision 2, clause (43)~~; and

378.24 (2) all payments made by parents according to a court order for spousal support or the
378.25 support of children not living in the parent's household.

378.26 **EFFECTIVE DATE.** This section is effective August 1, 2021.

378.27 Sec. 29. Minnesota Statutes 2020, section 256J.37, subdivision 3, is amended to read:

378.28 Subd. 3. **Earned income of wage, salary, and contractual employees.** The agency
378.29 must include gross earned income less any disregards in the initial ~~and monthly~~ income
378.30 test. Gross earned income received by persons employed on a contractual basis must be

379.1 prorated over the period covered by the contract even when payments are received over a
379.2 lesser period of time.

379.3 **EFFECTIVE DATE.** This section is effective March 1, 2023.

379.4 Sec. 30. Minnesota Statutes 2020, section 256J.37, subdivision 3a, is amended to read:

379.5 Subd. 3a. **Rental subsidies; unearned income.** (a) Effective July 1, 2003, the agency
379.6 shall count $50 of the value of public and assisted rental subsidies provided through the
379.7 Department of Housing and Urban Development (HUD) as unearned income to the cash
379.8 portion of the MFIP grant. The full amount of the subsidy must be counted as unearned
379.9 income when the subsidy is less than $50. The income from this subsidy shall be budgeted
379.10 according to section ~~256J.34~~ 256P.09.

379.11 (b) The provisions of this subdivision shall not apply to an MFIP assistance unit which
379.12 includes a participant who is:

379.13 (1) age 60 or older;

379.14 (2) a caregiver who is suffering from an illness, injury, or incapacity that has been
379.15 certified by a qualified professional when the illness, injury, or incapacity is expected to
379.16 continue for more than 30 days and severely limits the person's ability to obtain or maintain
379.17 suitable employment; or

379.18 (3) a caregiver whose presence in the home is required due to the illness or incapacity
379.19 of another member in the assistance unit, a relative in the household, or a foster child in the
379.20 household when the illness or incapacity and the need for the participant's presence in the
379.21 home has been certified by a qualified professional and is expected to continue for more
379.22 than 30 days.

379.23 (c) The provisions of this subdivision shall not apply to an MFIP assistance unit where
379.24 the parental caregiver is an SSI participant.

379.25 **EFFECTIVE DATE.** This section is effective March 1, 2023.

379.26 Sec. 31. Minnesota Statutes 2020, section 256J.626, subdivision 1, is amended to read:

379.27 Subdivision 1. **Consolidated fund.** The consolidated fund is established to support
379.28 counties and tribes in meeting their duties under this chapter. Counties and tribes must use
379.29 funds from the consolidated fund to develop programs and services that are designed to
379.30 improve participant outcomes as measured in section 256J.751, subdivision 2. Counties and
379.31 tribes that administer MFIP eligibility may use the funds for any allowable expenditures

380.1 under subdivision 2, including case management. Tribes that do not administer MFIP
380.2 eligibility may use the funds for any allowable expenditures under subdivision 2, including
380.3 case management, except those in subdivision 2, paragraph (a), clauses (1) and (6). All
380.4 payments made through the MFIP consolidated fund to support a caregiver's pursuit of
380.5 greater economic stability does not count when determining a family's available income.

380.6 Sec. 32. Minnesota Statutes 2020, section 256J.95, subdivision 9, is amended to read:

380.7 Subd. 9. **Property and income limitations.** The asset limits and exclusions in section
380.8 256P.02 apply to applicants and participants of DWP. All payments, ~~unless excluded in~~
380.9 ~~section 256J.21~~ as described in section 256P.06, subdivision 3, must be counted as income
380.10 to determine eligibility for the diversionary work program. The agency shall treat income
380.11 as outlined in section 256J.37, except for subdivision 3a. The initial income test and the
380.12 disregards in section 256J.21, subdivision 3, shall be followed for determining eligibility
380.13 for the diversionary work program.

380.14 **EFFECTIVE DATE.** This section is effective August 1, 2021.

380.15 Sec. 33. Minnesota Statutes 2020, section 256P.01, subdivision 3, is amended to read:

380.16 Subd. 3. **Earned income.** "Earned income" means ~~cash or in-kind~~ income earned through
380.17 the receipt of wages, salary, commissions, bonuses, tips, gratuities, profit from employment
380.18 activities, net profit from self-employment activities, payments made by an employer for
380.19 regularly accrued vacation or sick leave, severance pay based on accrued leave time,
380.20 ~~payments from training programs at a rate at or greater than the state's minimum wage,~~
380.21 royalties, honoraria, or other profit from activity that results from the client's work, ~~service,~~
380.22 effort, or labor for purposes other than student financial assistance, rehabilitation programs,
380.23 student training programs, or service programs such as AmeriCorps. The income must be
380.24 in return for, or as a result of, legal activity.

380.25 **EFFECTIVE DATE.** This section is effective August 1, 2021.

380.26 Sec. 34. Minnesota Statutes 2020, section 256P.01, is amended by adding a subdivision
380.27 to read:

380.28 Subd. 9. **Prospective budgeting.** "Prospective budgeting" means estimating the amount
380.29 of monthly income that an assistance unit will have in the payment month.

380.30 **EFFECTIVE DATE.** This section is effective March 1, 2023.

381.1 Sec. 35. Minnesota Statutes 2020, section 256P.04, subdivision 4, is amended to read:

381.2 Subd. 4. **Factors to be verified.** (a) The agency shall verify the following at application:

381.3 (1) identity of adults;

381.4 (2) age, if necessary to determine eligibility;

381.5 (3) immigration status;

381.6 (4) income;

381.7 (5) spousal support and child support payments made to persons outside the household;

381.8 (6) vehicles;

381.9 (7) checking and savings accounts;

381.10 (8) inconsistent information, if related to eligibility;

381.11 (9) residence; and

381.12 (10) Social Security number; and.

381.13 (11) use of nonrecurring income under section 256P.06, subdivision 3, clause (2), item
381.14 (ix), for the intended purpose for which it was given and received.

381.15 (b) Applicants who are qualified noncitizens and victims of domestic violence as defined
381.16 under section 256J.08, subdivision 73, clause (7) clauses (8) and (9), are not required to
381.17 verify the information in paragraph (a), clause (10). When a Social Security number is not
381.18 provided to the agency for verification, this requirement is satisfied when each member of
381.19 the assistance unit cooperates with the procedures for verification of Social Security numbers,
381.20 issuance of duplicate cards, and issuance of new numbers which have been established
381.21 jointly between the Social Security Administration and the commissioner.

381.22 **EFFECTIVE DATE.** This section is effective March 1, 2023, except for paragraph (b),
381.23 which is effective July 1, 2021.

381.24 Sec. 36. Minnesota Statutes 2020, section 256P.04, subdivision 8, is amended to read:

381.25 Subd. 8. **Recertification.** The agency shall recertify eligibility in an annual interview
381.26 with the participant. The interview may be conducted by telephone, by Internet telepresence,
381.27 or face-to-face in the county office or in another location mutually agreed upon. A participant
381.28 must be given the option of a telephone interview or Internet telepresence to recertify
381.29 eligibility annually. During the interview recertification and reporting under section 256P.10,
381.30 the agency shall verify the following:

382.1 (1) income, unless excluded, including self-employment earnings;

382.2 (2) assets when the value is within $200 of the asset limit; and

382.3 (3) inconsistent information, if related to eligibility.

382.4 **EFFECTIVE DATE.** This section is effective the day following final enactment.

382.5 Sec. 37. Minnesota Statutes 2020, section 256P.06, subdivision 2, is amended to read:

382.6 Subd. 2. ~~**Exempted individuals**~~ **Exemptions.** (a) The following members of an assistance
382.7 unit under chapters 119B and 256J are exempt from having their earned income count
382.8 ~~towards~~ toward the income of an assistance unit:

382.9 (1) children under six years old;

382.10 (2) caregivers under 20 years of age enrolled at least half-time in school; and

382.11 (3) minors enrolled in school full time.

382.12 (b) The following members of an assistance unit are exempt from having their earned
382.13 and unearned income count ~~towards~~ toward the income of an assistance unit for 12
382.14 consecutive calendar months, beginning the month following the marriage date, for benefits
382.15 under chapter 256J if the household income does not exceed 275 percent of the federal
382.16 poverty guideline:

382.17 (1) a new spouse to a caretaker in an existing assistance unit; and

382.18 (2) the spouse designated by a newly married couple, both of whom were already
382.19 members of an assistance unit under chapter 256J.

382.20 (c) If members identified in paragraph (b) also receive assistance under section 119B.05,
382.21 they are exempt from having their earned and unearned income count ~~towards~~ toward the
382.22 income of the assistance unit if the household income prior to the exemption does not exceed
382.23 67 percent of the state median income for recipients for 26 consecutive biweekly periods
382.24 beginning the second biweekly period after the marriage date.

382.25 (d) For individuals who are members of an assistance unit under chapters 256I and 256J,
382.26 the assistance standard effective in January 2020 for a household of one under chapter 256J
382.27 shall be counted as income under chapter 256I, and any subsequent increases to unearned
382.28 income under chapter 256J shall be exempt.

Sec. 38. Minnesota Statutes 2020, section 256P.06, subdivision 3, is amended to read:

Subd. 3. **Income inclusions.** The following must be included in determining the income of an assistance unit:

(1) earned income; and

(2) unearned income, which includes:

(i) interest and dividends from investments and savings;

(ii) capital gains as defined by the Internal Revenue Service from any sale of real property;

(iii) proceeds from rent and contract for deed payments in excess of the principal and interest portion owed on property;

(iv) income from trusts, excluding special needs and supplemental needs trusts;

(v) interest income from loans made by the participant or household;

(vi) cash prizes and winnings <u>according to guidance provided for the Supplemental Nutrition Assistance Program</u>;

(vii) unemployment insurance income <u>that is received by an adult member of the assistance unit unless the individual receiving unemployment insurance income is:</u>

<u>(A) 18 years of age and enrolled in a secondary school; or</u>

<u>(B) 18 or 19 years of age, a caregiver, and is enrolled in school at least half-time</u>;

(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)~~ <u>(ix)</u> retirement benefits;

~~(xi)~~ <u>(x)</u> cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I, and 256J;

~~(xii)~~ <u>(xi)</u> tribal per capita payments unless excluded by federal and state law;

~~(xiii)~~ <u>(xii)</u> income and payments from service and rehabilitation programs that meet or exceed the state's minimum wage rate;

~~(xiv)~~ <u>(xiii)</u> income from members of the United States armed forces unless excluded from income taxes according to federal or state law;

384.1 ~~(xv)~~ (xiv) all child support payments for programs under chapters 119B, 256D, and 256I;

384.2 ~~(xvi)~~ (xv) the amount of child support received that exceeds $100 for assistance units
384.3 with one child and $200 for assistance units with two or more children for programs under
384.4 chapter 256J; ~~and~~

384.5 ~~(xvii)~~ (xvi) spousal support~~.~~; and

384.6 (xvii) workers' compensation.

384.7 **EFFECTIVE DATE.** This section is effective March 1, 2023, except subdivision 3,
384.8 clause (2), item (vii), which is effective the day following final enactment and subdivision
384.9 3, clause (2), item (xvii), which is effective August 1, 2021.

384.10 Sec. 39. Minnesota Statutes 2020, section 256P.07, is amended to read:

384.11 **256P.07 REPORTING OF ~~INCOME AND~~ CHANGES.**

384.12 Subdivision 1. **Exempted programs.** Participants who receive Supplemental Security
384.13 Income and qualify for Minnesota supplemental aid under chapter 256D ~~and~~ or for housing
384.14 support under chapter 256I ~~on the basis of eligibility for Supplemental Security Income~~ are
384.15 exempt from ~~this section~~ reporting income.

384.16 Subd. 1a. **Child care assistance programs.** Participants who qualify for child care
384.17 assistance programs under chapter 119B are exempt from this section except for the reporting
384.18 requirements in subdivision 6.

384.19 Subd. 2. **Reporting requirements.** An applicant or participant must provide information
384.20 on an application and any subsequent reporting forms about the assistance unit's
384.21 circumstances that affect eligibility or benefits. An applicant or assistance unit must report
384.22 changes identified in ~~subdivision~~ subdivisions 3, 4, 5, 7, 8, and 9 during the application
384.23 period or by the tenth of the month following the month that the change occurred. When
384.24 information is not accurately reported, both an overpayment and a referral for a fraud
384.25 investigation may result. When information or documentation is not provided, the receipt
384.26 of any benefit may be delayed or denied, depending on the type of information required
384.27 and its effect on eligibility.

384.28 Subd. 3. **Changes that must be reported.** ~~An assistance unit must report the changes~~
384.29 ~~or anticipated changes specified in clauses (1) to (12) within ten days of the date they occur,~~
384.30 ~~at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or~~
384.31 ~~within eight calendar days of a reporting period, whichever occurs first. An assistance unit~~
384.32 ~~must report other changes at the time of recertification of eligibility under section 256P.04,~~

~~subdivisions 8 and 9, or at the end of a reporting period, as applicable. When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under clauses (1) to (12) had not occurred, the agency must determine whether a timely notice could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under section 119B.11, subdivision 2a, or 256P.08. Changes in circumstances that must be reported within ten days must also be reported for the reporting period in which those changes occurred. Within ten days, an assistance unit must report:~~

~~(1) a change in earned income of $100 per month or greater with the exception of a program under chapter 119B;~~

~~(2) a change in unearned income of $50 per month or greater with the exception of a program under chapter 119B;~~

~~(3) a change in employment status and hours with the exception of a program under chapter 119B;~~

~~(4) a change in address or residence;~~

~~(5) a change in household composition with the exception of programs under chapter 256I;~~

~~(6) a receipt of a lump-sum payment with the exception of a program under chapter 119B;~~

~~(7) an increase in assets if over $9,000 with the exception of programs under chapter 119B;~~

~~(8) a change in citizenship or immigration status;~~

~~(9) a change in family status with the exception of programs under chapter 256I;~~

~~(10) a change in disability status of a unit member, with the exception of programs under chapter 119B;~~

~~(11) a new rent subsidy or a change in rent subsidy with the exception of a program under chapter 119B; and~~

~~(12) a sale, purchase, or transfer of real property with the exception of a program under chapter 119B.~~ An assistance unit must report changes or anticipated changes as described in this section.

(a) An assistance unit must report:

386.1 (1) a change in eligibility for Supplemental Security Income, Retirement Survivors
386.2 Disability Insurance, or another federal income support;

386.3 (2) a change in address or residence;

386.4 (3) a change in household composition with the exception of programs under chapter
386.5 256I;

386.6 (4) cash prizes and winnings according to guidance provided for the Supplemental
386.7 Nutrition Assistance Program;

386.8 (5) a change in citizenship or immigration status;

386.9 (6) a change in family status with the exception of programs under chapter 256I; and

386.10 (7) assets when the value is at or above the asset limit.

386.11 (b) When an agency could have reduced or terminated assistance for one or more payment
386.12 months if a delay in reporting a change specified in clauses (1) to (7) had not occurred, the
386.13 agency must determine whether a timely notice could have been issued on the day that the
386.14 change occurred. When a timely notice could have been issued, each month's overpayment
386.15 subsequent to the notice must be considered a client error overpayment under section
386.16 256P.08.

386.17 Subd. 4. **MFIP-specific reporting.** In addition to subdivision 3, an assistance unit under
386.18 chapter 256J, ~~within ten days of the change,~~ must report:

386.19 (1) a pregnancy not resulting in birth when there are no other minor children; ~~and~~

386.20 (2) a change in school attendance of a parent under 20 years of age ~~or of an employed~~
386.21 ~~child.~~; and

386.22 (3) an individual who is 18 or 19 years of age attending high school who graduates or
386.23 drops out of school.

386.24 Subd. 5. **DWP-specific reporting.** In addition to subdivisions 3 and 4, an assistance
386.25 unit participating in the diversionary work program under section 256J.95 must report on
386.26 an application:

386.27 (1) shelter expenses; and

386.28 (2) utility expenses.

386.29 Subd. 6. **Child care assistance programs-specific reporting.** (a) ~~In addition to~~
386.30 ~~subdivision 3,~~ An assistance unit under chapter 119B, within ten days of the change, must
386.31 report:

387.1 (1) a change in a parentally responsible individual's custody schedule for any child
387.2 receiving child care assistance program benefits;

387.3 (2) a permanent end in a parentally responsible individual's authorized activity; ~~and~~

387.4 (3) if the unit's family's annual included income exceeds 85 percent of the state median
387.5 income, adjusted for family size~~.~~;

387.6 (4) a change in address or residence;

387.7 (5) a change in household composition;

387.8 (6) a change in citizenship or immigration status; and

387.9 (7) a change in family status.

387.10 (b) An assistance unit subject to section 119B.095, subdivision 1, paragraph (b), must
387.11 report a change in the unit's authorized activity status.

387.12 (c) An assistance unit must notify the county when the unit wants to reduce the number
387.13 of authorized hours for children in the unit.

387.14 Subd. 7. **Minnesota supplemental aid-specific reporting.** (a) In addition to subdivision
387.15 3 and notwithstanding the exemption in subdivision 1, an assistance unit participating in
387.16 the Minnesota supplemental aid program under ~~section 256D.44, subdivision 5, paragraph~~
387.17 ~~(g), within ten days of the change,~~ chapter 256D must report ~~shelter expenses.~~:

387.18 (1) a change in unearned income of $50 per month or greater; and

387.19 (2) a change in earned income of $100 per month or greater.

387.20 (b) An assistance unit receiving housing assistance under section 256D.44, subdivision
387.21 5, paragraph (g), including assistance units who also receive Supplemental Security Income,
387.22 must report:

387.23 (1) a change in shelter expenses; and

387.24 (2) a new rent subsidy or a change in a rent subsidy.

387.25 Subd. 8. **Housing support-specific reporting.** (a) In addition to subdivision 3, an
387.26 assistance unit participating in the housing support program under chapter 256I must report:

387.27 (1) a change in unearned income of $50 per month or greater; and

387.28 (2) a change in earned income of $100 per month or greater, with the exception of
387.29 participants already subject to six-month reporting requirements in section 256P.10.

388.1 (b) Notwithstanding the exemptions in subdivisions 1 and 3, an assistance unit receiving
388.2 housing support under chapter 256I, including an assistance unit that receives Supplemental
388.3 Security Income, must report:

388.4 (1) a new rent subsidy or a change in a rent subsidy;

388.5 (2) a change in the disability status of a unit member; and

388.6 (3) a change in household composition if the assistance unit is a participant in housing
388.7 support under section 256I.04, subdivision 3, paragraph (a), clause (3).

388.8 Subd. 9. **General assistance-specific reporting.** In addition to subdivision 3, an
388.9 assistance unit participating in the general assistance program under chapter 256D must
388.10 report:

388.11 (1) a change in unearned income of $50 per month or greater;

388.12 (2) a change in earned income of $100 per month or greater, with the exception of
388.13 participants who are already subject to six-month reporting requirements in section 256P.10;
388.14 and

388.15 (3) changes in any condition that would result in the loss of a basis for eligibility in
388.16 section 256D.05, subdivision 1, paragraph (a).

388.17 **EFFECTIVE DATE.** This section is effective March 1, 2023.

388.18 Sec. 40. **[256P.09] PROSPECTIVE BUDGETING OF BENEFITS.**

388.19 Subdivision 1. **Exempted programs.** Assistance units who qualify for child care
388.20 assistance programs under chapter 119B; housing support assistance units under chapter
388.21 256I who are not subject to reporting under section 256P.10; and assistance units who
388.22 qualify for Minnesota Supplemental Aid under chapter 256D are exempt from this section.

388.23 Subd. 2. **Prospective budgeting of benefits.** An agency must use prospective budgeting
388.24 to calculate an assistance payment amount.

388.25 Subd. 3. **Income changes.** Prospective budgeting must be used to determine the amount
388.26 of the assistance unit's benefit for the following six-month period. An increase in income
388.27 shall not affect an assistance unit's eligibility or benefit amount until the next case review
388.28 unless otherwise required by section 256P.07. A decrease in income shall be effective on
388.29 the date that the change occurs if the change is reported by the tenth of the month following
388.30 the month when the change occurred. If the decrease in income is not reported by the tenth
388.31 of the month following the month when the change occurred, the change in income shall
388.32 be effective the month following the month when the change is reported.

389.1 **EFFECTIVE DATE.** This section is effective March 1, 2023.

389.2 Sec. 41. **[256P.10] SIX-MONTH REPORTING.**

389.3 Subdivision 1. **Exempted programs.** Assistance units who qualify for child care
389.4 assistance programs under chapter 119B; assistance units who qualify for Minnesota
389.5 Supplemental Aid under chapter 256D; and assistance units who qualify for housing support
389.6 under chapter 256I and also receive Supplemental Security Income are exempt from this
389.7 section.

389.8 Subd. 2. **Reporting.** (a) Every six months, an assistance unit that qualifies for the
389.9 Minnesota family investment program under chapter 256J; an assistance unit that qualifies
389.10 for general assistance under chapter 256D with earned income of $100 per month or greater;
389.11 or an assistance unit that qualifies for housing support under chapter 256I with earned
389.12 income of $100 per month or greater is subject to six month case reviews. The initial
389.13 reporting period may be shorter than six months in order to align with other program reporting
389.14 periods.

389.15 (b) An assistance unit that qualifies for the Minnesota family investment program and
389.16 an assistance unit that qualifies for general assistance as described in paragraph (a) must
389.17 complete household report forms as prescribed by the commissioner for redetermination of
389.18 benefits.

389.19 (c) An assistance unit that qualifies for housing support as described in paragraph (a)
389.20 must complete household report forms as prescribed by the commissioner to provide
389.21 information about earned income.

389.22 (d) An assistance unit that qualifies for housing support and also receives assistance
389.23 through the Minnesota family investment program shall be subject to the requirements of
389.24 this section for purposes of the Minnesota family investment program but not for housing
389.25 support.

389.26 (e) An assistance unit must submit a household report form in compliance with the
389.27 provisions in section 256P.04, subdivision 11.

389.28 (f) An assistance unit may choose to report changes under this section at any time.

389.29 Subd. 3. **When to terminate assistance.** (a) An agency must terminate benefits when
389.30 the participant fails to submit the household report form before the end of the six month
389.31 review period. If the participant submits the household report form within 30 days of the
389.32 termination of benefits, benefits must be reinstated and made available retroactively for the
389.33 full benefit month.

390.1 (b) When an assistance unit is determined to be ineligible for assistance according to
390.2 this section and chapter 256D, 256I, or 256J, the agency must terminate assistance.

390.3 **EFFECTIVE DATE.** This section is effective March 1, 2023.

390.4 Sec. 42. Laws 2020, First Special Session chapter 7, section 1, as amended by Laws 2020,
390.5 Third Special Session chapter 1, section 3, is amended by adding a subdivision to read:

390.6 Subd. 5. **Waivers and modifications.** When the peacetime emergency declared by the
390.7 governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by
390.8 the proper authority, the following waivers and modifications to human services programs
390.9 issued by the commissioner of human services pursuant to Executive Orders 20-12 and
390.10 20-42, including any amendments to the waivers or modifications issued before the peacetime
390.11 emergency expires, shall remain in effect until December 31, 2021, unless necessary federal
390.12 approval is not received at any time for a waiver or modification:

390.13 (1) Executive Order 21-15: when determining eligibility for cash assistance programs,
390.14 not counting as income any emergency economic relief provided through the American
390.15 Rescue Plan Act of 2021; and

390.16 (2) CV.04.A4: waiving interviews for annual eligibility recertifications of households
390.17 receiving cash assistance in which all necessary information has been submitted and verified.

390.18 Sec. 43. **DIRECTION TO COMMISSIONER; LONG-TERM HOMELESS**
390.19 **SUPPORTIVE SERVICES REPORT.**

390.20 (a) No later than January 15, 2023, the commissioner of human services shall produce
390.21 a report which shows the projects funded under Minnesota Statutes, section 256K.26, and
390.22 provide a copy of the report to the chairs and ranking minority members of the legislative
390.23 committees with jurisdiction over services for persons experiencing homelessness.

390.24 (b) This report must be updated annually for two additional years and the commissioner
390.25 must provide copies of the updated reports to the chairs and ranking minority members of
390.26 the legislative committees with jurisdiction over services for persons experiencing
390.27 homelessness by January 15, 2024, and January 15, 2025.

390.28 Sec. 44. **2022 REPORT TO LEGISLATURE ON RUNAWAY AND HOMELESS**
390.29 **YOUTH.**

390.30 Subdivision 1. **Report development.** The commissioner of human services is exempt
390.31 from preparing the report required under Minnesota Statutes, section 256K.45, subdivision

391.1 2, in 2023 and shall instead update the information in the 2007 legislative report on runaway
391.2 and homeless youth. In developing the updated report, the commissioner must use existing
391.3 data, studies, and analysis provided by state, county, and other entities including:

391.4 (1) Minnesota Housing Finance Agency analysis on housing availability;

391.5 (2) the Minnesota state plan to end homelessness;

391.6 (3) the continuum of care counts of youth experiencing homelessness and assessments
391.7 as provided by Department of Housing and Urban Development (HUD) required coordinated
391.8 entry systems;

391.9 (4) the biannual Department of Human Services report on the Homeless Youth Act;

391.10 (5) the Wilder Research homeless study;

391.11 (6) the Voices of Youth Count sponsored by Hennepin County; and

391.12 (7) privately funded analysis, including:

391.13 (i) nine evidence-based principles to support youth in overcoming homelessness;

391.14 (ii) the return on investment analysis conducted for YouthLink by Foldes Consulting;
391.15 and

391.16 (iii) the evaluation of Homeless Youth Act resources conducted by Rainbow Research.

391.17 Subd. 2. **Key elements; due date.** (a) The report must include three key elements where
391.18 significant learning has occurred in the state since the 2007 report, including:

391.19 (1) the unique causes of youth homelessness;

391.20 (2) targeted responses to youth homelessness, including the significance of positive
391.21 youth development as fundamental to each targeted response; and

391.22 (3) recommendations based on existing reports and analysis on how to end youth
391.23 homelessness.

391.24 (b) To the extent that data is available, the report must include:

391.25 (1) a general accounting of the federal and philanthropic funds leveraged to support
391.26 homeless youth activities;

391.27 (2) a general accounting of the increase in volunteer responses to support youth
391.28 experiencing homelessness; and

391.29 (3) a data-driven accounting of geographic areas or distinct populations that have gaps
391.30 in service or are not yet served by homeless youth responses.

392.1 (c) The commissioner of human services shall consult with and incorporate the expertise
392.2 of community-based providers of homeless youth services and other expert stakeholders to
392.3 complete the report. The commissioner shall submit the report to the chairs and ranking
392.4 minority members of the legislative committees with jurisdiction over youth homelessness
392.5 by December 15, 2022.

392.6 Sec. 45. **REPEALER.**

392.7 (a) Minnesota Statutes 2020, sections 256D.051, subdivisions 1, 1a, 2, 2a, 3, 3a, 3b, 6b,
392.8 6c, 7, 8, 9, and 18; 256D.052, subdivision 3; and 256J.21, subdivisions 1 and 2, are repealed.

392.9 (b) Minnesota Statutes 2020, sections 256J.08, subdivisions 10, 53, 61, 62, 81, and 83;
392.10 256J.30, subdivisions 5, 7, and 8; 256J.33, subdivisions 3, 4, and 5; 256J.34, subdivisions
392.11 1, 2, 3, and 4; and 256J.37, subdivision 10, are repealed.

392.12 **EFFECTIVE DATE.** Paragraph (a) is effective August 1, 2021. Paragraph (b) is effective
392.13 March 1, 2023.

392.14 **ARTICLE 9**

392.15 **CHILD CARE ASSISTANCE**

392.16 Section 1. Minnesota Statutes 2020, section 119B.03, subdivision 4, is amended to read:

392.17 Subd. 4. **Funding priority.** (a) First priority for child care assistance under the basic
392.18 sliding fee program must be given to eligible non-MFIP families who do not have a high
392.19 school diploma or commissioner of education-selected high school equivalency certification
392.20 or who need remedial and basic skill courses in order to pursue employment or to pursue
392.21 education leading to employment and who need child care assistance to participate in the
392.22 education program. This includes student parents as defined under section 119B.011,
392.23 subdivision 19b. Within this priority, the following subpriorities must be used:

392.24 (1) child care needs of minor parents;

392.25 (2) child care needs of parents under 21 years of age; and

392.26 (3) child care needs of other parents within the priority group described in this paragraph.

392.27 (b) Second priority must be given to ~~parents who have completed their MFIP or DWP~~
392.28 ~~transition year, or parents who are no longer receiving or eligible for diversionary work~~
392.29 ~~program supports~~ families in which at least one parent is a veteran, as defined under section
392.30 197.447.

393.1 (c) Third priority must be given to eligible families who are eligible for portable basic
393.2 sliding fee assistance through the portability pool under subdivision 9 do not meet the
393.3 specifications of paragraph (a), (b), (d), or (e).

393.4 (d) Fourth priority must be given to families in which at least one parent is a veteran as
393.5 defined under section 197.447 who are eligible for portable basic sliding fee assistance
393.6 through the portability pool under subdivision 9.

393.7 (e) Fifth priority must be given to eligible families receiving services under section
393.8 119B.011, subdivision 20a, if the parents have completed their MFIP or DWP transition
393.9 year, or if the parents are no longer receiving or eligible for DWP supports.

393.10 (e) (f) Families under paragraph (b) (e) must be added to the basic sliding fee waiting
393.11 list on the date they begin the complete their transition year under section 119B.011,
393.12 subdivision 20, and must be moved into the basic sliding fee program as soon as possible
393.13 after they complete their transition year.

393.14 **EFFECTIVE DATE.** This section is effective July 1, 2021.

393.15 Sec. 2. Minnesota Statutes 2020, section 119B.03, subdivision 6, is amended to read:

393.16 Subd. 6. **Allocation formula.** The allocation component of basic sliding fee state and
393.17 federal funds shall be allocated on a calendar year basis. Funds shall be allocated first in
393.18 amounts equal to each county's guaranteed floor according to subdivision 8, with any
393.19 remaining available funds allocated according to the following formula:

393.20 (a) One-fourth of the funds shall be allocated in proportion to each county's total
393.21 expenditures for the basic sliding fee child care program reported during the most recent
393.22 fiscal year completed at the time of the notice of allocation.

393.23 (b) Up to one-fourth of the funds shall be allocated in proportion to the number of families
393.24 participating in the transition year child care program as reported during and averaged over
393.25 the most recent six months completed at the time of the notice of allocation. Funds in excess
393.26 of the amount necessary to serve all families in this category shall be allocated according
393.27 to paragraph (f) (e).

393.28 (c) Up to one-fourth of the funds shall be allocated in proportion to the average of each
393.29 county's most recent six months of reported first, second, and third priority waiting list as
393.30 defined in subdivision 2 and the reinstatement list of those families whose assistance was
393.31 terminated with the approval of the commissioner under Minnesota Rules, part 3400.0183,
393.32 subpart 1. Funds in excess of the amount necessary to serve all families in this category
393.33 shall be allocated according to paragraph (f).

394.1 ~~(d)~~ (c) Up to ~~one-fourth~~ one-half of the funds shall be allocated in proportion to the
394.2 average of each county's most recent ~~six~~ 12 months of reported waiting list as defined in
394.3 subdivision 2 and the reinstatement list of those families whose assistance was terminated
394.4 with the approval of the commissioner under Minnesota Rules, part 3400.0183, subpart 1.
394.5 Funds in excess of the amount necessary to serve all families in this category shall be
394.6 allocated according to paragraph ~~(f)~~ (e).

394.7 ~~(e)~~ (d) The amount necessary to serve all families in paragraphs (b)~~, (c),~~ and ~~(d)~~ (c) shall
394.8 be calculated based on the basic sliding fee average cost of care per family in the county
394.9 with the highest cost in the most recently completed calendar year.

394.10 ~~(f)~~ (e) Funds in excess of the amount necessary to serve all families in paragraphs (b)~~,~~
394.11 ~~(c),~~ and ~~(d)~~ (c) shall be allocated in proportion to each county's total expenditures for the
394.12 basic sliding fee child care program reported during the most recent fiscal year completed
394.13 at the time of the notice of allocation.

394.14 **EFFECTIVE DATE.** This section is effective January 1, 2022. The 2022 calendar year
394.15 shall be a phase-in year for the allocation formula in this section using phase-in provisions
394.16 determined by the commissioner of human services.

394.17 Sec. 3. Minnesota Statutes 2020, section 119B.09, subdivision 4, is amended to read:

394.18 Subd. 4. **Eligibility; annual income; calculation.** (a) Annual income of the applicant
394.19 family is the current monthly income of the family multiplied by 12 or the income for the
394.20 12-month period immediately preceding the date of application, or income calculated by
394.21 the method which provides the most accurate assessment of income available to the family.

394.22 (b) Self-employment income must be calculated based on gross receipts less operating
394.23 expenses.

394.24 (c) Income changes are processed under section 119B.025, subdivision 4. Included lump
394.25 sums counted as income under section ~~256P.06, subdivision 3~~ 119B.011, subdivision 15,
394.26 must be annualized over 12 months. Income must be verified with documentary evidence.
394.27 If the applicant does not have sufficient evidence of income, verification must be obtained
394.28 from the source of the income.

394.29 **EFFECTIVE DATE.** This section is effective March 1, 2023.

394.30 Sec. 4. Minnesota Statutes 2020, section 119B.11, subdivision 2a, is amended to read:

394.31 Subd. 2a. **Recovery of overpayments.** (a) An amount of child care assistance paid to a
394.32 recipient or provider in excess of the payment due is recoverable by the county agency or

395.1 commissioner under paragraphs (b) and (c), even when the overpayment was caused by
395.2 agency error or circumstances outside the responsibility and control of the family or provider.

395.3 (b) An overpayment must be recouped or recovered from the family if the overpayment
395.4 benefited the family by causing the family to pay less for child care expenses than the family
395.5 otherwise would have been required to pay under child care assistance program requirements.
395.6 If the family remains eligible for child care assistance, the overpayment must be recovered
395.7 through recoupment as identified in Minnesota Rules, part 3400.0187, except that the
395.8 overpayments must be calculated and collected on a service period basis. If the family no
395.9 longer remains eligible for child care assistance, the county or commissioner may choose
395.10 to initiate efforts to recover overpayments from the family for overpayment less than $50.
395.11 If the overpayment is greater than or equal to $50, the county or commissioner shall seek
395.12 voluntary repayment of the overpayment from the family. If the county or commissioner is
395.13 unable to recoup the overpayment through voluntary repayment, the county or commissioner
395.14 shall initiate civil court proceedings to recover the overpayment unless the county's or
395.15 commissioner's costs to recover the overpayment will exceed the amount of the overpayment.
395.16 A family with an outstanding debt under this subdivision is not eligible for child care
395.17 assistance until: (1) the debt is paid in full; ~~or~~ (2) satisfactory arrangements are made with
395.18 the county or commissioner to retire the debt consistent with the requirements of this chapter
395.19 and Minnesota Rules, chapter 3400, and the family is in compliance with the arrangements;
395.20 or (3) the commissioner determines that it is in the best interests of the state to compromise
395.21 debts owed to the state pursuant to section 16D.15. The commissioner's authority to recoup
395.22 and recover overpayments from families in this paragraph is limited to investigations
395.23 conducted under chapter 245E.

395.24 (c) The county or commissioner must recover an overpayment from a provider if the
395.25 overpayment did not benefit the family by causing it to receive more child care assistance
395.26 or to pay less for child care expenses than the family otherwise would have been eligible
395.27 to receive or required to pay under child care assistance program requirements, and benefited
395.28 the provider by causing the provider to receive more child care assistance than otherwise
395.29 would have been paid on the family's behalf under child care assistance program
395.30 requirements. If the provider continues to care for children receiving child care assistance,
395.31 the overpayment must be recovered through ~~reductions in child care assistance payments~~
395.32 ~~for services as described in an agreement with the county~~ recoupment as identified in
395.33 Minnesota Rules, part 3400.0187. The provider may not charge families using that provider
395.34 more to cover the cost of recouping the overpayment. If the provider no longer cares for
395.35 children receiving child care assistance, the county or commissioner may choose to initiate

396.1 efforts to recover overpayments of less than $50 from the provider. If the overpayment is
396.2 greater than or equal to $50, the county or commissioner shall seek voluntary repayment
396.3 of the overpayment from the provider. If the county or commissioner is unable to recoup
396.4 the overpayment through voluntary repayment, the county or commissioner shall initiate
396.5 civil court proceedings to recover the overpayment unless the county's or commissioner's
396.6 costs to recover the overpayment will exceed the amount of the overpayment. A provider
396.7 with an outstanding debt under this subdivision is not eligible to care for children receiving
396.8 child care assistance until:

396.9 (1) the debt is paid in full; ~~or~~

396.10 (2) satisfactory arrangements are made with the county or commissioner to retire the
396.11 debt consistent with the requirements of this chapter and Minnesota Rules, chapter 3400,
396.12 and the provider is in compliance with the arrangements~~.~~; or

396.13 (3) the commissioner determines that it is in the best interests of the state to compromise
396.14 debts owed to the state pursuant to section 16D.15.

396.15 (d) When both the family and the provider acted together to intentionally cause the
396.16 overpayment, both the family and the provider are jointly liable for the overpayment
396.17 regardless of who benefited from the overpayment. The county or commissioner must
396.18 recover the overpayment as provided in paragraphs (b) and (c). When the family or the
396.19 provider is in compliance with a repayment agreement, the party in compliance is eligible
396.20 to receive child care assistance or to care for children receiving child care assistance despite
396.21 the other party's noncompliance with repayment arrangements.

396.22 **EFFECTIVE DATE.** This section is effective August 1, 2021.

396.23 Sec. 5. Minnesota Statutes 2020, section 119B.125, subdivision 1, is amended to read:

396.24 Subdivision 1. **Authorization.** ~~Except as provided in subdivision 5,~~ A county or the
396.25 commissioner must authorize the provider chosen by an applicant or a participant before
396.26 the county can authorize payment for care provided by that provider. The commissioner
396.27 must establish the requirements necessary for authorization of providers. A provider must
396.28 be reauthorized every two years. A legal, nonlicensed family child care provider also must
396.29 be reauthorized when another person over the age of 13 joins the household, a current
396.30 household member turns 13, or there is reason to believe that a household member has a
396.31 factor that prevents authorization. The provider is required to report all family changes that
396.32 would require reauthorization. When a provider has been authorized for payment for
396.33 providing care for families in more than one county, the county responsible for

reauthorization of that provider is the county of the family with a current authorization for that provider and who has used the provider for the longest length of time.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 6. Minnesota Statutes 2020, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) The maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be ~~the greater of the 25th percentile of the 2018 child care provider rate survey or the rates in effect at the time of the update.~~ set in accordance with rates and policies established by the commissioner, dependent on federal funds, and consistent with federal law, up to a maximum of the 75th percentile of the most recent child care provider rate survey, but in no event shall the maximum rate be less than the greater of the 50th percentile of the most recent child care provider rate survey or the rates in effect at the time of the update. The rate increase is effective no later than the first full service period on or after January 1 of the year following the provider rate survey. For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid for child care assistance shall be equal to the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

(b) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(c) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

(d) If a child uses one provider, the maximum payment for one day of care must not exceed the daily rate. The maximum payment for one week of care must not exceed the weekly rate.

(e) If a child uses two providers under section 119B.097, the maximum payment must not exceed:

(1) the daily rate for one day of care;

(2) the weekly rate for one week of care by the child's primary provider; and

398.1 (3) two daily rates during two weeks of care by a child's secondary provider.

398.2 (f) Child care providers receiving reimbursement under this chapter must not be paid
398.3 activity fees or an additional amount above the maximum rates for care provided during
398.4 nonstandard hours for families receiving assistance.

398.5 (g) If the provider charge is greater than the maximum provider rate allowed, the parent
398.6 is responsible for payment of the difference in the rates in addition to any family co-payment
398.7 fee.

398.8 ~~(h) All maximum provider rates changes shall be implemented on the Monday following~~
398.9 ~~the effective date of the maximum provider rate.~~

398.10 ~~(i) Beginning September 21, 2020,~~ (h) The maximum registration fee paid for child care
398.11 assistance in any county or county price cluster under the child care fund shall be ~~the greater~~
398.12 ~~of the 25th percentile of the 2018 child care provider rate survey or the registration fee in~~
398.13 ~~effect at the time of the update.~~ set in accordance with rates and policies established by the
398.14 commissioner, dependent on federal funds, and consistent with federal law, up to a maximum
398.15 of the 75th percentile of the most recent child care provider rate survey, but in no event
398.16 shall the maximum registration fee be less than the greater of the 50th percentile of the most
398.17 recent child care provider rate survey or the registration fee in effect at the time of the update.
398.18 Each maximum registration fee update must be implemented on the same schedule as
398.19 maximum child care assistance rate increases under paragraph (a). Maximum registration
398.20 fees must be set for licensed family child care and for child care centers. For a child care
398.21 provider located in the boundaries of a city located in two or more of the counties of Benton,
398.22 Sherburne, and Stearns, the maximum registration fee paid for child care assistance shall
398.23 be equal to the maximum registration fee paid in the county with the highest maximum
398.24 registration fee or the provider's charge, whichever is less.

398.25 **EFFECTIVE DATE.** This section is effective the day following final enactment.

398.26 Sec. 7. Minnesota Statutes 2020, section 119B.13, subdivision 1a, is amended to read:

398.27 Subd. 1a. **Legal nonlicensed family child care provider rates.** (a) Legal nonlicensed
398.28 family child care providers receiving reimbursement under this chapter must be paid on an
398.29 hourly basis for care provided to families receiving assistance.

398.30 (b) The maximum rate paid to legal nonlicensed family child care providers must be ~~68~~
398.31 90 percent of the county maximum hourly rate for licensed family child care providers. The
398.32 rate increase is effective the first full service period on or after January 1 of the year following
398.33 the provider rate survey. In counties or county price clusters where the maximum hourly

rate for licensed family child care providers is higher than the maximum weekly rate for those providers divided by 50, the maximum hourly rate that may be paid to legal nonlicensed family child care providers is the rate equal to the maximum weekly rate for licensed family child care providers divided by 50 and then multiplied by ~~0.68~~ 0.90. The maximum payment to a provider for one day of care must not exceed the maximum hourly rate times ten. The maximum payment to a provider for one week of care must not exceed the maximum hourly rate times 50.

(c) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(d) Legal nonlicensed family child care providers receiving reimbursement under this chapter may not be paid registration fees for families receiving assistance.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 8. Minnesota Statutes 2020, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **Provider payments.** (a) A provider shall bill only for services documented according to section 119B.125, subdivision 6. The provider shall bill for services provided within ten days of the end of the service period. Payments under the child care fund shall be made within 21 days of receiving a complete bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(b) If a provider has received an authorization of care and been issued a billing form for an eligible family, the bill must be submitted within 60 days of the last date of service on the bill. A bill submitted more than 60 days after the last date of service must be paid if the county determines that the provider has shown good cause why the bill was not submitted within 60 days. Good cause must be defined in the county's child care fund plan under section 119B.08, subdivision 3, and the definition of good cause must include county error. Any bill submitted more than a year after the last date of service on the bill must not be paid.

(c) If a provider provided care for a time period without receiving an authorization of care and a billing form for an eligible family, payment of child care assistance may only be made retroactively for a maximum of ~~six~~ three months from the date the provider is issued an authorization of care and billing form. For a family at application, if a provider provided child care during a time period without receiving an authorization of care and a billing form, a county may only make child care assistance payments to the provider retroactively from the date that child care began, or from the date that the family's eligibility began under

400.1 section 119B.09, subdivision 7, or from the date that the family meets authorization
400.2 requirements, not to exceed six months from the date the provider is issued an authorization
400.3 of care and billing form, whichever is later.

400.4 (d) A county or the commissioner may refuse to issue a child care authorization to a
400.5 certified, licensed, or legal nonlicensed provider, revoke an existing child care authorization
400.6 to a certified, licensed, or legal nonlicensed provider, stop payment issued to a certified,
400.7 licensed, or legal nonlicensed provider, or refuse to pay a bill submitted by a certified,
400.8 licensed, or legal nonlicensed provider if:

400.9 (1) the provider admits to intentionally giving the county materially false information
400.10 on the provider's billing forms;

400.11 (2) a county or the commissioner finds by a preponderance of the evidence that the
400.12 provider intentionally gave the county materially false information on the provider's billing
400.13 forms, or provided false attendance records to a county or the commissioner;

400.14 (3) the provider is in violation of child care assistance program rules, until the agency
400.15 determines those violations have been corrected;

400.16 (4) the provider is operating after:

400.17 (i) an order of suspension of the provider's license issued by the commissioner;

400.18 (ii) an order of revocation of the provider's license issued by the commissioner; or

400.19 (iii) ~~a final order of conditional license issued by the commissioner for as long as the~~
400.20 ~~conditional license is in effect~~ an order of decertification issued to the provider;

400.21 (5) the provider submits false attendance reports or refuses to provide documentation
400.22 of the child's attendance upon request;

400.23 (6) the provider gives false child care price information; or

400.24 (7) the provider fails to report decreases in a child's attendance as required under section
400.25 119B.125, subdivision 9.

400.26 (e) For purposes of paragraph (d), clauses (3), (5), (6), and (7), the county or the
400.27 commissioner may withhold the provider's authorization or payment for a period of time
400.28 not to exceed three months beyond the time the condition has been corrected.

400.29 (f) A county's payment policies must be included in the county's child care plan under
400.30 section 119B.08, subdivision 3. If payments are made by the state, in addition to being in
400.31 compliance with this subdivision, the payments must be made in compliance with section
400.32 16A.124.

401.1 (g) If the commissioner or responsible county agency suspends or refuses payment to a
401.2 provider under paragraph (d), clause (1) or (2), or chapter 245E and the provider has:

401.3 (1) a disqualification for wrongfully obtaining assistance under section 256.98,
401.4 subdivision 8, paragraph (c);

401.5 (2) an administrative disqualification under section 256.046, subdivision 3; or

401.6 (3) a termination under section 245E.02, subdivision 4, paragraph (c), clause (4), or
401.7 245E.06;

401.8 then the provider forfeits the payment to the commissioner or the responsible county agency,
401.9 regardless of the amount assessed in an overpayment, charged in a criminal complaint, or
401.10 ordered as criminal restitution.

401.11 **EFFECTIVE DATE.** This section is effective August 1, 2021.

401.12 Sec. 9. Minnesota Statutes 2020, section 119B.13, subdivision 7, is amended to read:

401.13 Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers
401.14 must not be reimbursed for more than 25 full-day absent days per child, excluding holidays,
401.15 in a calendar year, or for more than ten consecutive full-day absent days. "Absent day"
401.16 means any day that the child is authorized and scheduled to be in care with a licensed
401.17 provider or license-exempt center, and the child is absent from the care for the entire day.
401.18 Legal nonlicensed family child care providers must not be reimbursed for absent days. If a
401.19 child attends for part of the time authorized to be in care in a day, but is absent for part of
401.20 the time authorized to be in care in that same day, the absent time must be reimbursed but
401.21 the time must not count toward the absent days limit. Child care providers must only be
401.22 reimbursed for absent days if the provider has a written policy for child absences and charges
401.23 all other families in care for similar absences.

401.24 (b) Notwithstanding paragraph (a), children with documented medical conditions that
401.25 cause more frequent absences may exceed the 25 absent days limit, or ten consecutive
401.26 full-day absent days limit. Absences due to a documented medical condition of a parent or
401.27 sibling who lives in the same residence as the child receiving child care assistance do not
401.28 count against the absent days limit in a calendar year. Documentation of medical conditions
401.29 must be on the forms and submitted according to the timelines established by the
401.30 commissioner. A public health nurse or school nurse may verify the illness in lieu of a
401.31 medical practitioner. If a provider sends a child home early due to a medical reason,
401.32 including, but not limited to, fever or contagious illness, the child care center director or
401.33 lead teacher may verify the illness in lieu of a medical practitioner.

402.1 (c) Notwithstanding paragraph (a), children in families may exceed the absent days limit
402.2 if at least one parent: (1) is under the age of 21; (2) does not have a high school diploma or
402.3 commissioner of education-selected high school equivalency certification; and (3) is a
402.4 student in a school district or another similar program that provides or arranges for child
402.5 care, parenting support, social services, career and employment supports, and academic
402.6 support to achieve high school graduation, upon request of the program and approval of the
402.7 county. If a child attends part of an authorized day, payment to the provider must be for the
402.8 full amount of care authorized for that day.

402.9 (d) Child care providers must be reimbursed for up to ten federal or state holidays or
402.10 designated holidays per year when the provider charges all families for these days and the
402.11 holiday or designated holiday falls on a day when the child is authorized to be in attendance.
402.12 Parents may substitute other cultural or religious holidays for the ten recognized state and
402.13 federal holidays. Holidays do not count toward the absent days limit.

402.14 (e) A family ~~or child care provider~~ must not be assessed an overpayment for an absent
402.15 day payment unless (1) there was an error in the amount of care authorized for the family,
402.16 or (2) all of the allowed full-day absent payments for the child have been paid~~, or (3) the~~
402.17 ~~family or provider did not timely report a change as required under law~~.

402.18 (f) The provider and family shall receive notification of the number of absent days used
402.19 upon initial provider authorization for a family and ongoing notification of the number of
402.20 absent days used as of the date of the notification.

402.21 (g) For purposes of this subdivision, "absent days limit" means 25 full-day absent days
402.22 per child, excluding holidays, in a calendar year; and ten consecutive full-day absent days.

402.23 (h) For purposes of this subdivision, "holidays limit" means ten full-day holidays per
402.24 child, excluding absent days, in a calendar year.

402.25 (i) If a day meets the criteria of an absent day or a holiday under this subdivision, the
402.26 provider must bill that day as an absent day or holiday. A provider's failure to properly bill
402.27 an absent day or a holiday results in an overpayment, regardless of whether the child reached,
402.28 or is exempt from, the absent days limit or holidays limit for the calendar year.

402.29 **EFFECTIVE DATE.** This section is effective August 1, 2021.

402.30 Sec. 10. Minnesota Statutes 2020, section 119B.25, subdivision 3, is amended to read:

402.31 Subd. 3. **Financing program.** A nonprofit corporation that receives a grant under this
402.32 section shall use the money to:

403.1 (1) establish a revolving loan fund to make loans to existing, expanding, and new licensed
403.2 and legal unlicensed child care and early childhood education sites;

403.3 (2) establish a fund to guarantee private loans to improve or construct a child care or
403.4 early childhood education site;

403.5 (3) establish a fund to provide forgivable loans or grants to match all or part of a loan
403.6 made under this section;

403.7 (4) establish a fund as a reserve against bad debt; ~~and~~

403.8 (5) establish a fund to provide business planning assistance for child care providers~~.~~;
403.9 and

403.10 (6) provide training and consultation for child care providers to build and strengthen
403.11 their businesses and acquire key business skills.

403.12 The nonprofit corporation shall establish the terms and conditions for loans and loan
403.13 guarantees including, but not limited to, interest rates, repayment agreements, private match
403.14 requirements, and conditions for loan forgiveness. The nonprofit corporation shall establish
403.15 a minimum interest rate for loans to ensure that necessary loan administration costs are
403.16 covered. The nonprofit corporation may use interest earnings for administrative expenses.

403.17 Sec. 11. **REPEALER.**

403.18 Minnesota Statutes 2020, section 119B.125, subdivision 5, is repealed.

403.19 **EFFECTIVE DATE.** This section is effective August 1, 2021.

403.20 **ARTICLE 10**
403.21 **CHILD PROTECTION**

403.22 Section 1. Minnesota Statutes 2020, section 256N.25, subdivision 2, is amended to read:

403.23 Subd. 2. **Negotiation of agreement.** (a) When a child is determined to be eligible for
403.24 Northstar kinship assistance or adoption assistance, the financially responsible agency, or,
403.25 if there is no financially responsible agency, the agency designated by the commissioner,
403.26 must negotiate with the caregiver to develop an agreement under subdivision 1. If and when
403.27 the caregiver and agency reach concurrence as to the terms of the agreement, both parties
403.28 shall sign the agreement. The agency must submit the agreement, along with the eligibility
403.29 determination outlined in sections 256N.22, subdivision 7, and 256N.23, subdivision 7, to
403.30 the commissioner for final review, approval, and signature according to subdivision 1.

404.1 (b) A monthly payment is provided as part of the adoption assistance or Northstar kinship
404.2 assistance agreement to support the care of children unless the child is eligible for adoption
404.3 assistance and determined to be an at-risk child, in which case no payment will be made
404.4 unless and until the caregiver obtains written documentation from a qualified expert that
404.5 the potential disability upon which eligibility for the agreement was based has manifested
404.6 itself.

404.7 (1) The amount of the payment made on behalf of a child eligible for Northstar kinship
404.8 assistance or adoption assistance is determined through agreement between the prospective
404.9 relative custodian or the adoptive parent and the financially responsible agency, or, if there
404.10 is no financially responsible agency, the agency designated by the commissioner, using the
404.11 assessment tool established by the commissioner in section 256N.24, subdivision 2, and the
404.12 associated benefit and payments outlined in section 256N.26. Except as provided under
404.13 section 256N.24, subdivision 1, paragraph (c), the assessment tool establishes the monthly
404.14 benefit level for a child under foster care. The monthly payment under a Northstar kinship
404.15 assistance agreement or adoption assistance agreement may be negotiated up to the monthly
404.16 benefit level under foster care. In no case may the amount of the payment under a Northstar
404.17 kinship assistance agreement or adoption assistance agreement exceed the foster care
404.18 maintenance payment which would have been paid during the month if the child with respect
404.19 to whom the Northstar kinship assistance or adoption assistance payment is made had been
404.20 in a foster family home in the state.

404.21 (2) The rate schedule for the agreement is determined based on the age of the child on
404.22 the date that the prospective adoptive parent or parents or relative custodian or custodians
404.23 sign the agreement.

404.24 (3) The income of the relative custodian or custodians or adoptive parent or parents must
404.25 not be taken into consideration when determining eligibility for Northstar kinship assistance
404.26 or adoption assistance or the amount of the payments under section 256N.26.

404.27 (4) With the concurrence of the relative custodian or adoptive parent, the amount of the
404.28 payment may be adjusted periodically using the assessment tool established by the
404.29 commissioner in section 256N.24, subdivision 2, and the agreement renegotiated under
404.30 subdivision 3 when there is a change in the child's needs or the family's circumstances.

404.31 (5) An adoptive parent of an at-risk child with an adoption assistance agreement may
404.32 request a reassessment of the child under section 256N.24, subdivision 10, and renegotiation
404.33 of the adoption assistance agreement under subdivision 3 to include a monthly payment, if
404.34 the caregiver has written documentation from a qualified expert that the potential disability

405.1 upon which eligibility for the agreement was based has manifested itself. Documentation
405.2 of the disability must be limited to evidence deemed appropriate by the commissioner.

405.3 (c) For Northstar kinship assistance agreements:

405.4 (1) the initial amount of the monthly Northstar kinship assistance payment must be
405.5 equivalent to the foster care rate in effect at the time that the agreement is signed ~~less any~~
405.6 ~~offsets under section 256N.26, subdivision 11~~, or a lesser negotiated amount if agreed to
405.7 by the prospective relative custodian and specified in that agreement, unless the Northstar
405.8 kinship assistance agreement is entered into when a child is under the age of six; and

405.9 (2) the amount of the monthly payment for a Northstar kinship assistance agreement for
405.10 a child who is under the age of six must be as specified in section 256N.26, subdivision 5.

405.11 (d) For adoption assistance agreements:

405.12 (1) for a child in foster care with the prospective adoptive parent immediately prior to
405.13 adoptive placement, the initial amount of the monthly adoption assistance payment must
405.14 be equivalent to the foster care rate in effect at the time that the agreement is signed ~~less~~
405.15 ~~any offsets in section 256N.26, subdivision 11~~, or a lesser negotiated amount if agreed to
405.16 by the prospective adoptive parents and specified in that agreement, unless the child is
405.17 identified as at-risk or the adoption assistance agreement is entered into when a child is
405.18 under the age of six;

405.19 (2) for an at-risk child who must be assigned level A as outlined in section 256N.26, no
405.20 payment will be made unless and until the potential disability manifests itself, as documented
405.21 by an appropriate professional, and the commissioner authorizes commencement of payment
405.22 by modifying the agreement accordingly;

405.23 (3) the amount of the monthly payment for an adoption assistance agreement for a child
405.24 under the age of six, other than an at-risk child, must be as specified in section 256N.26,
405.25 subdivision 5;

405.26 (4) for a child who is in the Northstar kinship assistance program immediately prior to
405.27 adoptive placement, the initial amount of the adoption assistance payment must be equivalent
405.28 to the Northstar kinship assistance payment in effect at the time that the adoption assistance
405.29 agreement is signed or a lesser amount if agreed to by the prospective adoptive parent and
405.30 specified in that agreement, unless the child is identified as an at-risk child; and

405.31 (5) for a child who is not in foster care placement or the Northstar kinship assistance
405.32 program immediately prior to adoptive placement or negotiation of the adoption assistance
405.33 agreement, the initial amount of the adoption assistance agreement must be determined

406.1 using the assessment tool and process in this section and the corresponding payment amount
406.2 outlined in section 256N.26.

406.3 Sec. 2. Minnesota Statutes 2020, section 256N.25, subdivision 3, is amended to read:

406.4 Subd. 3. **Renegotiation of agreement.** (a) A relative custodian or adoptive parent of a
406.5 child with a Northstar kinship assistance or adoption assistance agreement may request
406.6 renegotiation of the agreement when there is a change in the needs of the child or in the
406.7 family's circumstances. When a relative custodian or adoptive parent requests renegotiation
406.8 of the agreement, a reassessment of the child must be completed consistent with section
406.9 256N.24, subdivisions 10 and 11. If the reassessment indicates that the child's level has
406.10 changed, the financially responsible agency or, if there is no financially responsible agency,
406.11 the agency designated by the commissioner or the commissioner's designee, and the caregiver
406.12 must renegotiate the agreement to include a payment with the level determined through the
406.13 reassessment process. The agreement must not be renegotiated unless the commissioner,
406.14 the financially responsible agency, and the caregiver mutually agree to the changes. The
406.15 effective date of any renegotiated agreement must be determined by the commissioner.

406.16 (b) An adoptive parent of an at-risk child with an adoption assistance agreement may
406.17 request renegotiation of the agreement to include a monthly payment under section 256N.26
406.18 if the caregiver has written documentation from a qualified expert that the potential disability
406.19 upon which eligibility for the agreement was based has manifested itself. Documentation
406.20 of the disability must be limited to evidence deemed appropriate by the commissioner. Prior
406.21 to renegotiating the agreement, a reassessment of the child must be conducted as outlined
406.22 in section 256N.24, subdivision 10. The reassessment must be used to renegotiate the
406.23 agreement to include an appropriate monthly payment. The agreement must not be
406.24 renegotiated unless the commissioner, the financially responsible agency, and the caregiver
406.25 mutually agree to the changes. The effective date of any renegotiated agreement must be
406.26 determined by the commissioner.

406.27 ~~(c) Renegotiation of a Northstar kinship assistance or adoption assistance agreement is~~
406.28 ~~required when one of the circumstances outlined in section 256N.26, subdivision 13, occurs.~~

406.29 Sec. 3. Minnesota Statutes 2020, section 256N.26, subdivision 11, is amended to read:

406.30 Subd. 11. **Child income or income attributable to the child.** (a) A monthly Northstar
406.31 kinship assistance or adoption assistance payment must be considered as income and
406.32 resources attributable to the child. Northstar kinship assistance and adoption assistance are

exempt from garnishment, except as permissible under the laws of the state where the child resides.

(b) When a child is placed into foster care, any income and resources attributable to the child are treated as provided in sections 252.27 and 260C.331, or 260B.331, as applicable to the child being placed.

(c) ~~Consideration of income and resources attributable to the child must be part of the negotiation process outlined in section 256N.25, subdivision 2. In some circumstances, the receipt of other income on behalf of the child may impact the amount of the monthly payment received by the relative custodian or adoptive parent on behalf of the child through Northstar Care for Children.~~ Supplemental Security Income (SSI), retirement survivor's disability insurance (RSDI), veteran's benefits, railroad retirement benefits, and black lung benefits are considered income and resources attributable to the child.

Sec. 4. Minnesota Statutes 2020, section 256N.26, subdivision 13, is amended to read:

Subd. 13. **Treatment of retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, and black lung benefits.** ~~(a)~~ If a child placed in foster care receives retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits at the time of foster care placement or subsequent to placement in foster care, the financially responsible agency may apply to be the payee for the child for the duration of the child's placement in foster care. If it is anticipated that a child will be eligible to receive retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits after finalization of the adoption or assignment of permanent legal and physical custody, the permanent caregiver shall apply to be the payee of those benefits on the child's behalf. ~~The monthly amount of the other benefits must be considered an offset to the amount of the payment the child is determined eligible for under Northstar Care for Children.~~

~~(b) If a child becomes eligible for retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits, after the initial amount of the payment under Northstar Care for Children is finalized, the permanent caregiver shall contact the commissioner to redetermine the payment under Northstar Care for Children. The monthly amount of the other benefits must be considered an offset to the amount of the payment the child is determined eligible for under Northstar Care for Children.~~

~~(c) If a child ceases to be eligible for retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits after the initial amount of the payment under Northstar Care for Children is finalized, the permanent caregiver shall contact~~

408.1 ~~the commissioner to redetermine the payment under Northstar Care for Children. The~~
408.2 ~~monthly amount of the payment under Northstar Care for Children must be the amount the~~
408.3 ~~child was determined to be eligible for prior to consideration of any offset.~~

408.4 ~~(d) If the monthly payment received on behalf of the child under retirement survivor's~~
408.5 ~~disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits~~
408.6 ~~changes after the adoption assistance or Northstar kinship assistance agreement is finalized,~~
408.7 ~~the permanent caregiver shall notify the commissioner as to the new monthly payment~~
408.8 ~~amount, regardless of the amount of the change in payment. If the monthly payment changes~~
408.9 ~~by $75 or more, even if the change occurs incrementally over the duration of the term of~~
408.10 ~~the adoption assistance or Northstar kinship assistance agreement, the monthly payment~~
408.11 ~~under Northstar Care for Children must be adjusted without further consent to reflect the~~
408.12 ~~amount of the increase or decrease in the offset amount. Any subsequent change to the~~
408.13 ~~payment must be reported and handled in the same manner. A change of monthly payments~~
408.14 ~~of less than $75 is not a permissible reason to renegotiate the adoption assistance or Northstar~~
408.15 ~~kinship assistance agreement under section 256N.25, subdivision 3. The commissioner shall~~
408.16 ~~review and revise the limit at which the adoption assistance or Northstar kinship assistance~~
408.17 ~~agreement must be renegotiated in accordance with subdivision 9.~~

408.18 Sec. 5. Minnesota Statutes 2020, section 260.761, subdivision 2, is amended to read:

408.19 Subd. 2. **Agency and court notice to tribes.** (a) When a local social services agency
408.20 has information that a family assessment ~~or~~, investigation, or noncaregiver sex trafficking
408.21 assessment being conducted may involve an Indian child, the local social services agency
408.22 shall notify the Indian child's tribe of the family assessment ~~or~~, investigation, or noncaregiver
408.23 sex trafficking assessment according to section 260E.18. The local social services agency
408.24 shall provide initial notice ~~shall be provided~~ by telephone and by e-mail or facsimile. The
408.25 local social services agency shall request that the tribe or a designated tribal representative
408.26 participate in evaluating the family circumstances, identifying family and tribal community
408.27 resources, and developing case plans.

408.28 (b) When a local social services agency has information that a child receiving services
408.29 may be an Indian child, the local social services agency shall notify the tribe by telephone
408.30 and by e-mail or facsimile of the child's full name and date of birth, the full names and dates
408.31 of birth of the child's biological parents, and, if known, the full names and dates of birth of
408.32 the child's grandparents and of the child's Indian custodian. This notification must be provided
408.33 ~~so~~ for the tribe ~~can~~ to determine if the child is enrolled in the tribe or eligible for tribal
408.34 membership, and ~~must be provided~~ the agency must provide this notification to the tribe

within seven days of receiving information that the child may be an Indian child. If information regarding the child's grandparents or Indian custodian is not available within the seven-day period, the local social services agency shall continue to request this information and shall notify the tribe when it is received. Notice shall be provided to all tribes to which the child may have any tribal lineage. If the identity or location of the child's parent or Indian custodian and tribe cannot be determined, the local social services agency shall provide the notice required in this paragraph to the United States secretary of the interior.

(c) In accordance with sections 260C.151 and 260C.152, when a court has reason to believe that a child placed in emergency protective care is an Indian child, the court administrator or a designee shall, as soon as possible and before a hearing takes place, notify the tribal social services agency by telephone and by e-mail or facsimile of the date, time, and location of the emergency protective case hearing. The court shall make efforts to allow appearances by telephone for tribal representatives, parents, and Indian custodians.

(d) A local social services agency must provide the notices required under this subdivision at the earliest possible time to facilitate involvement of the Indian child's tribe. Nothing in this subdivision is intended to hinder the ability of the local social services agency and the court to respond to an emergency situation. Lack of participation by a tribe shall not prevent the tribe from intervening in services and proceedings at a later date. A tribe may participate in a case at any time. At any stage of the local social services agency's involvement with an Indian child, the agency shall provide full cooperation to the tribal social services agency, including disclosure of all data concerning the Indian child. Nothing in this subdivision relieves the local social services agency of satisfying the notice requirements in the Indian Child Welfare Act.

Sec. 6. Minnesota Statutes 2020, section 260C.007, subdivision 14, is amended to read:

Subd. 14. **Egregious harm.** "Egregious harm" means the infliction of bodily harm to a child or neglect of a child which demonstrates a grossly inadequate ability to provide minimally adequate parental care. ~~The~~ Egregious harm need not have occurred in the state or in the county where a termination of parental rights action is otherwise properly venued. Egregious harm includes, but is not limited to:

(1) conduct ~~towards~~ toward a child that constitutes a violation of sections 609.185 to 609.2114, 609.222, subdivision 2, 609.223, or any other similar law of any other state;

(2) the infliction of "substantial bodily harm" to a child, as defined in section 609.02, subdivision 7a;

410.1 (3) conduct ~~towards~~ toward a child that constitutes felony malicious punishment of a
410.2 child under section 609.377;

410.3 (4) conduct ~~towards~~ toward a child that constitutes felony unreasonable restraint of a
410.4 child under section 609.255, subdivision 3;

410.5 (5) conduct ~~towards~~ toward a child that constitutes felony neglect or endangerment of
410.6 a child under section 609.378;

410.7 (6) conduct ~~towards~~ toward a child that constitutes assault under section 609.221, 609.222,
410.8 or 609.223;

410.9 (7) conduct ~~towards~~ toward a child that constitutes sex trafficking, solicitation,
410.10 inducement, ~~or~~ promotion of, or receiving profit derived from prostitution under section
410.11 609.322;

410.12 (8) conduct ~~towards~~ toward a child that constitutes murder or voluntary manslaughter
410.13 as defined by United States Code, title 18, section 1111(a) or 1112(a);

410.14 (9) conduct ~~towards~~ toward a child that constitutes aiding or abetting, attempting,
410.15 conspiring, or soliciting to commit a murder or voluntary manslaughter that constitutes a
410.16 violation of United States Code, title 18, section 1111(a) or 1112(a); or

410.17 (10) conduct toward a child that constitutes criminal sexual conduct under sections
410.18 609.342 to 609.345.

410.19 Sec. 7. Minnesota Statutes 2020, section 260E.01, is amended to read:

410.20 **260E.01 POLICY.**

410.21 (a) The legislature hereby declares that the public policy of this state is to protect children
410.22 whose health or welfare may be jeopardized through maltreatment. While it is recognized
410.23 that most parents want to keep their children safe, sometimes circumstances or conditions
410.24 interfere with their ability to do so. When this occurs, the health and safety of the children
410.25 must be of paramount concern. Intervention and prevention efforts must address immediate
410.26 concerns for child safety and the ongoing risk of maltreatment and should engage the
410.27 protective capacities of families. In furtherance of this public policy, it is the intent of the
410.28 legislature under this chapter to:

410.29 (1) protect children and promote child safety;

410.30 (2) strengthen the family;

411.1 (3) make the home, school, and community safe for children by promoting responsible
411.2 child care in all settings; and

411.3 (4) provide, when necessary, a safe temporary or permanent home environment for
411.4 maltreated children.

411.5 (b) In addition, it is the policy of this state to:

411.6 (1) require the reporting of maltreatment of children in the home, school, and community
411.7 settings;

411.8 (2) provide for ~~the~~ voluntary reporting of maltreatment of children;

411.9 (3) require an investigation when the report alleges sexual abuse or substantial child
411.10 endangerment, except when the report alleges sex trafficking by a noncaregiver sex trafficker;

411.11 (4) provide a family assessment, if appropriate, when the report does not allege sexual
411.12 abuse or substantial child endangerment; ~~and~~

411.13 (5) provide a noncaregiver sex trafficking assessment when the report alleges sex
411.14 trafficking by a noncaregiver sex trafficker; and

411.15 (6) provide protective, family support, and family preservation services when needed
411.16 in appropriate cases.

411.17 Sec. 8. Minnesota Statutes 2020, section 260E.02, subdivision 1, is amended to read:

411.18 Subdivision 1. **Establishment of team.** A county shall establish a multidisciplinary
411.19 child protection team that may include, but is not ~~be~~ limited to, the director of the local
411.20 welfare agency or designees, the county attorney or designees, the county sheriff or designees,
411.21 representatives of health and education, representatives of mental health, representatives of
411.22 agencies providing specialized services or responding to youth who experience or are at
411.23 risk of experiencing sex trafficking or sexual exploitation, or other appropriate human
411.24 services or community-based agencies, and parent groups. As used in this section, a
411.25 "community-based agency" may include, but is not limited to, schools, social services
411.26 agencies, family service and mental health collaboratives, children's advocacy centers, early
411.27 childhood and family education programs, Head Start, or other agencies serving children
411.28 and families. A member of the team must be designated as the lead person of the team
411.29 responsible for the planning process to develop standards for the team's activities with
411.30 battered women's and domestic abuse programs and services.

412.1 Sec. 9. Minnesota Statutes 2020, section 260E.03, is amended by adding a subdivision to
412.2 read:

412.3 Subd. 15a. **Noncaregiver sex trafficker.** "Noncaregiver sex trafficker" means an
412.4 individual who is alleged to have engaged in the act of sex trafficking a child, who is not a
412.5 person responsible for the child's care, who does not have a significant relationship with
412.6 the child as defined in section 609.341, and who is not a person in a current or recent position
412.7 of authority as defined in section 609.341, subdivision 10.

412.8 Sec. 10. Minnesota Statutes 2020, section 260E.03, is amended by adding a subdivision
412.9 to read:

412.10 Subd. 15b. **Noncaregiver sex trafficking assessment.** "Noncaregiver sex trafficking
412.11 assessment" is a comprehensive assessment of child safety, the risk of subsequent child
412.12 maltreatment, and strengths and needs of the child and family. The local welfare agency
412.13 shall only perform a noncaregiver sex trafficking assessment when a maltreatment report
412.14 alleges sex trafficking of a child by someone other than the child's caregiver. A noncaregiver
412.15 sex trafficking assessment does not include a determination of whether child maltreatment
412.16 occurred. A noncaregiver sex trafficking assessment includes a determination of a family's
412.17 need for services to address the safety of the child or children, the safety of family members,
412.18 and the risk of subsequent child maltreatment.

412.19 Sec. 11. Minnesota Statutes 2020, section 260E.03, subdivision 22, is amended to read:

412.20 Subd. 22. **Substantial child endangerment.** "Substantial child endangerment" means
412.21 that a person responsible for a child's care, by act or omission, commits or attempts to
412.22 commit an act against a child ~~under their~~ in the person's care that constitutes any of the
412.23 following:

412.24 (1) egregious harm under subdivision 5;

412.25 (2) abandonment under section 260C.301, subdivision 2;

412.26 (3) neglect under subdivision 15, paragraph (a), clause (2), that substantially endangers
412.27 the child's physical or mental health, including a growth delay, which may be referred to
412.28 as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

412.29 (4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

412.30 (5) manslaughter in the first or second degree under section 609.20 or 609.205;

412.31 (6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

413.1 (7) sex trafficking, solicitation, inducement, ~~and~~ or promotion of prostitution under
413.2 section 609.322;

413.3 (8) criminal sexual conduct under sections 609.342 to 609.3451;

413.4 (9) solicitation of children to engage in sexual conduct under section 609.352;

413.5 (10) malicious punishment or neglect or endangerment of a child under section 609.377
413.6 or 609.378;

413.7 (11) use of a minor in sexual performance under section 617.246; or

413.8 (12) parental behavior, status, or condition ~~that mandates that~~ requiring the county
413.9 attorney to file a termination of parental rights petition under section 260C.503, subdivision
413.10 2.

413.11 Sec. 12. Minnesota Statutes 2020, section 260E.14, subdivision 2, is amended to read:

413.12 Subd. 2. **Sexual abuse.** (a) The local welfare agency is the agency responsible for
413.13 investigating an allegation of sexual abuse if the alleged offender is the parent, guardian,
413.14 sibling, or an individual functioning within the family unit as a person responsible for the
413.15 child's care, or a person with a significant relationship to the child if that person resides in
413.16 the child's household.

413.17 (b) The local welfare agency is also responsible for assessing or investigating when a
413.18 child is identified as a victim of sex trafficking.

413.19 Sec. 13. Minnesota Statutes 2020, section 260E.14, subdivision 5, is amended to read:

413.20 Subd. 5. **Law enforcement.** (a) The local law enforcement agency is the agency
413.21 responsible for investigating a report of maltreatment if a violation of a criminal statute is
413.22 alleged.

413.23 (b) Law enforcement and the responsible agency must coordinate their investigations
413.24 or assessments as required under this chapter when ~~the~~: (1) a report alleges maltreatment
413.25 that is a violation of a criminal statute by a person who is a parent, guardian, sibling, person
413.26 responsible for the child's care ~~functioning~~ within the family unit, or by a person who lives
413.27 in the child's household and who has a significant relationship to the child~~,~~ in a setting other
413.28 than a facility as defined in section 260E.03; or (2) a report alleges sex trafficking of a child.

Sec. 14. Minnesota Statutes 2020, section 260E.17, subdivision 1, is amended to read:

Subdivision 1. **Local welfare agency.** (a) Upon receipt of a report, the local welfare agency shall determine whether to conduct a family assessment ~~or~~, an investigation, or a noncaregiver sex trafficking assessment as appropriate to prevent or provide a remedy for maltreatment.

(b) The local welfare agency shall conduct an investigation when the report involves sexual abuse, except as indicated in paragraph (f), or substantial child endangerment.

(c) The local welfare agency shall begin an immediate investigation ~~if,~~ at any time when the local welfare agency is ~~using~~ responding with a family assessment ~~response,~~ and the local welfare agency determines that there is reason to believe that sexual abuse ~~or~~, substantial child endangerment, or a serious threat to the child's safety exists.

(d) The local welfare agency may conduct a family assessment for reports that do not allege sexual abuse, except as indicated in paragraph (f), or substantial child endangerment. In determining that a family assessment is appropriate, the local welfare agency may consider issues of child safety, parental cooperation, and the need for an immediate response.

(e) The local welfare agency may conduct a family assessment ~~on~~ for a report that was initially screened and assigned for an investigation. In determining that a complete investigation is not required, the local welfare agency must document the reason for terminating the investigation and notify the local law enforcement agency if the local law enforcement agency is conducting a joint investigation.

(f) The local welfare agency shall conduct a noncaregiver sex trafficking assessment when a maltreatment report alleges sex trafficking of a child and the alleged offender is a noncaregiver sex trafficker as defined by section 260E.03, subdivision 15a.

(g) During a noncaregiver sex trafficking assessment, the local welfare agency shall initiate an immediate investigation if there is reason to believe that a child's parent, caregiver, or household member allegedly engaged in the act of sex trafficking a child or was alleged to have engaged in any conduct requiring the agency to conduct an investigation.

Sec. 15. Minnesota Statutes 2020, section 260E.18, is amended to read:

260E.18 NOTICE TO CHILD'S TRIBE.

The local welfare agency shall provide immediate notice, according to section 260.761, subdivision 2, to an Indian child's tribe when the agency has reason to believe that the family assessment ~~or~~, investigation, or noncaregiver sex trafficking assessment may involve an

415.1 Indian child. For purposes of this section, "immediate notice" means notice provided within
415.2 24 hours.

415.3 Sec. 16. Minnesota Statutes 2020, section 260E.20, subdivision 2, is amended to read:

415.4 Subd. 2. **Face-to-face contact.** (a) Upon receipt of a screened in report, the local welfare
415.5 agency shall ~~conduct a~~ have face-to-face contact with the child reported to be maltreated
415.6 and with the child's primary caregiver sufficient to complete a safety assessment and ensure
415.7 the immediate safety of the child.

415.8 (b) Except in a noncaregiver sex trafficking assessment, the local welfare agency shall
415.9 have face-to-face contact with the child and primary caregiver ~~shall occur~~ immediately if
415.10 sexual abuse or substantial child endangerment is alleged and within five calendar days for
415.11 all other reports. If the alleged offender was not already interviewed as the primary caregiver,
415.12 the local welfare agency shall also conduct a face-to-face interview with the alleged offender
415.13 in the early stages of the assessment or investigation, except in a noncaregiver sex trafficking
415.14 assessment.

415.15 (c) At the initial contact with the alleged offender, the local welfare agency or the agency
415.16 responsible for assessing or investigating the report must inform the alleged offender of the
415.17 complaints or allegations made against the individual in a manner consistent with laws
415.18 protecting the rights of the person who made the report. The interview with the alleged
415.19 offender may be postponed if it would jeopardize an active law enforcement investigation.
415.20 In a noncaregiver sex trafficking assessment, the local child welfare agency is not required
415.21 to interview the alleged offender.

415.22 (d) The local welfare agency or the agency responsible for assessing or investigating
415.23 the report must provide the alleged offender with an opportunity to make a statement, except
415.24 in a noncaregiver sex trafficking assessment where the local welfare agency may rely on
415.25 law enforcement data. The alleged offender may submit supporting documentation relevant
415.26 to the assessment or investigation.

415.27 Sec. 17. Minnesota Statutes 2020, section 260E.24, subdivision 2, is amended to read:

415.28 Subd. 2. **Determination after family assessment or a noncaregiver sex trafficking**
415.29 **assessment.** After conducting a family assessment or a noncaregiver sex trafficking
415.30 assessment, the local welfare agency shall determine whether child protective services are
415.31 needed to address the safety of the child and other family members and the risk of subsequent
415.32 maltreatment.

416.1 Sec. 18. Minnesota Statutes 2020, section 260E.24, subdivision 7, is amended to read:

416.2 Subd. 7. **Notification at conclusion of family assessment or a noncaregiver sex**
416.3 **trafficking assessment.** Within ten working days of the conclusion of a family assessment
416.4 or a noncaregiver sex trafficking assessment, the local welfare agency shall notify the parent
416.5 or guardian of the child of the need for services to address child safety concerns or significant
416.6 risk of subsequent maltreatment. The local welfare agency and the family may also jointly
416.7 agree that family support and family preservation services are needed.

416.8 Sec. 19. Minnesota Statutes 2020, section 260E.33, subdivision 1, is amended to read:

416.9 Subdivision 1. **Following a family assessment or a noncaregiver sex trafficking**
416.10 **assessment.** Administrative reconsideration is not applicable to a family assessment or
416.11 noncaregiver sex trafficking assessment since no determination concerning maltreatment
416.12 is made.

416.13 Sec. 20. Minnesota Statutes 2020, section 260E.35, subdivision 6, is amended to read:

416.14 Subd. 6. **Data retention.** (a) Notwithstanding sections 138.163 and 138.17, a record
416.15 maintained or a record derived from a report of maltreatment by a local welfare agency,
416.16 agency responsible for assessing or investigating the report, court services agency, or school
416.17 under this chapter shall be destroyed as provided in paragraphs (b) to (e) by the responsible
416.18 authority.

416.19 (b) For a report alleging maltreatment that was not accepted for an assessment or an
416.20 investigation, a family assessment case, a noncaregiver sex trafficking assessment case, and
416.21 a case where an investigation results in no determination of maltreatment or the need for
416.22 child protective services, the record must be maintained for a period of five years after the
416.23 date that the report was not accepted for assessment or investigation or the date of the final
416.24 entry in the case record. A record of a report that was not accepted must contain sufficient
416.25 information to identify the subjects of the report, the nature of the alleged maltreatment,
416.26 and the reasons ~~as to~~ why the report was not accepted. Records under this paragraph may
416.27 not be used for employment, background checks, or purposes other than to assist in future
416.28 screening decisions and risk and safety assessments.

416.29 (c) All records relating to reports that, upon investigation, indicate ~~either~~ maltreatment
416.30 or a need for child protective services shall be maintained for ten years after the date of the
416.31 final entry in the case record.

417.1 (d) All records regarding a report of maltreatment, including a notification of intent to
417.2 interview that was received by a school under section 260E.22, subdivision 7, shall be
417.3 destroyed by the school when ordered to do so by the agency conducting the assessment or
417.4 investigation. The agency shall order the destruction of the notification when other records
417.5 relating to the report under investigation or assessment are destroyed under this subdivision.

417.6 (e) Private or confidential data released to a court services agency under subdivision 3,
417.7 paragraph (d), must be destroyed by the court services agency when ordered to do so by the
417.8 local welfare agency that released the data. The local welfare agency or agency responsible
417.9 for assessing or investigating the report shall order destruction of the data when other records
417.10 relating to the assessment or investigation are destroyed under this subdivision.

417.11 **ARTICLE 11**

417.12 **CHILD PROTECTION POLICY**

417.13 Section 1. Minnesota Statutes 2020, section 245.4885, subdivision 1, is amended to read:

417.14 Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the
417.15 case of an emergency, all children referred for treatment of severe emotional disturbance
417.16 in a treatment foster care setting, residential treatment facility, or informally admitted to a
417.17 regional treatment center shall undergo an assessment to determine the appropriate level of
417.18 care if public funds are used to pay for the child's services.

417.19 (b) The responsible social services agency shall determine the appropriate level of care
417.20 for a child when county-controlled funds are used to pay for the child's services or placement
417.21 in a qualified residential treatment facility under chapter 260C and licensed by the
417.22 commissioner under chapter 245A. In accordance with section 260C.157, a juvenile treatment
417.23 screening team shall conduct a screening of a child before the team may recommend whether
417.24 to place a child in a qualified residential treatment program as defined in section 260C.007,
417.25 subdivision 26d. When a social services agency does not have responsibility for a child's
417.26 placement and the child is enrolled in a prepaid health program under section 256B.69, the
417.27 enrolled child's contracted health plan must determine the appropriate level of care for the
417.28 child. When Indian Health Services funds or funds of a tribally owned facility funded under
417.29 the Indian Self-Determination and Education Assistance Act, Public Law 93-638, are to be
417.30 used for a child, the Indian Health Services or 638 tribal health facility must determine the
417.31 appropriate level of care for the child. When more than one entity bears responsibility for
417.32 a child's coverage, the entities shall coordinate level of care determination activities for the
417.33 child to the extent possible.

418.1 (c) The responsible social services agency must make the child's level of care
418.2 determination available to the child's juvenile treatment screening team, as permitted under
418.3 chapter 13. The level of care determination shall inform the juvenile treatment screening
418.4 team process and the assessment in section 260C.704 when considering whether to place
418.5 the child in a qualified residential treatment program. When the responsible social services
418.6 agency is not involved in determining a child's placement, the child's level of care
418.7 determination shall determine whether the proposed treatment:

418.8 (1) is necessary;

418.9 (2) is appropriate to the child's individual treatment needs;

418.10 (3) cannot be effectively provided in the child's home; and

418.11 (4) provides a length of stay as short as possible consistent with the individual child's
418.12 ~~need~~ needs.

418.13 (d) When a level of care determination is conducted, the responsible social services
418.14 agency or other entity may not determine that a screening of a child under section 260C.157
418.15 or referral or admission to a treatment foster care setting or residential treatment facility is
418.16 not appropriate solely because services were not first provided to the child in a less restrictive
418.17 setting and the child failed to make progress toward or meet treatment goals in the less
418.18 restrictive setting. The level of care determination must be based on a diagnostic assessment
418.19 of a child that includes a functional assessment which evaluates the child's family, school,
418.20 and community living situations; and an assessment of the child's need for care out of the
418.21 home using a validated tool which assesses a child's functional status and assigns an
418.22 appropriate level of care to the child. The validated tool must be approved by the
418.23 commissioner of human services and may be the validated tool approved for the child's
418.24 assessment under section 260C.704 if the juvenile treatment screening team recommended
418.25 placement of the child in a qualified residential treatment program. If a diagnostic assessment
418.26 including a functional assessment has been completed by a mental health professional within
418.27 the past 180 days, a new diagnostic assessment need not be completed unless in the opinion
418.28 of the current treating mental health professional the child's mental health status has changed
418.29 markedly since the assessment was completed. The child's parent shall be notified if an
418.30 assessment will not be completed and of the reasons. A copy of the notice shall be placed
418.31 in the child's file. Recommendations developed as part of the level of care determination
418.32 process shall include specific community services needed by the child and, if appropriate,
418.33 the child's family, and shall indicate whether ~~or not~~ these services are available and accessible
418.34 to the child and the child's family.

419.1 (e) During the level of care determination process, the child, child's family, or child's
419.2 legal representative, as appropriate, must be informed of the child's eligibility for case
419.3 management services and family community support services and that an individual family
419.4 community support plan is being developed by the case manager, if assigned.

419.5 (f) When the responsible social services agency has authority, the agency must engage
419.6 the child's parents in case planning under sections 260C.212 and 260C.708 and chapter
419.7 260D unless a court terminates the parent's rights or court orders restrict the parent from
419.8 participating in case planning, visitation, or parental responsibilities.

419.9 (g) The level of care determination, ~~and~~ placement decision, and recommendations for
419.10 mental health services must be documented in the child's record, as required in ~~chapter~~
419.11 chapters 260C and 260D.

419.12 **EFFECTIVE DATE.** This section is effective September 30, 2021.

419.13 Sec. 2. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to
419.14 read:

419.15 Subd. 3c. **At risk of becoming a victim of sex trafficking or commercial sexual**
419.16 **exploitation.** For the purposes of section 245A.25, a youth who is "at risk of becoming a
419.17 victim of sex trafficking or commercial sexual exploitation" means a youth who meets the
419.18 criteria established by the commissioner of human services for this purpose.

419.19 **EFFECTIVE DATE.** This section is effective the day following final enactment.

419.20 Sec. 3. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to
419.21 read:

419.22 Subd. 4a. **Children's residential facility.** "Children's residential facility" is defined as
419.23 a residential program licensed under this chapter or chapter 241 according to the applicable
419.24 standards in Minnesota Rules, parts 2960.0010 to 2960.0710.

419.25 **EFFECTIVE DATE.** This section is effective the day following final enactment.

419.26 Sec. 4. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to
419.27 read:

419.28 Subd. 6d. **Foster family setting.** "Foster family setting" has the meaning given in
419.29 Minnesota Rules, chapter 2960.3010, subpart 23, and includes settings licensed by the
419.30 commissioner of human services or the commissioner of corrections.

419.31 **EFFECTIVE DATE.** This section is effective the day following final enactment.

420.1 Sec. 5. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to
420.2 read:

420.3 Subd. 6e. **Foster residence setting.** "Foster residence setting" has the meaning given
420.4 in Minnesota Rules, chapter 2960.3010, subpart 26, and includes settings licensed by the
420.5 commissioner of human services or the commissioner of corrections.

420.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.

420.7 Sec. 6. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to
420.8 read:

420.9 Subd. 18a. **Trauma.** For the purposes of section 245A.25, "trauma" means an event,
420.10 series of events, or set of circumstances experienced by an individual as physically or
420.11 emotionally harmful or life-threatening and has lasting adverse effects on the individual's
420.12 functioning and mental, physical, social, emotional, or spiritual well-being. Trauma includes
420.13 the cumulative emotional or psychological harm of group traumatic experiences transmitted
420.14 across generations within a community that are often associated with racial and ethnic
420.15 population groups that have suffered major intergenerational losses.

420.16 **EFFECTIVE DATE.** This section is effective the day following final enactment.

420.17 Sec. 7. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to
420.18 read:

420.19 Subd. 23. **Victim of sex trafficking or commercial sexual exploitation.** For the purposes
420.20 of section 245A.25, "victim of sex trafficking or commercial sexual exploitation" means a
420.21 person who meets the definitions in section 260C.007, subdivision 31, clauses (4) and (5).

420.22 **EFFECTIVE DATE.** This section is effective the day following final enactment.

420.23 Sec. 8. Minnesota Statutes 2020, section 245A.02, is amended by adding a subdivision to
420.24 read:

420.25 Subd. 24. **Youth.** For the purposes of section 245A.25, "youth" means a "child" as
420.26 defined in section 260C.007, subdivision 4, and includes individuals under 21 years of age
420.27 who are in foster care pursuant to section 260C.451.

420.28 **EFFECTIVE DATE.** This section is effective the day following final enactment.

421.1 Sec. 9. Minnesota Statutes 2020, section 245A.041, is amended by adding a subdivision
421.2 to read:

421.3 Subd. 6. **First date of working in a facility or setting; documentation**
421.4 **requirements.** Children's residential facility and foster residence setting license holders
421.5 must document the first date that a person who is a background study subject begins working
421.6 in the license holder's facility or setting. If the license holder does not maintain documentation
421.7 of each background study subject's first date of working in the facility or setting in the
421.8 license holder's personnel files, the license holder must provide documentation to the
421.9 commissioner that contains the first date that each background study subject began working
421.10 in the license holder's program upon the commissioner's request.

421.11 **EFFECTIVE DATE.** This section is effective August 1, 2021.

421.12 Sec. 10. **[245A.25] RESIDENTIAL PROGRAM CERTIFICATIONS FOR**
421.13 **COMPLIANCE WITH THE FAMILY FIRST PREVENTION SERVICES ACT.**

421.14 Subdivision 1. **Certification scope and applicability.** (a) This section establishes the
421.15 requirements that a children's residential facility or child foster residence setting must meet
421.16 to be certified for the purposes of Title IV-E funding requirements as:

421.17 (1) a qualified residential treatment program;

421.18 (2) a residential setting specializing in providing care and supportive services for youth
421.19 who have been or are at risk of becoming victims of sex trafficking or commercial sexual
421.20 exploitation;

421.21 (3) a residential setting specializing in providing prenatal, postpartum, or parenting
421.22 support for youth; or

421.23 (4) a supervised independent living setting for youth who are 18 years of age or older.

421.24 (b) This section does not apply to a foster family setting in which the license holder
421.25 resides in the foster home.

421.26 (c) Children's residential facilities licensed as detention settings according to Minnesota
421.27 Rules, parts 2960.0230 to 2960.0290, or secure programs according to Minnesota Rules,
421.28 parts 2960.0300 to 2960.0420, may not be certified under this section.

421.29 (d) For purposes of this section, "license holder" means an individual, organization, or
421.30 government entity that was issued a children's residential facility or foster residence setting
421.31 license by the commissioner of human services under this chapter or by the commissioner
421.32 of corrections under chapter 241.

422.1 (e) Certifications issued under this section for foster residence settings may only be
422.2 issued by the commissioner of human services and are not delegated to county or private
422.3 licensing agencies under section 245A.16.

422.4 Subd. 2. **Program certification types and requests for certification.** (a) By July 1,
422.5 2021, the commissioner of human services must offer certifications to license holders for
422.6 the following types of programs:

422.7 (1) qualified residential treatment programs;

422.8 (2) residential settings specializing in providing care and supportive services for youth
422.9 who have been or are at risk of becoming victims of sex trafficking or commercial sexual
422.10 exploitation;

422.11 (3) residential settings specializing in providing prenatal, postpartum, or parenting
422.12 support for youth; and

422.13 (4) supervised independent living settings for youth who are 18 years of age or older.

422.14 (b) An applicant or license holder must submit a request for certification under this
422.15 section on a form and in a manner prescribed by the commissioner of human services. The
422.16 decision of the commissioner of human services to grant or deny a certification request is
422.17 final and not subject to appeal under chapter 14.

422.18 Subd. 3. **Trauma-informed care.** (a) Programs certified under subdivisions 4 or 5 must
422.19 provide services to a person according to a trauma-informed model of care that meets the
422.20 requirements of this subdivision, except that programs certified under subdivision 5 are not
422.21 required to meet the requirements of paragraph (e).

422.22 (b) For the purposes of this section, "trauma-informed care" is defined as care that:

422.23 (1) acknowledges the effects of trauma on a person receiving services and on the person's
422.24 family;

422.25 (2) modifies services to respond to the effects of trauma on the person receiving services;

422.26 (3) emphasizes skill and strength-building rather than symptom management; and

422.27 (4) focuses on the physical and psychological safety of the person receiving services
422.28 and the person's family.

422.29 (c) The license holder must have a process for identifying the signs and symptoms of
422.30 trauma in a youth and must address the youth's needs related to trauma. This process must
422.31 include:

423.1 (1) screening for trauma by completing a trauma-specific screening tool with each youth
423.2 upon the youth's admission or obtaining the results of a trauma-specific screening tool that
423.3 was completed with the youth within 30 days prior to the youth's admission to the program;
423.4 and

423.5 (2) ensuring that trauma-based interventions targeting specific trauma-related symptoms
423.6 are available to each youth when needed to assist the youth in obtaining services. For
423.7 qualified residential treatment programs, this must include the provision of services in
423.8 paragraph (e).

423.9 (d) The license holder must develop and provide services to each youth according to the
423.10 principles of trauma-informed care including:

423.11 (1) recognizing the impact of trauma on a youth when determining the youth's service
423.12 needs and providing services to the youth;

423.13 (2) allowing each youth to participate in reviewing and developing the youth's
423.14 individualized treatment or service plan;

423.15 (3) providing services to each youth that are person-centered and culturally responsive;
423.16 and

423.17 (4) adjusting services for each youth to address additional needs of the youth.

423.18 (e) In addition to the other requirements of this subdivision, qualified residential treatment
423.19 programs must use a trauma-based treatment model that includes:

423.20 (1) assessing each youth to determine if the youth needs trauma-specific treatment
423.21 interventions;

423.22 (2) identifying in each youth's treatment plan how the program will provide
423.23 trauma-specific treatment interventions to the youth;

423.24 (3) providing trauma-specific treatment interventions to a youth that target the youth's
423.25 specific trauma-related symptoms; and

423.26 (4) training all clinical staff of the program on trauma-specific treatment interventions.

423.27 (f) At the license holder's program, the license holder must provide a physical, social,
423.28 and emotional environment that:

423.29 (1) promotes the physical and psychological safety of each youth;

423.30 (2) avoids aspects that may be retraumatizing;

423.31 (3) responds to trauma experienced by each youth and the youth's other needs; and

424.1 (4) includes designated spaces that are available to each youth for engaging in sensory
424.2 and self-soothing activities.

424.3 (g) The license holder must base the program's policies and procedures on
424.4 trauma-informed principles. In the program's policies and procedures, the license holder
424.5 must:

424.6 (1) describe how the program provides services according to a trauma-informed model
424.7 of care;

424.8 (2) describe how the program's environment fulfills the requirements of paragraph (f);

424.9 (3) prohibit the use of aversive consequences for a youth's violation of program rules
424.10 or any other reason;

424.11 (4) describe the process for how the license holder incorporates trauma-informed
424.12 principles and practices into the organizational culture of the license holder's program; and

424.13 (5) if the program is certified to use restrictive procedures under Minnesota Rules, part
424.14 2960.0710, describe how the program uses restrictive procedures only when necessary for
424.15 a youth in a manner that addresses the youth's history of trauma and avoids causing the
424.16 youth additional trauma.

424.17 (h) Prior to allowing a staff person to have direct contact, as defined in section 245C.02,
424.18 subdivision 11, with a youth and annually thereafter, the license holder must train each staff
424.19 person about:

424.20 (1) concepts of trauma-informed care and how to provide services to each youth according
424.21 to these concepts; and

424.22 (2) impacts of each youth's culture, race, gender, and sexual orientation on the youth's
424.23 behavioral health and traumatic experiences.

424.24 Subd. 4. **Qualified residential treatment programs; certification requirements.** (a)
424.25 To be certified as a qualified residential treatment program, a license holder must meet:

424.26 (1) the definition of a qualified residential treatment program in section 260C.007,
424.27 subdivision 26d;

424.28 (2) the requirements for providing trauma-informed care and using a trauma-based
424.29 treatment model in subdivision 3; and

424.30 (3) the requirements of this subdivision.

425.1 (b) For each youth placed at the license holder's program, the license holder must
425.2 collaborate with the responsible social services agency and other appropriate parties to
425.3 implement the youth's out-of-home placement plan and the youth's short-term and long-term
425.4 mental health and behavioral health goals in the assessment required by sections 260C.212,
425.5 subdivision 1; 260C.704; and 260C.708.

425.6 (c) A qualified residential treatment program must use a trauma-based treatment model
425.7 that meets all of the requirements of subdivision 3 that is designed to address the needs,
425.8 including clinical needs, of youth with serious emotional or behavioral disorders or
425.9 disturbances. The license holder must develop, document, and review a treatment plan for
425.10 each youth according to the requirements of Minnesota Rules, parts 2960.0180, subpart 2,
425.11 item B; and 2960.0190, subpart 2.

425.12 (d) The following types of staff must be on-site according to the program's treatment
425.13 model and must be available 24 hours a day and seven days a week to provide care within
425.14 the scope of their practice:

425.15 (1) a registered nurse or licensed practical nurse licensed by the Minnesota Board of
425.16 Nursing to practice professional nursing or practical nursing as defined in section 148.171,
425.17 subdivisions 14 and 15; and

425.18 (2) other licensed clinical staff to meet each youth's clinical needs.

425.19 (e) A qualified residential treatment program must be accredited by one of the following
425.20 independent, not-for-profit organizations:

425.21 (1) the Commission on Accreditation of Rehabilitation Facilities (CARF);

425.22 (2) the Joint Commission;

425.23 (3) the Council on Accreditation (COA); or

425.24 (4) another independent, not-for-profit accrediting organization approved by the Secretary
425.25 of the United States Department of Health and Human Services.

425.26 (f) The license holder must facilitate participation of a youth's family members in the
425.27 youth's treatment program, consistent with the youth's best interests and according to the
425.28 youth's out-of-home placement plan required by sections 260C.212, subdivision 1; and
425.29 260C.708.

425.30 (g) The license holder must contact and facilitate outreach to each youth's family
425.31 members, including the youth's siblings, and must document outreach to the youth's family
425.32 members in the youth's file, including the contact method and each family member's contact

426.1 information. In the youth's file, the license holder must record and maintain the contact
426.2 information for all known biological family members and fictive kin of the youth.

426.3 (h) The license holder must document in the youth's file how the program integrates
426.4 family members into the treatment process for the youth, including after the youth's discharge
426.5 from the program, and how the program maintains the youth's connections to the youth's
426.6 siblings.

426.7 (i) The program must provide discharge planning and family-based aftercare support to
426.8 each youth for at least six months after the youth's discharge from the program. When
426.9 providing aftercare to a youth, the program must have monthly contact with the youth and
426.10 the youth's caregivers to promote the youth's engagement in aftercare services and to regularly
426.11 evaluate the family's needs. The program's monthly contact with the youth may be
426.12 face-to-face, by telephone, or virtual.

426.13 (j) The license holder must maintain a service delivery plan that describes how the
426.14 program provides services according to the requirements in paragraphs (b) to (i).

426.15 Subd. 5. **Residential settings specializing in providing care and supportive services**
426.16 **for youth who have been or are at risk of becoming victims of sex trafficking or**
426.17 **commercial sexual exploitation; certification requirements.** (a) To be certified as a
426.18 residential setting specializing in providing care and supportive services for youth who have
426.19 been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation,
426.20 a license holder must meet the requirements of this subdivision.

426.21 (b) Settings certified according to this subdivision are exempt from the requirements of
426.22 section 245A.04, subdivision 11, paragraph (b).

426.23 (c) The program must use a trauma-informed model of care that meets all of the applicable
426.24 requirements of subdivision 3, and that is designed to address the needs, including emotional
426.25 and mental health needs, of youth who have been or are at risk of becoming victims of sex
426.26 trafficking or commercial sexual exploitation.

426.27 (d) The program must provide high quality care and supportive services for youth who
426.28 have been or are at risk of becoming victims of sex trafficking or commercial sexual
426.29 exploitation and must:

426.30 (1) offer a safe setting to each youth designed to prevent ongoing and future trafficking
426.31 of the youth;

426.32 (2) provide equitable, culturally responsive, and individualized services to each youth;

427.1 (3) assist each youth with accessing medical, mental health, legal, advocacy, and family
427.2 services based on the youth's individual needs;

427.3 (4) provide each youth with relevant educational, life skills, and employment supports
427.4 based on the youth's individual needs;

427.5 (5) offer a trafficking prevention education curriculum and provide support for each
427.6 youth at risk of future sex trafficking or commercial sexual exploitation; and

427.7 (6) engage with the discharge planning process for each youth and the youth's family.

427.8 (e) The license holder must maintain a service delivery plan that describes how the
427.9 program provides services according to the requirements in paragraphs (c) and (d).

427.10 (f) The license holder must ensure that each staff person who has direct contact, as
427.11 defined in section 245C.02, subdivision 11, with a youth served by the license holder's
427.12 program completes a human trafficking training approved by the Department of Human
427.13 Services' Children and Family Services Administration before the staff person has direct
427.14 contact with a youth served by the program and annually thereafter. For programs certified
427.15 prior to January 1, 2022, the license holder must ensure that each staff person at the license
427.16 holder's program completes the initial training by January 1, 2022.

427.17 Subd. 6. **Residential settings specializing in providing prenatal, postpartum, or**
427.18 **parenting supports for youth; certification requirements.** (a) To be certified as a
427.19 residential setting specializing in providing prenatal, postpartum, or parenting supports for
427.20 youth, a license holder must meet the requirements of this subdivision.

427.21 (b) The license holder must collaborate with the responsible social services agency and
427.22 other appropriate parties to implement each youth's out-of-home placement plan required
427.23 by section 260C.212, subdivision 1.

427.24 (c) The license holder must specialize in providing prenatal, postpartum, or parenting
427.25 supports for youth and must:

427.26 (1) provide equitable, culturally responsive, and individualized services to each youth;

427.27 (2) assist each youth with accessing postpartum services during the same period of time
427.28 that a woman is considered pregnant for the purposes of medical assistance eligibility under
427.29 section 256B.055, subdivision 6, including providing each youth with:

427.30 (i) sexual and reproductive health services and education; and

427.31 (ii) a postpartum mental health assessment and follow-up services; and

427.32 (3) discharge planning that includes the youth and the youth's family.

428.1 (d) On or before the date of a child's initial physical presence at the facility, the license
428.2 holder must provide education to the child's parent related to safe bathing and reducing the
428.3 risk of sudden unexpected infant death and abusive head trauma from shaking infants and
428.4 young children. The license holder must use the educational material developed by the
428.5 commissioner of human services to comply with this requirement. At a minimum, the
428.6 education must address:

428.7 (1) instruction that: (i) a child or infant should never be left unattended around water;
428.8 (ii) a tub should be filled with only two to four inches of water for infants; and (iii) an infant
428.9 should never be put into a tub when the water is running; and

428.10 (2) the risk factors related to sudden unexpected infant death and abusive head trauma
428.11 from shaking infants and young children and means of reducing the risks, including the
428.12 safety precautions identified in section 245A.1435 and the risks of co-sleeping.

428.13 The license holder must document the parent's receipt of the education and keep the
428.14 documentation in the parent's file. The documentation must indicate whether the parent
428.15 agrees to comply with the safeguards described in this paragraph. If the parent refuses to
428.16 comply, program staff must provide additional education to the parent as described in the
428.17 parental supervision plan. The parental supervision plan must include the intervention,
428.18 frequency, and staff responsible for the duration of the parent's participation in the program
428.19 or until the parent agrees to comply with the safeguards described in this paragraph.

428.20 (e) On or before the date of a child's initial physical presence at the facility, the license
428.21 holder must document the parent's capacity to meet the health and safety needs of the child
428.22 while on the facility premises considering the following factors:

428.23 (1) the parent's physical and mental health;

428.24 (2) the parent being under the influence of drugs, alcohol, medications, or other chemicals;

428.25 (3) the child's physical and mental health; and

428.26 (4) any other information available to the license holder indicating that the parent may
428.27 not be able to adequately care for the child.

428.28 (f) The license holder must have written procedures specifying the actions that staff shall
428.29 take if a parent is or becomes unable to adequately care for the parent's child.

428.30 (g) If the parent refuses to comply with the safeguards described in paragraph (d) or is
428.31 unable to adequately care for the child, the license holder must develop a parental supervision
428.32 plan in conjunction with the parent. The plan must account for any factors in paragraph (e)

429.1 that contribute to the parent's inability to adequately care for the child. The plan must be
429.2 dated and signed by the staff person who completed the plan.

429.3 (h) The license holder must have written procedures addressing whether the program
429.4 permits a parent to arrange for supervision of the parent's child by another youth in the
429.5 program. If permitted, the facility must have a procedure that requires staff approval of the
429.6 supervision arrangement before the supervision by the nonparental youth occurs. The
429.7 procedure for approval must include an assessment of the nonparental youth's capacity to
429.8 assume the supervisory responsibilities using the criteria in paragraph (e). The license holder
429.9 must document the license holder's approval of the supervisory arrangement and the
429.10 assessment of the nonparental youth's capacity to supervise the child and must keep this
429.11 documentation in the file of the parent whose child is being supervised by the nonparental
429.12 youth.

429.13 (i) The license holder must maintain a service delivery plan that describes how the
429.14 program provides services according to paragraphs (b) to (h).

429.15 Subd. 7. **Supervised independent living settings for youth 18 years of age or older;**
429.16 **certification requirements.** (a) To be certified as a supervised independent living setting
429.17 for youth who are 18 years of age or older, a license holder must meet the requirements of
429.18 this subdivision.

429.19 (b) A license holder must provide training, counseling, instruction, supervision, and
429.20 assistance for independent living, to meet the needs of the youth being served.

429.21 (c) A license holder may provide services to assist the youth with locating housing,
429.22 money management, meal preparation, shopping, health care, transportation, and any other
429.23 support services necessary to meet the youth's needs and improve the youth's ability to
429.24 conduct such tasks independently.

429.25 (d) The service plan for the youth must contain an objective of independent living skills.

429.26 (e) The license holder must maintain a service delivery plan that describes how the
429.27 program provides services according to paragraphs (b) to (d).

429.28 Subd. 8. **Monitoring and inspections.** (a) For a program licensed by the commissioner
429.29 of human services, the commissioner of human services may review a program's compliance
429.30 with certification requirements by conducting an inspection, a licensing review, or an
429.31 investigation of the program. The commissioner may issue a correction order to the license
429.32 holder for a program's noncompliance with the certification requirements of this section.
429.33 For a program licensed by the commissioner of human services, a license holder must make

430.1 a request for reconsideration of a correction order according to section 245A.06, subdivision
430.2 2.

430.3 (b) For a program licensed by the commissioner of corrections, the commissioner of
430.4 human services may review the program's compliance with the requirements for a certification
430.5 issued under this section biennially and may issue a correction order identifying the program's
430.6 noncompliance with the requirements of this section. The correction order must state the
430.7 following:

430.8 (1) the conditions that constitute a violation of a law or rule;

430.9 (2) the specific law or rule violated; and

430.10 (3) the time allowed for the program to correct each violation.

430.11 (c) For a program licensed by the commissioner of corrections, if a license holder believes
430.12 that there are errors in the correction order of the commissioner of human services, the
430.13 license holder may ask the Department of Human Services to reconsider the parts of the
430.14 correction order that the license holder alleges are in error. To submit a request for
430.15 reconsideration, the license holder must send a written request for reconsideration by United
430.16 States mail to the commissioner of human services. The request for reconsideration must
430.17 be postmarked within 20 calendar days of the date that the correction order was received
430.18 by the license holder and must:

430.19 (1) specify the parts of the correction order that are alleged to be in error;

430.20 (2) explain why the parts of the correction order are in error; and

430.21 (3) include documentation to support the allegation of error.

430.22 A request for reconsideration does not stay any provisions or requirements of the correction
430.23 order. The commissioner of human services' disposition of a request for reconsideration is
430.24 final and not subject to appeal under chapter 14.

430.25 (d) Nothing in this subdivision prohibits the commissioner of human services from
430.26 decertifying a license holder according to subdivision 9 prior to issuing a correction order.

430.27 Subd. 9. **Decertification.** (a) The commissioner of human services may rescind a
430.28 certification issued under this section if a license holder fails to comply with the certification
430.29 requirements in this section.

430.30 (b) The license holder may request reconsideration of a decertification by notifying the
430.31 commissioner of human services by certified mail or personal service. The license holder
430.32 must request reconsideration of a decertification in writing. If the license holder sends the

431.1 request for reconsideration of a decertification by certified mail, the license holder must
431.2 send the request by United States mail to the commissioner of human services and the
431.3 request must be postmarked within 20 calendar days after the license holder received the
431.4 notice of decertification. If the license holder requests reconsideration of a decertification
431.5 by personal service, the request for reconsideration must be received by the commissioner
431.6 of human services within 20 calendar days after the license holder received the notice of
431.7 decertification. When submitting a request for reconsideration of a decertification, the license
431.8 holder must submit a written argument or evidence in support of the request for
431.9 reconsideration.

431.10 (c) The commissioner of human services' disposition of a request for reconsideration is
431.11 final and not subject to appeal under chapter 14.

431.12 Subd. 10. **Variances.** The commissioner of human services may grant variances to the
431.13 requirements in this section that do not affect a youth's health or safety or compliance with
431.14 federal requirements for Title IV-E funding if the conditions in section 245A.04, subdivision
431.15 9, are met.

431.16 **EFFECTIVE DATE.** This section is effective the day following final enactment.

431.17 Sec. 11. Minnesota Statutes 2020, section 256.01, subdivision 14b, is amended to read:

431.18 Subd. 14b. **American Indian child welfare projects.** (a) The commissioner of human
431.19 services may authorize projects to initiate tribal delivery of child welfare services to American
431.20 Indian children and their parents and custodians living on the reservation. The commissioner
431.21 has authority to solicit and determine which tribes may participate in a project. Grants may
431.22 be issued to Minnesota Indian tribes to support the projects. The commissioner may waive
431.23 existing state rules as needed to accomplish the projects. The commissioner may authorize
431.24 projects to use alternative methods of (1) screening, investigating, and assessing reports of
431.25 child maltreatment, and (2) administrative reconsideration, administrative appeal, and
431.26 judicial appeal of maltreatment determinations, provided the alternative methods used by
431.27 the projects comply with the provisions of section 256.045 and chapter 260E that deal with
431.28 the rights of individuals who are the subjects of reports or investigations, including notice
431.29 and appeal rights and data practices requirements. The commissioner shall only authorize
431.30 alternative methods that comply with the public policy under section 260E.01. The
431.31 commissioner may seek any federal approval necessary to carry out the projects as well as
431.32 seek and use any funds available to the commissioner, including use of federal funds,
431.33 foundation funds, existing grant funds, and other funds. The commissioner is authorized to
431.34 advance state funds as necessary to operate the projects. Federal reimbursement applicable

432.1 to the projects is appropriated to the commissioner for the purposes of the projects. The
432.2 projects must be required to address responsibility for safety, permanency, and well-being
432.3 of children.

432.4 (b) For the purposes of this section, "American Indian child" means a person under 21
432.5 years old and who is a tribal member or eligible for membership in one of the tribes chosen
432.6 for a project under this subdivision and who is residing on the reservation of that tribe.

432.7 (c) In order to qualify for an American Indian child welfare project, a tribe must:

432.8 (1) be one of the existing tribes with reservation land in Minnesota;

432.9 (2) have a tribal court with jurisdiction over child custody proceedings;

432.10 (3) have a substantial number of children for whom determinations of maltreatment have
432.11 occurred;

432.12 (4)(i) have capacity to respond to reports of abuse and neglect under chapter 260E; or
432.13 (ii) have codified the tribe's screening, investigation, and assessment of reports of child
432.14 maltreatment procedures, if authorized to use an alternative method by the commissioner
432.15 under paragraph (a);

432.16 (5) provide a wide range of services to families in need of child welfare services; ~~and~~

432.17 (6) have a tribal-state title IV-E agreement in effect~~.~~; and

432.18 (7) enter into host Tribal contracts pursuant to section 256.0112, subdivision 6.

432.19 (d) Grants awarded under this section may be used for the nonfederal costs of providing
432.20 child welfare services to American Indian children on the tribe's reservation, including costs
432.21 associated with:

432.22 (1) assessment and prevention of child abuse and neglect;

432.23 (2) family preservation;

432.24 (3) facilitative, supportive, and reunification services;

432.25 (4) out-of-home placement for children removed from the home for child protective
432.26 purposes; and

432.27 (5) other activities and services approved by the commissioner that further the goals of
432.28 providing safety, permanency, and well-being of American Indian children.

432.29 (e) When a tribe has initiated a project and has been approved by the commissioner to
432.30 assume child welfare responsibilities for American Indian children of that tribe under this
432.31 section, the affected county social service agency is relieved of responsibility for responding

433.1 to reports of abuse and neglect under chapter 260E for those children during the time within
433.2 which the tribal project is in effect and funded. The commissioner shall work with tribes
433.3 and affected counties to develop procedures for data collection, evaluation, and clarification
433.4 of ongoing role and financial responsibilities of the county and tribe for child welfare services
433.5 prior to initiation of the project. Children who have not been identified by the tribe as
433.6 participating in the project shall remain the responsibility of the county. Nothing in this
433.7 section shall alter responsibilities of the county for law enforcement or court services.

433.8 (f) Participating tribes may conduct children's mental health screenings under section
433.9 245.4874, subdivision 1, paragraph (a), clause (12), for children who are eligible for the
433.10 initiative and living on the reservation and who meet one of the following criteria:

433.11 (1) the child must be receiving child protective services;

433.12 (2) the child must be in foster care; or

433.13 (3) the child's parents must have had parental rights suspended or terminated.

433.14 Tribes may access reimbursement from available state funds for conducting the screenings.
433.15 Nothing in this section shall alter responsibilities of the county for providing services under
433.16 section 245.487.

433.17 (g) Participating tribes may establish a local child mortality review panel. In establishing
433.18 a local child mortality review panel, the tribe agrees to conduct local child mortality reviews
433.19 for child deaths or near-fatalities occurring on the reservation under subdivision 12. Tribes
433.20 with established child mortality review panels shall have access to nonpublic data and shall
433.21 protect nonpublic data under subdivision 12, paragraphs (c) to (e). The tribe shall provide
433.22 written notice to the commissioner and affected counties when a local child mortality review
433.23 panel has been established and shall provide data upon request of the commissioner for
433.24 purposes of sharing nonpublic data with members of the state child mortality review panel
433.25 in connection to an individual case.

433.26 (h) The commissioner shall collect information on outcomes relating to child safety,
433.27 permanency, and well-being of American Indian children who are served in the projects.
433.28 Participating tribes must provide information to the state in a format and completeness
433.29 deemed acceptable by the state to meet state and federal reporting requirements.

433.30 (i) In consultation with the White Earth Band, the commissioner shall develop and submit
433.31 to the chairs and ranking minority members of the legislative committees with jurisdiction
433.32 over health and human services a plan to transfer legal responsibility for providing child
433.33 protective services to White Earth Band member children residing in Hennepin County to

434.1 the White Earth Band. The plan shall include a financing proposal, definitions of key terms,
434.2 statutory amendments required, and other provisions required to implement the plan. The
434.3 commissioner shall submit the plan by January 15, 2012.

434.4 **EFFECTIVE DATE.** This section is effective the day following final enactment.

434.5 Sec. 12. Minnesota Statutes 2020, section 256.0112, subdivision 6, is amended to read:

434.6 Subd. 6. **Contracting within and across county lines; lead county contracts; lead**
434.7 **tribal contracts.** Paragraphs (a) to (e) govern contracting within and across county lines
434.8 and lead county contracts. Paragraphs (a) to (e) govern contracting within and across
434.9 reservation boundaries and lead tribal contracts for initiative tribes under section 256.01,
434.10 subdivision 14b. For purposes of this subdivision, "local agency" includes a tribe or a county
434.11 agency.

434.12 (a) Once a local agency and an approved vendor execute a contract that meets the
434.13 requirements of this subdivision, the contract governs all other purchases of service from
434.14 the vendor by all other local agencies for the term of the contract. The local agency that
434.15 negotiated and entered into the contract becomes the lead tribe or county for the contract.

434.16 (b) When the local agency in the county or reservation where a vendor is located wants
434.17 to purchase services from that vendor and the vendor has no contract with the local agency
434.18 or any other tribe or county, the local agency must negotiate and execute a contract with
434.19 the vendor.

434.20 (c) When a local agency ~~in one county~~ wants to purchase services from a vendor located
434.21 in another county or reservation, it must notify the local agency in the county or reservation
434.22 where the vendor is located. Within 30 days of being notified, the local agency in the vendor's
434.23 county or reservation must:

434.24 (1) if it has a contract with the vendor, send a copy to the inquiring local agency;

434.25 (2) if there is a contract with the vendor for which another local agency is the lead tribe
434.26 or county, identify the lead tribe or county to the inquiring agency; or

434.27 (3) if no local agency has a contract with the vendor, inform the inquiring agency whether
434.28 it will negotiate a contract and become the lead tribe or county. If the agency where the
434.29 vendor is located will not negotiate a contract with the vendor because of concerns related
434.30 to clients' health and safety, the agency must share those concerns with the inquiring local
434.31 agency.

435.1 (d) If the local agency in the county where the vendor is located declines to negotiate a
435.2 contract with the vendor or fails to respond within 30 days of receiving the notification
435.3 under paragraph (c), the inquiring agency is authorized to negotiate a contract and must
435.4 notify the local agency that declined or failed to respond.

435.5 (e) When the inquiring ~~county~~ local agency under paragraph (d) becomes the lead tribe
435.6 or county for a contract and the contract expires and needs to be renegotiated, that tribe or
435.7 county must again follow the requirements under paragraph (c) and notify the local agency
435.8 where the vendor is located. The local agency where the vendor is located has the option
435.9 of becoming the lead tribe or county for the new contract. If the local agency does not
435.10 exercise the option, paragraph (d) applies.

435.11 (f) This subdivision does not affect the requirement to seek county concurrence under
435.12 section 256B.092, subdivision 8a, when the services are to be purchased for a person with
435.13 a developmental disability or under section 245.4711, subdivision 3, when the services to
435.14 be purchased are for an adult with serious and persistent mental illness.

435.15 **EFFECTIVE DATE.** This section is effective the day following final enactment.

435.16 Sec. 13. Minnesota Statutes 2020, section 260C.007, subdivision 6, is amended to read:

435.17 Subd. 6. **Child in need of protection or services.** "Child in need of protection or
435.18 services" means a child who is in need of protection or services because the child:

435.19 (1) is abandoned or without parent, guardian, or custodian;

435.20 (2)(i) has been a victim of physical or sexual abuse as defined in section 260E.03,
435.21 subdivision 18 or 20, (ii) resides with or has resided with a victim of child abuse as defined
435.22 in subdivision 5 or domestic child abuse as defined in subdivision 13, (iii) resides with or
435.23 would reside with a perpetrator of domestic child abuse as defined in subdivision 13 or child
435.24 abuse as defined in subdivision 5 or 13, or (iv) is a victim of emotional maltreatment as
435.25 defined in subdivision 15;

435.26 (3) is without necessary food, clothing, shelter, education, or other required care for the
435.27 child's physical or mental health or morals because the child's parent, guardian, or custodian
435.28 is unable or unwilling to provide that care;

435.29 (4) is without the special care made necessary by a physical, mental, or emotional
435.30 condition because the child's parent, guardian, or custodian is unable or unwilling to provide
435.31 that care;

436.1 (5) is medically neglected, which includes, but is not limited to, the withholding of
436.2 medically indicated treatment from an infant with a disability with a life-threatening
436.3 condition. The term "withholding of medically indicated treatment" means the failure to
436.4 respond to the infant's life-threatening conditions by providing treatment, including
436.5 appropriate nutrition, hydration, and medication which, in the treating physician's or advanced
436.6 practice registered nurse's reasonable medical judgment, will be most likely to be effective
436.7 in ameliorating or correcting all conditions, except that the term does not include the failure
436.8 to provide treatment other than appropriate nutrition, hydration, or medication to an infant
436.9 when, in the treating physician's or advanced practice registered nurse's reasonable medical
436.10 judgment:

436.11 (i) the infant is chronically and irreversibly comatose;

436.12 (ii) the provision of the treatment would merely prolong dying, not be effective in
436.13 ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be
436.14 futile in terms of the survival of the infant; or

436.15 (iii) the provision of the treatment would be virtually futile in terms of the survival of
436.16 the infant and the treatment itself under the circumstances would be inhumane;

436.17 (6) is one whose parent, guardian, or other custodian for good cause desires to be relieved
436.18 of the child's care and custody, including a child who entered foster care under a voluntary
436.19 placement agreement between the parent and the responsible social services agency under
436.20 section 260C.227;

436.21 (7) has been placed for adoption or care in violation of law;

436.22 (8) is without proper parental care because of the emotional, mental, or physical disability,
436.23 or state of immaturity of the child's parent, guardian, or other custodian;

436.24 (9) is one whose behavior, condition, or environment is such as to be injurious or
436.25 dangerous to the child or others. An injurious or dangerous environment may include, but
436.26 is not limited to, the exposure of a child to criminal activity in the child's home;

436.27 (10) is experiencing growth delays, which may be referred to as failure to thrive, that
436.28 have been diagnosed by a physician and are due to parental neglect;

436.29 (11) is a sexually exploited youth;

436.30 (12) has committed a delinquent act or a juvenile petty offense before becoming ~~ten~~ 13
436.31 years old;

436.32 (13) is a runaway;

437.1 (14) is a habitual truant;

437.2 (15) has been found incompetent to proceed or has been found not guilty by reason of
437.3 mental illness or mental deficiency in connection with a delinquency proceeding, a
437.4 certification under section 260B.125, an extended jurisdiction juvenile prosecution, or a
437.5 proceeding involving a juvenile petty offense; or

437.6 (16) has a parent whose parental rights to one or more other children were involuntarily
437.7 terminated or whose custodial rights to another child have been involuntarily transferred to
437.8 a relative and there is a case plan prepared by the responsible social services agency
437.9 documenting a compelling reason why filing the termination of parental rights petition under
437.10 section 260C.503, subdivision 2, is not in the best interests of the child.

437.11 Sec. 14. Minnesota Statutes 2020, section 260C.007, subdivision 26c, is amended to read:

437.12 Subd. 26c. **Qualified individual.** (a) "Qualified individual" means a trained culturally
437.13 competent professional or licensed clinician, including a mental health professional under
437.14 section 245.4871, subdivision 27, who is ~~not~~ qualified to conduct the assessment approved
437.15 by the commissioner. The qualified individual must not be an employee of the responsible
437.16 social services agency and who is not connected to or affiliated with any placement setting
437.17 in which a responsible social services agency has placed children.

437.18 (b) When the Indian Child Welfare Act of 1978, United States Code, title 25, sections
437.19 1901 to 1963, applies to a child, the county must contact the child's tribe without delay to
437.20 give the tribe the option to designate a qualified individual who is a trained culturally
437.21 competent professional or licensed clinician, including a mental health professional under
437.22 section 245.4871, subdivision 27, who is not employed by the responsible social services
437.23 agency and who is not connected to or affiliated with any placement setting in which a
437.24 responsible social services agency has placed children. Only a federal waiver that
437.25 demonstrates maintained objectivity may allow a responsible social services agency employee
437.26 or tribal employee affiliated with any placement setting in which the responsible social
437.27 services agency has placed children to be designated the qualified individual.

437.28 Sec. 15. Minnesota Statutes 2020, section 260C.007, subdivision 31, is amended to read:

437.29 Subd. 31. **Sexually exploited youth.** "Sexually exploited youth" means an individual
437.30 who:

(1) is alleged to have engaged in conduct which would, if committed by an adult, violate any federal, state, or local law relating to being hired, offering to be hired, or agreeing to be hired by another individual to engage in sexual penetration or sexual conduct;

(2) is a victim of a crime described in section 609.342, 609.343, 609.344, 609.345, 609.3451, 609.3453, 609.352, 617.246, or 617.247;

(3) is a victim of a crime described in United States Code, title 18, section 2260; 2421; 2422; 2423; 2425; 2425A; or 2256; ~~or~~

(4) is a sex trafficking victim as defined in section 609.321, subdivision 7b~~.~~; or

(5) is a victim of commercial sexual exploitation as defined in United States Code, title 22, section 7102(11)(A) and (12).

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 16. Minnesota Statutes 2020, section 260C.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services agency shall establish a juvenile treatment screening team to conduct screenings under this chapter ~~and section 245.487, subdivision 3,~~ and chapter 260D for a child to receive treatment for an emotional disturbance, a developmental disability, or related condition in a residential treatment facility licensed by the commissioner of human services under chapter 245A, or licensed or approved by a tribe. A screening team is not required for a child to be in: (1) a residential facility specializing in prenatal, postpartum, or parenting support; (2) a facility specializing in high-quality residential care and supportive services to children and youth who ~~are~~ have been or are at risk of becoming victims of sex-trafficking ~~victims or are at risk of becoming sex-trafficking victims~~ or commercial sexual exploitation; (3) supervised settings for youth who are 18 years ~~old~~ of age or older and living independently; or (4) a licensed residential family-based treatment facility for substance abuse consistent with section 260C.190. Screenings are also not required when a child must be placed in a facility due to an emotional crisis or other mental health emergency.

(b) The responsible social services agency shall conduct screenings within 15 days of a request for a screening, unless the screening is for the purpose of residential treatment and the child is enrolled in a prepaid health program under section 256B.69, in which case the agency shall conduct the screening within ten working days of a request. The responsible social services agency shall convene the juvenile treatment screening team, which may be constituted under section 245.4885 or 256B.092 or Minnesota Rules, parts 9530.6600 to 9530.6655. The team shall consist of social workers; persons with expertise in the treatment

of juveniles who are emotionally ~~disabled~~ disturbed, chemically dependent, or have a developmental disability; and the child's parent, guardian, or permanent legal custodian. The team may include the child's relatives as defined in section 260C.007, subdivisions 26b and 27, the child's foster care provider, and professionals who are a resource to the child's family such as teachers, medical or mental health providers, and clergy, as appropriate, consistent with the family and permanency team as defined in section 260C.007, subdivision 16a. Prior to forming the team, the responsible social services agency must consult with the child's parents, the child if the child is age 14 or older, ~~the child's parents,~~ and, if applicable, the child's tribe to obtain recommendations regarding which individuals to include on the team and to ensure that the team is family-centered and will act in the child's best ~~interest~~ interests. If the child, child's parents, or legal guardians raise concerns about specific relatives or professionals, the team should not include those individuals. This provision does not apply to paragraph (c).

(c) If the agency provides notice to tribes under section 260.761, and the child screened is an Indian child, the responsible social services agency must make a rigorous and concerted effort to include a designated representative of the Indian child's tribe on the juvenile treatment screening team, unless the child's tribal authority declines to appoint a representative. The Indian child's tribe may delegate its authority to represent the child to any other federally recognized Indian tribe, as defined in section 260.755, subdivision 12. The provisions of the Indian Child Welfare Act of 1978, United States Code, title 25, sections 1901 to 1963, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835, apply to this section.

(d) If the court, prior to, or as part of, a final disposition or other court order, proposes to place a child with an emotional disturbance or developmental disability or related condition in residential treatment, the responsible social services agency must conduct a screening. If the team recommends treating the child in a qualified residential treatment program, the agency must follow the requirements of sections 260C.70 to 260C.714.

The court shall ascertain whether the child is an Indian child and shall notify the responsible social services agency and, if the child is an Indian child, shall notify the Indian child's tribe as paragraph (c) requires.

(e) When the responsible social services agency is responsible for placing and caring for the child and the screening team recommends placing a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, the agency must: (1) begin the assessment and processes required in section 260C.704 without delay; and (2) conduct a relative search according to section 260C.221 to assemble the child's family and

440.1 permanency team under section 260C.706. Prior to notifying relatives regarding the family
440.2 and permanency team, the responsible social services agency must consult with the child's
440.3 parent or legal guardian, the child if the child is age 14 or older, ~~the child's parents~~ and, if
440.4 applicable, the child's tribe to ensure that the agency is providing notice to individuals who
440.5 will act in the child's best ~~interest~~ interests. The child and the child's parents may identify
440.6 a culturally competent qualified individual to complete the child's assessment. The agency
440.7 shall make efforts to refer the assessment to the identified qualified individual. The
440.8 assessment may not be delayed for the purpose of having the assessment completed by a
440.9 specific qualified individual.

440.10 (f) When a screening team determines that a child does not need treatment in a qualified
440.11 residential treatment program, the screening team must:

440.12 (1) document the services and supports that will prevent the child's foster care placement
440.13 and will support the child remaining at home;

440.14 (2) document the services and supports that the agency will arrange to place the child
440.15 in a family foster home; or

440.16 (3) document the services and supports that the agency has provided in any other setting.

440.17 (g) When the Indian child's tribe or tribal health care services provider or Indian Health
440.18 Services provider proposes to place a child for the primary purpose of treatment for an
440.19 emotional disturbance, a developmental disability, or co-occurring emotional disturbance
440.20 and chemical dependency, the Indian child's tribe or the tribe delegated by the child's tribe
440.21 shall submit necessary documentation to the county juvenile treatment screening team,
440.22 which must invite the Indian child's tribe to designate a representative to the screening team.

440.23 (h) The responsible social services agency must conduct and document the screening in
440.24 a format approved by the commissioner of human services.

440.25 **EFFECTIVE DATE.** This section is effective September 30, 2021.

440.26 Sec. 17. Minnesota Statutes 2020, section 260C.212, subdivision 1a, is amended to read:

440.27 Subd. 1a. **Out-of-home placement plan update.** (a) Within 30 days of placing the child
440.28 in foster care, the agency must file the child's initial out-of-home placement plan with the
440.29 court. After filing the child's initial out-of-home placement plan, the agency shall update
440.30 and file the child's out-of-home placement plan with the court as follows:

440.31 (1) when the agency moves a child to a different foster care setting, the agency shall
440.32 inform the court within 30 days of the child's placement change or court-ordered trial home

441.1 visit. The agency must file the child's updated out-of-home placement plan with the court
441.2 at the next required review hearing;

441.3 (2) when the agency places a child in a qualified residential treatment program as defined
441.4 in section 260C.007, subdivision 26d, or moves a child from one qualified residential
441.5 treatment program to a different qualified residential treatment program, the agency must
441.6 update the child's out-of-home placement plan within 60 days. To meet the requirements
441.7 of section 260C.708, the agency must file the child's out-of-home placement plan with the
441.8 court as part of the 60-day hearing and along with the agency's report seeking the court's
441.9 approval of the child's placement at a qualified residential treatment program under section
441.10 260C.71. After the court issues an order, the agency must update the child's out-of-home
441.11 placement plan after the court hearing to document the court's approval or disapproval of
441.12 the child's placement in a qualified residential treatment program;

441.13 (3) when the agency places a child with the child's parent in a licensed residential
441.14 family-based substance use disorder treatment program under section 260C.190, the agency
441.15 must identify the treatment program where the child will be placed in the child's out-of-home
441.16 placement plan prior to the child's placement. The agency must file the child's out-of-home
441.17 placement plan with the court at the next required review hearing; and

441.18 (4) under sections 260C.227 and 260C.521, the agency must update the child's
441.19 out-of-home placement plan and file the child's out-of-home placement plan with the court.

441.20 (b) When none of the items in paragraph (a) apply, the agency must update the child's
441.21 out-of-home placement plan no later than 180 days after the child's initial placement and
441.22 every six months thereafter, consistent with section 260C.203, paragraph (a).

441.23 **EFFECTIVE DATE.** This section is effective September 30, 2021.

441.24 Sec. 18. Minnesota Statutes 2020, section 260C.212, subdivision 13, is amended to read:

441.25 Subd. 13. **Protecting missing and runaway children and youth at risk of sex**
441.26 **trafficking or commercial sexual exploitation.** (a) The local social services agency shall
441.27 expeditiously locate any child missing from foster care.

441.28 (b) The local social services agency shall report immediately, but no later than 24 hours,
441.29 after receiving information on a missing or abducted child to the local law enforcement
441.30 agency for entry into the National Crime Information Center (NCIC) database of the Federal
441.31 Bureau of Investigation, and to the National Center for Missing and Exploited Children.

442.1 (c) The local social services agency shall not discharge a child from foster care or close
442.2 the social services case until diligent efforts have been exhausted to locate the child and the
442.3 court terminates the agency's jurisdiction.

442.4 (d) The local social services agency shall determine the primary factors that contributed
442.5 to the child's running away or otherwise being absent from care and, to the extent possible
442.6 and appropriate, respond to those factors in current and subsequent placements.

442.7 (e) The local social services agency shall determine what the child experienced while
442.8 absent from care, including screening the child to determine if the child is a possible sex
442.9 trafficking or commercial sexual exploitation victim as defined in section ~~609.321,~~
442.10 ~~subdivision 7b~~ 260C.007, subdivision 31.

442.11 (f) The local social services agency shall report immediately, but no later than 24 hours,
442.12 to the local law enforcement agency any reasonable cause to believe a child is, or is at risk
442.13 of being, a sex trafficking or commercial sexual exploitation victim.

442.14 (g) The local social services agency shall determine appropriate services as described
442.15 in section 145.4717 with respect to any child for whom the local social services agency has
442.16 responsibility for placement, care, or supervision when the local social services agency has
442.17 reasonable cause to believe that the child is, or is at risk of being, a sex trafficking or
442.18 commercial sexual exploitation victim.

442.19 **EFFECTIVE DATE.** This section is effective September 30, 2021.

442.20 Sec. 19. Minnesota Statutes 2020, section 260C.4412, is amended to read:

442.21 **260C.4412 PAYMENT FOR RESIDENTIAL PLACEMENTS.**

442.22 (a) When a child is placed in a foster care group residential setting under Minnesota
442.23 Rules, parts 2960.0020 to 2960.0710, a foster residence licensed under chapter 245A that
442.24 meets the standards of Minnesota Rules, parts 2960.3200 to 2960.3230, or a children's
442.25 residential facility licensed or approved by a tribe, foster care maintenance payments must
442.26 be made on behalf of the child to cover the cost of providing food, clothing, shelter, daily
442.27 supervision, school supplies, child's personal incidentals and supports, reasonable travel for
442.28 visitation, or other transportation needs associated with the items listed. Daily supervision
442.29 in the group residential setting includes routine day-to-day direction and arrangements to
442.30 ensure the well-being and safety of the child. It may also include reasonable costs of
442.31 administration and operation of the facility.

442.32 (b) The commissioner of human services shall specify the title IV-E administrative
442.33 procedures under section 256.82 for each of the following residential program settings:

(1) residential programs licensed under chapter 245A or licensed by a tribe, including:

(i) qualified residential treatment programs as defined in section 260C.007, subdivision 26d;

(ii) program settings specializing in providing prenatal, postpartum, or parenting supports for youth; and

(iii) program settings providing high-quality residential care and supportive services to children and youth who are, or are at risk of becoming, sex trafficking victims;

(2) licensed residential family-based substance use disorder treatment programs as defined in section 260C.007, subdivision 22a; and

(3) supervised settings in which a foster child age 18 or older may live independently, consistent with section 260C.451.

(c) A lead county contract under section 256.0112, subdivision 6, is not required to establish the foster care maintenance payment in paragraph (a) for foster residence settings licensed under chapter 245A that meet the standards of Minnesota Rules, parts 2960.3200 to 2960.3230. The foster care maintenance payment for these settings must be consistent with section 256N.26, subdivision 3, and subject to the annual revision as specified in section 256N.26, subdivision 9.

Sec. 20. Minnesota Statutes 2020, section 260C.452, is amended to read:

260C.452 SUCCESSFUL TRANSITION TO ADULTHOOD.

Subdivision 1. **Scope and purpose.** (a) For purposes of this section, "youth" means a person who is at least 14 years of age and under 23 years of age.

(b) This section pertains to a ~~child~~ youth who:

(1) is in foster care and is 14 years of age or older, including a youth who is under the guardianship of the commissioner of human services~~, or who~~;

(2) has a permanency disposition of permanent custody to the agency~~, or who~~;

(3) will leave foster care ~~at 18 to 21 years of age.~~ when the youth is 18 years of age or older and under 21 years of age;

(4) has left foster care due to adoption when the youth was 16 years of age or older;

(5) has left foster care due to a transfer of permanent legal and physical custody to a relative, or Tribal equivalent, when the youth was 16 years of age or older; or

444.1 (6) was reunified with the youth's primary caretaker when the youth was 14 years of age
444.2 or older and under 18 years of age.

444.3 (c) The purpose of this section is to provide support to each youth who is transitioning
444.4 to adulthood by providing services to the youth in the areas of:

444.5 (1) education;

444.6 (2) employment;

444.7 (3) daily living skills such as financial literacy training and driving instruction; preventive
444.8 health activities including promoting abstinence from substance use and smoking; and
444.9 nutrition education and pregnancy prevention;

444.10 (4) forming meaningful, permanent connections with caring adults;

444.11 (5) engaging in age and developmentally appropriate activities under section 260C.212,
444.12 subdivision 14, and positive youth development;

444.13 (6) financial, housing, counseling, and other services to assist a youth over 18 years of
444.14 age in achieving self-sufficiency and accepting personal responsibility for the transition
444.15 from adolescence to adulthood; and

444.16 (7) making vouchers available for education and training.

444.17 (d) The responsible social services agency may provide support and case management
444.18 services to a youth as defined in paragraph (a) until the youth reaches the age of 23 years.
444.19 According to section 260C.451, a youth's placement in a foster care setting will end when
444.20 the youth reaches the age of 21 years.

444.21 Subd. 1a. **Case management services.** Case management services include the
444.22 responsibility for planning, coordinating, authorizing, monitoring, and evaluating services
444.23 for a youth and shall be provided to a youth by the responsible social services agency or
444.24 the contracted agency. Case management services include the out-of-home placement plan
444.25 under section 260C.212, subdivision 1, when the youth is in out-of-home placement.

444.26 Subd. 2. **Independent living plan.** When the ~~child~~ youth is 14 years of age or older and
444.27 is receiving support from the responsible social services agency under this section, the
444.28 responsible social services agency, in consultation with the ~~child~~ youth, shall complete the
444.29 youth's independent living plan according to section 260C.212, subdivision 1, paragraph
444.30 (c), clause (12), regardless of the youth's current placement status.

444.31 ~~Subd. 3.~~ ~~**Notification.**~~ ~~Six months before the child is expected to be discharged from~~
444.32 ~~foster care, the responsible social services agency shall provide written notice to the child~~

~~regarding the right to continued access to services for certain children in foster care past 18 years of age and of the right to appeal a denial of social services under section 256.045.~~

Subd. 4. **Administrative or court review of placements.** (a) When the ~~child~~ youth is 14 years of age or older, the court, in consultation with the ~~child~~ youth, shall review the youth's independent living plan according to section 260C.203, paragraph (d).

(b) The responsible social services agency shall file a copy of the notification ~~required in subdivision 3~~ of foster care benefits for a youth who is 18 years of age or older according to section 260C.451, subdivision 1, with the court. If the responsible social services agency does not file the notice by the time the ~~child~~ youth is 17-1/2 years of age, the court shall require the responsible social services agency to file the notice.

(c) When a youth is 18 years of age or older, the court shall ensure that the responsible social services agency assists the ~~child~~ youth in obtaining the following documents before the ~~child~~ youth leaves foster care: a Social Security card; an official or certified copy of the ~~child's~~ youth's birth certificate; a state identification card or driver's license, tribal enrollment identification card, green card, or school visa; health insurance information; the ~~child's~~ youth's school, medical, and dental records; a contact list of the ~~child's~~ youth's medical, dental, and mental health providers; and contact information for the ~~child's~~ youth's siblings, if the siblings are in foster care.

(d) For a ~~child~~ youth who will be discharged from foster care at 18 years of age or older because the youth is not eligible for extended foster care benefits or chooses to leave foster care, the responsible social services agency must develop a personalized transition plan as directed by the ~~child~~ youth during the 90-day period immediately prior to the expected date of discharge. The transition plan must be as detailed as the ~~child~~ youth elects and include specific options, including but not limited to:

(1) affordable housing with necessary supports that does not include a homeless shelter;

(2) health insurance, including eligibility for medical assistance as defined in section 256B.055, subdivision 17;

(3) education, including application to the Education and Training Voucher Program;

(4) local opportunities for mentors and continuing support services~~, including the Healthy Transitions and Homeless Prevention program, if available~~;

(5) workforce supports and employment services;

446.1 (6) a copy of the ~~child's~~ youth's consumer credit report as defined in section 13C.001
446.2 and assistance in interpreting and resolving any inaccuracies in the report, at no cost to the
446.3 ~~child~~ youth;

446.4 (7) information on executing a health care directive under chapter 145C and on the
446.5 importance of designating another individual to make health care decisions on behalf of the
446.6 ~~child~~ youth if the ~~child~~ youth becomes unable to participate in decisions;

446.7 (8) appropriate contact information through 21 years of age if the ~~child~~ youth needs
446.8 information or help dealing with a crisis situation; and

446.9 (9) official documentation that the youth was previously in foster care.

446.10 Subd. 5. **Notice of termination of ~~foster care~~ social services.** (a) ~~When~~ Before a ~~child~~
446.11 youth who is 18 years of age or older leaves foster care ~~at 18 years of age or older~~, the
446.12 responsible social services agency shall give the ~~child~~ youth written notice that foster care
446.13 shall terminate 30 days from the date that the notice is sent by the agency according to
446.14 section 260C.451, subdivision 8.

446.15 ~~(b) The child or the child's guardian ad litem may file a motion asking the court to review~~
446.16 ~~the responsible social services agency's determination within 15 days of receiving the notice.~~
446.17 ~~The child shall not be discharged from foster care until the motion is heard. The responsible~~
446.18 ~~social services agency shall work with the child to transition out of foster care.~~

446.19 ~~(c) The written notice of termination of benefits shall be on a form prescribed by the~~
446.20 ~~commissioner and shall give notice of the right to have the responsible social services~~
446.21 ~~agency's determination reviewed by the court under this section or sections 260C.203,~~
446.22 ~~260C.317, and 260C.515, subdivision 5 or 6. A copy of the termination notice shall be sent~~
446.23 ~~to the child and the child's attorney, if any, the foster care provider, the child's guardian ad~~
446.24 ~~litem, and the court. The responsible social services agency is not responsible for paying~~
446.25 ~~foster care benefits for any period of time after the child leaves foster care.~~

446.26 (b) Before case management services will end for a youth who is at least 18 years of
446.27 age and under 23 years of age, the responsible social services agency shall give the youth:
446.28 (1) written notice that case management services for the youth shall terminate; and (2)
446.29 written notice that the youth has the right to appeal the termination of case management
446.30 services under section 256.045, subdivision 3, by responding in writing within ten days of
446.31 the date that the agency mailed the notice. The termination notice must include information
446.32 about services for which the youth is eligible and how to access the services.

446.33 **EFFECTIVE DATE.** This section is effective July 1, 2021.

447.1 Sec. 21. Minnesota Statutes 2020, section 260C.704, is amended to read:

447.2 **260C.704 REQUIREMENTS FOR THE QUALIFIED INDIVIDUAL'S**
447.3 **ASSESSMENT OF THE CHILD FOR PLACEMENT IN A QUALIFIED**
447.4 **RESIDENTIAL TREATMENT PROGRAM.**

447.5 (a) A qualified individual must complete an assessment of the child prior to ~~or within~~
447.6 ~~30 days of~~ the child's placement in a qualified residential treatment program in a format
447.7 approved by the commissioner of human services~~, and~~ <u>unless, due to a crisis, the child must</u>
447.8 <u>immediately be placed in a qualified residential treatment program. When a child must</u>
447.9 <u>immediately be placed in a qualified residential treatment program without an assessment,</u>
447.10 <u>the qualified individual must complete the child's assessment within 30 days of the child's</u>
447.11 <u>placement. The qualified individual</u> must:

447.12 (1) assess the child's needs and strengths, using an age-appropriate, evidence-based,
447.13 validated, functional assessment approved by the commissioner of human services;

447.14 (2) determine whether the child's needs can be met by the child's family members or
447.15 through placement in a family foster home; or, if not, determine which residential setting
447.16 would provide the child with the most effective and appropriate level of care to the child
447.17 in the least restrictive environment;

447.18 (3) develop a list of short- and long-term mental and behavioral health goals for the
447.19 child; and

447.20 (4) work with the child's family and permanency team using culturally competent
447.21 practices.

447.22 <u>If a level of care determination was conducted under section 245.4885, that information</u>
447.23 <u>must be shared with the qualified individual and the juvenile treatment screening team.</u>

447.24 (b) The child and the child's parents, when appropriate, may request that a specific
447.25 culturally competent qualified individual complete the child's assessment. The agency shall
447.26 make efforts to refer the child to the identified qualified individual to complete the
447.27 assessment. The assessment must not be delayed for a specific qualified individual to
447.28 complete the assessment.

447.29 (c) The qualified individual must provide the assessment, when complete, to the
447.30 responsible social services agency~~, the child's parents or legal guardians, the guardian ad~~
447.31 ~~litem, and the court~~<u>. If the assessment recommends placement of the child in a qualified</u>
447.32 <u>residential treatment facility, the agency must distribute the assessment to the child's parent</u>
447.33 <u>or legal guardian and file the assessment with the court report</u> as required in section 260C.71<u>,</u>

448.1 subdivision 2. If the assessment does not recommend placement in a qualified residential
448.2 treatment facility, the agency must provide a copy of the assessment to the parents or legal
448.3 guardians and the guardian ad litem and file the assessment determination with the court at
448.4 the next required hearing as required in section 260C.71, subdivision 5. If court rules and
448.5 chapter 13 permit disclosure of the results of the child's assessment, the agency may share
448.6 the results of the child's assessment with the child's foster care provider, other members of
448.7 the child's family, and the family and permanency team. The agency must not share the
448.8 child's private medical data with the family and permanency team unless: (1) chapter 13
448.9 permits the agency to disclose the child's private medical data to the family and permanency
448.10 team; or (2) the child's parent has authorized the agency to disclose the child's private medical
448.11 data to the family and permanency team.

448.12 (d) For an Indian child, the assessment of the child must follow the order of placement
448.13 preferences in the Indian Child Welfare Act of 1978, United States Code, title 25, section
448.14 1915.

448.15 (e) In the assessment determination, the qualified individual must specify in writing:

448.16 (1) the reasons why the child's needs cannot be met by the child's family or in a family
448.17 foster home. A shortage of family foster homes is not an acceptable reason for determining
448.18 that a family foster home cannot meet a child's needs;

448.19 (2) why the recommended placement in a qualified residential treatment program will
448.20 provide the child with the most effective and appropriate level of care to meet the child's
448.21 needs in the least restrictive environment possible and how placing the child at the treatment
448.22 program is consistent with the short-term and long-term goals of the child's permanency
448.23 plan; and

448.24 (3) if the qualified individual's placement recommendation is not the placement setting
448.25 that the parent, family and permanency team, child, or tribe prefer, the qualified individual
448.26 must identify the reasons why the qualified individual does not recommend the parent's,
448.27 family and permanency team's, child's, or tribe's placement preferences. The out-of-home
448.28 placement plan under section 260C.708 must also include reasons why the qualified
448.29 individual did not recommend the preferences of the parents, family and permanency team,
448.30 child, or tribe.

448.31 (f) If the qualified individual determines that the child's family or a family foster home
448.32 or other less restrictive placement may meet the child's needs, the agency must move the
448.33 child out of the qualified residential treatment program and transition the child to a less
448.34 restrictive setting within 30 days of the determination. If the responsible social services

449.1 agency has placement authority of the child, the agency must make a plan for the child's
449.2 placement according to section 260C.212, subdivision 2. The agency must file the child's
449.3 assessment determination with the court at the next required hearing.

449.4 (g) If the qualified individual recommends placing the child in a qualified residential
449.5 treatment program and if the responsible social services agency has placement authority of
449.6 the child, the agency shall make referrals to appropriate qualified residential treatment
449.7 programs and upon acceptance by an appropriate program, place the child in an approved
449.8 or certified qualified residential treatment program.

449.9 **EFFECTIVE DATE.** This section is effective September 30, 2021.

449.10 Sec. 22. Minnesota Statutes 2020, section 260C.706, is amended to read:

449.11 **260C.706 FAMILY AND PERMANENCY TEAM REQUIREMENTS.**

449.12 (a) When the responsible social services agency's juvenile treatment screening team, as
449.13 defined in section 260C.157, recommends placing the child in a qualified residential treatment
449.14 program, the agency must assemble a family and permanency team within ten days.

449.15 (1) The team must include all appropriate biological family members, the child's parents,
449.16 legal guardians or custodians, foster care providers, and relatives as defined in section
449.17 260C.007, subdivisions ~~26c~~ 26b and 27, and professionals, as appropriate, who are a resource
449.18 to the child's family, such as teachers, medical or mental health providers, or clergy.

449.19 (2) When a child is placed in foster care prior to the qualified residential treatment
449.20 program, the agency shall include relatives responding to the relative search notice as
449.21 required under section 260C.221 on this team, unless the juvenile court finds that contacting
449.22 a specific relative would ~~endanger~~ present a safety or health risk to the parent, guardian,
449.23 child, sibling, or any other family member.

449.24 (3) When a qualified residential treatment program is the child's initial placement setting,
449.25 the responsible social services agency must engage with the child and the child's parents to
449.26 determine the appropriate family and permanency team members.

449.27 (4) When the permanency goal is to reunify the child with the child's parent or legal
449.28 guardian, the purpose of the relative search and focus of the family and permanency team
449.29 is to preserve family relationships and identify and develop supports for the child and parents.

449.30 (5) The responsible agency must make a good faith effort to identify and assemble all
449.31 appropriate individuals to be part of the child's family and permanency team and request
449.32 input from the parents regarding relative search efforts consistent with section 260C.221.

450.1 The out-of-home placement plan in section 260C.708 must include all contact information
450.2 for the team members, as well as contact information for family members or relatives who
450.3 are not a part of the family and permanency team.

450.4 (6) If the child is age 14 or older, the team must include members of the family and
450.5 permanency team that the child selects in accordance with section 260C.212, subdivision
450.6 1, paragraph (b).

450.7 (7) Consistent with section 260C.221, a responsible social services agency may disclose
450.8 relevant and appropriate private data about the child to relatives in order for the relatives
450.9 to participate in caring and planning for the child's placement.

450.10 (8) If the child is an Indian child under section 260.751, the responsible social services
450.11 agency must make active efforts to include the child's tribal representative on the family
450.12 and permanency team.

450.13 (b) The family and permanency team shall meet regarding the assessment required under
450.14 section 260C.704 to determine whether it is necessary and appropriate to place the child in
450.15 a qualified residential treatment program and to participate in case planning under section
450.16 260C.708.

450.17 (c) When reunification of the child with the child's parent or legal guardian is the
450.18 permanency plan, the family and permanency team shall support the parent-child relationship
450.19 by recognizing the parent's legal authority, consulting with the parent regarding ongoing
450.20 planning for the child, and assisting the parent with visiting and contacting the child.

450.21 (d) When the agency's permanency plan is to transfer the child's permanent legal and
450.22 physical custody to a relative or for the child's adoption, the team shall:

450.23 (1) coordinate with the proposed guardian to provide the child with educational services,
450.24 medical care, and dental care;

450.25 (2) coordinate with the proposed guardian, the agency, and the foster care facility to
450.26 meet the child's treatment needs after the child is placed in a permanent placement with the
450.27 proposed guardian;

450.28 (3) plan to meet the child's need for safety, stability, and connection with the child's
450.29 family and community after the child is placed in a permanent placement with the proposed
450.30 guardian; and

450.31 (4) in the case of an Indian child, communicate with the child's tribe to identify necessary
450.32 and appropriate services for the child, transition planning for the child, the child's treatment

451.1 needs, and how to maintain the child's connections to the child's community, family, and
451.2 tribe.

451.3 (e) The agency shall invite the family and permanency team to participate in case planning
451.4 and the agency shall give the team notice of court reviews under sections 260C.152 and
451.5 260C.221 until: (1) the child is reunited with the child's parents; or (2) the child's foster care
451.6 placement ends and the child is in a permanent placement.

451.7 **EFFECTIVE DATE.** This section is effective September 30, 2021.

451.8 Sec. 23. Minnesota Statutes 2020, section 260C.708, is amended to read:

451.9 **260C.708 OUT-OF-HOME PLACEMENT PLAN FOR QUALIFIED**
451.10 **RESIDENTIAL TREATMENT PROGRAM PLACEMENTS.**

451.11 (a) When the responsible social services agency places a child in a qualified residential
451.12 treatment program as defined in section 260C.007, subdivision 26d, the out-of-home
451.13 placement plan must include:

451.14 (1) the case plan requirements in section ~~260.212, subdivision 1~~ 260C.212;

451.15 (2) the reasonable and good faith efforts of the responsible social services agency to
451.16 identify and include all of the individuals required to be on the child's family and permanency
451.17 team under section 260C.007;

451.18 (3) all contact information for members of the child's family and permanency team and
451.19 for other relatives who are not part of the family and permanency team;

451.20 (4) evidence that the agency scheduled meetings of the family and permanency team,
451.21 including meetings relating to the assessment required under section 260C.704, at a time
451.22 and place convenient for the family;

451.23 (5) evidence that the family and permanency team is involved in the assessment required
451.24 under section 260C.704 to determine the appropriateness of the child's placement in a
451.25 qualified residential treatment program;

451.26 (6) the family and permanency team's placement preferences for the child in the
451.27 assessment required under section 260C.704. When making a decision about the child's
451.28 placement preferences, the family and permanency team must recognize:

451.29 (i) that the agency should place a child with the child's siblings unless a court finds that
451.30 placing a child with the child's siblings is not possible due to a child's specialized placement
451.31 needs or is otherwise contrary to the child's best interests; and

452.1 (ii) that the agency should place an Indian child according to the requirements of the
452.2 Indian Child Welfare Act, the Minnesota Family Preservation Act under sections 260.751
452.3 to 260.835, and section 260C.193, subdivision 3, paragraph (g);

452.4 ~~(5)~~ (7) when reunification of the child with the child's parent or legal guardian is the
452.5 agency's goal, evidence demonstrating that the parent or legal guardian provided input about
452.6 the members of the family and permanency team under section 260C.706;

452.7 ~~(6)~~ (8) when the agency's permanency goal is to reunify the child with the child's parent
452.8 or legal guardian, the out-of-home placement plan must identify services and supports that
452.9 maintain the parent-child relationship and the parent's legal authority, decision-making, and
452.10 responsibility for ongoing planning for the child. In addition, the agency must assist the
452.11 parent with visiting and contacting the child;

452.12 ~~(7)~~ (9) when the agency's permanency goal is to transfer permanent legal and physical
452.13 custody of the child to a proposed guardian or to finalize the child's adoption, the case plan
452.14 must document the agency's steps to transfer permanent legal and physical custody of the
452.15 child or finalize adoption, as required in section 260C.212, subdivision 1, paragraph (c),
452.16 clauses (6) and (7); and

452.17 ~~(8)~~ (10) the qualified individual's recommendation regarding the child's placement in a
452.18 qualified residential treatment program and the court approval or disapproval of the placement
452.19 as required in section 260C.71.

452.20 (b) If the placement preferences of the family and permanency team, child, and tribe, if
452.21 applicable, are not consistent with the placement setting that the qualified individual
452.22 recommends, the case plan must include the reasons why the qualified individual did not
452.23 recommend following the preferences of the family and permanency team, child, and the
452.24 tribe.

452.25 (c) The agency must file the out-of-home placement plan with the court as part of the
452.26 60-day ~~hearing~~ court order under section 260C.71.

452.27 **EFFECTIVE DATE.** This section is effective September 30, 2021.

452.28 Sec. 24. Minnesota Statutes 2020, section 260C.71, is amended to read:

452.29 **260C.71 COURT APPROVAL REQUIREMENTS.**

452.30 Subdivision 1. **Judicial review.** When the responsible social services agency has legal
452.31 authority to place a child at a qualified residential treatment facility under section 260C.007,
452.32 subdivision 21a, and the child's assessment under section 260C.704 recommends placing

453.1 the child in a qualified residential treatment facility, the agency shall place the child at a
453.2 qualified residential facility. Within 60 days of placing the child at a qualified residential
453.3 treatment facility, the agency must obtain a court order finding that the child's placement
453.4 is appropriate and meets the child's individualized needs.

453.5 Subd. 2. **Qualified residential treatment program; agency report to court.** (a) The
453.6 responsible social services agency shall file a written report with the court after receiving
453.7 the qualified individual's assessment as specified in section 260C.704 prior to the child's
453.8 placement or within 35 days of the date of the child's placement in a qualified residential
453.9 treatment facility. The written report shall contain or have attached:

453.10 (1) the child's name, date of birth, race, gender, and current address;

453.11 (2) the names, races, dates of birth, residence, and post office address of the child's
453.12 parents or legal custodian, or guardian;

453.13 (3) the name and address of the qualified residential treatment program, including a
453.14 chief administrator of the facility;

453.15 (4) a statement of the facts that necessitated the child's foster care placement;

453.16 (5) the child's out-of-home placement plan under section 260C.212, subdivision 1,
453.17 including the requirements in section 260C.708;

453.18 (6) if the child is placed in an out-of-state qualified residential treatment program, the
453.19 compelling reasons why the child's needs cannot be met by an in-state placement;

453.20 (7) the qualified individual's assessment of the child under section 260C.704, paragraph
453.21 (c), in a format approved by the commissioner;

453.22 (8) if, at the time required for the report under this subdivision, the child's parent or legal
453.23 guardian, a child who is ten years of age or older, the family and permanency team, or a
453.24 tribe disagrees with the recommended qualified residential treatment program placement,
453.25 the agency shall include information regarding the disagreement, and to the extent possible,
453.26 the basis for the disagreement in the report;

453.27 (9) any other information that the responsible social services agency, child's parent, legal
453.28 custodian or guardian, child, or in the case of an Indian child, tribe would like the court to
453.29 consider; and

453.30 (10) the agency shall file the written report with the court and serve on the parties a
453.31 request for a hearing or a court order without a hearing.

454.1 (b) The agency must inform the child's parent or legal guardian and a child who is ten
454.2 years of age or older of the court review requirements of this section and the child's and
454.3 child's parent's or legal guardian's right to submit information to the court:

454.4 (1) the agency must inform the child's parent or legal guardian and a child who is ten
454.5 years of age or older of the reporting date and the date by which the agency must receive
454.6 information from the child and child's parent so that the agency is able to submit the report
454.7 required by this subdivision to the court;

454.8 (2) the agency must inform the child's parent or legal guardian and a child who is ten
454.9 years of age or older that the court will hold a hearing upon the request of the child or the
454.10 child's parent; and

454.11 (3) the agency must inform the child's parent or legal guardian and a child who is ten
454.12 years of age or older that they have the right to request a hearing and the right to present
454.13 information to the court for the court's review under this subdivision.

454.14 Subd. 3. **Court hearing.** (a) The court shall hold a hearing when a party or a child who
454.15 is ten years of age or older requests a hearing.

454.16 (b) In all other circumstances, the court has the discretion to hold a hearing or issue an
454.17 order without a hearing.

454.18 Subd. 4. **Court findings and order.** (a) Within 60 days from the beginning of each
454.19 placement in a qualified residential treatment program when the qualified individual's
454.20 assessment of the child recommends placing the child in a qualified residential treatment
454.21 program, the court must consider the qualified individual's assessment of the child under
454.22 section 260C.704 and issue an order to:

454.23 ~~(1) consider the qualified individual's assessment of whether it is necessary and~~
454.24 ~~appropriate to place the child in a qualified residential treatment program under section~~
454.25 ~~260C.704;~~

454.26 ~~(2)~~ (1) determine whether a family foster home can meet the child's needs, whether it is
454.27 necessary and appropriate to place a child in a qualified residential treatment program that
454.28 is the least restrictive environment possible, and whether the child's placement is consistent
454.29 with the child's short and long term goals as specified in the permanency plan; and

454.30 ~~(3)~~ (2) approve or disapprove of the child's placement.

454.31 (b) ~~In the out-of-home placement plan, the agency must document the court's approval~~
454.32 ~~or disapproval of the placement, as specified in section 260C.708.~~ If the court disapproves
454.33 of the child's placement in a qualified residential treatment program, the responsible social

455.1 services agency shall: (1) remove the child from the qualified residential treatment program
455.2 within 30 days of the court's order; and (2) make a plan for the child's placement that is
455.3 consistent with the child's best interests under section 260C.212, subdivision 2.

455.4 Subd. 5. **Court review and approval not required.** When the responsible social services
455.5 agency has legal authority to place a child under section 260C.007, subdivision 21a, and
455.6 the qualified individual's assessment of the child does not recommend placing the child in
455.7 a qualified residential treatment program, the court is not required to hold a hearing and the
455.8 court is not required to issue an order. Pursuant to section 260C.704, paragraph (f), the
455.9 responsible social services agency shall make a plan for the child's placement consistent
455.10 with the child's best interests under section 260C.212, subdivision 2. The agency must file
455.11 the agency's assessment determination for the child with the court at the next required
455.12 hearing.

455.13 **EFFECTIVE DATE.** This section is effective September 30, 2021.

455.14 Sec. 25. Minnesota Statutes 2020, section 260C.712, is amended to read:

455.15 **260C.712 ONGOING REVIEWS AND PERMANENCY HEARING**
455.16 **REQUIREMENTS.**

455.17 As long as a child remains placed in a qualified residential treatment program, the
455.18 responsible social services agency shall submit evidence at each administrative review under
455.19 section 260C.203; each court review under sections 260C.202, 260C.203, ~~and~~ 260C.204,
455.20 260D.06, 260D.07, and 260D.08; and each permanency hearing under section 260C.515,
455.21 260C.519, ~~or~~ 260C.521, or 260D.07 that:

455.22 (1) demonstrates that an ongoing assessment of the strengths and needs of the child
455.23 continues to support the determination that the child's needs cannot be met through placement
455.24 in a family foster home;

455.25 (2) demonstrates that the placement of the child in a qualified residential treatment
455.26 program provides the most effective and appropriate level of care for the child in the least
455.27 restrictive environment;

455.28 (3) demonstrates how the placement is consistent with the short-term and long-term
455.29 goals for the child, as specified in the child's permanency plan;

455.30 (4) documents how the child's specific treatment or service needs will be met in the
455.31 placement;

456.1 (5) documents the length of time that the agency expects the child to need treatment or
456.2 services; ~~and~~

456.3 (6) documents the responsible social services agency's efforts to prepare the child to
456.4 return home or to be placed with a fit and willing relative, legal guardian, adoptive parent,
456.5 or foster family~~.~~; and

456.6 (7) if the child is placed in a qualified residential treatment program out-of-state, the
456.7 compelling reasons for placing the child out-of-state and the reasons that the child's needs
456.8 cannot be met by an in-state placement.

456.9 **EFFECTIVE DATE.** This section is effective September 30, 2021.

456.10 Sec. 26. Minnesota Statutes 2020, section 260C.714, is amended to read:

456.11 **260C.714 REVIEW OF EXTENDED QUALIFIED RESIDENTIAL TREATMENT**
456.12 **PROGRAM PLACEMENTS.**

456.13 (a) When a responsible social services agency places a child in a qualified residential
456.14 treatment program for more than 12 consecutive months or 18 nonconsecutive months or,
456.15 in the case of a child who is under 13 years of age, for more than six consecutive or
456.16 nonconsecutive months, the agency must submit: (1) the signed approval by the county
456.17 social services director of the responsible social services agency; and (2) the evidence
456.18 supporting the child's placement at the most recent court review or permanency hearing
456.19 under section 260C.712~~, paragraph (b)~~.

456.20 (b) The commissioner shall specify the procedures and requirements for the agency's
456.21 review and approval of a child's extended qualified residential treatment program placement.
456.22 The commissioner may consult with counties, tribes, child-placing agencies, mental health
456.23 providers, licensed facilities, the child, the child's parents, and the family and permanency
456.24 team members to develop case plan requirements and engage in periodic reviews of the
456.25 case plan.

456.26 **EFFECTIVE DATE.** This section is effective September 30, 2021.

456.27 Sec. 27. Minnesota Statutes 2020, section 260D.01, is amended to read:

456.28 **260D.01 CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.**

456.29 (a) Sections 260D.01 to 260D.10, may be cited as the "child in voluntary foster care for
456.30 treatment" provisions of the Juvenile Court Act.

457.1 (b) The juvenile court has original and exclusive jurisdiction over a child in voluntary
457.2 foster care for treatment upon the filing of a report or petition required under this chapter.
457.3 All obligations of the responsible social services agency to a child and family in foster care
457.4 contained in chapter 260C not inconsistent with this chapter are also obligations of the
457.5 agency with regard to a child in foster care for treatment under this chapter.

457.6 (c) This chapter shall be construed consistently with the mission of the children's mental
457.7 health service system as set out in section 245.487, subdivision 3, and the duties of an agency
457.8 under sections 256B.092 and 260C.157 and Minnesota Rules, parts 9525.0004 to 9525.0016,
457.9 to meet the needs of a child with a developmental disability or related condition. This
457.10 chapter:

457.11 (1) establishes voluntary foster care through a voluntary foster care agreement as the
457.12 means for an agency and a parent to provide needed treatment when the child must be in
457.13 foster care to receive necessary treatment for an emotional disturbance or developmental
457.14 disability or related condition;

457.15 (2) establishes court review requirements for a child in voluntary foster care for treatment
457.16 due to emotional disturbance or developmental disability or a related condition;

457.17 (3) establishes the ongoing responsibility of the parent as legal custodian to visit the
457.18 child, to plan together with the agency for the child's treatment needs, to be available and
457.19 accessible to the agency to make treatment decisions, and to obtain necessary medical,
457.20 dental, and other care for the child; ~~and~~

457.21 (4) applies to voluntary foster care when the child's parent and the agency agree that the
457.22 child's treatment needs require foster care either:

457.23 (i) due to a level of care determination by the agency's screening team informed by the
457.24 child's diagnostic and functional assessment under section 245.4885; or

457.25 (ii) due to a determination regarding the level of services needed by the child by the
457.26 responsible social ~~services'~~ services agency's screening team under section 256B.092, and
457.27 Minnesota Rules, parts 9525.0004 to 9525.0016~~.~~; and

457.28 (5) includes the requirements for a child's placement in sections 260C.70 to 260C.714,
457.29 when the juvenile treatment screening team recommends placing a child in a qualified
457.30 residential treatment program, except as modified by this chapter.

457.31 (d) This chapter does not apply when there is a current determination under chapter
457.32 260E that the child requires child protective services or when the child is in foster care for
457.33 any reason other than treatment for the child's emotional disturbance or developmental

458.1 disability or related condition. When there is a determination under chapter 260E that the
458.2 child requires child protective services based on an assessment that there are safety and risk
458.3 issues for the child that have not been mitigated through the parent's engagement in services
458.4 or otherwise, or when the child is in foster care for any reason other than the child's emotional
458.5 disturbance or developmental disability or related condition, the provisions of chapter 260C
458.6 apply.

458.7 (e) The paramount consideration in all proceedings concerning a child in voluntary foster
458.8 care for treatment is the safety, health, and the best interests of the child. The purpose of
458.9 this chapter is:

458.10 (1) to ensure that a child with a disability is provided the services necessary to treat or
458.11 ameliorate the symptoms of the child's disability;

458.12 (2) to preserve and strengthen the child's family ties whenever possible and in the child's
458.13 best interests, approving the child's placement away from the child's parents only when the
458.14 child's need for care or treatment requires ~~it~~ out-of-home placement and the child cannot
458.15 be maintained in the home of the parent; and

458.16 (3) to ensure that the child's parent retains legal custody of the child and associated
458.17 decision-making authority unless the child's parent willfully fails or is unable to make
458.18 decisions that meet the child's safety, health, and best interests. The court may not find that
458.19 the parent willfully fails or is unable to make decisions that meet the child's needs solely
458.20 because the parent disagrees with the agency's choice of foster care facility, unless the
458.21 agency files a petition under chapter 260C, and establishes by clear and convincing evidence
458.22 that the child is in need of protection or services.

458.23 (f) The legal parent-child relationship shall be supported under this chapter by maintaining
458.24 the parent's legal authority and responsibility for ongoing planning for the child and by the
458.25 agency's assisting the parent, ~~where~~ when necessary, to exercise the parent's ongoing right
458.26 and obligation to visit or to have reasonable contact with the child. Ongoing planning means:

458.27 (1) actively participating in the planning and provision of educational services, medical,
458.28 and dental care for the child;

458.29 (2) actively planning and participating with the agency and the foster care facility for
458.30 the child's treatment needs; ~~and~~

458.31 (3) planning to meet the child's need for safety, stability, and permanency, and the child's
458.32 need to stay connected to the child's family and community~~.~~;

459.1 (4) engaging with the responsible social services agency to ensure that the family and
459.2 permanency team under section 260C.706 consists of appropriate family members. For
459.3 purposes of voluntary placement of a child in foster care for treatment under chapter 260D,
459.4 prior to forming the child's family and permanency team, the responsible social services
459.5 agency must consult with the child's parent or legal guardian, the child if the child is 14
459.6 years of age or older, and, if applicable, the child's tribe to obtain recommendations regarding
459.7 which individuals to include on the team and to ensure that the team is family-centered and
459.8 will act in the child's best interests. If the child, child's parents, or legal guardians raise
459.9 concerns about specific relatives or professionals, the team should not include those
459.10 individuals unless the individual is a treating professional or an important connection to the
459.11 youth as outlined in the case or crisis plan; and

459.12 (5) For a voluntary placement under this chapter in a qualified residential treatment
459.13 program, as defined in section 260C.007, subdivision 26d, for purposes of engaging in a
459.14 relative search as provided in section 260C.221, the county agency must consult with the
459.15 child's parent or legal guardian, the child if the child is 14 years of age or older, and, if
459.16 applicable, the child's tribe to obtain recommendations regarding which adult relatives the
459.17 county agency should notify. If the child, child's parents, or legal guardians raise concerns
459.18 about specific relatives, the county agency should not notify those relatives.

459.19 (g) The provisions of section 260.012 to ensure placement prevention, family
459.20 reunification, and all active and reasonable effort requirements of that section apply. This
459.21 chapter shall be construed consistently with the requirements of the Indian Child Welfare
459.22 Act of 1978, United States Code, title 25, section 1901, et al., and the provisions of the
459.23 Minnesota Indian Family Preservation Act, sections 260.751 to 260.835.

459.24 **EFFECTIVE DATE.** This section is effective September 30, 2021.

459.25 Sec. 28. Minnesota Statutes 2020, section 260D.05, is amended to read:

459.26 **260D.05 ADMINISTRATIVE REVIEW OF CHILD IN VOLUNTARY FOSTER**
459.27 **CARE FOR TREATMENT.**

459.28 The administrative reviews required under section 260C.203 must be conducted for a
459.29 child in voluntary foster care for treatment, except that the initial administrative review
459.30 must take place prior to the submission of the report to the court required under section
459.31 260D.06, subdivision 2. When a child is placed in a qualified residential treatment program
459.32 as defined in section 260C.007, subdivision 26d, the responsible social services agency
459.33 must submit evidence to the court as specified in section 260C.712.

460.1 **EFFECTIVE DATE.** This section is effective September 30, 2021.

460.2 Sec. 29. Minnesota Statutes 2020, section 260D.06, subdivision 2, is amended to read:

460.3 Subd. 2. **Agency report to court; court review.** The agency shall obtain judicial review
460.4 by reporting to the court according to the following procedures:

460.5 (a) A written report shall be forwarded to the court within 165 days of the date of the
460.6 voluntary placement agreement. The written report shall contain or have attached:

460.7 (1) a statement of facts that necessitate the child's foster care placement;

460.8 (2) the child's name, date of birth, race, gender, and current address;

460.9 (3) the names, race, date of birth, residence, and post office addresses of the child's
460.10 parents or legal custodian;

460.11 (4) a statement regarding the child's eligibility for membership or enrollment in an Indian
460.12 tribe and the agency's compliance with applicable provisions of sections 260.751 to 260.835;

460.13 (5) the names and addresses of the foster parents or chief administrator of the facility in
460.14 which the child is placed, if the child is not in a family foster home or group home;

460.15 (6) a copy of the out-of-home placement plan required under section 260C.212,
460.16 subdivision 1;

460.17 (7) a written summary of the proceedings of any administrative review required under
460.18 section 260C.203; ~~and~~

460.19 (8) evidence as specified in section 260C.712 when a child is placed in a qualified
460.20 residential treatment program as defined in section 260C.007, subdivision 26d; and

460.21 (9) any other information the agency, parent or legal custodian, the child or the foster
460.22 parent, or other residential facility wants the court to consider.

460.23 (b) In the case of a child in placement due to emotional disturbance, the written report
460.24 shall include as an attachment, the child's individual treatment plan developed by the child's
460.25 treatment professional, as provided in section 245.4871, subdivision 21, or the child's
460.26 standard written plan, as provided in section 125A.023, subdivision 3, paragraph (e).

460.27 (c) In the case of a child in placement due to developmental disability or a related
460.28 condition, the written report shall include as an attachment, the child's individual service
460.29 plan, as provided in section 256B.092, subdivision 1b; the child's individual program plan,
460.30 as provided in Minnesota Rules, part 9525.0004, subpart 11; the child's waiver care plan;

461.1 or the child's standard written plan, as provided in section 125A.023, subdivision 3, paragraph
461.2 (e).

461.3 (d) The agency must inform the child, age 12 or older, the child's parent, and the foster
461.4 parent or foster care facility of the reporting and court review requirements of this section
461.5 and of their right to submit information to the court:

461.6 (1) if the child or the child's parent or the foster care provider wants to send information
461.7 to the court, the agency shall advise those persons of the reporting date and the date by
461.8 which the agency must receive the information they want forwarded to the court so the
461.9 agency is timely able submit it with the agency's report required under this subdivision;

461.10 (2) the agency must also inform the child, age 12 or older, the child's parent, and the
461.11 foster care facility that they have the right to be heard in person by the court and how to
461.12 exercise that right;

461.13 (3) the agency must also inform the child, age 12 or older, the child's parent, and the
461.14 foster care provider that an in-court hearing will be held if requested by the child, the parent,
461.15 or the foster care provider; and

461.16 (4) if, at the time required for the report under this section, a child, age 12 or older,
461.17 disagrees about the foster care facility or services provided under the out-of-home placement
461.18 plan required under section 260C.212, subdivision 1, the agency shall include information
461.19 regarding the child's disagreement, and to the extent possible, the basis for the child's
461.20 disagreement in the report required under this section.

461.21 (e) After receiving the required report, the court has jurisdiction to make the following
461.22 determinations and must do so within ten days of receiving the forwarded report, whether
461.23 a hearing is requested:

461.24 (1) whether the voluntary foster care arrangement is in the child's best interests;

461.25 (2) whether the parent and agency are appropriately planning for the child; and

461.26 (3) in the case of a child age 12 or older, who disagrees with the foster care facility or
461.27 services provided under the out-of-home placement plan, whether it is appropriate to appoint
461.28 counsel and a guardian ad litem for the child using standards and procedures under section
461.29 260C.163.

461.30 (f) Unless requested by a parent, representative of the foster care facility, or the child,
461.31 no in-court hearing is required in order for the court to make findings and issue an order as
461.32 required in paragraph (e).

462.1 (g) If the court finds the voluntary foster care arrangement is in the child's best interests
462.2 and that the agency and parent are appropriately planning for the child, the court shall issue
462.3 an order containing explicit, individualized findings to support its determination. The
462.4 individualized findings shall be based on the agency's written report and other materials
462.5 submitted to the court. The court may make this determination notwithstanding the child's
462.6 disagreement, if any, reported under paragraph (d).

462.7 (h) The court shall send a copy of the order to the county attorney, the agency, parent,
462.8 child, age 12 or older, and the foster parent or foster care facility.

462.9 (i) The court shall also send the parent, the child, age 12 or older, the foster parent, or
462.10 representative of the foster care facility notice of the permanency review hearing required
462.11 under section 260D.07, paragraph (e).

462.12 (j) If the court finds continuing the voluntary foster care arrangement is not in the child's
462.13 best interests or that the agency or the parent are not appropriately planning for the child,
462.14 the court shall notify the agency, the parent, the foster parent or foster care facility, the child,
462.15 age 12 or older, and the county attorney of the court's determinations and the basis for the
462.16 court's determinations. In this case, the court shall set the matter for hearing and appoint a
462.17 guardian ad litem for the child under section 260C.163, subdivision 5.

462.18 **EFFECTIVE DATE.** This section is effective September 30, 2021.

462.19 Sec. 30. Minnesota Statutes 2020, section 260D.07, is amended to read:

462.20 **260D.07 REQUIRED PERMANENCY REVIEW HEARING.**

462.21 (a) When the court has found that the voluntary arrangement is in the child's best interests
462.22 and that the agency and parent are appropriately planning for the child pursuant to the report
462.23 submitted under section 260D.06, and the child continues in voluntary foster care as defined
462.24 in section 260D.02, subdivision 10, for 13 months from the date of the voluntary foster care
462.25 agreement, or has been in placement for 15 of the last 22 months, the agency must:

462.26 (1) terminate the voluntary foster care agreement and return the child home; or

462.27 (2) determine whether there are compelling reasons to continue the voluntary foster care
462.28 arrangement and, if the agency determines there are compelling reasons, seek judicial
462.29 approval of its determination; or

462.30 (3) file a petition for the termination of parental rights.

462.31 (b) When the agency is asking for the court's approval of its determination that there are
462.32 compelling reasons to continue the child in the voluntary foster care arrangement, the agency

463.1 shall file a "Petition for Permanency Review Regarding a Child in Voluntary Foster Care
463.2 for Treatment" and ask the court to proceed under this section.

463.3 (c) The "Petition for Permanency Review Regarding a Child in Voluntary Foster Care
463.4 for Treatment" shall be drafted or approved by the county attorney and be under oath. The
463.5 petition shall include:

463.6 (1) the date of the voluntary placement agreement;

463.7 (2) whether the petition is due to the child's developmental disability or emotional
463.8 disturbance;

463.9 (3) the plan for the ongoing care of the child and the parent's participation in the plan;

463.10 (4) a description of the parent's visitation and contact with the child;

463.11 (5) the date of the court finding that the foster care placement was in the best interests
463.12 of the child, if required under section 260D.06, or the date the agency filed the motion under
463.13 section 260D.09, paragraph (b);

463.14 (6) the agency's reasonable efforts to finalize the permanent plan for the child, including
463.15 returning the child to the care of the child's family; ~~and~~

463.16 (7) a citation to this chapter as the basis for the petition~~.~~<u>; and</u>

463.17 <u>(8) evidence as specified in section 260C.712 when a child is placed in a qualified</u>
463.18 <u>residential treatment program as defined in section 260C.007, subdivision 26d.</u>

463.19 (d) An updated copy of the out-of-home placement plan required under section 260C.212,
463.20 subdivision 1, shall be filed with the petition.

463.21 (e) The court shall set the date for the permanency review hearing no later than 14 months
463.22 after the child has been in placement or within 30 days of the petition filing date when the
463.23 child has been in placement 15 of the last 22 months. The court shall serve the petition
463.24 together with a notice of hearing by United States mail on the parent, the child age 12 or
463.25 older, the child's guardian ad litem, if one has been appointed, the agency, the county
463.26 attorney, and counsel for any party.

463.27 (f) The court shall conduct the permanency review hearing on the petition no later than
463.28 14 months after the date of the voluntary placement agreement, within 30 days of the filing
463.29 of the petition when the child has been in placement 15 of the last 22 months, or within 15
463.30 days of a motion to terminate jurisdiction and to dismiss an order for foster care under
463.31 chapter 260C, as provided in section 260D.09, paragraph (b).

463.32 (g) At the permanency review hearing, the court shall:

464.1 (1) inquire of the parent if the parent has reviewed the "Petition for Permanency Review
464.2 Regarding a Child in Voluntary Foster Care for Treatment," whether the petition is accurate,
464.3 and whether the parent agrees to the continued voluntary foster care arrangement as being
464.4 in the child's best interests;

464.5 (2) inquire of the parent if the parent is satisfied with the agency's reasonable efforts to
464.6 finalize the permanent plan for the child, including whether there are services available and
464.7 accessible to the parent that might allow the child to safely be with the child's family;

464.8 (3) inquire of the parent if the parent consents to the court entering an order that:

464.9 (i) approves the responsible agency's reasonable efforts to finalize the permanent plan
464.10 for the child, which includes ongoing future planning for the safety, health, and best interests
464.11 of the child; and

464.12 (ii) approves the responsible agency's determination that there are compelling reasons
464.13 why the continued voluntary foster care arrangement is in the child's best interests; and

464.14 (4) inquire of the child's guardian ad litem and any other party whether the guardian or
464.15 the party agrees that:

464.16 (i) the court should approve the responsible agency's reasonable efforts to finalize the
464.17 permanent plan for the child, which includes ongoing and future planning for the safety,
464.18 health, and best interests of the child; and

464.19 (ii) the court should approve of the responsible agency's determination that there are
464.20 compelling reasons why the continued voluntary foster care arrangement is in the child's
464.21 best interests.

464.22 (h) At a permanency review hearing under this section, the court may take the following
464.23 actions based on the contents of the sworn petition and the consent of the parent:

464.24 (1) approve the agency's compelling reasons that the voluntary foster care arrangement
464.25 is in the best interests of the child; and

464.26 (2) find that the agency has made reasonable efforts to finalize the permanent plan for
464.27 the child.

464.28 (i) A child, age 12 or older, may object to the agency's request that the court approve its
464.29 compelling reasons for the continued voluntary arrangement and may be heard on the reasons
464.30 for the objection. Notwithstanding the child's objection, the court may approve the agency's
464.31 compelling reasons and the voluntary arrangement.

465.1 (j) If the court does not approve the voluntary arrangement after hearing from the child
465.2 or the child's guardian ad litem, the court shall dismiss the petition. In this case, either:

465.3 (1) the child must be returned to the care of the parent; or

465.4 (2) the agency must file a petition under section 260C.141, asking for appropriate relief
465.5 under sections 260C.301 or 260C.503 to 260C.521.

465.6 (k) When the court approves the agency's compelling reasons for the child to continue
465.7 in voluntary foster care for treatment, and finds that the agency has made reasonable efforts
465.8 to finalize a permanent plan for the child, the court shall approve the continued voluntary
465.9 foster care arrangement, and continue the matter under the court's jurisdiction for the purposes
465.10 of reviewing the child's placement every 12 months while the child is in foster care.

465.11 (l) A finding that the court approves the continued voluntary placement means the agency
465.12 has continued legal authority to place the child while a voluntary placement agreement
465.13 remains in effect. The parent or the agency may terminate a voluntary agreement as provided
465.14 in section 260D.10. Termination of a voluntary foster care placement of an Indian child is
465.15 governed by section 260.765, subdivision 4.

465.16 **EFFECTIVE DATE.** This section is effective September 30, 2021.

465.17 Sec. 31. Minnesota Statutes 2020, section 260D.08, is amended to read:

465.18 **260D.08 ANNUAL REVIEW.**

465.19 (a) After the court conducts a permanency review hearing under section 260D.07, the
465.20 matter must be returned to the court for further review of the responsible social services
465.21 reasonable efforts to finalize the permanent plan for the child and the child's foster care
465.22 placement at least every 12 months while the child is in foster care. The court shall give
465.23 notice to the parent and child, age 12 or older, and the foster parents of the continued review
465.24 requirements under this section at the permanency review hearing.

465.25 (b) Every 12 months, the court shall determine whether the agency made reasonable
465.26 efforts to finalize the permanency plan for the child, which means the exercise of due
465.27 diligence by the agency to:

465.28 (1) ensure that the agreement for voluntary foster care is the most appropriate legal
465.29 arrangement to meet the child's safety, health, and best interests and to conduct a genuine
465.30 examination of whether there is another permanency disposition order under chapter 260C,
465.31 including returning the child home, that would better serve the child's need for a stable and
465.32 permanent home;

(2) engage and support the parent in continued involvement in planning and decision making for the needs of the child;

(3) strengthen the child's ties to the parent, relatives, and community;

(4) implement the out-of-home placement plan required under section 260C.212, subdivision 1, and ensure that the plan requires the provision of appropriate services to address the physical health, mental health, and educational needs of the child; ~~and~~

(5) submit evidence to the court as specified in section 260C.712 when a child is placed in a qualified residential treatment program setting as defined in section 260C.007, subdivision 26d; and

~~(5)~~ (6) ensure appropriate planning for the child's safe, permanent, and independent living arrangement after the child's 18th birthday.

EFFECTIVE DATE. This section is effective September 30, 2021.

Sec. 32. Minnesota Statutes 2020, section 260D.14, is amended to read:

260D.14 SUCCESSFUL TRANSITION TO ADULTHOOD FOR ~~CHILDREN~~ YOUTH IN VOLUNTARY PLACEMENT.

Subdivision 1. **Case planning.** When ~~the child~~ a youth is 14 years of age or older, the responsible social services agency shall ensure that a ~~child~~ youth in foster care under this chapter is provided with the case plan requirements in section 260C.212, subdivisions 1 and 14.

Subd. 2. **Notification.** The responsible social services agency shall provide a youth with written notice of ~~the right to continued access to services for certain children in foster care past 18 years of age under section 260C.452, subdivision 3~~ foster care benefits that a youth who is 18 years of age or older may continue to receive according to section 260C.451, subdivision 1, and of the right to appeal a denial of social services under section 256.045. The notice must be provided to the ~~child~~ youth six months before the ~~child's~~ youth's 18th birthday.

Subd. 3. **Administrative or court reviews.** When ~~the child~~ a youth is ~~17~~ 14 years of age or older, the administrative review or court hearing must include a review of the responsible social services agency's support for the ~~child's~~ youth's successful transition to adulthood as required in section 260C.452, subdivision 4.

EFFECTIVE DATE. This section is effective July 1, 2021.

467.1 Sec. 33. Minnesota Statutes 2020, section 260E.06, subdivision 1, is amended to read:

467.2 Subdivision 1. **Mandatory reporters.** (a) A person who knows or has reason to believe
467.3 a child is being maltreated, as defined in section 260E.03, or has been maltreated within
467.4 the preceding three years shall immediately report the information to the local welfare
467.5 agency, agency responsible for assessing or investigating the report, police department,
467.6 county sheriff, tribal social services agency, or tribal police department if the person is:

467.7 (1) a professional or professional's delegate who is engaged in the practice of the healing
467.8 arts, social services, hospital administration, psychological or psychiatric treatment, child
467.9 care, education, correctional supervision, probation and correctional services, or law
467.10 enforcement; ~~or~~

467.11 (2) employed as a member of the clergy and received the information while engaged in
467.12 ministerial duties, provided that a member of the clergy is not required by this subdivision
467.13 to report information that is otherwise privileged under section 595.02, subdivision 1,
467.14 paragraph (c)~~.~~; or

467.15 (3) an owner, administrator, or employee who is 18 years of age or older of a public or
467.16 private youth recreation program or other organization that provides services or activities
467.17 requiring face-to-face contact with and supervision of children.

467.18 (b) "Practice of social services" for the purposes of this subdivision includes but is not
467.19 limited to employee assistance counseling and the provision of guardian ad litem and
467.20 parenting time expeditor services.

467.21 Sec. 34. Minnesota Statutes 2020, section 260E.20, subdivision 2, is amended to read:

467.22 Subd. 2. **Face-to-face contact.** (a) Upon receipt of a screened in report, the local welfare
467.23 agency shall conduct a face-to-face contact with the child reported to be maltreated and
467.24 with the child's primary caregiver sufficient to complete a safety assessment and ensure the
467.25 immediate safety of the child.

467.26 (b) ~~The~~ Face-to-face contact with the child and primary caregiver shall occur immediately
467.27 if sexual abuse or substantial child endangerment is alleged and within five calendar days
467.28 for all other reports. If the alleged offender was not already interviewed as the primary
467.29 caregiver, the local welfare agency shall also conduct a face-to-face interview with the
467.30 alleged offender in the early stages of the assessment or investigation. Face-to-face contact
467.31 with the child and primary caregiver in response to a report alleging sexual abuse or
467.32 substantial child endangerment may be postponed for no more than five calendar days if
467.33 the child is residing in a location that is confirmed to restrict contact with the alleged offender

468.1 as established in guidelines issued by the commissioner, or if the local welfare agency is
468.2 pursuing a court order for the child's caregiver to produce the child for questioning under
468.3 section 260E.22, subdivision 5.

468.4 (c) At the initial contact with the alleged offender, the local welfare agency or the agency
468.5 responsible for assessing or investigating the report must inform the alleged offender of the
468.6 complaints or allegations made against the individual in a manner consistent with laws
468.7 protecting the rights of the person who made the report. The interview with the alleged
468.8 offender may be postponed if it would jeopardize an active law enforcement investigation.

468.9 (d) The local welfare agency or the agency responsible for assessing or investigating
468.10 the report must provide the alleged offender with an opportunity to make a statement. The
468.11 alleged offender may submit supporting documentation relevant to the assessment or
468.12 investigation.

468.13 Sec. 35. Minnesota Statutes 2020, section 260E.31, subdivision 1, is amended to read:

468.14 Subdivision 1. **Reports required.** (a) Except as provided in paragraph (b), a person
468.15 mandated to report under this chapter shall immediately report to the local welfare agency
468.16 if the person knows or has reason to believe that a woman is pregnant and has used a
468.17 controlled substance for a nonmedical purpose during the pregnancy, including but not
468.18 limited to tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy
468.19 in any way that is habitual or excessive.

468.20 (b) A health care professional or a social service professional who is mandated to report
468.21 under this chapter is exempt from reporting under paragraph (a) ~~a woman's use or~~
468.22 ~~consumption of tetrahydrocannabinol or alcoholic beverages during pregnancy~~ if the
468.23 professional is providing or collaborating with other professionals to provide the woman
468.24 with prenatal care, postpartum care, or other health care services, including care of the
468.25 woman's infant. If the woman does not continue to receive regular prenatal or postpartum
468.26 care, after the woman's health care professional has made attempts to contact the woman,
468.27 then the professional is required to report under paragraph (a).

468.28 (c) Any person may make a voluntary report if the person knows or has reason to believe
468.29 that a woman is pregnant and has used a controlled substance for a nonmedical purpose
468.30 during the pregnancy, including but not limited to tetrahydrocannabinol, or has consumed
468.31 alcoholic beverages during the pregnancy in any way that is habitual or excessive.

468.32 (d) An oral report shall be made immediately by telephone or otherwise. An oral report
468.33 made by a person required to report shall be followed within 72 hours, exclusive of weekends

469.1 and holidays, by a report in writing to the local welfare agency. Any report shall be of
469.2 sufficient content to identify the pregnant woman, the nature and extent of the use, if known,
469.3 and the name and address of the reporter. The local welfare agency shall accept a report
469.4 made under paragraph (c) notwithstanding refusal by a voluntary reporter to provide the
469.5 reporter's name or address as long as the report is otherwise sufficient.

469.6 (e) For purposes of this section, "prenatal care" means the comprehensive package of
469.7 medical and psychological support provided throughout the pregnancy.

469.8 Sec. 36. Minnesota Statutes 2020, section 260E.33, is amended by adding a subdivision
469.9 to read:

469.10 Subd. 6a. **Notification of contested case hearing.** When an appeal of a lead investigative
469.11 agency determination results in a contested case hearing under chapter 245A or 245C, the
469.12 administrative law judge shall notify the parent, legal custodian, or guardian of the child
469.13 who is the subject of the maltreatment determination. The notice must be sent by certified
469.14 mail and inform the parent, legal custodian, or guardian of the child of the right to file a
469.15 signed written statement in the proceedings and the right to attend and participate in the
469.16 hearing. The parent, legal custodian, or guardian of the child may file a written statement
469.17 with the administrative law judge hearing the case no later than five business days before
469.18 commencement of the hearing. The administrative law judge shall include the written
469.19 statement in the hearing record and consider the statement in deciding the appeal. The lead
469.20 investigative agency shall provide to the administrative law judge the address of the parent,
469.21 legal custodian, or guardian of the child. If the lead investigative agency is not reasonably
469.22 able to determine the address of the parent, legal custodian, or guardian of the child, the
469.23 administrative law judge is not required to send a hearing notice under this subdivision.

469.24 Sec. 37. Minnesota Statutes 2020, section 260E.36, is amended by adding a subdivision
469.25 to read:

469.26 Subd. 1b. **Sex trafficking and sexual exploitation training requirement.** As required
469.27 by the Child Abuse Prevention and Treatment Act amendments through Public Law 114-22
469.28 and to implement Public Law 115-123, all child protection social workers and social services
469.29 staff who have responsibility for child protective duties under this chapter or chapter 260C
469.30 shall complete training implemented by the commissioner of human services regarding sex
469.31 trafficking and sexual exploitation of children and youth.

469.32 **EFFECTIVE DATE.** This section is effective July 1, 2021.

470.1 Sec. 38. **DIRECTION TO THE COMMISSIONER; QUALIFIED RESIDENTIAL**
470.2 **TREATMENT TRANSITION SUPPORTS.**

470.3 The commissioner of human services shall consult with stakeholders to develop policies
470.4 regarding aftercare supports for the transition of a child from a qualified residential treatment
470.5 program, as defined in Minnesota Statutes, section 260C.007, subdivision 26d, to
470.6 reunification with the child's parent or legal guardian, including potential placement in a
470.7 less restrictive setting prior to reunification that aligns with the child's permanency plan and
470.8 person-centered support plan, when applicable. The policies must be consistent with
470.9 Minnesota Rules, part 2960.0190, and Minnesota Statutes, section 245A.25, subdivision 4,
470.10 paragraph (i), and address the coordination of the qualified residential treatment program
470.11 discharge planning and aftercare supports where needed, the county social services case
470.12 plan, and services from community-based providers, to maintain the child's progress with
470.13 behavioral health goals in the child's treatment plan. The commissioner must complete
470.14 development of the policy guidance by December 31, 2022.

470.15 Sec. 39. **REVISOR INSTRUCTION.**

470.16 The revisor of statutes shall place the following first grade headnote in Minnesota
470.17 Statutes, chapter 260C, preceding Minnesota Statutes, sections 260C.70 to 260C.714:
470.18 PLACEMENT OF CHILDREN IN QUALIFIED RESIDENTIAL TREATMENT.

470.19 **ARTICLE 12**
470.20 **BEHAVIORAL HEALTH**

470.21 Section 1. Minnesota Statutes 2020, section 245.462, subdivision 17, is amended to read:

470.22 Subd. 17. **Mental health practitioner.** (a) "Mental health practitioner" means a person
470.23 providing services to adults with mental illness or children with emotional disturbance who
470.24 is qualified in at least one of the ways described in paragraphs (b) to (g). A mental health
470.25 practitioner for a child client must have training working with children. A mental health
470.26 practitioner for an adult client must have training working with adults.

470.27 (b) For purposes of this subdivision, a practitioner is qualified through relevant
470.28 coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in
470.29 behavioral sciences or related fields and:

470.30 (1) has at least 2,000 hours of supervised experience in the delivery of services to adults
470.31 or children with:

470.32 (i) mental illness, substance use disorder, or emotional disturbance; or

471.1 (ii) traumatic brain injury or developmental disabilities and completes training on mental
471.2 illness, recovery from mental illness, mental health de-escalation techniques, co-occurring
471.3 mental illness and substance abuse, and psychotropic medications and side effects;

471.4 (2) is fluent in the non-English language of the ethnic group to which at least 50 percent
471.5 of the practitioner's clients belong, completes 40 hours of training in the delivery of services
471.6 to adults with mental illness or children with emotional disturbance, and receives clinical
471.7 supervision from a mental health professional at least once a week until the requirement of
471.8 2,000 hours of supervised experience is met;

471.9 (3) is working in a day treatment program under section 245.4712, subdivision 2; ~~or~~

471.10 (4) has completed a practicum or internship that (i) requires direct interaction with adults
471.11 or children served, and (ii) is focused on behavioral sciences or related fields~~.~~; or

471.12 (5) is in the process of completing a practicum or internship as part of a formal
471.13 undergraduate or graduate training program in social work, psychology, or counseling.

471.14 (c) For purposes of this subdivision, a practitioner is qualified through work experience
471.15 if the person:

471.16 (1) has at least 4,000 hours of supervised experience in the delivery of services to adults
471.17 or children with:

471.18 (i) mental illness, substance use disorder, or emotional disturbance; or

471.19 (ii) traumatic brain injury or developmental disabilities and completes training on mental
471.20 illness, recovery from mental illness, mental health de-escalation techniques, co-occurring
471.21 mental illness and substance abuse, and psychotropic medications and side effects; or

471.22 (2) has at least 2,000 hours of supervised experience in the delivery of services to adults
471.23 or children with:

471.24 (i) mental illness, emotional disturbance, or substance use disorder, and receives clinical
471.25 supervision as required by applicable statutes and rules from a mental health professional
471.26 at least once a week until the requirement of 4,000 hours of supervised experience is met;
471.27 or

471.28 (ii) traumatic brain injury or developmental disabilities; completes training on mental
471.29 illness, recovery from mental illness, mental health de-escalation techniques, co-occurring
471.30 mental illness and substance abuse, and psychotropic medications and side effects; and
471.31 receives clinical supervision as required by applicable statutes and rules at least once a week

472.1 from a mental health professional until the requirement of 4,000 hours of supervised
472.2 experience is met.

472.3 (d) For purposes of this subdivision, a practitioner is qualified through a graduate student
472.4 internship if the practitioner is a graduate student in behavioral sciences or related fields
472.5 and is formally assigned by an accredited college or university to an agency or facility for
472.6 clinical training.

472.7 (e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's
472.8 degree if the practitioner:

472.9 (1) holds a master's or other graduate degree in behavioral sciences or related fields; or

472.10 (2) holds a bachelor's degree in behavioral sciences or related fields and completes a
472.11 practicum or internship that (i) requires direct interaction with adults or children served,
472.12 and (ii) is focused on behavioral sciences or related fields.

472.13 (f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical
472.14 care if the practitioner meets the definition of vendor of medical care in section 256B.02,
472.15 subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.

472.16 (g) For purposes of medical assistance coverage of diagnostic assessments, explanations
472.17 of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health
472.18 practitioner working as a clinical trainee means that the practitioner's clinical supervision
472.19 experience is helping the practitioner gain knowledge and skills necessary to practice
472.20 effectively and independently. This may include supervision of direct practice, treatment
472.21 team collaboration, continued professional learning, and job management. The practitioner
472.22 must also:

472.23 (1) comply with requirements for licensure or board certification as a mental health
472.24 professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart
472.25 5, item A, including supervised practice in the delivery of mental health services for the
472.26 treatment of mental illness; or

472.27 (2) be a student in a bona fide field placement or internship under a program leading to
472.28 completion of the requirements for licensure as a mental health professional according to
472.29 the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.

472.30 (h) For purposes of this subdivision, "behavioral sciences or related fields" has the
472.31 meaning given in section 256B.0623, subdivision 5, paragraph (d).

(i) Notwithstanding the licensing requirements established by a health-related licensing board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other statute or rule.

Sec. 2. Minnesota Statutes 2020, section 245.4876, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** All providers of outpatient services, day treatment services, professional home-based family treatment, residential treatment, and acute care hospital inpatient treatment, and all regional treatment centers that provide mental health services for children must develop an individual treatment plan for each child client. The individual treatment plan must be based on a diagnostic assessment. To the extent appropriate, the child and the child's family shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment, professional home-based family treatment, and acute care hospital inpatient treatment, and regional treatment centers must develop the individual treatment plan within ten working days of client intake or admission and must review the individual treatment plan every 90 days after intake~~, except that the administrative review of the treatment plan of a child placed in a residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9~~. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Providers of outpatient and day treatment services must review the individual treatment plan every 90 days after intake.

Sec. 3. Minnesota Statutes 2020, section 245.4882, subdivision 1, is amended to read:

Subdivision 1. **Availability of residential treatment services.** County boards must provide or contract for enough residential treatment services to meet the needs of each child with severe emotional disturbance residing in the county and needing this level of care. Length of stay is based on the child's residential treatment need and shall be ~~subject to the six-month review process established in section 260C.203, and for children in voluntary placement for treatment, the court review process in section 260D.06~~ reviewed every 90 days. Services must be appropriate to the child's age and treatment needs and must be made available as close to the county as possible. Residential treatment must be designed to:

(1) help the child improve family living and social interaction skills;

(2) help the child gain the necessary skills to return to the community;

(3) stabilize crisis admissions; and

(4) work with families throughout the placement to improve the ability of the families to care for children with severe emotional disturbance in the home.

Sec. 4. Minnesota Statutes 2020, section 245.4882, subdivision 3, is amended to read:

Subd. 3. **Transition to community.** Residential treatment facilities and regional treatment centers serving children must plan for and assist those children and their families in making a transition to less restrictive community-based services. Discharge planning for the child to return to the community must include identification of and referrals to appropriate home and community supports that meet the needs of the child and family. Discharge planning must begin within 30 days after the child enters residential treatment and be updated every 60 days. Residential treatment facilities must also arrange for appropriate follow-up care in the community. Before a child is discharged, the residential treatment facility or regional treatment center shall provide notification to the child's case manager, if any, so that the case manager can monitor and coordinate the transition and make timely arrangements for the child's appropriate follow-up care in the community.

Sec. 5. Minnesota Statutes 2020, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the case of an emergency, all children referred for treatment of severe emotional disturbance in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center shall undergo an assessment to determine the appropriate level of care if ~~public~~ county funds are used to pay for the child's services.

(b) The ~~responsible social services agency~~ county board shall determine the appropriate level of care for a child when county-controlled funds are used to pay for the child's ~~services or placement in a qualified residential treatment facility under chapter 260C and licensed by the commissioner under chapter 245A. In accordance with section 260C.157, a juvenile treatment screening team shall conduct a screening before the team may recommend whether to place a child~~ residential treatment under this chapter, including residential treatment provided in a qualified residential treatment program as defined in section 260C.007, subdivision 26d. When a ~~social services agency~~ county board does not have responsibility for a child's placement and the child is enrolled in a prepaid health program under section

475.1 256B.69, the enrolled child's contracted health plan must determine the appropriate level
475.2 of care for the child. When Indian Health Services funds or funds of a tribally owned facility
475.3 funded under the Indian Self-Determination and Education Assistance Act, Public Law
475.4 93-638, are to be used for the child, the Indian Health Services or 638 tribal health facility
475.5 must determine the appropriate level of care for the child. When more than one entity bears
475.6 responsibility for a child's coverage, the entities shall coordinate level of care determination
475.7 activities for the child to the extent possible.

475.8 (c) The responsible social services agency must make the level of care determination
475.9 available to the juvenile treatment screening team, as permitted under chapter 13. The level
475.10 of care determination shall inform the juvenile treatment screening team process and the
475.11 assessment in section 260C.704 when considering whether to place the child in a qualified
475.12 residential treatment program. When the responsible social services agency is not involved
475.13 in determining a child's placement, the child's level of care determination shall determine
475.14 whether the proposed treatment:

475.15 (1) is necessary;

475.16 (2) is appropriate to the child's individual treatment needs;

475.17 (3) cannot be effectively provided in the child's home; and

475.18 (4) provides a length of stay as short as possible consistent with the individual child's
475.19 need needs.

475.20 (d) When a level of care determination is conducted, the responsible social services
475.21 agency county board or other entity may not determine that a screening under section
475.22 260C.157 or, referral, or admission to a treatment foster care setting or residential treatment
475.23 facility is not appropriate solely because services were not first provided to the child in a
475.24 less restrictive setting and the child failed to make progress toward or meet treatment goals
475.25 in the less restrictive setting. The level of care determination must be based on a diagnostic
475.26 assessment of a child that includes a functional assessment which evaluates family, school,
475.27 and community living situations; and an assessment of the child's need for care out of the
475.28 home using a validated tool which assesses a child's functional status and assigns an
475.29 appropriate level of care to the child. The validated tool must be approved by the
475.30 commissioner of human services. If a diagnostic assessment including a functional assessment
475.31 has been completed by a mental health professional within the past 180 days, a new diagnostic
475.32 assessment need not be completed unless in the opinion of the current treating mental health
475.33 professional the child's mental health status has changed markedly since the assessment
475.34 was completed. The child's parent shall be notified if an assessment will not be completed

476.1 and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations
476.2 developed as part of the level of care determination process shall include specific community
476.3 services needed by the child and, if appropriate, the child's family, and shall indicate whether
476.4 or not these services are available and accessible to the child and the child's family. The
476.5 child and the child's family must be invited to any meeting where the level of care
476.6 determination is discussed and decisions regarding residential treatment are made. The child
476.7 and the child's family may invite other relatives, friends, or advocates to attend these
476.8 meetings.

476.9 (e) During the level of care determination process, the child, child's family, or child's
476.10 legal representative, as appropriate, must be informed of the child's eligibility for case
476.11 management services and family community support services and that an individual family
476.12 community support plan is being developed by the case manager, if assigned.

476.13 ~~(f) When the responsible social services agency has authority, the agency must engage~~
476.14 ~~the child's parents in case planning under sections 260C.212 and 260C.708 unless a court~~
476.15 ~~terminates the parent's rights or court orders restrict the parent from participating in case~~
476.16 ~~planning, visitation, or parental responsibilities.~~

476.17 ~~(g)~~ (f) The level of care determination, and placement decision, and recommendations
476.18 for mental health services must be documented in the child's record~~, as required in chapter~~
476.19 ~~260C~~ and made available to the child's family, as appropriate.

476.20 **EFFECTIVE DATE.** This section is effective September 30, 2021.

476.21 Sec. 6. Minnesota Statutes 2020, section 245.4889, subdivision 1, is amended to read:

476.22 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to
476.23 make grants from available appropriations to assist:

476.24 (1) counties;

476.25 (2) Indian tribes;

476.26 (3) children's collaboratives under section 124D.23 or 245.493; or

476.27 (4) mental health service providers.

476.28 (b) The following services are eligible for grants under this section:

476.29 (1) services to children with emotional disturbances as defined in section 245.4871,
476.30 subdivision 15, and their families;

477.1 (2) transition services under section 245.4875, subdivision 8, for young adults under
477.2 age 21 and their families;

477.3 (3) respite care services for children with emotional disturbances or severe emotional
477.4 disturbances who are at risk of out-of-home placement. A child is not required to have case
477.5 management services to receive respite care services;

477.6 (4) children's mental health crisis services;

477.7 (5) mental health services for people from cultural and ethnic minorities, including
477.8 supervision of clinical trainees who are Black, indigenous, or people of color, providing
477.9 services in clinics that serve clients enrolled in medical assistance;

477.10 (6) children's mental health screening and follow-up diagnostic assessment and treatment;

477.11 (7) services to promote and develop the capacity of providers to use evidence-based
477.12 practices in providing children's mental health services;

477.13 (8) school-linked mental health services under section 245.4901;

477.14 (9) building evidence-based mental health intervention capacity for children birth to age
477.15 five;

477.16 (10) suicide prevention and counseling services that use text messaging statewide;

477.17 (11) mental health first aid training;

477.18 (12) training for parents, collaborative partners, and mental health providers on the
477.19 impact of adverse childhood experiences and trauma and development of an interactive
477.20 website to share information and strategies to promote resilience and prevent trauma;

477.21 (13) transition age services to develop or expand mental health treatment and supports
477.22 for adolescents and young adults 26 years of age or younger;

477.23 (14) early childhood mental health consultation;

477.24 (15) evidence-based interventions for youth at risk of developing or experiencing a first
477.25 episode of psychosis, and a public awareness campaign on the signs and symptoms of
477.26 psychosis;

477.27 (16) psychiatric consultation for primary care practitioners; ~~and~~

477.28 (17) providers to begin operations and meet program requirements when establishing a
477.29 new children's mental health program. These may be start-up grants~~.~~; and

478.1 (18) mental health services based on traditional, spiritual, and holistic healing practices,
478.2 provided by cultural healers from African American, American Indian, Asian American,
478.3 Latinx, Pacific Islander, and Pan-African communities.

478.4 (c) Services under paragraph (b) must be designed to help each child to function and
478.5 remain with the child's family in the community and delivered consistent with the child's
478.6 treatment plan. Transition services to eligible young adults under this paragraph must be
478.7 designed to foster independent living in the community.

478.8 (d) As a condition of receiving grant funds, a grantee shall obtain all available third-party
478.9 reimbursement sources, if applicable.

478.10 Sec. 7. **[245.4902] CULTURALLY INFORMED AND CULTURALLY RESPONSIVE**
478.11 **MENTAL HEALTH TASK FORCE.**

478.12 Subdivision 1. **Establishment; duties.** The Culturally Informed and Culturally
478.13 Responsive Mental Health Task Force is established to evaluate and make recommendations
478.14 on improving the provision of culturally informed and culturally responsive mental health
478.15 services throughout Minnesota. The task force must make recommendations on:

478.16 (1) recruiting mental health providers from diverse racial and ethnic communities;

478.17 (2) training all mental health providers on cultural competency and cultural humility;

478.18 (3) assessing the extent to which mental health provider organizations embrace diversity
478.19 and demonstrate proficiency in culturally competent mental health treatment and services;
478.20 and

478.21 (4) increasing the number of mental health organizations owned, managed, or led by
478.22 individuals who are Black, indigenous, or people of color.

478.23 Subd. 2. **Membership.** (a) The task force must consist of the following 16 members:

478.24 (1) the commissioner of human services or the commissioner's designee;

478.25 (2) one representative from the Board of Psychology;

478.26 (3) one representative from the Board of Marriage and Family Therapy;

478.27 (4) one representative from the Board of Behavioral Health and Therapy;

478.28 (5) one representative from the Board of Social Work;

478.29 (6) three members representing undergraduate and graduate-level mental health
478.30 professional education programs, appointed by the governor;

479.1 (7) three mental health providers who are members of communities of color or
479.2 underrepresented communities, as defined in section 148E.010, subdivision 20, appointed
479.3 by the governor;

479.4 (8) two members representing mental health advocacy organizations, appointed by the
479.5 governor;

479.6 (9) two mental health providers, appointed by the governor; and

479.7 (10) one expert in providing training and education in cultural competency and cultural
479.8 responsiveness, appointed by the governor.

479.9 (b) Appointments to the task force must be made no later than June 1, 2022.

479.10 (c) Member compensation and reimbursement for expenses are governed by section
479.11 15.059, subdivision 3.

479.12 Subd. 3. **Chairs; meetings.** The members of the task force must elect two cochairs of
479.13 the task force no earlier than July 1, 2022, and the cochairs must convene the first meeting
479.14 of the task force no later than August 15, 2022. The task force must meet upon the call of
479.15 the cochairs, sufficiently often to accomplish the duties identified in this section. The task
479.16 force is subject to the open meeting law under chapter 13D.

479.17 Subd. 4. **Administrative support.** The Department of Human Services must provide
479.18 administrative support and meeting space for the task force.

479.19 Subd. 5. **Reports.** No later than January 1, 2023, and by January 1 of each year thereafter,
479.20 the task force must submit a written report to the members of the legislative committees
479.21 with jurisdiction over health and human services on the recommendations developed under
479.22 subdivision 1.

479.23 Subd. 6. **Expiration.** The task force expires on January 1, 2025.

479.24 Sec. 8. Minnesota Statutes 2020, section 245.735, subdivision 3, is amended to read:

479.25 Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall
479.26 establish a state certification process for certified community behavioral health clinics
479.27 (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this
479.28 section to be eligible for reimbursement under medical assistance, without service area
479.29 limits based on geographic area or region. The commissioner shall consult with CCBHC
479.30 stakeholders before establishing and implementing changes in the certification process and
479.31 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

481.1 (ii) other community services, supports, and providers, including schools, child welfare
481.2 agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally
481.3 licensed health care and mental health facilities, urban Indian health clinics, Department of
481.4 Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals,
481.5 and hospital outpatient clinics;

481.6 (8) be certified as mental health clinics under section 245.69, subdivision 2;

481.7 (9) comply with standards established by the commissioner relating to ~~mental health~~
481.8 ~~services in Minnesota Rules, parts 9505.0370 to 9505.0372~~ CCBHC screenings, assessments,
481.9 and evaluations;

481.10 (10) be licensed to provide substance use disorder treatment under chapter 245G;

481.11 (11) be certified to provide children's therapeutic services and supports under section
481.12 256B.0943;

481.13 (12) be certified to provide adult rehabilitative mental health services under section
481.14 256B.0623;

481.15 (13) be enrolled to provide mental health crisis response services under sections
481.16 256B.0624 and 256B.0944;

481.17 (14) be enrolled to provide mental health targeted case management under section
481.18 256B.0625, subdivision 20;

481.19 (15) comply with standards relating to mental health case management in Minnesota
481.20 Rules, parts 9520.0900 to 9520.0926;

481.21 (16) provide services that comply with the evidence-based practices described in
481.22 paragraph (e); and

481.23 (17) comply with standards relating to peer services under sections 256B.0615,
481.24 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer
481.25 services are provided.

481.26 (b) If ~~an entity~~ a certified CCBHC is unable to provide one or more of the services listed
481.27 in paragraph (a), clauses (6) to (17), the ~~commissioner may certify the entity as a~~ CCBHC~~,~~
481.28 ~~if the entity has a current~~ may contract with another entity that has the required authority
481.29 to provide that service and that meets ~~federal CCBHC~~ the following criteria as a designated
481.30 collaborating organization~~, or, to the extent allowed by the federal CCBHC criteria, the~~
481.31 ~~commissioner may approve a referral arrangement. The CCBHC must meet federal~~
481.32 ~~requirements regarding the type and scope of services to be provided directly by the CCBHC.~~:

482.1 (1) the entity has a formal agreement with the CCBHC to furnish one or more of the
482.2 services under paragraph (a), clause (6);

482.3 (2) the entity provides assurances that it will provide services according to CCBHC
482.4 service standards and provider requirements;

482.5 (3) the entity agrees that the CCBHC is responsible for coordinating care and has clinical
482.6 and financial responsibility for the services that the entity provides under the agreement;
482.7 and

482.8 (4) the entity meets any additional requirements issued by the commissioner.

482.9 (c) Notwithstanding any other law that requires a county contract or other form of county
482.10 approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets
482.11 CCBHC requirements may receive the prospective payment under section 256B.0625,
482.12 subdivision 5m, for those services without a county contract or county approval. As part of
482.13 the certification process in paragraph (a), the commissioner shall require a letter of support
482.14 from the CCBHC's host county confirming that the CCBHC and the county or counties it
482.15 serves have an ongoing relationship to facilitate access and continuity of care, especially
482.16 for individuals who are uninsured or who may go on and off medical assistance.

482.17 (d) When the standards listed in paragraph (a) or other applicable standards conflict or
482.18 address similar issues in duplicative or incompatible ways, the commissioner may grant
482.19 variances to state requirements if the variances do not conflict with federal requirements
482.20 for services reimbursed under medical assistance. If standards overlap, the commissioner
482.21 may substitute all or a part of a licensure or certification that is substantially the same as
482.22 another licensure or certification. The commissioner shall consult with stakeholders, as
482.23 described in subdivision 4, before granting variances under this provision. For the CCBHC
482.24 that is certified but not approved for prospective payment under section 256B.0625,
482.25 subdivision 5m, the commissioner may grant a variance under this paragraph if the variance
482.26 does not increase the state share of costs.

482.27 (e) The commissioner shall issue a list of required evidence-based practices to be
482.28 delivered by CCBHCs, and may also provide a list of recommended evidence-based practices.
482.29 The commissioner may update the list to reflect advances in outcomes research and medical
482.30 services for persons living with mental illnesses or substance use disorders. The commissioner
482.31 shall take into consideration the adequacy of evidence to support the efficacy of the practice,
482.32 the quality of workforce available, and the current availability of the practice in the state.
482.33 At least 30 days before issuing the initial list and any revisions, the commissioner shall
482.34 provide stakeholders with an opportunity to comment.

483.1 (f) The commissioner shall recertify CCBHCs at least every three years. The
483.2 commissioner shall establish a process for decertification and shall require corrective action,
483.3 medical assistance repayment, or decertification of a CCBHC that no longer meets the
483.4 requirements in this section or that fails to meet the standards provided by the commissioner
483.5 in the application and certification process.

483.6 Sec. 9. Minnesota Statutes 2020, section 245.735, subdivision 5, is amended to read:

483.7 Subd. 5. **Information systems support.** The commissioner and the state chief information
483.8 officer shall provide information systems support to the projects as necessary to comply
483.9 with state and federal requirements.

483.10 Sec. 10. Minnesota Statutes 2020, section 245.735, is amended by adding a subdivision
483.11 to read:

483.12 Subd. 6. **Demonstration entities.** The commissioner may operate the demonstration
483.13 program established by section 223 of the Protecting Access to Medicare Act if federal
483.14 funding for the demonstration program remains available from the United States Department
483.15 of Health and Human Services. To the extent practicable, the commissioner shall align the
483.16 requirements of the demonstration program with the requirements under this section for
483.17 CCBHCs receiving medical assistance reimbursement. A CCBHC may not apply to
483.18 participate as a billing provider in both the CCBHC federal demonstration and the benefit
483.19 for CCBHCs under the medical assistance program.

483.20 Sec. 11. Minnesota Statutes 2020, section 254B.01, subdivision 4a, is amended to read:

483.21 Subd. 4a. **Culturally specific or culturally responsive program.** (a) "Culturally specific
483.22 or culturally responsive program" means a substance use disorder treatment service program
483.23 or subprogram that is ~~recovery-focused and~~ culturally responsive or culturally specific when
483.24 the program attests that it:

483.25 (1) improves service quality to and outcomes of a specific ~~population~~ community that
483.26 shares a common language, racial, ethnic, or social background by advancing health equity
483.27 to help eliminate health disparities; ~~and~~

483.28 (2) ensures effective, equitable, comprehensive, and respectful quality care services that
483.29 are responsive to an individual within a specific ~~population's~~ community's values, beliefs
483.30 and practices, health literacy, preferred language, and other communication needs~~.~~; and

483.31 (3) is compliant with the national standards for culturally and linguistically appropriate
483.32 services or other equivalent standards, as determined by the commissioner.

484.1 (b) A tribally licensed substance use disorder program that is designated as serving a
484.2 culturally specific population by the applicable tribal government is deemed to satisfy this
484.3 subdivision.

484.4 (c) A program satisfies the requirements of this subdivision if it attests that the program:

484.5 (1) is designed to address the unique needs of individuals who share a common language,
484.6 racial, ethnic, or social background;

484.7 (2) is governed with significant input from individuals of that specific background; and

484.8 (3) employs individuals to provide treatment services, at least 50 percent of whom are
484.9 members of the specific community being served.

484.10 **EFFECTIVE DATE.** This section is effective January 1, 2022.

484.11 Sec. 12. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision
484.12 to read:

484.13 Subd. 4b. **Disability responsive program.** "Disability responsive program" means a
484.14 program that:

484.15 (1) is designed to serve individuals with disabilities, including individuals with traumatic
484.16 brain injuries, developmental disabilities, cognitive disabilities, and physical disabilities;
484.17 and

484.18 (2) employs individuals to provide treatment services who have the necessary professional
484.19 training, as approved by the commissioner, to serve individuals with the specific disabilities
484.20 that the program is designed to serve.

484.21 **EFFECTIVE DATE.** This section is effective January 1, 2022.

484.22 Sec. 13. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

484.23 Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance
484.24 use disorder services and service enhancements funded under this chapter.

484.25 (b) Eligible substance use disorder treatment services include:

484.26 (1) outpatient treatment services that are licensed according to sections 245G.01 to
484.27 245G.17, or applicable tribal license;

484.28 (2) comprehensive assessments provided according to sections 245.4863, paragraph (a),
484.29 and 245G.05;

485.1 (3) care coordination services provided according to section 245G.07, subdivision 1,
485.2 paragraph (a), clause (5);

485.3 (4) peer recovery support services provided according to section 245G.07, subdivision
485.4 2, clause (8);

485.5 (5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management
485.6 services provided according to chapter 245F;

485.7 (6) medication-assisted therapy services that are licensed according to sections 245G.01
485.8 to 245G.17 and 245G.22, or applicable tribal license;

485.9 (7) medication-assisted therapy plus enhanced treatment services that meet the
485.10 requirements of clause (6) and provide nine hours of clinical services each week;

485.11 (8) high, medium, and low intensity residential treatment services that are licensed
485.12 according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which
485.13 provide, respectively, 30, 15, and five hours of clinical services each week;

485.14 (9) hospital-based treatment services that are licensed according to sections 245G.01 to
485.15 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to
485.16 144.56;

485.17 (10) adolescent treatment programs that are licensed as outpatient treatment programs
485.18 according to sections 245G.01 to 245G.18 or as residential treatment programs according
485.19 to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or
485.20 applicable tribal license;

485.21 (11) high-intensity residential treatment services that are licensed according to sections
485.22 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of
485.23 clinical services each week provided by a state-operated vendor or to clients who have been
485.24 civilly committed to the commissioner, present the most complex and difficult care needs,
485.25 and are a potential threat to the community; and

485.26 (12) room and board facilities that meet the requirements of subdivision 1a.

485.27 (c) The commissioner shall establish higher rates for programs that meet the requirements
485.28 of paragraph (b) and one of the following additional requirements:

485.29 (1) programs that serve parents with their children if the program:

485.30 (i) provides on-site child care during the hours of treatment activity that:

485.31 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
485.32 9503; or

486.1 (B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph
486.2 (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

486.3 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
486.4 licensed under chapter 245A as:

486.5 (A) a child care center under Minnesota Rules, chapter 9503; or

486.6 (B) a family child care home under Minnesota Rules, chapter 9502~~;~~

486.7 (2) culturally specific <u>or culturally responsive</u> programs as defined in section 254B.01,
486.8 subdivision 4a~~,~~<u>;</u> or

486.9 <u>(3) disability responsive programs as defined in section 254B.01, subdivision 4b.</u>

486.10 ~~programs or subprograms serving special populations, if the program or subprogram~~
486.11 ~~meets the following requirements:~~

486.12 ~~(i) is designed to address the unique needs of individuals who share a common language,~~
486.13 ~~racial, ethnic, or social background;~~

486.14 ~~(ii) is governed with significant input from individuals of that specific background; and~~

486.15 ~~(iii) employs individuals to provide individual or group therapy, at least 50 percent of~~
486.16 ~~whom are of that specific background, except when the common social background of the~~
486.17 ~~individuals served is a traumatic brain injury or cognitive disability and the program employs~~
486.18 ~~treatment staff who have the necessary professional training, as approved by the~~
486.19 ~~commissioner, to serve clients with the specific disabilities that the program is designed to~~
486.20 ~~serve;~~

486.21 ~~(3) programs that offer medical services delivered by appropriately credentialed health~~
486.22 ~~care staff in an amount equal to two hours per client per week if the medical needs of the~~
486.23 ~~client and the nature and provision of any medical services provided are documented in the~~
486.24 ~~client file; and~~

486.25 ~~(4) programs that offer services to individuals with co-occurring mental health and~~
486.26 ~~chemical dependency problems if:~~

486.27 ~~(i) the program meets the co-occurring requirements in section 245G.20;~~

486.28 ~~(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined~~
486.29 ~~in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates~~
486.30 ~~under the supervision of a licensed alcohol and drug counselor supervisor and licensed~~
486.31 ~~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)~~ (e) Subject to federal approval, ~~chemical dependency~~ substance use disorder services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video according to section 256B.0625, subdivision 3b. ~~The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.~~

~~(g)~~ (f) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

488.1 (g) Payment for outpatient substance use disorder services that are licensed according
488.2 to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless
488.3 prior authorization of a greater number of hours is obtained from the commissioner.

488.4 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
488.5 whichever is later, except paragraph (e) is effective July 1, 2021.

488.6 Sec. 14. Minnesota Statutes 2020, section 254B.12, is amended by adding a subdivision
488.7 to read:

488.8 Subd. 4. **Culturally specific or culturally responsive program and disability**
488.9 **responsive program provider rate increase.** For the chemical dependency services listed
488.10 in section 254B.05, subdivision 5, provided by programs that meet the requirements of
488.11 section 254B.05, subdivision 5, paragraph (c), clauses (1), (2), and (3), on or after January
488.12 1, 2022, payment rates shall increase by five percent over the rates in effect on January 1,
488.13 2021. The commissioner shall increase prepaid medical assistance capitation rates as
488.14 appropriate to reflect this increase.

488.15 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
488.16 whichever is later.

488.17 Sec. 15. **[254B.151] SUBSTANCE USE DISORDER COMMUNITY OF PRACTICE.**

488.18 Subdivision 1. **Establishment; purpose.** The commissioner of human services, in
488.19 consultation with substance use disorder subject matter experts, shall establish a substance
488.20 use disorder community of practice. The purposes of the community of practice are to
488.21 improve treatment outcomes for individuals with substance use disorders and reduce
488.22 disparities by using evidence-based and best practices through peer-to-peer and
488.23 person-to-provider sharing.

488.24 Subd. 2. **Participants; meetings.** (a) The community of practice must include the
488.25 following participants:

488.26 (1) researchers or members of the academic community who are substance use disorder
488.27 subject matter experts, who do not have financial relationships with treatment providers;

488.28 (2) substance use disorder treatment providers;

488.29 (3) representatives from recovery community organizations;

488.30 (4) a representative from the Department of Human Services;

488.31 (5) a representative from the Department of Health;

489.1 (6) a representative from the Department of Corrections;

489.2 (7) representatives from county social services agencies;

489.3 (8) representatives from tribal nations or tribal social services providers; and

489.4 (9) representatives from managed care organizations.

489.5 (b) The community of practice must include individuals who have used substance use
489.6 disorder treatment services and must highlight the voices and experiences of individuals
489.7 who are Black, indigenous, people of color, and people from other communities that are
489.8 disproportionately impacted by substance use disorders.

489.9 (c) The community of practice must meet regularly and must hold its first meeting before
489.10 January 1, 2022.

489.11 (d) Compensation and reimbursement for expenses for participants in paragraph (b) are
489.12 governed by section 15.059, subdivision 3.

489.13 Subd. 3. **Duties.** (a) The community of practice must:

489.14 (1) identify gaps in substance use disorder treatment services;

489.15 (2) enhance collective knowledge of issues related to substance use disorder;

489.16 (3) understand evidence-based practices, best practices, and promising approaches to
489.17 address substance use disorder;

489.18 (4) use knowledge gathered through the community of practice to develop strategic plans
489.19 to improve outcomes for individuals who participate in substance use disorder treatment
489.20 and related services in Minnesota;

489.21 (5) increase knowledge about the challenges and opportunities learned by implementing
489.22 strategies; and

489.23 (6) develop capacity for community advocacy.

489.24 (b) The commissioner, in collaboration with subject matter experts and other participants,
489.25 may issue reports and recommendations to the legislative chairs and ranking minority
489.26 members of committees with jurisdiction over health and human services policy and finance
489.27 and local and regional governments.

490.1 Sec. 16. Minnesota Statutes 2020, section 256.042, subdivision 2, is amended to read:

490.2 Subd. 2. **Membership.** (a) The council shall consist of the following ~~19~~ 28 voting
490.3 members, appointed by the commissioner of human services except as otherwise specified,
490.4 and three nonvoting members:

490.5 (1) two members of the house of representatives, appointed in the following sequence:
490.6 the first from the majority party appointed by the speaker of the house and the second from
490.7 the minority party appointed by the minority leader. Of these two members, one member
490.8 must represent a district outside of the seven-county metropolitan area, and one member
490.9 must represent a district that includes the seven-county metropolitan area. The appointment
490.10 by the minority leader must ensure that this requirement for geographic diversity in
490.11 appointments is met;

490.12 (2) two members of the senate, appointed in the following sequence: the first from the
490.13 majority party appointed by the senate majority leader and the second from the minority
490.14 party appointed by the senate minority leader. Of these two members, one member must
490.15 represent a district outside of the seven-county metropolitan area and one member must
490.16 represent a district that includes the seven-county metropolitan area. The appointment by
490.17 the minority leader must ensure that this requirement for geographic diversity in appointments
490.18 is met;

490.19 (3) one member appointed by the Board of Pharmacy;

490.20 (4) one member who is a physician appointed by the Minnesota Medical Association;

490.21 (5) one member representing opioid treatment programs, sober living programs, or
490.22 substance use disorder programs licensed under chapter 245G;

490.23 (6) one member appointed by the Minnesota Society of Addiction Medicine who is an
490.24 addiction psychiatrist;

490.25 (7) one member representing professionals providing alternative pain management
490.26 therapies, including, but not limited to, acupuncture, chiropractic, or massage therapy;

490.27 (8) one member representing nonprofit organizations conducting initiatives to address
490.28 the opioid epidemic, with the commissioner's initial appointment being a member
490.29 representing the Steve Rummler Hope Network, and subsequent appointments representing
490.30 this or other organizations;

490.31 (9) one member appointed by the Minnesota Ambulance Association who is serving
490.32 with an ambulance service as an emergency medical technician, advanced emergency
490.33 medical technician, or paramedic;

491.1 (10) one member representing the Minnesota courts who is a judge or law enforcement
491.2 officer;

491.3 (11) one public member who is a Minnesota resident and who is in opioid addiction
491.4 recovery;

491.5 (12) ~~two~~ 11 members representing Indian tribes, one representing ~~the Ojibwe tribes and~~
491.6 ~~one representing the Dakota tribes~~ each of Minnesota's tribal nations;

491.7 (13) one public member who is a Minnesota resident and who is suffering from chronic
491.8 pain, intractable pain, or a rare disease or condition;

491.9 (14) one mental health advocate representing persons with mental illness;

491.10 (15) one member appointed by the Minnesota Hospital Association;

491.11 (16) one member representing a local health department; and

491.12 (17) the commissioners of human services, health, and corrections, or their designees,
491.13 who shall be ex officio nonvoting members of the council.

491.14 (b) The commissioner of human services shall coordinate the commissioner's
491.15 appointments to provide geographic, racial, and gender diversity, and shall ensure that at
491.16 least one-half of council members appointed by the commissioner reside outside of the
491.17 seven-county metropolitan area. Of the members appointed by the commissioner, to the
491.18 extent practicable, at least one member must represent a community of color
491.19 disproportionately affected by the opioid epidemic.

491.20 (c) The council is governed by section 15.059, except that members of the council shall
491.21 serve three-year terms and shall receive no compensation other than reimbursement for
491.22 expenses. Notwithstanding section 15.059, subdivision 6, the council shall not expire.

491.23 (d) The chair shall convene the council at least quarterly, and may convene other meetings
491.24 as necessary. The chair shall convene meetings at different locations in the state to provide
491.25 geographic access, and shall ensure that at least one-half of the meetings are held at locations
491.26 outside of the seven-county metropolitan area.

491.27 (e) The commissioner of human services shall provide staff and administrative services
491.28 for the advisory council.

491.29 (f) The council is subject to chapter 13D.

Sec. 17. Minnesota Statutes 2020, section 256.042, subdivision 4, is amended to read:

Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the grants proposed by the advisory council to be awarded for the upcoming ~~fiscal~~ calendar year to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by ~~March~~ December 1 of each year, beginning March 1, 2020.

(b) The commissioner of human services shall award grants from the opiate epidemic response fund under section 256.043. The grants shall be awarded to proposals selected by the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1) to (4), unless otherwise appropriated by the legislature. No more than ~~three~~ ten percent of the grant amount may be used by a grantee for administration.

Sec. 18. Minnesota Statutes 2020, section 256.043, subdivision 3, is amended to read:

Subd. 3. **Appropriations from fund.** (a) After the appropriations in Laws 2019, chapter 63, article 3, section 1, paragraphs (e), (f), (g), and (h) are made, $249,000 is appropriated to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph (e).

(b) $126,000 is appropriated to the Board of Pharmacy for the collection of the registration fees under section 151.066.

(c) $672,000 is appropriated to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

(d) After the appropriations in paragraphs (a) to (c) are made, 50 percent of the remaining amount is appropriated to the commissioner of human services for distribution to county social service and tribal social service agencies to provide child protection services to children and families who are affected by addiction. The commissioner shall distribute this money proportionally to counties and tribal social service agencies based on out-of-home placement episodes where parental drug abuse is the primary reason for the out-of-home placement using data from the previous calendar year. County and tribal social service agencies receiving funds from the opiate epidemic response fund must annually report to the commissioner on how the funds were used to provide child protection services, including measurable outcomes, as determined by the commissioner. County social service agencies and tribal social service agencies must not use funds received under this paragraph to supplant

current state or local funding received for child protection services for children and families who are affected by addiction.

(e) After making the appropriations in paragraphs (a) to (d), the remaining amount in the fund is appropriated to the commissioner to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise appropriated by the legislature.

(f) Beginning in fiscal year 2022 and each year thereafter, funds for county social service and tribal social service agencies under paragraph (d) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph (e) shall be distributed on a calendar year basis.

Sec. 19. Minnesota Statutes 2020, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers certified community behavioral health clinic (CCBHC) services that meet the requirements of section 245.735, subdivision 3.

(b) The commissioner shall ~~establish standards and methodologies for a~~ reimburse CCBHCs on a per-visit basis under the prospective payment system for medical assistance payments ~~for services delivered by a CCBHC, in accordance with guidance issued by the Centers for Medicare and Medicaid Services~~ as described in paragraph (c). The commissioner shall include a quality ~~bonus~~ incentive payment in the prospective payment system ~~based on federal criteria~~, as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC prospective payment system.

(c) ~~Unless otherwise indicated in applicable federal requirements, the prospective payment system must continue to be based on the federal instructions issued for the federal section 223 CCBHC demonstration, except:~~ The commissioner shall ensure that the prospective payment system for CCBHC payments under medical assistance meets the following requirements:

(1) the prospective payment rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable costs for CCBHCs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under

494.1 section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as
494.2 insurance or supplies needed to provide CCBHC services;

494.3 (2) payment shall be limited to one payment per day per medical assistance enrollee for
494.4 each CCBHC visit eligible for reimbursement. A CCBHC visit is eligible for reimbursement
494.5 if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph
494.6 (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or
494.7 licensed agency employed by or under contract with a CCBHC;

494.8 (3) new payment rates set by the commissioner for newly certified CCBHCs under
494.9 section 245.735, subdivision 3, shall be based on rates for established CCBHCs with a
494.10 similar scope of services. If no comparable CCBHC exists, the commissioner shall establish
494.11 a clinic-specific rate using audited historical cost report data adjusted for the estimated cost
494.12 of delivering CCBHC services, including the estimated cost of providing the full scope of
494.13 services and the projected change in visits resulting from the change in scope;

494.14 (1) (4) the commissioner shall rebase CCBHC rates at least once every three years and
494.15 12 months following an initial rate or a rate change due to a change in the scope of services,
494.16 whichever is earlier;

494.17 (2) (5) the commissioner shall provide for a 60-day appeals process after notice of the
494.18 results of the rebasing;

494.19 (3) the prohibition against inclusion of new facilities in the demonstration does not apply
494.20 after the demonstration ends;

494.21 (4) (6) the prospective payment rate under this section does not apply to services rendered
494.22 by CCBHCs to individuals who are dually eligible for Medicare and medical assistance
494.23 when Medicare is the primary payer for the service. An entity that receives a prospective
494.24 payment system rate that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

494.25 (5) (7) payments for CCBHC services to individuals enrolled in managed care shall be
494.26 coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall
494.27 complete the phase-out of CCBHC wrap payments within 60 days of the implementation
494.28 of the prospective payment system in the Medicaid Management Information System
494.29 (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments
494.30 due made payable to CCBHCs no later than 18 months thereafter;

494.31 (6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be
494.32 based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner

495.1 ~~shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for~~
495.2 ~~changes in the scope of services;~~

495.3 ~~(7)~~ (8) the prospective payment rate for each CCBHC shall be ~~adjusted annually~~ updated
495.4 by trending each provider-specific rate by the Medicare Economic Index ~~as defined for the~~
495.5 ~~federal section 223 CCBHC demonstration~~ for primary care services. This update shall
495.6 occur each year in between rebasing periods determined by the commissioner in accordance
495.7 with clause (4). CCBHCs must provide data on costs and visits to the state annually using
495.8 the CCBHC cost report established by the commissioner; and

495.9 (9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of
495.10 services when such changes are expected to result in an adjustment to the CCBHC payment
495.11 rate by 2.5 percent or more. The CCBHC must provide the commissioner with information
495.12 regarding the changes in the scope of services, including the estimated cost of providing
495.13 the new or modified services and any projected increase or decrease in the number of visits
495.14 resulting from the change. Rate adjustments for changes in scope shall occur no more than
495.15 once per year in between rebasing periods per CCBHC and are effective on the date of the
495.16 annual CCBHC rate update.

495.17 ~~(8) the commissioner shall seek federal approval for a CCBHC rate methodology that~~
495.18 ~~allows for rate modifications based on changes in scope for an individual CCBHC, including~~
495.19 ~~for changes to the type, intensity, or duration of services. Upon federal approval, a CCBHC~~
495.20 ~~may submit a change of scope request to the commissioner if the change in scope would~~
495.21 ~~result in a change of 2.5 percent or more in the prospective payment system rate currently~~
495.22 ~~received by the CCBHC. CCBHC change of scope requests must be according to a format~~
495.23 ~~and timeline to be determined by the commissioner in consultation with CCBHCs.~~

495.24 (d) Managed care plans and county-based purchasing plans shall reimburse CCBHC
495.25 providers at the prospective payment rate. The commissioner shall monitor the effect of
495.26 this requirement on the rate of access to the services delivered by CCBHC providers. If, for
495.27 any contract year, federal approval is not received for this paragraph, the commissioner
495.28 must adjust the capitation rates paid to managed care plans and county-based purchasing
495.29 plans for that contract year to reflect the removal of this provision. Contracts between
495.30 managed care plans and county-based purchasing plans and providers to whom this paragraph
495.31 applies must allow recovery of payments from those providers if capitation rates are adjusted
495.32 in accordance with this paragraph. Payment recoveries must not exceed the amount equal
495.33 to any increase in rates that results from this provision. This paragraph expires if federal
495.34 approval is not received for this paragraph at any time.

496.1 (e) The commissioner shall implement a quality incentive payment program for CCBHCs
496.2 that meets the following requirements:

496.3 (1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric
496.4 thresholds for performance metrics established by the commissioner, in addition to payments
496.5 for which the CCBHC is eligible under the prospective payment system described in
496.6 paragraph (c);

496.7 (2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement
496.8 year to be eligible for incentive payments;

496.9 (3) each CCBHC shall receive written notice of the criteria that must be met in order to
496.10 receive quality incentive payments at least 90 days prior to the measurement year; and

496.11 (4) a CCBHC must provide the commissioner with data needed to determine incentive
496.12 payment eligibility within six months following the measurement year. The commissioner
496.13 shall notify CCBHC providers of their performance on the required measures and the
496.14 incentive payment amount within 12 months following the measurement year.

496.15 (f) All claims to managed care plans for CCBHC services as provided under this section
496.16 shall be submitted directly to, and paid by, the commissioner on the dates specified no later
496.17 than January 1 of the following calendar year, if:

496.18 (1) one or more managed care plans does not comply with the federal requirement for
496.19 payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42,
496.20 section 447.45(b), and the managed care plan does not resolve the payment issue within 30
496.21 days of noncompliance; and

496.22 (2) the total amount of clean claims not paid in accordance with federal requirements
496.23 by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims
496.24 eligible for payment by managed care plans.

496.25 If the conditions in this paragraph are met between January 1 and June 30 of a calendar
496.26 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of
496.27 the following year. If the conditions in this paragraph are met between July 1 and December
496.28 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning
496.29 on July 1 of the following year.

496.30 Sec. 20. Minnesota Statutes 2020, section 256B.0625, subdivision 20, is amended to read:

496.31 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
496.32 state agency, medical assistance covers case management services to persons with serious

and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative or a contact by interactive video that meets the requirements of subdivision 20b; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 20b with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county ~~or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe~~ must be calculated in accordance with section 256B.076, subdivision 2. Payment for mental health case management provided by vendors who contract with a Tribe must be based on a monthly rate negotiated by the Tribe. The ~~negotiated~~ rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the ~~county or tribe may negotiate a team rate with a vendor~~

498.1 ~~who is a member of the team. The~~ team shall determine how to distribute the rate among
498.2 its members. No reimbursement received by contracted vendors shall be returned to the
498.3 county or tribe, except to reimburse the county or tribe for advance funding provided by
498.4 the county or tribe to the vendor.

498.5 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
498.6 and county or state staff, the costs for county or state staff participation in the team shall be
498.7 included in the rate for county-provided services. In this case, the contracted vendor, the
498.8 tribal agency, and the county may each receive separate payment for services provided by
498.9 each entity in the same month. In order to prevent duplication of services, each entity must
498.10 document, in the recipient's file, the need for team case management and a description of
498.11 the roles of the team members.

498.12 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
498.13 mental health case management shall be provided by the recipient's county of responsibility,
498.14 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
498.15 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal
498.16 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state
498.17 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
498.18 the recipient's county of responsibility.

498.19 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
498.20 and MinnesotaCare include mental health case management. When the service is provided
498.21 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
498.22 share.

498.23 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
498.24 that does not meet the reporting or other requirements of this section. The county of
498.25 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,
498.26 is responsible for any federal disallowances. The county or tribe may share this responsibility
498.27 with its contracted vendors.

498.28 (k) The commissioner shall set aside a portion of the federal funds earned for county
498.29 expenditures under this section to repay the special revenue maximization account under
498.30 section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

498.31 (1) the costs of developing and implementing this section; and

498.32 (2) programming the information systems.

499.1 (l) Payments to counties and tribal agencies for case management expenditures under
499.2 this section shall only be made from federal earnings from services provided under this
499.3 section. When this service is paid by the state without a federal share through fee-for-service,
499.4 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
499.5 shall include the federal earnings, the state share, and the county share.

499.6 (m) Case management services under this subdivision do not include therapy, treatment,
499.7 legal, or outreach services.

499.8 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
499.9 and the recipient's institutional care is paid by medical assistance, payment for case
499.10 management services under this subdivision is limited to the lesser of:

499.11 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
499.12 than six months in a calendar year; or

499.13 (2) the limits and conditions which apply to federal Medicaid funding for this service.

499.14 (o) Payment for case management services under this subdivision shall not duplicate
499.15 payments made under other program authorities for the same purpose.

499.16 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
499.17 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
499.18 mental health targeted case management services must actively support identification of
499.19 community alternatives for the recipient and discharge planning.

499.20 Sec. 21. Minnesota Statutes 2020, section 256B.0759, subdivision 2, is amended to read:

499.21 Subd. 2. **Provider participation.** (a) Outpatient substance use disorder treatment
499.22 providers may elect to participate in the demonstration project and meet the requirements
499.23 of subdivision 3. To participate, a provider must notify the commissioner of the provider's
499.24 intent to participate in a format required by the commissioner and enroll as a demonstration
499.25 project provider.

499.26 (b) A program licensed by the Department of Human Services as a residential treatment
499.27 program according to section 245G.21 and that receives payment under this chapter must
499.28 enroll as a demonstration project provider and meet the requirements of subdivision 3 by
499.29 January 1, 2022. The commissioner may grant an extension, for a period not to exceed six
499.30 months, to a program that is unable to meet the requirements of subdivision 3 due to
499.31 demonstrated extraordinary circumstances. A program seeking an extension must apply in
499.32 a format approved by the commissioner by November 1, 2021. A program that does not

500.1 meet the requirements under this paragraph by July 1, 2023, is ineligible for payment for
500.2 services provided under sections 254B.05 and 256B.0625.

500.3 (c) A program licensed by the Department of Human Services as a withdrawal
500.4 management program according to chapter 245F and that receives payment under this
500.5 chapter must enroll as a demonstration project provider and meet the requirements of
500.6 subdivision 3 by January 1, 2022. The commissioner may grant an extension, for a period
500.7 not to exceed six months, to a program that is unable to meet the requirements of subdivision
500.8 3 due to demonstrated extraordinary circumstances. A program seeking an extension must
500.9 apply in a format approved by the commissioner by November 1, 2021. A program that
500.10 does not meet the requirements under this paragraph by July 1, 2023, is ineligible for payment
500.11 for services provided under sections 254B.05 and 256B.0625.

500.12 (d) An out-of-state residential substance use disorder treatment program that receives
500.13 payment under this chapter must enroll as a demonstration project provider and meet the
500.14 requirements of subdivision 3 by January 1, 2022. The commissioner may grant an extension,
500.15 for a period not to exceed six months, to a program that is unable to meet the requirements
500.16 of subdivision 3 due to demonstrated extraordinary circumstances. A program seeking an
500.17 extension must apply in a format approved by the commissioner by November 1, 2021.
500.18 Programs that do not meet the requirements under this paragraph by July 1, 2023, are
500.19 ineligible for payment for services provided under sections 254B.05 and 256B.0625.

500.20 (e) Tribally licensed programs may elect to participate in the demonstration project and
500.21 meet the requirements of subdivision 3. The Department of Human Services must consult
500.22 with tribal nations to discuss participation in the substance use disorder demonstration
500.23 project.

500.24 (f) All rate enhancements for services rendered by demonstration project providers that
500.25 voluntarily enrolled before July 1, 2021, are applicable only to dates of service on or after
500.26 the effective date of the provider's enrollment in the demonstration project, except as
500.27 authorized under paragraph (g). The commissioner shall recoup any rate enhancements paid
500.28 under paragraph (g) to a provider that does not meet the requirements of subdivision 3 by
500.29 July 1, 2021.

500.30 (g) The commissioner may allow providers enrolled in the demonstration project before
500.31 July 1, 2021, to receive applicable rate enhancements authorized under subdivision 4 for
500.32 services provided to fee-for-service enrollees on dates of service no earlier than July 22,
500.33 2020, and to managed care enrollees on dates of service no earlier than January 1, 2021, if:

501.1 (1) the provider attests that during the time period for which it is seeking the rate
501.2 enhancement, it was taking meaningful steps and had a reasonable plan approved by the
501.3 commissioner to meet the demonstration project requirements in subdivision 3;

501.4 (2) the provider submits the attestation and evidence of meeting the requirements of
501.5 subdivision 3, including all information requested by the commissioner, in a format specified
501.6 by the commissioner; and

501.7 (3) the commissioner received the provider's application for enrollment on or before
501.8 June 1, 2021.

501.9 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
501.10 whichever is later, except paragraphs (f) and (g) are effective the day following final
501.11 enactment.

501.12 Sec. 22. Minnesota Statutes 2020, section 256B.0759, subdivision 4, is amended to read:

501.13 Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must
501.14 be increased for services provided to medical assistance enrollees. To receive a rate increase,
501.15 participating providers must meet demonstration project requirements, provider standards
501.16 under subdivision 3, and provide evidence of formal referral arrangements with providers
501.17 delivering step-up or step-down levels of care.

501.18 (b) The commissioner may temporarily suspend payments to the provider according to
501.19 section 256B.04, subdivision 21, paragraph (d), if the requirements in paragraph (a) are not
501.20 met. Payments withheld from the provider must be made once the commissioner determines
501.21 that the requirements in paragraph (a) are met.

501.22 ~~(b)~~ (c) For substance use disorder services under section 254B.05, subdivision 5,
501.23 paragraph (b), clause (8), provided on or after July 1, 2020, payment rates must be increased
501.24 by ~~15~~ 30 percent over the rates in effect on December 31, 2019.

501.25 ~~(c)~~ (d) For substance use disorder services under section 254B.05, subdivision 5,
501.26 paragraph (b), clauses (1), (6), and (7), and adolescent treatment programs that are licensed
501.27 as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on
501.28 or after January 1, 2021, payment rates must be increased by ~~ten~~ 25 percent over the rates
501.29 in effect on December 31, 2020.

501.30 ~~(d)~~ (e) Effective January 1, 2021, and contingent on annual federal approval, managed
501.31 care plans and county-based purchasing plans must reimburse providers of the substance
501.32 use disorder services meeting the criteria described in paragraph (a) who are employed by
501.33 or under contract with the plan an amount that is at least equal to the fee-for-service base

502.1 rate payment for the substance use disorder services described in paragraphs ~~(b)~~ (c) and ~~(c)~~
502.2 (d). The commissioner must monitor the effect of this requirement on the rate of access to
502.3 substance use disorder services and residential substance use disorder rates. Capitation rates
502.4 paid to managed care organizations and county-based purchasing plans must reflect the
502.5 impact of this requirement. This paragraph expires if federal approval is not received at any
502.6 time as required under this paragraph.

502.7 ~~(e)~~ (f) Effective July 1, 2021, contracts between managed care plans and county-based
502.8 purchasing plans and providers to whom paragraph ~~(d)~~ (e) applies must allow recovery of
502.9 payments from those providers if, for any contract year, federal approval for the provisions
502.10 of paragraph ~~(d)~~ (e) is not received, and capitation rates are adjusted as a result. Payment
502.11 recoveries must not exceed the amount equal to any decrease in rates that results from this
502.12 provision.

502.13 **EFFECTIVE DATE.** This section is effective July 1, 2021, except the amendments to
502.14 the payment rate percentage increases in paragraphs (c) and (d) are effective January 1,
502.15 2022.

502.16 Sec. 23. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision
502.17 to read:

502.18 Subd. 6. **Data and outcome measures; public posting.** Beginning July 1, 2021, and at
502.19 least annually thereafter, all data and outcome measures from the previous year of the
502.20 demonstration project shall be posted publicly on the Department of Human Services website
502.21 in an accessible and user-friendly format.

502.22 **EFFECTIVE DATE.** This section is effective July 1, 2021.

502.23 Sec. 24. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision
502.24 to read:

502.25 Subd. 7. **Federal approval; demonstration project extension.** The commissioner shall
502.26 seek a five-year extension of the demonstration project under this section and to receive
502.27 enhanced federal financial participation.

502.28 **EFFECTIVE DATE.** This section is effective July 1, 2021.

503.1 Sec. 25. Minnesota Statutes 2020, section 256B.0759, is amended by adding a subdivision
503.2 to read:

503.3 Subd. 8. **Demonstration project evaluation work group.** Beginning October 1, 2021,
503.4 the commissioner shall assemble a work group of relevant stakeholders, including but not
503.5 limited to demonstration project participants and the Minnesota Association of Resources
503.6 for Recovery and Chemical Health, that shall meet quarterly for the duration of the
503.7 demonstration to evaluate the long-term sustainability of any improvements to quality or
503.8 access to substance use disorder treatment services caused by participation in the
503.9 demonstration project. The work group shall also determine how to implement successful
503.10 outcomes of the demonstration project once the project expires.

503.11 **EFFECTIVE DATE.** This section is effective July 1, 2021.

503.12 Sec. 26. **[256B.076] CASE MANAGEMENT SERVICES.**

503.13 Subdivision 1. **Generally.** (a) It is the policy of this state to ensure that individuals on
503.14 medical assistance receive cost-effective and coordinated care, including efforts to address
503.15 the profound effects of housing instability, food insecurity, and other social determinants
503.16 of health. Therefore, subject to federal approval, medical assistance covers targeted case
503.17 management services as described in this section.

503.18 (b) The commissioner, in collaboration with tribes, counties, providers, and individuals
503.19 served, must propose further modifications to targeted case management services to ensure
503.20 a program that complies with all federal requirements, delivers services in a cost-effective
503.21 and efficient manner, creates uniform expectations for targeted case management services,
503.22 addresses health disparities, and promotes person- and family-centered services.

503.23 Subd. 2. **Rate setting.** (a) The commissioner must develop and implement a statewide
503.24 rate methodology for any county that subcontracts targeted case management services to a
503.25 vendor. On January 1, 2022, or upon federal approval, whichever is later, a county must
503.26 use this methodology for any targeted case management services paid by medical assistance
503.27 and delivered through a subcontractor.

503.28 (b) In setting this rate, the commissioner must include the following:

503.29 (1) prevailing wages;

503.30 (2) employee-related expense factor;

503.31 (3) paid time off and training factors;

503.32 (4) supervision and span of control;

504.1 (5) distribution of time factor;

504.2 (6) administrative factor;

504.3 (7) absence factor;

504.4 (8) program support factor; and

504.5 (9) caseload sizes as described in subdivision 3.

504.6 (c) A county may request that the commissioner authorize a rate based on a lower caseload
504.7 size when a subcontractor is assigned to serve individuals with needs, such as homelessness
504.8 or specific linguistic or cultural needs, that significantly exceed other eligible populations.
504.9 A county must include the following in the request:

504.10 (1) the number of clients to be served by a full-time equivalent staffer;

504.11 (2) the specific factors that require a case manager to provide significantly more hours
504.12 of reimbursable services to a client; and

504.13 (3) how the county intends to monitor case size and outcomes.

504.14 (d) The commissioner must adjust only the factor for caseload in paragraph (b), clause
504.15 (9), in response to a request under paragraph (c).

504.16 Subd. 3. **Caseload sizes.** A county-subcontracted provider of targeted case management
504.17 services to the following populations must not exceed the following limits:

504.18 (1) for children with severe emotional disturbance, 15 clients to one full-time equivalent
504.19 case manager;

504.20 (2) for adults with severe and persistent mental illness, 30 clients to one full-time
504.21 equivalent case manager;

504.22 (3) for child welfare targeted case management, 25 clients to one full-time equivalent
504.23 case manager; and

504.24 (4) for vulnerable adults and adults who have developmental disabilities, 45 clients to
504.25 one full-time equivalent case manager.

504.26 Sec. 27. Minnesota Statutes 2020, section 256B.0924, subdivision 6, is amended to read:

504.27 Subd. 6. **Payment for targeted case management.** (a) Medical assistance and
504.28 MinnesotaCare payment for targeted case management shall be made on a monthly basis.
504.29 In order to receive payment for an eligible adult, the provider must document at least one
504.30 contact per month and not more than two consecutive months without a face-to-face contact

505.1 with the adult or the adult's legal representative, family, primary caregiver, or other relevant
505.2 persons identified as necessary to the development or implementation of the goals of the
505.3 personal service plan.

505.4 (b) Payment for targeted case management provided by county staff under this subdivision
505.5 shall be based on the monthly rate methodology under section 256B.094, subdivision 6,
505.6 paragraph (b), calculated as one combined average rate together with adult mental health
505.7 case management under section 256B.0625, subdivision 20, except for calendar year 2002.
505.8 In calendar year 2002, the rate for case management under this section shall be the same as
505.9 the rate for adult mental health case management in effect as of December 31, 2001. Billing
505.10 and payment must identify the recipient's primary population group to allow tracking of
505.11 revenues.

505.12 (c) Payment for targeted case management provided by county-contracted vendors shall
505.13 be based on a monthly rate ~~negotiated by the host county~~ calculated in accordance with
505.14 section 256B.076, subdivision 2. The ~~negotiated~~ rate must not exceed the rate charged by
505.15 the vendor for the same service to other payers. If the service is provided by a team of
505.16 contracted vendors, the ~~county may negotiate a team rate with a vendor who is a member~~
505.17 ~~of the team. The~~ team shall determine how to distribute the rate among its members. No
505.18 reimbursement received by contracted vendors shall be returned to the county, except to
505.19 reimburse the county for advance funding provided by the county to the vendor.

505.20 (d) If the service is provided by a team that includes contracted vendors and county staff,
505.21 the costs for county staff participation on the team shall be included in the rate for
505.22 county-provided services. In this case, the contracted vendor and the county may each
505.23 receive separate payment for services provided by each entity in the same month. In order
505.24 to prevent duplication of services, the county must document, in the recipient's file, the need
505.25 for team targeted case management and a description of the different roles of the team
505.26 members.

505.27 (e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
505.28 targeted case management shall be provided by the recipient's county of responsibility, as
505.29 defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
505.30 used to match other federal funds.

505.31 (f) The commissioner may suspend, reduce, or terminate reimbursement to a provider
505.32 that does not meet the reporting or other requirements of this section. The county of
505.33 responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal
505.34 disallowances. The county may share this responsibility with its contracted vendors.

506.1 (g) The commissioner shall set aside five percent of the federal funds received under
506.2 this section for use in reimbursing the state for costs of developing and implementing this
506.3 section.

506.4 (h) Payments to counties for targeted case management expenditures under this section
506.5 shall only be made from federal earnings from services provided under this section. Payments
506.6 to contracted vendors shall include both the federal earnings and the county share.

506.7 (i) Notwithstanding section 256B.041, county payments for the cost of case management
506.8 services provided by county staff shall not be made to the commissioner of management
506.9 and budget. For the purposes of targeted case management services provided by county
506.10 staff under this section, the centralized disbursement of payments to counties under section
506.11 256B.041 consists only of federal earnings from services provided under this section.

506.12 (j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
506.13 and the recipient's institutional care is paid by medical assistance, payment for targeted case
506.14 management services under this subdivision is limited to the lesser of:

506.15 (1) the last 180 days of the recipient's residency in that facility; or

506.16 (2) the limits and conditions which apply to federal Medicaid funding for this service.

506.17 (k) Payment for targeted case management services under this subdivision shall not
506.18 duplicate payments made under other program authorities for the same purpose.

506.19 (l) Any growth in targeted case management services and cost increases under this
506.20 section shall be the responsibility of the counties.

506.21 Sec. 28. Minnesota Statutes 2020, section 256B.094, subdivision 6, is amended to read:

506.22 Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical
506.23 assistance reimbursement for services under this section shall be made on a monthly basis.
506.24 Payment is based on face-to-face or telephone contacts between the case manager and the
506.25 client, client's family, primary caregiver, legal representative, or other relevant person
506.26 identified as necessary to the development or implementation of the goals of the individual
506.27 service plan regarding the status of the client, the individual service plan, or the goals for
506.28 the client. These contacts must meet the minimum standards in clauses (1) and (2):

506.29 (1) there must be a face-to-face contact at least once a month except as provided in clause
506.30 (2); and

506.31 (2) for a client placed outside of the county of financial responsibility, or a client served
506.32 by tribal social services placed outside the reservation, in an excluded time facility under

507.1 section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of
507.2 Children, section 260.93, and the placement in either case is more than 60 miles beyond
507.3 the county or reservation boundaries, there must be at least one contact per month and not
507.4 more than two consecutive months without a face-to-face contact.

507.5 (b) Except as provided under paragraph (c), the payment rate is established using time
507.6 study data on activities of provider service staff and reports required under sections 245.482
507.7 and 256.01, subdivision 2, paragraph (p).

507.8 (c) Payments for tribes may be made according to section 256B.0625 or other relevant
507.9 federally approved rate setting methodology for child welfare targeted case management
507.10 provided by Indian health services and facilities operated by a tribe or tribal organization.

507.11 (d) Payment for case management provided by county ~~or tribal social services~~ contracted
507.12 vendors ~~shall be based on a monthly rate negotiated by the host county or tribal social~~
507.13 ~~services~~ must be calculated in accordance with section 256B.076, subdivision 2. Payment
507.14 for case management provided by vendors who contract with a Tribe must be based on a
507.15 monthly rate negotiated by the Tribe. The ~~negotiated~~ rate must not exceed the rate charged
507.16 by the vendor for the same service to other payers. If the service is provided by a team of
507.17 contracted vendors, the ~~county or tribal social services may negotiate a team rate with a~~
507.18 ~~vendor who is a member of the team. The~~ team shall determine how to distribute the rate
507.19 among its members. No reimbursement received by contracted vendors shall be returned
507.20 to the county or tribal social services, except to reimburse the county or tribal social services
507.21 for advance funding provided by the county or tribal social services to the vendor.

507.22 (e) If the service is provided by a team that includes contracted vendors and county or
507.23 tribal social services staff, the costs for county or tribal social services staff participation in
507.24 the team shall be included in the rate for county or tribal social services provided services.
507.25 In this case, the contracted vendor and the county or tribal social services may each receive
507.26 separate payment for services provided by each entity in the same month. To prevent
507.27 duplication of services, each entity must document, in the recipient's file, the need for team
507.28 case management and a description of the roles and services of the team members.

507.29 Separate payment rates may be established for different groups of providers to maximize
507.30 reimbursement as determined by the commissioner. The payment rate will be reviewed
507.31 annually and revised periodically to be consistent with the most recent time study and other
507.32 data. Payment for services will be made upon submission of a valid claim and verification
507.33 of proper documentation described in subdivision 7. Federal administrative revenue earned
507.34 through the time study, or under paragraph (c), shall be distributed according to earnings,

508.1 to counties, reservations, or groups of counties or reservations which have the same payment
508.2 rate under this subdivision, and to the group of counties or reservations which are not
508.3 certified providers under section 256F.10. The commissioner shall modify the requirements
508.4 set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.

508.5 Sec. 29. **DIRECTION TO THE COMMISSIONER; ADULT MENTAL HEALTH**
508.6 **INITIATIVES REFORM.**

508.7 In establishing a legislative proposal for reforming the funding formula to distribute
508.8 adult mental health initiative funds, the commissioner of human services shall ensure that
508.9 funding currently received as a result of the closure of the Moose Lake Regional Treatment
508.10 Center is not reallocated from any region that does not have a community behavioral health
508.11 hospital. Upon finalization of the adult mental health initiatives reform, the commissioner
508.12 shall notify the chairs and ranking minority members of the legislative committees with
508.13 jurisdiction over health and human services finance and policy.

508.14 Sec. 30. **DIRECTION TO THE COMMISSIONER; ALTERNATIVE MENTAL**
508.15 **HEALTH PROFESSIONAL LICENSING PATHWAYS WORK GROUP.**

508.16 (a) The commissioners of human services and health must convene a work group
508.17 consisting of representatives from the Board of Psychology; the Board of Marriage and
508.18 Family Therapy; the Board of Social Work; the Board of Behavioral Health and Therapy;
508.19 five mental health providers from diverse cultural communities; a representative from the
508.20 Minnesota Council of Health Plans; a representative from a state health care program; two
508.21 representatives from mental health associations or community mental health clinics led by
508.22 individuals who are Black, indigenous, or people of color; and representatives from mental
508.23 health professional graduate programs to evaluate and make recommendations on possible
508.24 alternative pathways to mental health professional licensure in Minnesota. The work group
508.25 must:

508.26 (1) identify barriers to licensure in mental health professions;

508.27 (2) collect data on the number of individuals graduating from educational programs but
508.28 not passing licensing exams;

508.29 (3) evaluate the feasibility of alternative pathways for licensure in mental health
508.30 professions, ensuring provider competency and professionalism; and

508.31 (4) consult with national behavioral health testing entities.

509.1 (b) Mental health providers participating in the work group may be reimbursed for
509.2 expenses in the same manner as authorized by the commissioner's plan adopted under
509.3 Minnesota Statutes, section 43A.18, subdivision 2, upon approval by the commissioner.
509.4 Members who, as a result of time spent attending work group meetings, incur child care
509.5 expenses that would not otherwise have been incurred, may be reimbursed for those expenses
509.6 upon approval by the commissioner. Reimbursements may be approved for no more than
509.7 five individual providers.

509.8 (c) No later than February 1, 2023, the commissioners must submit a written report to
509.9 the members of the legislative committees with jurisdiction over health and human services
509.10 on the work group's findings and recommendations developed on alternative licensing
509.11 pathways.

509.12 Sec. 31. **DIRECTION TO THE COMMISSIONER; CHILDREN'S MENTAL**
509.13 **HEALTH RESIDENTIAL TREATMENT WORK GROUP.**

509.14 The commissioner of human services, in consultation with counties, children's mental
509.15 health residential providers, and children's mental health advocates, must organize a work
509.16 group and develop recommendations on how to efficiently and effectively fund room and
509.17 board costs for children's mental health residential treatment under the children's mental
509.18 health act. The work group may also provide recommendations on how to address systemic
509.19 barriers in transitioning children into the community and community-based treatment options.
509.20 The commissioner shall submit the recommendations to the chairs and ranking minority
509.21 members of the legislative committees with jurisdiction over health and human services
509.22 policy and finance by February 15, 2022.

509.23 Sec. 32. **DIRECTION TO THE COMMISSIONER; CULTURALLY AND**
509.24 **LINGUISTICALLY APPROPRIATE SERVICES.**

509.25 The commissioner of human services, in consultation with substance use disorder
509.26 treatment providers, lead agencies, and individuals who receive substance use disorder
509.27 treatment services, shall develop a statewide implementation and transition plan for culturally
509.28 and linguistically appropriate services (CLAS) national standards, including technical
509.29 assistance for providers to transition to the CLAS standards and to improve disparate
509.30 treatment outcomes. The commissioner must consult with individuals who are Black,
509.31 indigenous, people of color, and linguistically diverse in the development of the
509.32 implementation and transition plans under this section.

510.1 Sec. 33. **DIRECTION TO THE COMMISSIONER; RATE RECOMMENDATIONS**
510.2 **FOR OPIOID TREATMENT PROGRAMS.**

510.3 The commissioner of human services shall evaluate the rate structure for opioid treatment
510.4 programs licensed under Minnesota Statutes, section 245G.22, and report recommendations,
510.5 including a revised rate structure and proposed draft legislation, to the chairs and ranking
510.6 minority members of the legislative committees with jurisdiction over human services policy
510.7 and finance by October 1, 2021.

510.8 Sec. 34. **DIRECTION TO THE COMMISSIONER; SOBER HOUSING PROGRAM**
510.9 **RECOMMENDATIONS.**

510.10 (a) The commissioner of human services, in consultation with stakeholders, must develop
510.11 recommendations on:

510.12 (1) increasing access to sober housing programs;

510.13 (2) promoting person-centered practices and cultural responsiveness in sober housing
510.14 programs;

510.15 (3) potential oversight of sober housing programs; and

510.16 (4) providing consumer protections for individuals in sober housing programs with
510.17 substance use disorders and individuals with co-occurring mental illnesses.

510.18 (b) Stakeholders include but are not limited to the Minnesota Association of Sober
510.19 Homes, the Minnesota Association of Resources for Recovery and Chemical Health,
510.20 Minnesota Recovery Connection, NAMI Minnesota, the National Alliance of Recovery
510.21 Residencies (NARR), Oxford Houses, Inc., sober housing programs based in Minnesota
510.22 that are not members of the Minnesota Association of Sober Homes, a member of Alcoholics
510.23 Anonymous, and residents and former residents of sober housing programs based in
510.24 Minnesota. Stakeholders must equitably represent various geographic areas of the state and
510.25 must include individuals in recovery and providers representing Black, indigenous, people
510.26 of color, or immigrant communities.

510.27 (c) The commissioner must complete and submit a report on these recommendations to
510.28 the chairs and ranking minority members of the legislative committees with jurisdiction
510.29 over health and human services policy and finance on or before March 1, 2022.

511.1 Sec. 35. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER**
511.2 **TREATMENT PAPERWORK REDUCTION.**

511.3 (a) The commissioner of human services, in consultation with counties, tribes, managed
511.4 care organizations, substance use disorder treatment professional associations, and other
511.5 relevant stakeholders, shall develop, assess, and recommend systems improvements to
511.6 minimize regulatory paperwork and improve systems for substance use disorder programs
511.7 licensed under Minnesota Statutes, chapter 245A, and regulated under Minnesota Statutes,
511.8 chapters 245F and 245G, and Minnesota Rules, chapters 2960 and 9530. The commissioner
511.9 of human services shall make available any resources needed from other divisions within
511.10 the department to implement systems improvements.

511.11 (b) The commissioner of health shall make available needed information and resources
511.12 from the Division of Health Policy.

511.13 (c) The Office of MN.IT Services shall provide advance consultation and implementation
511.14 of the changes needed in data systems.

511.15 (d) The commissioner of human services shall contract with a vendor that has experience
511.16 with developing statewide system changes for multiple states at the payer and provider
511.17 levels. If the commissioner, after exercising reasonable diligence, is unable to secure a
511.18 vendor with the requisite qualifications, then the commissioner may select the best qualified
511.19 vendor available. When developing recommendations, the commissioner shall consider
511.20 input from all stakeholders. The commissioner's recommendations shall maximize benefits
511.21 for clients and utility for providers, regulatory agencies, and payers.

511.22 (e) The commissioner of human services and contracted vendor shall follow the
511.23 recommendations from the report issued in response to Laws 2019, First Special Session
511.24 chapter 9, article 6, section 76.

511.25 (f) By December 15, 2022, the commissioner of human services shall take steps to
511.26 implement paperwork reductions and systems improvements within the commissioner's
511.27 authority and submit to the chairs and ranking minority members of the legislative committees
511.28 with jurisdiction over health and human services a report that includes recommendations
511.29 for changes in statutes that would further enhance systems improvements to reduce
511.30 paperwork. The report shall include a summary of the approaches developed and assessed
511.31 by the commissioner of human services and stakeholders and the results of any assessments
511.32 conducted.

512.1 Sec. 36. **DIRECTION TO THE COMMISSIONER; TRIBAL OVERPAYMENT**
512.2 **PROTOCOLS.**

512.3 The commissioner of human services, in consultation with the Tribal nations, shall
512.4 develop protocols that must be used to address and attempt to resolve any future overpayment
512.5 involving any Tribal nation in Minnesota.

512.6 Sec. 37. **SUBSTANCE USE DISORDER TREATMENT RATE RESTRUCTURE**
512.7 **ANALYSIS.**

512.8 (a) By January 1, 2022, the commissioner shall issue a request for proposals for
512.9 frameworks and modeling of substance use disorder rates. Rates must be predicated on a
512.10 uniform methodology that is transparent, culturally responsive, supports staffing needed to
512.11 treat a patient's assessed need, and promotes quality service delivery and patient choice.
512.12 The commissioner must consult with substance use disorder treatment programs across the
512.13 spectrum of services, substance use disorder treatment programs from across each region
512.14 of the state, and culturally responsive providers in the development of the request for proposal
512.15 process and for the duration of the contract.

512.16 (b) By January 15, 2023, the commissioner of human services shall submit a report to
512.17 the chairs and ranking minority members of the legislative committees with jurisdiction
512.18 over human services policy and finance on the results of the vendor's work. The report must
512.19 include legislative language necessary to implement a new substance use disorder treatment
512.20 rate methodology and a detailed fiscal analysis.

512.21 Sec. 38. **REVISOR INSTRUCTION.**

512.22 The revisor of statutes shall replace "EXCELLENCE IN MENTAL HEALTH
512.23 DEMONSTRATION PROJECT" with "CERTIFIED COMMUNITY BEHAVIORAL
512.24 HEALTH CLINIC SERVICES" in the section headnote for Minnesota Statutes, section
512.25 245.735.

512.26 Sec. 39. **REPEALER.**

512.27 (a) Minnesota Statutes 2020, section 256B.0596, is repealed.

512.28 (b) Minnesota Statutes 2020, section 245.735, subdivisions 1, 2, and 4, are repealed.

512.29 (c) Minnesota Statutes 2020, section 245.4871, subdivision 32a, is repealed.

512.30 **EFFECTIVE DATE.** Paragraph (c) is effective September 30, 2021.

513.1 **ARTICLE 13**
513.2 **DIRECT CARE AND TREATMENT**

513.3 Section 1. Minnesota Statutes 2020, section 246.54, subdivision 1b, is amended to read:

513.4 Subd. 1b. **Community behavioral health hospitals.** A county's payment of the cost of
513.5 care provided at state-operated community-based behavioral health hospitals for adults and
513.6 children shall be according to the following schedule:

513.7 (1) 100 percent for each day during the stay, including the day of admission, when the
513.8 facility determines that it is clinically appropriate for the client to be discharged; and

513.9 (2) the county shall not be entitled to reimbursement from the client, the client's estate,
513.10 or from the client's relatives, except as provided in section 246.53.

513.11 **ARTICLE 14**
513.12 **DISABILITY SERVICES AND CONTINUING CARE FOR OLDER ADULTS**

513.13 Section 1. Minnesota Statutes 2020, section 144.0724, subdivision 4, is amended to read:

513.14 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically
513.15 submit to the ~~commissioner of health~~ federal database MDS assessments that conform with
513.16 the assessment schedule defined by ~~Code of Federal Regulations, title 42, section 483.20,~~
513.17 ~~and published by the United States Department of Health and Human Services, Centers for~~
513.18 ~~Medicare and Medicaid Services, in~~ the Long Term Care Facility Resident Assessment
513.19 Instrument User's Manual, version 3.0~~, and subsequent updates when~~ or its successor issued
513.20 by the Centers for Medicare and Medicaid Services. The commissioner of health may
513.21 substitute successor manuals or question and answer documents published by the United
513.22 States Department of Health and Human Services, Centers for Medicare and Medicaid
513.23 Services, to replace or supplement the current version of the manual or document.

513.24 (b) The assessments required under the Omnibus Budget Reconciliation Act of 1987
513.25 (OBRA) used to determine a case mix classification for reimbursement include the following:

513.26 (1) a new admission comprehensive assessment, which must have an assessment reference
513.27 date (ARD) within 14 calendar days after admission, excluding readmissions;

513.28 (2) an annual comprehensive assessment, which must have an ~~assessment reference date~~
513.29 ~~(ARD)~~ ARD within 92 days of ~~the~~ a previous quarterly review assessment ~~and the~~ or a
513.30 previous comprehensive assessment, which must occur at least once every 366 days;

513.31 (3) a significant change in status comprehensive assessment, which must ~~be completed~~
513.32 have an ARD within 14 days ~~of the identification of~~ after the facility determines, or should

have determined, that there has been a significant change in the resident's physical or mental condition, whether an improvement or a decline, and regardless of the amount of time since the last ~~significant change in status~~ comprehensive assessment or quarterly review assessment;

(4) ~~all~~ a quarterly ~~assessments~~ review assessment must have an ~~assessment reference date (ARD)~~ ARD within 92 days of the ARD of the previous quarterly review assessment or a previous comprehensive assessment;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; ~~and~~

(6) any significant correction to a prior quarterly review assessment, if the assessment being corrected is the current one being used for RUG classification~~.~~;

(7) a required significant change in status assessment when:

(i) all speech, occupational, and physical therapies have ended. The ARD of this assessment must be set on day eight after all therapy services have ended; and

(ii) isolation for an infectious disease has ended. The ARD of this assessment must be set on day 15 after isolation has ended; and

(8) any modifications to the most recent assessments under clauses (1) to (7).

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by the Senior LinkAge Line or other organization under contract with the Minnesota Board on Aging; and

(2) a nursing facility level of care determination as provided for under section 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment completed under section 256B.0911, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Sec. 2. Minnesota Statutes 2020, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license

holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (h), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; ~~or~~

(5) new foster care licenses or community residential setting licenses for people receiving services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and for which a license is required. This exception does not apply to people living in their own home. For purposes of this clause, there is a presumption that a foster care or community residential setting license is required for services provided to three or more people in a dwelling unit when the setting is controlled by the provider. A license holder subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2018. This exception is available when:

516.1 (i) the person's case manager provided the person with information about the choice of
516.2 service, service provider, and location of service, including in the person's home, to help
516.3 the person make an informed choice; and

516.4 (ii) the person's services provided in the licensed foster care or community residential
516.5 setting are less than or equal to the cost of the person's services delivered in the unlicensed
516.6 setting as determined by the lead agency.; or

516.7 (6) new foster care licenses or community residential setting licenses for people receiving
516.8 customized living or 24-hour customized living services under the brain injury or community
516.9 access for disability inclusion waiver plans under section 256B.49 and residing in the
516.10 customized living setting before July 1, 2022, for which a license is required. A customized
516.11 living service provider subject to this exception may rebut the presumption that a license
516.12 is required by seeking a reconsideration of the commissioner's determination. The
516.13 commissioner's disposition of a request for reconsideration is final and not subject to appeal
516.14 under chapter 14. The exception is available until June 30, 2023. This exception is available
516.15 when:

516.16 (i) the person's customized living services are provided in a customized living service
516.17 setting serving four or fewer people under the brain injury or community access for disability
516.18 inclusion waiver plans under section 256B.49 in a single-family home operational on or
516.19 before June 30, 2021. Operational is defined in section 256B.49, subdivision 28;

516.20 (ii) the person's case manager provided the person with information about the choice of
516.21 service, service provider, and location of service, including in the person's home, to help
516.22 the person make an informed choice; and

516.23 (iii) the person's services provided in the licensed foster care or community residential
516.24 setting are less than or equal to the cost of the person's services delivered in the customized
516.25 living setting as determined by the lead agency.

516.26 (b) The commissioner shall determine the need for newly licensed foster care homes or
516.27 community residential settings as defined under this subdivision. As part of the determination,
516.28 the commissioner shall consider the availability of foster care capacity in the area in which
516.29 the licensee seeks to operate, and the recommendation of the local county board. The
516.30 determination by the commissioner must be final. A determination of need is not required
516.31 for a change in ownership at the same address.

516.32 (c) When an adult resident served by the program moves out of a foster home that is not
516.33 the primary residence of the license holder according to section 256B.49, subdivision 15,
516.34 paragraph (f), or the adult community residential setting, the county shall immediately

517.1 inform the Department of Human Services Licensing Division. The department may decrease
517.2 the statewide licensed capacity for adult foster care settings.

517.3 (d) Residential settings that would otherwise be subject to the decreased license capacity
517.4 established in paragraph (c) shall be exempt if the license holder's beds are occupied by
517.5 residents whose primary diagnosis is mental illness and the license holder is certified under
517.6 the requirements in subdivision 6a or section 245D.33.

517.7 (e) A resource need determination process, managed at the state level, using the available
517.8 reports required by section 144A.351, and other data and information shall be used to
517.9 determine where the reduced capacity determined under section 256B.493 will be
517.10 implemented. The commissioner shall consult with the stakeholders described in section
517.11 144A.351, and employ a variety of methods to improve the state's capacity to meet the
517.12 informed decisions of those people who want to move out of corporate foster care or
517.13 community residential settings, long-term service needs within budgetary limits, including
517.14 seeking proposals from service providers or lead agencies to change service type, capacity,
517.15 or location to improve services, increase the independence of residents, and better meet
517.16 needs identified by the long-term services and supports reports and statewide data and
517.17 information.

517.18 (f) At the time of application and reapplication for licensure, the applicant and the license
517.19 holder that are subject to the moratorium or an exclusion established in paragraph (a) are
517.20 required to inform the commissioner whether the physical location where the foster care
517.21 will be provided is or will be the primary residence of the license holder for the entire period
517.22 of licensure. If the primary residence of the applicant or license holder changes, the applicant
517.23 or license holder must notify the commissioner immediately. The commissioner shall print
517.24 on the foster care license certificate whether or not the physical location is the primary
517.25 residence of the license holder.

517.26 (g) License holders of foster care homes identified under paragraph (f) that are not the
517.27 primary residence of the license holder and that also provide services in the foster care home
517.28 that are covered by a federally approved home and community-based services waiver, as
517.29 authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human
517.30 services licensing division that the license holder provides or intends to provide these
517.31 waiver-funded services.

517.32 (h) The commissioner may adjust capacity to address needs identified in section
517.33 144A.351. Under this authority, the commissioner may approve new licensed settings or
517.34 delicense existing settings. Delicensing of settings will be accomplished through a process

518.1 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
518.2 information and data on capacity of licensed long-term services and supports, actions taken
518.3 under the subdivision to manage statewide long-term services and supports resources, and
518.4 any recommendations for change to the legislative committees with jurisdiction over the
518.5 health and human services budget.

518.6 (i) The commissioner must notify a license holder when its corporate foster care or
518.7 community residential setting licensed beds are reduced under this section. The notice of
518.8 reduction of licensed beds must be in writing and delivered to the license holder by certified
518.9 mail or personal service. The notice must state why the licensed beds are reduced and must
518.10 inform the license holder of its right to request reconsideration by the commissioner. The
518.11 license holder's request for reconsideration must be in writing. If mailed, the request for
518.12 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
518.13 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
518.14 reconsideration is made by personal service, it must be received by the commissioner within
518.15 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

518.16 (j) The commissioner shall not issue an initial license for children's residential treatment
518.17 services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter
518.18 for a program that Centers for Medicare and Medicaid Services would consider an institution
518.19 for mental diseases. Facilities that serve only private pay clients are exempt from the
518.20 moratorium described in this paragraph. The commissioner has the authority to manage
518.21 existing statewide capacity for children's residential treatment services subject to the
518.22 moratorium under this paragraph and may issue an initial license for such facilities if the
518.23 initial license would not increase the statewide capacity for children's residential treatment
518.24 services subject to the moratorium under this paragraph.

518.25 **EFFECTIVE DATE.** This section is effective July 1, 2022.

518.26 Sec. 3. Minnesota Statutes 2020, section 256.9741, subdivision 1, is amended to read:

518.27 Subdivision 1. **Long-term care facility.** "Long-term care facility" means a nursing home
518.28 licensed under sections 144A.02 to 144A.10; a boarding care home licensed under sections
518.29 144.50 to 144.56; an assisted living facility or an assisted living facility with dementia care
518.30 licensed under chapter 144G; ~~or~~ a licensed or registered residential setting that provides or
518.31 arranges for the provision of home care services; or a setting defined under section 144G.08,
518.32 subdivision 7, clauses (10) to (13), that provides or arranges for the provision of home care
518.33 services.

518.34 **EFFECTIVE DATE.** This section is effective August 1, 2021.

519.1 Sec. 4. Minnesota Statutes 2020, section 256B.0911, subdivision 3a, is amended to read:

519.2 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
519.3 planning, or other assistance intended to support community-based living, including persons
519.4 who need assessment in order to determine waiver or alternative care program eligibility,
519.5 must be visited by a long-term care consultation team within 20 calendar days after the date
519.6 on which an assessment was requested or recommended. Upon statewide implementation
519.7 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
519.8 requesting personal care assistance services. The commissioner shall provide at least a
519.9 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face
519.10 assessments must be conducted according to paragraphs (b) to (i).

519.11 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
519.12 assessors to conduct the assessment. For a person with complex health care needs, a public
519.13 health or registered nurse from the team must be consulted.

519.14 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
519.15 be used to complete a comprehensive, conversation-based, person-centered assessment.
519.16 The assessment must include the health, psychological, functional, environmental, and
519.17 social needs of the individual necessary to develop a person-centered community support
519.18 plan that meets the individual's needs and preferences.

519.19 (d) The assessment must be conducted by a certified assessor in a face-to-face
519.20 conversational interview with the person being assessed. The person's legal representative
519.21 must provide input during the assessment process and may do so remotely if requested. At
519.22 the request of the person, other individuals may participate in the assessment to provide
519.23 information on the needs, strengths, and preferences of the person necessary to develop a
519.24 community support plan that ensures the person's health and safety. Except for legal
519.25 representatives or family members invited by the person, persons participating in the
519.26 assessment may not be a provider of service or have any financial interest in the provision
519.27 of services. For persons who are to be assessed for elderly waiver customized living or adult
519.28 day services under chapter 256S, with the permission of the person being assessed or the
519.29 person's designated or legal representative, the client's current or proposed provider of
519.30 services may submit a copy of the provider's nursing assessment or written report outlining
519.31 its recommendations regarding the client's care needs. The person conducting the assessment
519.32 must notify the provider of the date by which this information is to be submitted. This
519.33 information shall be provided to the person conducting the assessment prior to the assessment.
519.34 For a person who is to be assessed for waiver services under section 256B.092 or 256B.49,
519.35 with the permission of the person being assessed or the person's designated legal

520.1 representative, the person's current provider of services may submit a written report outlining
520.2 recommendations regarding the person's care needs the person completed in consultation
520.3 with someone who is known to the person and has interaction with the person on a regular
520.4 basis. The provider must submit the report at least 60 days before the end of the person's
520.5 current service agreement. The certified assessor must consider the content of the submitted
520.6 report prior to finalizing the person's assessment or reassessment.

520.7 (e) The certified assessor and the individual responsible for developing the coordinated
520.8 service and support plan must complete the community support plan and the coordinated
520.9 service and support plan no more than 60 calendar days from the assessment visit. The
520.10 person or the person's legal representative must be provided with a written community
520.11 support plan within the timelines established by the commissioner, regardless of whether
520.12 the person is eligible for Minnesota health care programs.

520.13 (f) For a person being assessed for elderly waiver services under chapter 256S, a provider
520.14 who submitted information under paragraph (d) shall receive the final written community
520.15 support plan when available and the Residential Services Workbook.

520.16 (g) The written community support plan must include:

520.17 (1) a summary of assessed needs as defined in paragraphs (c) and (d);

520.18 (2) the individual's options and choices to meet identified needs, including:

520.19 (i) all available options for case management services and providers;

520.20 (ii) all available options for employment services, settings, and providers;

520.21 (iii) all available options for living arrangements;

520.22 (iv) all available options for self-directed services and supports, including self-directed
520.23 budget options; and

520.24 (v) service provided in a non-disability-specific setting;

520.25 (3) identification of health and safety risks and how those risks will be addressed,
520.26 including personal risk management strategies;

520.27 (4) referral information; and

520.28 (5) informal caregiver supports, if applicable.

520.29 For a person determined eligible for state plan home care under subdivision 1a, paragraph
520.30 (b), clause (1), the person or person's representative must also receive a copy of the home
520.31 care service plan developed by the certified assessor.

521.1 (h) A person may request assistance in identifying community supports without
521.2 participating in a complete assessment. Upon a request for assistance identifying community
521.3 support, the person must be transferred or referred to long-term care options counseling
521.4 services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for
521.5 telephone assistance and follow up.

521.6 (i) The person has the right to make the final decision:

521.7 (1) between institutional placement and community placement after the recommendations
521.8 have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

521.9 (2) between community placement in a setting controlled by a provider and living
521.10 independently in a setting not controlled by a provider;

521.11 (3) between day services and employment services; and

521.12 (4) regarding available options for self-directed services and supports, including
521.13 self-directed funding options.

521.14 (j) The lead agency must give the person receiving long-term care consultation services
521.15 or the person's legal representative, materials, and forms supplied by the commissioner
521.16 containing the following information:

521.17 (1) written recommendations for community-based services and consumer-directed
521.18 options;

521.19 (2) documentation that the most cost-effective alternatives available were offered to the
521.20 individual. For purposes of this clause, "cost-effective" means community services and
521.21 living arrangements that cost the same as or less than institutional care. For an individual
521.22 found to meet eligibility criteria for home and community-based service programs under
521.23 chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally
521.24 approved waiver plan for each program;

521.25 (3) the need for and purpose of preadmission screening conducted by long-term care
521.26 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
521.27 nursing facility placement. If the individual selects nursing facility placement, the lead
521.28 agency shall forward information needed to complete the level of care determinations and
521.29 screening for developmental disability and mental illness collected during the assessment
521.30 to the long-term care options counselor using forms provided by the commissioner;

521.31 (4) the role of long-term care consultation assessment and support planning in eligibility
521.32 determination for waiver and alternative care programs, and state plan home care, case

522.1 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
522.2 and (b);

522.3 (5) information about Minnesota health care programs;

522.4 (6) the person's freedom to accept or reject the recommendations of the team;

522.5 (7) the person's right to confidentiality under the Minnesota Government Data Practices
522.6 Act, chapter 13;

522.7 (8) the certified assessor's decision regarding the person's need for institutional level of
522.8 care as determined under criteria established in subdivision 4e and the certified assessor's
522.9 decision regarding eligibility for all services and programs as defined in subdivision 1a,
522.10 paragraphs (a), clause (6), and (b);

522.11 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
522.12 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
522.13 (8), and (b), and incorporating the decision regarding the need for institutional level of care
522.14 or the lead agency's final decisions regarding public programs eligibility according to section
522.15 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
522.16 to the person and must visually point out where in the document the right to appeal is stated;
522.17 and

522.18 (10) documentation that available options for employment services, independent living,
522.19 and self-directed services and supports were described to the individual.

522.20 (k) Face-to-face assessment completed as part of an eligibility determination for multiple
522.21 programs for the alternative care, elderly waiver, developmental disabilities, community
522.22 access for disability inclusion, community alternative care, and brain injury waiver programs
522.23 under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish
522.24 service eligibility for no more than 60 calendar days after the date of assessment.

522.25 (l) The effective eligibility start date for programs in paragraph (k) can never be prior
522.26 to the date of assessment. If an assessment was completed more than 60 days before the
522.27 effective waiver or alternative care program eligibility start date, assessment and support
522.28 plan information must be updated and documented in the department's Medicaid Management
522.29 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
522.30 state plan services, the effective date of eligibility for programs included in paragraph (k)
522.31 cannot be prior to the date the most recent updated assessment is completed.

522.32 (m) If an eligibility update is completed within 90 days of the previous face-to-face
522.33 assessment and documented in the department's Medicaid Management Information System

523.1 (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date
523.2 of the previous face-to-face assessment when all other eligibility requirements are met.

523.3 (n) If a person who receives home- and community-based waiver services under section
523.4 256B.0913, 256B.092, or 256B.49, or chapter 256S, temporarily enters for 121 days or less
523.5 a hospital, institution of mental disease, nursing facility, intensive residential treatment
523.6 services program, transitional care unit, or inpatient substance use disorder treatment setting,
523.7 the person may return to the community with home- and community-based waiver services
523.8 under the same waiver, without requiring an assessment or reassessment under this section,
523.9 unless the person's annual reassessment is otherwise due. Nothing in this section shall change
523.10 annual long-term care consultation reassessment requirements, payment for institutional or
523.11 treatment services, medical assistance financial eligibility, or any other law.

523.12 ~~(n)~~ (o) At the time of reassessment, the certified assessor shall assess each person
523.13 receiving waiver residential supports and services currently residing in a community
523.14 residential setting, licensed adult foster care home that is either not the primary residence
523.15 of the license holder or in which the license holder is not the primary caregiver, family adult
523.16 foster care residence, customized living setting, or supervised living facility to determine
523.17 if that person would prefer to be served in a community-living setting as defined in section
523.18 256B.49, subdivision 23, in a setting not controlled by a provider, or to receive integrated
523.19 community supports as described in section 245D.03, subdivision 1, paragraph (c), clause
523.20 (8). The certified assessor shall offer the person, through a person-centered planning process,
523.21 the option to receive alternative housing and service options.

523.22 ~~(o)~~ (p) At the time of reassessment, the certified assessor shall assess each person
523.23 receiving waiver day services to determine if that person would prefer to receive employment
523.24 services as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7).
523.25 The certified assessor shall describe to the person through a person-centered planning process
523.26 the option to receive employment services.

523.27 ~~(p)~~ (q) At the time of reassessment, the certified assessor shall assess each person
523.28 receiving non-self-directed waiver services to determine if that person would prefer an
523.29 available service and setting option that would permit self-directed services and supports.
523.30 The certified assessor shall describe to the person through a person-centered planning process
523.31 the option to receive self-directed services and supports.

523.32 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
523.33 shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. Minnesota Statutes 2020, section 256B.092, subdivision 4, is amended to read:

Subd. 4. **Home and community-based services for developmental disabilities.** (a) The commissioner shall make payments to approved vendors participating in the medical assistance program to pay costs of providing home and community-based services, including case management service activities provided as an approved home and community-based service, to medical assistance eligible persons with developmental disabilities who have been screened under subdivision 7 and according to federal requirements. Federal requirements include those services and limitations included in the federally approved application for home and community-based services for persons with developmental disabilities and subsequent amendments.

~~(b) Effective July 1, 1995, contingent upon federal approval and state appropriations made available for this purpose, and in conjunction with Laws 1995, chapter 207, article 8, section 40, the commissioner of human services shall allocate resources to county agencies for home and community-based waivered services for persons with developmental disabilities authorized but not receiving those services as of June 30, 1995, based upon the average resource need of persons with similar functional characteristics. To ensure service continuity for service recipients receiving home and community-based waivered services for persons with developmental disabilities prior to July 1, 1995, the commissioner shall make available to the county of financial responsibility home and community-based waivered services resources based upon fiscal year 1995 authorized levels.~~

~~(c) Home and community-based resources for all recipients shall be managed by the county of financial responsibility within an allowable reimbursement average established for each county. Payments for home and community-based services provided to individual recipients shall not exceed amounts authorized by the county of financial responsibility. For specifically identified former residents of nursing facilities, the commissioner shall be responsible for authorizing payments and payment limits under the appropriate home and community-based service program. Payment is available under this subdivision only for persons who, if not provided these services, would require the level of care provided in an intermediate care facility for persons with developmental disabilities.~~

~~(d)~~ (b) The commissioner shall comply with the requirements in the federally approved transition plan for the home and community-based services waivers for the elderly authorized under this section.

525.1 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
525.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
525.3 when federal approval is obtained.

525.4 Sec. 6. Minnesota Statutes 2020, section 256B.092, subdivision 5, is amended to read:

525.5 Subd. 5. **Federal waivers.** (a) The commissioner shall apply for any federal waivers
525.6 necessary to secure, to the extent allowed by law, federal financial participation under United
525.7 States Code, title 42, sections 1396 et seq., as amended, for the provision of services to
525.8 persons who, in the absence of the services, would need the level of care provided in a
525.9 regional treatment center or a community intermediate care facility for persons with
525.10 developmental disabilities. The commissioner may seek amendments to the waivers or apply
525.11 for additional waivers under United States Code, title 42, sections 1396 et seq., as amended,
525.12 to contain costs. The commissioner shall ensure that payment for the cost of providing home
525.13 and community-based alternative services under the federal waiver plan shall not exceed
525.14 the cost of intermediate care services including day training and habilitation services that
525.15 would have been provided without the waivered services.

525.16 The commissioner shall seek an amendment to the 1915c home and community-based
525.17 waiver to allow properly licensed adult foster care homes to provide residential services to
525.18 up to five individuals with developmental disabilities. If the amendment to the waiver is
525.19 approved, adult foster care providers that can accommodate five individuals shall increase
525.20 their capacity to five beds, provided the providers continue to meet all applicable licensing
525.21 requirements.

525.22 (b) The commissioner, in administering home and community-based waivers for persons
525.23 with developmental disabilities, shall ensure that day services for eligible persons are not
525.24 provided by the person's residential service provider, unless the person or the person's legal
525.25 representative is offered a choice of providers and agrees in writing to provision of day
525.26 services by the residential service provider. The coordinated service and support plan for
525.27 individuals who choose to have their residential service provider provide their day services
525.28 must describe how health, safety, protection, and habilitation needs will be met, including
525.29 how frequent and regular contact with persons other than the residential service provider
525.30 will occur. The coordinated service and support plan must address the provision of services
525.31 during the day outside the residence on weekdays.

525.32 (c) When a lead agency is evaluating denials, reductions, or terminations of home and
525.33 community-based services under section 256B.0916 for an individual, the lead agency shall
525.34 offer to meet with the individual or the individual's guardian in order to discuss the

526.1 prioritization of service needs within the coordinated service and support plan. The reduction
526.2 in the authorized services for an individual due to changes in funding for waivered services
526.3 may not exceed the amount needed to ensure medically necessary services to meet the
526.4 individual's health, safety, and welfare.

526.5 (d) The commissioner shall seek federal approval to allow for the reconfiguration of the
526.6 1915(c) home and community-based waivers in this section, as authorized under section
526.7 1915(c) of the federal Social Security Act, to implement a two-waiver program structure.

526.8 (e) The transition to two disability home and community-based services waiver programs
526.9 must align with the independent living first policy under section 256B.4905. Unless
526.10 superseded by any other state or federal law, waiver eligibility criteria shall be the same for
526.11 each waiver. The waiver program that a person uses shall be determined by the support
526.12 planning process and whether the person chooses to live in a provider-controlled setting or
526.13 in the person's own home.

526.14 (f) The commissioner shall seek federal approval for the 1915(c) home and
526.15 community-based waivers in this section, as authorized under section 1915(c) of the federal
526.16 Social Security Act, to implement an individual resource allocation methodology.

526.17 **EFFECTIVE DATE.** This section is effective January 1, 2023, or 90 days after federal
526.18 approval, whichever is later. The commissioner of human services shall notify the revisor
526.19 of statutes when federal approval is obtained.

526.20 Sec. 7. Minnesota Statutes 2020, section 256B.092, subdivision 12, is amended to read:

526.21 Subd. 12. ~~**Waivered**~~ **Waiver services statewide priorities.** (a) The commissioner shall
526.22 establish statewide priorities for individuals on the waiting list for developmental disabilities
526.23 (DD) waiver services, as of January 1, 2010. The statewide priorities must include, but are
526.24 not limited to, individuals who continue to have a need for waiver services after they have
526.25 maximized the use of state plan services and other funding resources, including natural
526.26 supports, prior to accessing waiver services, and who meet at least one of the following
526.27 criteria:

526.28 (1) no longer require the intensity of services provided where they are currently living;
526.29 or

526.30 (2) make a request to move from an institutional setting.

526.31 (b) After the priorities in paragraph (a) are met, priority must also be given to individuals
526.32 who meet at least one of the following criteria:

527.1 (1) have unstable living situations due to the age, incapacity, or sudden loss of the primary
527.2 caregivers;

527.3 (2) are moving from an institution due to bed closures;

527.4 (3) experience a sudden closure of their current living arrangement;

527.5 (4) require protection from confirmed abuse, neglect, or exploitation;

527.6 (5) experience a sudden change in need that can no longer be met through state plan
527.7 services or other funding resources alone; or

527.8 (6) meet other priorities established by the department.

527.9 (c) When allocating new enrollment resources to lead agencies, the commissioner must
527.10 take into consideration the number of individuals waiting who meet statewide priorities ~~and~~
527.11 ~~the lead agencies' current use of waiver funds and existing service options~~. ~~The commissioner~~
527.12 ~~has the authority to transfer funds between counties, groups of counties, and tribes to~~
527.13 ~~accommodate statewide priorities and resource needs while accounting for a necessary base~~
527.14 ~~level reserve amount for each county, group of counties, and tribe.~~

527.15 Sec. 8. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision
527.16 to read:

527.17 Subd. 7. **Regional quality councils and systems improvement.** The commissioner of
527.18 human services shall maintain the regional quality councils initially established under
527.19 Minnesota Statutes 2020, section 256B.097, subdivision 4. The regional quality councils
527.20 shall:

527.21 (1) support efforts and initiatives that drive overall systems and social change to promote
527.22 inclusion of people who have disabilities in the state of Minnesota;

527.23 (2) improve person-centered outcomes in disability services; and

527.24 (3) identify or enhance quality of life indicators for people who have disabilities.

527.25 Sec. 9. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision
527.26 to read:

527.27 Subd. 8. **Membership and staff.** (a) Regional quality councils shall be comprised of
527.28 key stakeholders including, but not limited to:

527.29 (1) individuals who have disabilities;

527.30 (2) family members of people who have disabilities;

528.1 (3) disability service providers;

528.2 (4) disability advocacy groups;

528.3 (5) lead agency staff; and

528.4 (6) staff of state agencies with jurisdiction over special education and disability services.

528.5 (b) Membership in a regional quality council must be representative of the communities
528.6 in which the council operates, with an emphasis on individuals with lived experience from
528.7 diverse racial and cultural backgrounds.

528.8 (c) Each regional quality council may hire staff to perform the duties assigned in
528.9 subdivision 9.

528.10 Sec. 10. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision
528.11 to read:

528.12 Subd. 9. **Duties.** (a) Each regional quality council shall:

528.13 (1) identify issues and barriers that impede Minnesotans who have disabilities from
528.14 optimizing choice of home and community-based services;

528.15 (2) promote informed decision making, autonomy, and self-direction;

528.16 (3) analyze and review quality outcomes and critical incident data, and immediately
528.17 report incidents of life safety concerns to the Department of Human Services Licensing
528.18 Division;

528.19 (4) inform a comprehensive system for effective incident reporting, investigation, analysis,
528.20 and follow-up;

528.21 (5) collaborate on projects and initiatives to advance priorities shared with state agencies,
528.22 lead agencies, educational institutions, advocacy organizations, community partners, and
528.23 other entities engaged in disability service improvements;

528.24 (6) establish partnerships and working relationships with individuals and groups in the
528.25 regions;

528.26 (7) identify and implement regional and statewide quality improvement projects;

528.27 (8) transform systems and drive social change in alignment with the disability rights and
528.28 disability justice movements identified by leaders who have disabilities;

529.1 (9) provide information and training programs for persons who have disabilities and
529.2 their families and legal representatives on formal and informal support options and quality
529.3 expectations;

529.4 (10) make recommendations to state agencies and other key decision-makers regarding
529.5 disability services and supports;

529.6 (11) submit every two years a report to committees with jurisdiction over disability
529.7 services on the status, outcomes, improvement priorities, and activities in the region;

529.8 (12) support people by advocating to resolve complaints between the counties, providers,
529.9 persons receiving services, and their families and legal representatives; and

529.10 (13) recruit, train, and assign duties to regional quality council teams, including council
529.11 members, interns, and volunteers, taking into account the skills necessary for the team
529.12 members to be successful in this work.

529.13 (b) Each regional quality council may engage in quality improvement initiatives related
529.14 to but not limited to:

529.15 (1) the home and community-based services waiver programs for persons with
529.16 developmental disabilities under section 256B.092, subdivision 4, or section 256B.49,
529.17 including brain injuries and services for those persons who qualify for nursing facility level
529.18 of care or hospital facility level of care and any other services licensed under chapter 245D;

529.19 (2) home care services under section 256B.0651;

529.20 (3) family support grants under section 252.32;

529.21 (4) consumer support grants under section 256.476;

529.22 (5) semi-independent living services under section 252.275; and

529.23 (6) services provided through an intermediate care facility for persons with developmental
529.24 disabilities.

529.25 (c) Each regional quality council's work must be informed and directed by the needs
529.26 and desires of persons who have disabilities in the region in which the council operates.

529.27 Sec. 11. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision
529.28 to read:

529.29 Subd. 10. **Compensation.** (a) A member of a regional quality council who does not
529.30 receive a salary or wages from an employer may be paid a per diem and reimbursed for
529.31 expenses related to the member's participation in efforts and initiatives described in

530.1 subdivision 9 in the same manner and in an amount not to exceed the amount authorized
530.2 by the commissioner's plan adopted under section 43A.18, subdivision 2.

530.3 (b) Regional quality councils may charge fees for their services.

530.4 Sec. 12. Minnesota Statutes 2020, section 256B.439, is amended by adding a subdivision
530.5 to read:

530.6 Subd. 3c. **Contact information for consumer surveys for nursing facilities and home**
530.7 **and community-based services.** For purposes of conducting the consumer surveys under
530.8 subdivisions 3 and 3a, the commissioner may request contact information of clients and
530.9 associated key representatives. Providers must furnish the contact information available to
530.10 the provider.

530.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

530.12 Sec. 13. Minnesota Statutes 2020, section 256B.439, is amended by adding a subdivision
530.13 to read:

530.14 Subd. 3d. **Resident experience survey and family survey for assisted living**
530.15 **facilities.** The commissioner shall develop and administer a resident experience survey for
530.16 assisted living facility residents and a family survey for families of assisted living facility
530.17 residents. Money appropriated to the commissioner to administer the resident experience
530.18 survey and family survey is available in either fiscal year of the biennium in which it is
530.19 appropriated.

530.20 Sec. 14. Minnesota Statutes 2020, section 256B.49, subdivision 11, is amended to read:

530.21 Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and
530.22 community-based service waivers, as authorized under section 1915(c) of the federal Social
530.23 Security Act to serve persons under the age of 65 who are determined to require the level
530.24 of care provided in a nursing home and persons who require the level of care provided in a
530.25 hospital. The commissioner shall apply for the home and community-based waivers in order
530.26 to:

530.27 (1) promote the support of persons with disabilities in the most integrated settings;

530.28 (2) expand the availability of services for persons who are eligible for medical assistance;

530.29 (3) promote cost-effective options to institutional care; and

530.30 (4) obtain federal financial participation.

531.1 (b) The provision of ~~waivered~~ waiver services to medical assistance recipients with
531.2 disabilities shall comply with the requirements outlined in the federally approved applications
531.3 for home and community-based services and subsequent amendments, including provision
531.4 of services according to a service plan designed to meet the needs of the individual. For
531.5 purposes of this section, the approved home and community-based application is considered
531.6 the necessary federal requirement.

531.7 (c) The commissioner shall provide interested persons serving on agency advisory
531.8 committees, task forces, the Centers for Independent Living, and others who request to be
531.9 on a list to receive, notice of, and an opportunity to comment on, at least 30 days before
531.10 any effective dates, (1) any substantive changes to the state's disability services program
531.11 manual, or (2) changes or amendments to the federally approved applications for home and
531.12 community-based waivers, prior to their submission to the federal Centers for Medicare
531.13 and Medicaid Services.

531.14 (d) The commissioner shall seek approval, as authorized under section 1915(c) of the
531.15 federal Social Security Act, to allow medical assistance eligibility under this section for
531.16 children under age 21 without deeming of parental income or assets.

531.17 (e) The commissioner shall seek approval, as authorized under section 1915(c) of the
531.18 Social Act, to allow medical assistance eligibility under this section for individuals under
531.19 age 65 without deeming the spouse's income or assets.

531.20 (f) The commissioner shall comply with the requirements in the federally approved
531.21 transition plan for the home and community-based services waivers authorized under this
531.22 section.

531.23 (g) The commissioner shall seek federal approval to allow for the reconfiguration of the
531.24 1915(c) home and community-based waivers in this section, as authorized under section
531.25 1915(c) of the federal Social Security Act, to implement a two-waiver program structure.

531.26 (h) The commissioner shall seek federal approval for the 1915(c) home and
531.27 community-based waivers in this section, as authorized under section 1915(c) of the federal
531.28 Social Security Act, to implement an individual resource allocation methodology.

531.29 **EFFECTIVE DATE.** This section is effective January 1, 2023, or 90 days after federal
531.30 approval, whichever is later. The commissioner of human services shall notify the revisor
531.31 of statutes when federal approval is obtained.

532.1 Sec. 15. Minnesota Statutes 2020, section 256B.49, subdivision 11a, is amended to read:

532.2 Subd. 11a. **~~Waivered~~ Waiver services statewide priorities.** (a) The commissioner shall
532.3 establish statewide priorities for individuals on the waiting list for community alternative
532.4 care, community access for disability inclusion, and brain injury waiver services, as of
532.5 January 1, 2010. The statewide priorities must include, but are not limited to, individuals
532.6 who continue to have a need for waiver services after they have maximized the use of state
532.7 plan services and other funding resources, including natural supports, prior to accessing
532.8 waiver services, and who meet at least one of the following criteria:

532.9 (1) no longer require the intensity of services provided where they are currently living;
532.10 or

532.11 (2) make a request to move from an institutional setting.

532.12 (b) After the priorities in paragraph (a) are met, priority must also be given to individuals
532.13 who meet at least one of the following criteria:

532.14 (1) have unstable living situations due to the age, incapacity, or sudden loss of the primary
532.15 caregivers;

532.16 (2) are moving from an institution due to bed closures;

532.17 (3) experience a sudden closure of their current living arrangement;

532.18 (4) require protection from confirmed abuse, neglect, or exploitation;

532.19 (5) experience a sudden change in need that can no longer be met through state plan
532.20 services or other funding resources alone; or

532.21 (6) meet other priorities established by the department.

532.22 (c) When allocating new enrollment resources to lead agencies, the commissioner must
532.23 take into consideration the number of individuals waiting who meet statewide priorities ~~and~~
532.24 ~~the lead agencies' current use of waiver funds and existing service options~~. ~~The commissioner~~
532.25 ~~has the authority to transfer funds between counties, groups of counties, and tribes to~~
532.26 ~~accommodate statewide priorities and resource needs while accounting for a necessary base~~
532.27 ~~level reserve amount for each county, group of counties, and tribe.~~

532.28 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
532.29 whichever is later. The commissioner of human services shall notify the revisor of statutes
532.30 when federal approval is obtained.

533.1 Sec. 16. Minnesota Statutes 2020, section 256B.49, subdivision 17, is amended to read:

533.2 Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure that the
533.3 average per capita expenditures estimated in any fiscal year for home and community-based
533.4 waiver recipients does not exceed the average per capita expenditures that would have been
533.5 made to provide institutional services for recipients in the absence of the waiver.

533.6 ~~(b) The commissioner shall implement on January 1, 2002, one or more aggregate,~~
533.7 ~~need-based methods for allocating to local agencies the home and community-based waivered~~
533.8 ~~service resources available to support recipients with disabilities in need of the level of care~~
533.9 ~~provided in a nursing facility or a hospital. The commissioner shall allocate resources to~~
533.10 ~~single counties and county partnerships in a manner that reflects consideration of:~~

533.11 ~~(1) an incentive-based payment process for achieving outcomes;~~

533.12 ~~(2) the need for a state-level risk pool;~~

533.13 ~~(3) the need for retention of management responsibility at the state agency level; and~~

533.14 ~~(4) a phase-in strategy as appropriate.~~

533.15 ~~(c) Until the allocation methods described in paragraph (b) are implemented, the annual~~
533.16 ~~allowable reimbursement level of home and community-based waiver services shall be the~~
533.17 ~~greater of:~~

533.18 ~~(1) the statewide average payment amount which the recipient is assigned under the~~
533.19 ~~waiver reimbursement system in place on June 30, 2001, modified by the percentage of any~~
533.20 ~~provider rate increase appropriated for home and community-based services; or~~

533.21 ~~(2) an amount approved by the commissioner based on the recipient's extraordinary~~
533.22 ~~needs that cannot be met within the current allowable reimbursement level. The increased~~
533.23 ~~reimbursement level must be necessary to allow the recipient to be discharged from an~~
533.24 ~~institution or to prevent imminent placement in an institution. The additional reimbursement~~
533.25 ~~may be used to secure environmental modifications; assistive technology and equipment;~~
533.26 ~~and increased costs for supervision, training, and support services necessary to address the~~
533.27 ~~recipient's extraordinary needs. The commissioner may approve an increased reimbursement~~
533.28 ~~level for up to one year of the recipient's relocation from an institution or up to six months~~
533.29 ~~of a determination that a current waiver recipient is at imminent risk of being placed in an~~
533.30 ~~institution.~~

533.31 ~~(d)~~ <u>(b)</u> Beginning July 1, 2001, medically necessary home care nursing services will be
533.32 authorized under this section as complex and regular care according to sections 256B.0651
533.33 to 256B.0654 and 256B.0659. The rate established by the commissioner for registered nurse

534.1 or licensed practical nurse services under any home and community-based waiver as of
534.2 January 1, 2001, shall not be reduced.

534.3 ~~(e)~~ (c) Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009
534.4 legislature adopts a rate reduction that impacts payment to providers of adult foster care
534.5 services, the commissioner may issue adult foster care licenses that permit a capacity of
534.6 five adults. The application for a five-bed license must meet the requirements of section
534.7 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care services,
534.8 the county must negotiate a revised per diem rate for room and board and waiver services
534.9 that reflects the legislated rate reduction and results in an overall average per diem reduction
534.10 for all foster care recipients in that home. The revised per diem must allow the provider to
534.11 maintain, as much as possible, the level of services or enhanced services provided in the
534.12 residence, while mitigating the losses of the legislated rate reduction.

534.13 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
534.14 whichever is later. The commissioner of human services shall notify the revisor of statutes
534.15 when federal approval is obtained.

534.16 Sec. 17. Minnesota Statutes 2020, section 256B.49, is amended by adding a subdivision
534.17 to read:

534.18 Subd. 28. **Customized living moratorium for brain injury and community access**
534.19 **for disability inclusion waivers.** (a) Notwithstanding section 245A.03, subdivision 2,
534.20 paragraph (a), clause (23), the commissioner shall not enroll new customized living settings
534.21 serving four or fewer people in a single-family home to deliver customized living services
534.22 as defined under the brain injury or community access for disability inclusion waiver plans
534.23 under section 256B.49 to prevent new developments of customized living settings that
534.24 otherwise meet the residential program definition under section 245A.02, subdivision 14.

534.25 (b) The commissioner may approve an exception to paragraph (a) when:

534.26 (1) a customized living setting with a change in ownership at the same address is in
534.27 existence and operational on or before June 30, 2021; and

534.28 (2) a customized living setting is serving four or fewer people in a multiple-family
534.29 dwelling if each person has a personal self-contained living unit that contains living, sleeping,
534.30 eating, cooking, and bathroom areas.

534.31 (c) Customized living settings operational on or before June 30, 2021, are considered
534.32 existing customized living settings.

535.1 (d) For any new customized living settings operational on or after July 1, 2021, serving
535.2 four or fewer people in a single-family home to deliver customized living services as defined
535.3 in paragraph (a), the authorizing lead agency is financially responsible for all home and
535.4 community-based service payments in the setting.

535.5 (e) For purposes of this subdivision, "operational" means customized living services are
535.6 authorized and delivered to a person on or before June 30, 2021, in the customized living
535.7 setting.

535.8 **EFFECTIVE DATE.** This section is effective July 1, 2021. This section applies only
535.9 to customized living services as defined under the brain injury or community access for
535.10 disability inclusion waiver plans under Minnesota Statutes, section 256B.49.

535.11 Sec. 18. Minnesota Statutes 2020, section 256B.4914, subdivision 5, is amended to read:

535.12 Subd. 5. **Base wage index and standard component values.** (a) The base wage index
535.13 is established to determine staffing costs associated with providing services to individuals
535.14 receiving home and community-based services. For purposes of developing and calculating
535.15 the proposed base wage, Minnesota-specific wages taken from job descriptions and standard
535.16 occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in
535.17 the most recent edition of the Occupational Handbook must be used. The base wage index
535.18 must be calculated as follows:

535.19 (1) for residential direct care staff, the sum of:

535.20 (i) 15 percent of the subtotal of 50 percent of the median wage for personal and home
535.21 health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC
535.22 code 31-1014); and 20 percent of the median wage for social and human services aide (SOC
535.23 code 21-1093); and

535.24 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
535.25 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
535.26 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
535.27 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
535.28 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

535.29 (2) for adult day services, 70 percent of the median wage for nursing assistant (SOC
535.30 code 31-1014); and 30 percent of the median wage for personal care aide (SOC code
535.31 39-9021);

535.32 (3) for day services, day support services, and prevocational services, 20 percent of the
535.33 median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for

536.1 psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social
536.2 and human services aide (SOC code 21-1093);

536.3 (4) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota
536.4 for large employers~~, except in a family foster care setting, the wage is 36 percent of the~~
536.5 ~~minimum wage in Minnesota for large employers~~;

536.6 (5) for positive supports analyst staff, 100 percent of the median wage for mental health
536.7 counselors (SOC code 21-1014);

536.8 (6) for positive supports professional staff, 100 percent of the median wage for clinical
536.9 counseling and school psychologist (SOC code 19-3031);

536.10 (7) for positive supports specialist staff, 100 percent of the median wage for psychiatric
536.11 technicians (SOC code 29-2053);

536.12 (8) for supportive living services staff, 20 percent of the median wage for nursing assistant
536.13 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
536.14 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
536.15 21-1093);

536.16 (9) for housing access coordination staff, 100 percent of the median wage for community
536.17 and social services specialist (SOC code 21-1099);

536.18 (10) for in-home family support and individualized home supports with family training
536.19 staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of
536.20 the median wage for community social service specialist (SOC code 21-1099); 40 percent
536.21 of the median wage for social and human services aide (SOC code 21-1093); and ten percent
536.22 of the median wage for psychiatric technician (SOC code 29-2053);

536.23 (11) for individualized home supports with training services staff, 40 percent of the
536.24 median wage for community social service specialist (SOC code 21-1099); 50 percent of
536.25 the median wage for social and human services aide (SOC code 21-1093); and ten percent
536.26 of the median wage for psychiatric technician (SOC code 29-2053);

536.27 (12) for independent living skills staff, 40 percent of the median wage for community
536.28 social service specialist (SOC code 21-1099); 50 percent of the median wage for social and
536.29 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
536.30 technician (SOC code 29-2053);

536.31 (13) for employment support services staff, 50 percent of the median wage for
536.32 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
536.33 community and social services specialist (SOC code 21-1099);

537.1 (14) for employment exploration services staff, 50 percent of the median wage for
537.2 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
537.3 community and social services specialist (SOC code 21-1099);

537.4 (15) for employment development services staff, 50 percent of the median wage for
537.5 education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent
537.6 of the median wage for community and social services specialist (SOC code 21-1099);

537.7 (16) for individualized home support staff, 50 percent of the median wage for personal
537.8 and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing
537.9 assistant (SOC code 31-1014);

537.10 (17) for adult companion staff, 50 percent of the median wage for personal and home
537.11 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
537.12 (SOC code 31-1014);

537.13 (18) for night supervision staff, 20 percent of the median wage for home health aide
537.14 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
537.15 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
537.16 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
537.17 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

537.18 (19) for respite staff, 50 percent of the median wage for personal and home care aide
537.19 (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code
537.20 31-1014);

537.21 (20) for personal support staff, 50 percent of the median wage for personal and home
537.22 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
537.23 (SOC code 31-1014);

537.24 (21) for supervisory staff, 100 percent of the median wage for community and social
537.25 services specialist (SOC code 21-1099), with the exception of the supervisor of positive
537.26 supports professional, positive supports analyst, and positive supports specialists, which is
537.27 100 percent of the median wage for clinical counseling and school psychologist (SOC code
537.28 19-3031);

537.29 (22) for registered nurse staff, 100 percent of the median wage for registered nurses
537.30 (SOC code 29-1141); and

537.31 (23) for licensed practical nurse staff, 100 percent of the median wage for licensed
537.32 practical nurses (SOC code 29-2061).

538.1 (b) Component values for corporate foster care services, corporate supportive living
538.2 services daily, community residential services, and integrated community support services
538.3 are:

538.4 (1) competitive workforce factor: 4.7 percent;

538.5 (2) supervisory span of control ratio: 11 percent;

538.6 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

538.7 (4) employee-related cost ratio: 23.6 percent;

538.8 (5) general administrative support ratio: 13.25 percent;

538.9 (6) program-related expense ratio: 1.3 percent; and

538.10 (7) absence and utilization factor ratio: 3.9 percent.

538.11 ~~(c) Component values for family foster care are:~~

538.12 ~~(1) competitive workforce factor: 4.7 percent;~~

538.13 ~~(2) supervisory span of control ratio: 11 percent;~~

538.14 ~~(3) employee vacation, sick, and training allowance ratio: 8.71 percent;~~

538.15 ~~(4) employee-related cost ratio: 23.6 percent;~~

538.16 ~~(5) general administrative support ratio: 3.3 percent;~~

538.17 ~~(6) program-related expense ratio: 1.3 percent; and~~

538.18 ~~(7) absence factor: 1.7 percent.~~

538.19 ~~(d)~~ (c) Component values for day training and habilitation, day support services, and
538.20 prevocational services are:

538.21 (1) competitive workforce factor: 4.7 percent;

538.22 (2) supervisory span of control ratio: 11 percent;

538.23 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

538.24 (4) employee-related cost ratio: 23.6 percent;

538.25 (5) program plan support ratio: 5.6 percent;

538.26 (6) client programming and support ratio: ten percent;

538.27 (7) general administrative support ratio: 13.25 percent;

538.28 (8) program-related expense ratio: 1.8 percent; and

539.1 (9) absence and utilization factor ratio: 9.4 percent.

539.2 (d) Component values for day support services and prevocational services delivered
539.3 remotely are:

539.4 (1) competitive workforce factor: 4.7 percent;

539.5 (2) supervisory span of control ratio: 11 percent;

539.6 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

539.7 (4) employee-related cost ratio: 23.6 percent;

539.8 (5) program plan support ratio: 5.6 percent;

539.9 (6) client programming and support ratio: 7.67 percent;

539.10 (7) general administrative support ratio: 13.25 percent;

539.11 (8) program-related expense ratio: 1.8 percent; and

539.12 (9) absence and utilization factor ratio: 9.4 percent.

539.13 (e) Component values for adult day services are:

539.14 (1) competitive workforce factor: 4.7 percent;

539.15 (2) supervisory span of control ratio: 11 percent;

539.16 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

539.17 (4) employee-related cost ratio: 23.6 percent;

539.18 (5) program plan support ratio: 5.6 percent;

539.19 (6) client programming and support ratio: 7.4 percent;

539.20 (7) general administrative support ratio: 13.25 percent;

539.21 (8) program-related expense ratio: 1.8 percent; and

539.22 (9) absence and utilization factor ratio: 9.4 percent.

539.23 (f) Component values for unit-based services with programming are:

539.24 (1) competitive workforce factor: 4.7 percent;

539.25 (2) supervisory span of control ratio: 11 percent;

539.26 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

539.27 (4) employee-related cost ratio: 23.6 percent;

540.1 (5) program plan supports ratio: 15.5 percent;

540.2 (6) client programming and supports ratio: 4.7 percent;

540.3 (7) general administrative support ratio: 13.25 percent;

540.4 (8) program-related expense ratio: 6.1 percent; and

540.5 (9) absence and utilization factor ratio: 3.9 percent.

540.6 (g) Component values for unit-based services with programming delivered remotely
540.7 are:

540.8 (1) competitive workforce factor: 4.7 percent;

540.9 (2) supervisory span of control ratio: 11 percent;

540.10 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

540.11 (4) employee-related cost ratio: 23.6 percent;

540.12 (5) program plan supports ratio: 5.6 percent;

540.13 (6) client programming and supports ratio: 1.53 percent;

540.14 (7) general administrative support ratio: 13.25 percent;

540.15 (8) program-related expense ratio: 6.1 percent; and

540.16 (9) absence and utilization factor ratio: 3.9 percent.

540.17 ~~(g)~~ (h) Component values for unit-based services without programming except respite
540.18 are:

540.19 (1) competitive workforce factor: 4.7 percent;

540.20 (2) supervisory span of control ratio: 11 percent;

540.21 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

540.22 (4) employee-related cost ratio: 23.6 percent;

540.23 (5) program plan support ratio: 7.0 percent;

540.24 (6) client programming and support ratio: 2.3 percent;

540.25 (7) general administrative support ratio: 13.25 percent;

540.26 (8) program-related expense ratio: 2.9 percent; and

540.27 (9) absence and utilization factor ratio: 3.9 percent.

541.1 (i) Component values for unit-based services without programming delivered remotely,
541.2 except respite, are:

541.3 (1) competitive workforce factor: 4.7 percent;

541.4 (2) supervisory span of control ratio: 11 percent;

541.5 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

541.6 (4) employee-related cost ratio: 23.6 percent;

541.7 (5) program plan support ratio: 1.3 percent;

541.8 (6) client programming and support ratio: 1.14 percent;

541.9 (7) general administrative support ratio: 13.25 percent;

541.10 (8) program-related expense ratio: 2.9 percent; and

541.11 (9) absence and utilization factor ratio: 3.9 percent.

541.12 ~~(h)~~ (j) Component values for unit-based services without programming for respite are:

541.13 (1) competitive workforce factor: 4.7 percent;

541.14 (2) supervisory span of control ratio: 11 percent;

541.15 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

541.16 (4) employee-related cost ratio: 23.6 percent;

541.17 (5) general administrative support ratio: 13.25 percent;

541.18 (6) program-related expense ratio: 2.9 percent; and

541.19 (7) absence and utilization factor ratio: 3.9 percent.

541.20 ~~(i)~~ (k) On July 1, 2022, and every two years thereafter, the commissioner shall update
541.21 the base wage index in paragraph (a) based on wage data by SOC from the Bureau of Labor
541.22 Statistics available 30 months and one day prior to the scheduled update. The commissioner
541.23 shall publish these updated values and load them into the rate management system.

541.24 ~~(j)~~ (l) Beginning February 1, 2021, and every two years thereafter, the commissioner
541.25 shall report to the chairs and ranking minority members of the legislative committees and
541.26 divisions with jurisdiction over health and human services policy and finance an analysis
541.27 of the competitive workforce factor. The report must include recommendations to update
541.28 the competitive workforce factor using:

542.1 (1) the most recently available wage data by SOC code for the weighted average wage
542.2 for direct care staff for residential services and direct care staff for day services;

542.3 (2) the most recently available wage data by SOC code of the weighted average wage
542.4 of comparable occupations; and

542.5 (3) workforce data as required under subdivision 10a, paragraph (g).

542.6 The commissioner shall not recommend an increase or decrease of the competitive workforce
542.7 factor from the current value by more than two percentage points. If, after a biennial analysis
542.8 for the next report, the competitive workforce factor is less than or equal to zero, the
542.9 commissioner shall recommend a competitive workforce factor of zero.

542.10 (k) (m) On July 1, 2022, and every two years thereafter, the commissioner shall update
542.11 the framework components in paragraph (d) (c), clause (6); paragraph (e) (d), clause (6);
542.12 paragraph (f) (e), clause (6); and paragraph (g) (f), clause (6); paragraph (g), clause (6);
542.13 paragraph (h), clause 6; and paragraph (i), clause (6); subdivision 6, paragraphs (b), clauses
542.14 (9) and (10), and (e), clause (10); and subdivision 7, clauses (11), (17), and (18); and
542.15 subdivision 18, for changes in the Consumer Price Index. The commissioner shall adjust
542.16 these values higher or lower by the percentage change in the CPI-U from the date of the
542.17 previous update to the data available 30 months and one day prior to the scheduled update.
542.18 The commissioner shall publish these updated values and load them into the rate management
542.19 system.

542.20 (l) (n) Upon the implementation of the updates under paragraphs (i) (k) and (k) (m), rate
542.21 adjustments authorized under section 256B.439, subdivision 7; Laws 2013, chapter 108,
542.22 article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall be removed
542.23 from service rates calculated under this section.

542.24 (m) (o) Any rate adjustments applied to the service rates calculated under this section
542.25 outside of the cost components and rate methodology specified in this section shall be
542.26 removed from rate calculations upon implementation of the updates under paragraphs (i)
542.27 (k) and (k) (m).

542.28 (n) (p) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer
542.29 Price Index items are unavailable in the future, the commissioner shall recommend to the
542.30 legislature codes or items to update and replace missing component values.

542.31 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
542.32 whichever is later. The commissioner of human services shall notify the revisor of statutes
542.33 when federal approval is obtained.

543.1 Sec. 19. Minnesota Statutes 2020, section 256B.4914, subdivision 6, is amended to read:

543.2 Subd. 6. **Payments for residential support services.** (a) For purposes of this subdivision,
543.3 residential support services includes 24-hour customized living services, community
543.4 residential services, customized living services, ~~family residential services, foster care~~
543.5 ~~services,~~ and integrated community supports~~, and supportive living services daily~~.

543.6 (b) Payments for community residential services~~, corporate foster care services, corporate~~
543.7 ~~supportive living services daily, family residential services, and family foster care services~~
543.8 must be calculated as follows:

543.9 (1) determine the number of shared staffing and individual direct staff hours to meet a
543.10 recipient's needs provided on site or through monitoring technology;

543.11 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
543.12 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
543.13 5;

543.14 (3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
543.15 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
543.16 5, paragraph (b), clause (1);

543.17 (4) for a recipient requiring customization for deaf and hard-of-hearing language
543.18 accessibility under subdivision 12, add the customization rate provided in subdivision 12
543.19 to the result of clause (3);

543.20 (5) multiply the number of shared and individual direct staff hours provided on site or
543.21 through monitoring technology and nursing hours by the appropriate staff wages;

543.22 (6) multiply the number of shared and individual direct staff hours provided on site or
543.23 through monitoring technology and nursing hours by the product of the supervision span
543.24 of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervision
543.25 wage in subdivision 5, paragraph (a), clause (21);

543.26 (7) combine the results of clauses (5) and (6), excluding any shared and individual direct
543.27 staff hours provided through monitoring technology, and multiply the result by one plus
543.28 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b),
543.29 clause (3). This is defined as the direct staffing cost;

543.30 (8) for employee-related expenses, multiply the direct staffing cost, excluding any shared
543.31 and individual direct staff hours provided through monitoring technology, by one plus the
543.32 employee-related cost ratio in subdivision 5, paragraph (b), clause (4);

544.1 (9) for client programming and supports, the commissioner shall add $2,179; and

544.2 (10) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if
544.3 customized for adapted transport, based on the resident with the highest assessed need.

544.4 (c) The total rate must be calculated using the following steps:

544.5 (1) subtotal paragraph (b), clauses (8) to (10), and the direct staffing cost of any shared
544.6 and individual direct staff hours provided through monitoring technology that was excluded
544.7 in clause (8);

544.8 (2) sum the standard general and administrative rate, the program-related expense ratio,
544.9 and the absence and utilization ratio;

544.10 (3) divide the result of clause (1) by one minus the result of clause (2). This is the total
544.11 payment amount; and

544.12 (4) adjust the result of clause (3) by a factor to be determined by the commissioner to
544.13 adjust for regional differences in the cost of providing services.

544.14 (d) The payment methodology for customized living, 24-hour customized living, and
544.15 residential care services must be the customized living tool. Revisions to the customized
544.16 living tool must be made to reflect the services and activities unique to disability-related
544.17 recipient needs. Customized living and 24-hour customized living rates determined under
544.18 this section shall not include more than 24 hours of support in a daily unit. The commissioner
544.19 shall establish acuity-based input limits, based on case mix, for customized living and
544.20 24-hour customized living rates determined under this section.

544.21 (e) Payments for integrated community support services must be calculated as follows:

544.22 (1) the base shared staffing shall be eight hours divided by the number of people receiving
544.23 support in the integrated community support setting;

544.24 (2) the individual staffing hours shall be the average number of direct support hours
544.25 provided directly to the service recipient;

544.26 (3) the personnel hourly wage rate must be based on the most recent Bureau of Labor
544.27 Statistics Minnesota-specific rates or rates derived by the commissioner as provided in
544.28 subdivision 5;

544.29 (4) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
544.30 result of clause (3) by the product of one plus the competitive workforce factor in subdivision
544.31 5, paragraph (b), clause (1);

545.1 (5) for a recipient requiring customization for deaf and hard-of-hearing language
545.2 accessibility under subdivision 12, add the customization rate provided in subdivision 12
545.3 to the result of clause (4);

545.4 (6) multiply the number of shared and individual direct staff hours in clauses (1) and
545.5 (2) by the appropriate staff wages;

545.6 (7) multiply the number of shared and individual direct staff hours in clauses (1) and
545.7 (2) by the product of the supervisory span of control ratio in subdivision 5, paragraph (b),
545.8 clause (2), and the appropriate supervisory wage in subdivision 5, paragraph (a), clause
545.9 (21);

545.10 (8) combine the results of clauses (6) and (7) and multiply the result by one plus the
545.11 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause
545.12 (3). This is defined as the direct staffing cost;

545.13 (9) for employee-related expenses, multiply the direct staffing cost by one plus the
545.14 employee-related cost ratio in subdivision 5, paragraph (b), clause (4); and

545.15 (10) for client programming and supports, the commissioner shall add $2,260.21 divided
545.16 by 365.

545.17 (f) The total rate must be calculated as follows:

545.18 (1) add the results of paragraph (e), clauses (9) and (10);

545.19 (2) add the standard general and administrative rate, the program-related expense ratio,
545.20 and the absence and utilization factor ratio;

545.21 (3) divide the result of clause (1) by one minus the result of clause (2). This is the total
545.22 payment amount; and

545.23 (4) adjust the result of clause (3) by a factor to be determined by the commissioner to
545.24 adjust for regional differences in the cost of providing services.

545.25 (g) The payment methodology for customized living and 24-hour customized living
545.26 services must be the customized living tool. The commissioner shall revise the customized
545.27 living tool to reflect the services and activities unique to disability-related recipient needs
545.28 and adjust for regional differences in the cost of providing services.

545.29 (h) The number of days authorized for all individuals enrolling in residential services
545.30 must include every day that services start and end.

546.1 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
546.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
546.3 when federal approval is obtained.

546.4 Sec. 20. Minnesota Statutes 2020, section 256B.4914, subdivision 7, is amended to read:

546.5 Subd. 7. **Payments for day programs.** Payments for services with day programs
546.6 including adult day services, day treatment and habilitation, day support services,
546.7 prevocational services, and structured day services, provided in person or remotely, must
546.8 be calculated as follows:

546.9 (1) determine the number of units of service and staffing ratio to meet a recipient's needs:

546.10 (i) the staffing ratios for the units of service provided to a recipient in a typical week
546.11 must be averaged to determine an individual's staffing ratio; and

546.12 (ii) the commissioner, in consultation with service providers, shall develop a uniform
546.13 staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

546.14 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
546.15 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
546.16 5;

546.17 (3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
546.18 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
546.19 5, paragraph ~~(d)~~ (c), clause (1);

546.20 (4) for a recipient requiring customization for deaf and hard-of-hearing language
546.21 accessibility under subdivision 12, add the customization rate provided in subdivision 12
546.22 to the result of clause (3);

546.23 (5) multiply the number of day program direct staff hours and nursing hours by the
546.24 appropriate staff wage;

546.25 (6) multiply the number of day direct staff hours by the product of the supervision span
546.26 of control ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (2), for in-person services or
546.27 subdivision 5, paragraph (d), clause (2), for remote services, and the appropriate supervision
546.28 wage in subdivision 5, paragraph (a), clause (21);

546.29 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
546.30 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(d)~~ (c),
546.31 clause (3), for in-person services or subdivision 5, paragraph (d), clause (3), for remote
546.32 services. This is defined as the direct staffing rate;

547.1 (8) for program plan support, multiply the result of clause (7) by one plus the program
547.2 plan support ratio in subdivision 5, paragraph (d) (c), clause (5), for in-person services or
547.3 subdivision 5, paragraph (d), clause (5), for remote services;

547.4 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
547.5 employee-related cost ratio in subdivision 5, paragraph (d) (c), clause (4), for in-person
547.6 services or subdivision 5, paragraph (d), clause (4), for remote services;

547.7 (10) for client programming and supports, multiply the result of clause (9) by one plus
547.8 the client programming and support ratio in subdivision 5, paragraph (d) (c), clause (6), for
547.9 in-person services or subdivision 5, paragraph (d), clause (6), for remote services;

547.10 (11) for program facility costs, add $19.30 per week with consideration of staffing ratios
547.11 to meet individual needs for in-person service only;

547.12 (12) for adult day bath services, add $7.01 per 15 minute unit;

547.13 (13) this is the subtotal rate;

547.14 (14) sum the standard general and administrative rate, the program-related expense ratio,
547.15 and the absence and utilization factor ratio;

547.16 (15) divide the result of clause (13) by one minus the result of clause (14). This is the
547.17 total payment amount;

547.18 (16) adjust the result of clause (15) by a factor to be determined by the commissioner
547.19 to adjust for regional differences in the cost of providing services;

547.20 (17) for transportation provided as part of day training and habilitation for an individual
547.21 who does not require a lift, add:

547.22 (i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without
547.23 a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a
547.24 vehicle with a lift;

547.25 (ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without
547.26 a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a
547.27 vehicle with a lift;

547.28 (iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without
547.29 a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a
547.30 vehicle with a lift; or

548.1 (iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift,
548.2 $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle
548.3 with a lift;

548.4 (18) for transportation provided as part of day training and habilitation for an individual
548.5 who does require a lift, add:

548.6 (i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a
548.7 lift, and $15.05 for a shared ride in a vehicle with a lift;

548.8 (ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a
548.9 lift, and $28.16 for a shared ride in a vehicle with a lift;

548.10 (iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a
548.11 lift, and $58.76 for a shared ride in a vehicle with a lift; or

548.12 (iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift,
548.13 and $80.93 for a shared ride in a vehicle with a lift.

548.14 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
548.15 whichever is later. The commissioner of human services shall notify the revisor of statutes
548.16 when federal approval is obtained.

548.17 Sec. 21. Minnesota Statutes 2020, section 256B.4914, subdivision 8, is amended to read:

548.18 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based
548.19 services with programming, including employment exploration services, employment
548.20 development services, housing access coordination, individualized home supports with
548.21 family training, individualized home supports with training, in-home family support,
548.22 independent living skills training, and hourly supported living services provided to an
548.23 individual outside of any day or residential service plan, provided in person or remotely,
548.24 must be calculated as follows, unless the services are authorized separately under subdivision
548.25 6 or 7:

548.26 (1) determine the number of units of service to meet a recipient's needs;

548.27 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
548.28 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
548.29 5;

548.30 (3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
548.31 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
548.32 5, paragraph (f), clause (1);

549.1 (4) for a recipient requiring customization for deaf and hard-of-hearing language
549.2 accessibility under subdivision 12, add the customization rate provided in subdivision 12
549.3 to the result of clause (3);

549.4 (5) multiply the number of direct staff hours by the appropriate staff wage;

549.5 (6) multiply the number of direct staff hours by the product of the supervision span of
549.6 control ratio in subdivision 5, paragraph (f), clause (2), for in-person services or subdivision
549.7 5, paragraph (g), clause (2), for remote services, and the appropriate supervision wage in
549.8 subdivision 5, paragraph (a), clause (21);

549.9 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
549.10 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause
549.11 (3), for in-person services or subdivision 5, paragraph (g), clause (3), for remote services.
549.12 This is defined as the direct staffing rate;

549.13 (8) for program plan support, multiply the result of clause (7) by one plus the program
549.14 plan supports ratio in subdivision 5, paragraph (f), clause (5), for in-person services or
549.15 subdivision 5, paragraph (g), clause (5), for remote services;

549.16 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
549.17 employee-related cost ratio in subdivision 5, paragraph (f), clause (4), for in-person services
549.18 or subdivision 5, paragraph (g), clause (4), for remote services;

549.19 (10) for client programming and supports, multiply the result of clause (9) by one plus
549.20 the client programming and supports ratio in subdivision 5, paragraph (f), clause (6), for
549.21 in-person services or subdivision 5, paragraph (g), clause (6), for remote services;

549.22 (11) this is the subtotal rate;

549.23 (12) sum the standard general and administrative rate, the program-related expense ratio,
549.24 and the absence and utilization factor ratio;

549.25 (13) divide the result of clause (11) by one minus the result of clause (12). This is the
549.26 total payment amount;

549.27 (14) for employment exploration services provided in a shared manner, divide the total
549.28 payment amount in clause (13) by the number of service recipients, not to exceed five. For
549.29 employment support services provided in a shared manner, divide the total payment amount
549.30 in clause (13) by the number of service recipients, not to exceed six. For independent living
549.31 skills training, individualized home supports with training, and individualized home supports
549.32 with family training provided in a shared manner, divide the total payment amount in clause
549.33 (13) by the number of service recipients, not to exceed two; and

550.1 (15) adjust the result of clause (14) by a factor to be determined by the commissioner
550.2 to adjust for regional differences in the cost of providing services.

550.3 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
550.4 whichever is later. The commissioner of human services shall notify the revisor of statutes
550.5 when federal approval is obtained.

550.6 Sec. 22. Minnesota Statutes 2020, section 256B.4914, subdivision 9, is amended to read:

550.7 Subd. 9. **Payments for unit-based services without programming.** Payments for
550.8 unit-based services without programming, including individualized home supports, night
550.9 supervision, personal support, respite, and companion care provided to an individual outside
550.10 of any day or residential service plan, provided in person or remotely, must be calculated
550.11 as follows unless the services are authorized separately under subdivision 6 or 7:

550.12 (1) for all services except respite, determine the number of units of service to meet a
550.13 recipient's needs;

550.14 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
550.15 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

550.16 (3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
550.17 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
550.18 5, paragraph ~~(g)~~ (h), clause (1);

550.19 (4) for a recipient requiring customization for deaf and hard-of-hearing language
550.20 accessibility under subdivision 12, add the customization rate provided in subdivision 12
550.21 to the result of clause (3);

550.22 (5) multiply the number of direct staff hours by the appropriate staff wage;

550.23 (6) multiply the number of direct staff hours by the product of the supervision span of
550.24 control ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (2), for in-person services or
550.25 subdivision 5, paragraph (i), clause (2), for remote services, and the appropriate supervision
550.26 wage in subdivision 5, paragraph (a), clause (21);

550.27 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
550.28 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(g)~~ (h),
550.29 clause (3), for in-person services or subdivision 5, paragraph (i), clause (3), for remote
550.30 services. This is defined as the direct staffing rate;

551.1 (8) for program plan support, multiply the result of clause (7) by one plus the program
551.2 plan support ratio in subdivision 5, paragraph (g) (h), clause (5), for in-person services or
551.3 subdivision 5, paragraph (i), clause (5), for remote services;

551.4 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
551.5 employee-related cost ratio in subdivision 5, paragraph (g) (h), clause (4), for in-person
551.6 services or subdivision 5, paragraph (i), clause (4), for remote services;

551.7 (10) for client programming and supports, multiply the result of clause (9) by one plus
551.8 the client programming and support ratio in subdivision 5, paragraph (g) (h), clause (6), for
551.9 in-person services or subdivision 5, paragraph (i), clause (6), for remote services;

551.10 (11) this is the subtotal rate;

551.11 (12) sum the standard general and administrative rate, the program-related expense ratio,
551.12 and the absence and utilization factor ratio;

551.13 (13) divide the result of clause (11) by one minus the result of clause (12). This is the
551.14 total payment amount;

551.15 (14) for respite services, determine the number of day units of service to meet an
551.16 individual's needs;

551.17 (15) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
551.18 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

551.19 (16) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
551.20 result of clause (15) by the product of one plus the competitive workforce factor in
551.21 subdivision 5, paragraph (h) (j), clause (1);

551.22 (17) for a recipient requiring deaf and hard-of-hearing customization under subdivision
551.23 12, add the customization rate provided in subdivision 12 to the result of clause (16);

551.24 (18) multiply the number of direct staff hours by the appropriate staff wage;

551.25 (19) multiply the number of direct staff hours by the product of the supervisory span of
551.26 control ratio in subdivision 5, paragraph (h) (j), clause (2), and the appropriate supervision
551.27 wage in subdivision 5, paragraph (a), clause (21);

551.28 (20) combine the results of clauses (18) and (19), and multiply the result by one plus
551.29 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (h)
551.30 (j), clause (3). This is defined as the direct staffing rate;

551.31 (21) for employee-related expenses, multiply the result of clause (20) by one plus the
551.32 employee-related cost ratio in subdivision 5, paragraph (h) (j), clause (4);

552.1 (22) this is the subtotal rate;

552.2 (23) sum the standard general and administrative rate, the program-related expense ratio,
552.3 and the absence and utilization factor ratio;

552.4 (24) divide the result of clause (22) by one minus the result of clause (23). This is the
552.5 total payment amount;

552.6 (25) for individualized home supports provided in a shared manner, divide the total
552.7 payment amount in clause (13) by the number of service recipients, not to exceed two;

552.8 (26) for respite care services provided in a shared manner, divide the total payment
552.9 amount in clause (24) by the number of service recipients, not to exceed three; and

552.10 (27) adjust the result of clauses (13), (25), and (26) by a factor to be determined by the
552.11 commissioner to adjust for regional differences in the cost of providing services.

552.12 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
552.13 whichever is later. The commissioner of human services shall notify the revisor of statutes
552.14 when federal approval is obtained.

552.15 Sec. 23. Minnesota Statutes 2020, section 256B.4914, is amended by adding a subdivision
552.16 to read:

552.17 Subd. 18. **Payments for family residential services.** The commissioner shall establish
552.18 rates for family residential services based on a person's assessed needs as described in the
552.19 federally approved waiver plans.

552.20 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
552.21 whichever is later. The commissioner of human services shall notify the revisor of statutes
552.22 when federal approval is obtained.

552.23 Sec. 24. Minnesota Statutes 2020, section 256B.69, subdivision 5a, is amended to read:

552.24 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and
552.25 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner
552.26 may issue separate contracts with requirements specific to services to medical assistance
552.27 recipients age 65 and older.

552.28 (b) A prepaid health plan providing covered health services for eligible persons pursuant
552.29 to chapters 256B and 256L is responsible for complying with the terms of its contract with
552.30 the commissioner. Requirements applicable to managed care programs under chapters 256B

553.1 and 256L established after the effective date of a contract with the commissioner take effect
553.2 when the contract is next issued or renewed.

553.3 (c) The commissioner shall withhold five percent of managed care plan payments under
553.4 this section and county-based purchasing plan payments under section 256B.692 for the
553.5 prepaid medical assistance program pending completion of performance targets. Each
553.6 performance target must be quantifiable, objective, measurable, and reasonably attainable,
553.7 except in the case of a performance target based on a federal or state law or rule. Criteria
553.8 for assessment of each performance target must be outlined in writing prior to the contract
553.9 effective date. Clinical or utilization performance targets and their related criteria must
553.10 consider evidence-based research and reasonable interventions when available or applicable
553.11 to the populations served, and must be developed with input from external clinical experts
553.12 and stakeholders, including managed care plans, county-based purchasing plans, and
553.13 providers. The managed care or county-based purchasing plan must demonstrate, to the
553.14 commissioner's satisfaction, that the data submitted regarding attainment of the performance
553.15 target is accurate. The commissioner shall periodically change the administrative measures
553.16 used as performance targets in order to improve plan performance across a broader range
553.17 of administrative services. The performance targets must include measurement of plan
553.18 efforts to contain spending on health care services and administrative activities. The
553.19 commissioner may adopt plan-specific performance targets that take into account factors
553.20 affecting only one plan, including characteristics of the plan's enrollee population. The
553.21 withheld funds must be returned no sooner than July of the following year if performance
553.22 targets in the contract are achieved. The commissioner may exclude special demonstration
553.23 projects under subdivision 23.

553.24 (d) The commissioner shall require that managed care plans:

553.25 (1) use the assessment and authorization processes, forms, timelines, standards,
553.26 documentation, and data reporting requirements, protocols, billing processes, and policies
553.27 consistent with medical assistance fee-for-service or the Department of Human Services
553.28 contract requirements for all personal care assistance services under section 256B.0659.;
553.29 and

553.30 (2) by January 30 of each year that follows a rate increase for any aspect of services
553.31 under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking
553.32 minority members of the legislative committees with jurisdiction over rates determined
553.33 under section 256B.851 of the amount of the rate increase that is paid to each personal care
553.34 assistance provider agency with which the plan has a contract.

554.1 (e) Effective for services rendered on or after January 1, 2012, the commissioner shall
554.2 include as part of the performance targets described in paragraph (c) a reduction in the health
554.3 plan's emergency department utilization rate for medical assistance and MinnesotaCare
554.4 enrollees, as determined by the commissioner. For 2012, the reduction shall be based on
554.5 the health plan's utilization in 2009. To earn the return of the withhold each subsequent
554.6 year, the managed care plan or county-based purchasing plan must achieve a qualifying
554.7 reduction of no less than ten percent of the plan's emergency department utilization rate for
554.8 medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described
554.9 in subdivisions 23 and 28, compared to the previous measurement year until the final
554.10 performance target is reached. When measuring performance, the commissioner must
554.11 consider the difference in health risk in a managed care or county-based purchasing plan's
554.12 membership in the baseline year compared to the measurement year, and work with the
554.13 managed care or county-based purchasing plan to account for differences that they agree
554.14 are significant.

554.15 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
554.16 the following calendar year if the managed care plan or county-based purchasing plan
554.17 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate
554.18 was achieved. The commissioner shall structure the withhold so that the commissioner
554.19 returns a portion of the withheld funds in amounts commensurate with achieved reductions
554.20 in utilization less than the targeted amount.

554.21 The withhold described in this paragraph shall continue for each consecutive contract
554.22 period until the plan's emergency room utilization rate for state health care program enrollees
554.23 is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance
554.24 and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the
554.25 health plans in meeting this performance target and shall accept payment withholds that
554.26 may be returned to the hospitals if the performance target is achieved.

554.27 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall
554.28 include as part of the performance targets described in paragraph (c) a reduction in the plan's
554.29 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as
554.30 determined by the commissioner. To earn the return of the withhold each year, the managed
554.31 care plan or county-based purchasing plan must achieve a qualifying reduction of no less
554.32 than five percent of the plan's hospital admission rate for medical assistance and
554.33 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
554.34 28, compared to the previous calendar year until the final performance target is reached.
554.35 When measuring performance, the commissioner must consider the difference in health risk

555.1 in a managed care or county-based purchasing plan's membership in the baseline year
555.2 compared to the measurement year, and work with the managed care or county-based
555.3 purchasing plan to account for differences that they agree are significant.

555.4 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
555.5 the following calendar year if the managed care plan or county-based purchasing plan
555.6 demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization
555.7 rate was achieved. The commissioner shall structure the withhold so that the commissioner
555.8 returns a portion of the withheld funds in amounts commensurate with achieved reductions
555.9 in utilization less than the targeted amount.

555.10 The withhold described in this paragraph shall continue until there is a 25 percent
555.11 reduction in the hospital admission rate compared to the hospital admission rates in calendar
555.12 year 2011, as determined by the commissioner. The hospital admissions in this performance
555.13 target do not include the admissions applicable to the subsequent hospital admission
555.14 performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting
555.15 this performance target and shall accept payment withholds that may be returned to the
555.16 hospitals if the performance target is achieved.

555.17 (g) Effective for services rendered on or after January 1, 2012, the commissioner shall
555.18 include as part of the performance targets described in paragraph (c) a reduction in the plan's
555.19 hospitalization admission rates for subsequent hospitalizations within 30 days of a previous
555.20 hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare
555.21 enrollees, as determined by the commissioner. To earn the return of the withhold each year,
555.22 the managed care plan or county-based purchasing plan must achieve a qualifying reduction
555.23 of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees,
555.24 excluding enrollees in programs described in subdivisions 23 and 28, of no less than five
555.25 percent compared to the previous calendar year until the final performance target is reached.

555.26 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
555.27 the following calendar year if the managed care plan or county-based purchasing plan
555.28 demonstrates to the satisfaction of the commissioner that a qualifying reduction in the
555.29 subsequent hospitalization rate was achieved. The commissioner shall structure the withhold
555.30 so that the commissioner returns a portion of the withheld funds in amounts commensurate
555.31 with achieved reductions in utilization less than the targeted amount.

555.32 The withhold described in this paragraph must continue for each consecutive contract
555.33 period until the plan's subsequent hospitalization rate for medical assistance and
555.34 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and

556.1 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year
556.2 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall
556.3 accept payment withholds that must be returned to the hospitals if the performance target
556.4 is achieved.

556.5 (h) Effective for services rendered on or after January 1, 2013, through December 31,
556.6 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
556.7 this section and county-based purchasing plan payments under section 256B.692 for the
556.8 prepaid medical assistance program. The withheld funds must be returned no sooner than
556.9 July 1 and no later than July 31 of the following year. The commissioner may exclude
556.10 special demonstration projects under subdivision 23.

556.11 (i) Effective for services rendered on or after January 1, 2014, the commissioner shall
556.12 withhold three percent of managed care plan payments under this section and county-based
556.13 purchasing plan payments under section 256B.692 for the prepaid medical assistance
556.14 program. The withheld funds must be returned no sooner than July 1 and no later than July
556.15 31 of the following year. The commissioner may exclude special demonstration projects
556.16 under subdivision 23.

556.17 (j) A managed care plan or a county-based purchasing plan under section 256B.692 may
556.18 include as admitted assets under section 62D.044 any amount withheld under this section
556.19 that is reasonably expected to be returned.

556.20 (k) Contracts between the commissioner and a prepaid health plan are exempt from the
556.21 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
556.22 7.

556.23 (l) The return of the withhold under paragraphs (h) and (i) is not subject to the
556.24 requirements of paragraph (c).

556.25 (m) Managed care plans and county-based purchasing plans shall maintain current and
556.26 fully executed agreements for all subcontractors, including bargaining groups, for
556.27 administrative services that are expensed to the state's public health care programs.
556.28 Subcontractor agreements determined to be material, as defined by the commissioner after
556.29 taking into account state contracting and relevant statutory requirements, must be in the
556.30 form of a written instrument or electronic document containing the elements of offer,
556.31 acceptance, consideration, payment terms, scope, duration of the contract, and how the
556.32 subcontractor services relate to state public health care programs. Upon request, the
556.33 commissioner shall have access to all subcontractor documentation under this paragraph.

557.1 Nothing in this paragraph shall allow release of information that is nonpublic data pursuant
557.2 to section 13.02.

557.3 **EFFECTIVE DATE.** This section is effective January 1, 2023.

557.4 Sec. 25. Minnesota Statutes 2020, section 256B.85, subdivision 2, is amended to read:

557.5 Subd. 2. **Definitions.** (a) For the purposes of this section and section 256B.851, the terms
557.6 defined in this subdivision have the meanings given.

557.7 (b) "Activities of daily living" or "ADLs" means eating, toileting, grooming, dressing,
557.8 bathing, mobility, positioning, and transferring.

557.9 (c) "Agency-provider model" means a method of CFSS under which a qualified agency
557.10 provides services and supports through the agency's own employees and policies. The agency
557.11 must allow the participant to have a significant role in the selection and dismissal of support
557.12 workers of their choice for the delivery of their specific services and supports.

557.13 (d) "Behavior" means a description of a need for services and supports used to determine
557.14 the home care rating and additional service units. The presence of Level I behavior is used
557.15 to determine the home care rating.

557.16 (e) "Budget model" means a service delivery method of CFSS that allows the use of a
557.17 service budget and assistance from a financial management services (FMS) provider for a
557.18 participant to directly employ support workers and purchase supports and goods.

557.19 (f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that
557.20 has been ordered by a physician, and is specified in a community support plan, including:

557.21 (1) tube feedings requiring:

557.22 (i) a gastrojejunostomy tube; or

557.23 (ii) continuous tube feeding lasting longer than 12 hours per day;

557.24 (2) wounds described as:

557.25 (i) stage III or stage IV;

557.26 (ii) multiple wounds;

557.27 (iii) requiring sterile or clean dressing changes or a wound vac; or

557.28 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized
557.29 care;

557.30 (3) parenteral therapy described as:

558.1 (i) IV therapy more than two times per week lasting longer than four hours for each
558.2 treatment; or

558.3 (ii) total parenteral nutrition (TPN) daily;

558.4 (4) respiratory interventions, including:

558.5 (i) oxygen required more than eight hours per day;

558.6 (ii) respiratory vest more than one time per day;

558.7 (iii) bronchial drainage treatments more than two times per day;

558.8 (iv) sterile or clean suctioning more than six times per day;

558.9 (v) dependence on another to apply respiratory ventilation augmentation devices such
558.10 as BiPAP and CPAP; and

558.11 (vi) ventilator dependence under section 256B.0651;

558.12 (5) insertion and maintenance of catheter, including:

558.13 (i) sterile catheter changes more than one time per month;

558.14 (ii) clean intermittent catheterization, and including self-catheterization more than six
558.15 times per day; or

558.16 (iii) bladder irrigations;

558.17 (6) bowel program more than two times per week requiring more than 30 minutes to
558.18 perform each time;

558.19 (7) neurological intervention, including:

558.20 (i) seizures more than two times per week and requiring significant physical assistance
558.21 to maintain safety; or

558.22 (ii) swallowing disorders diagnosed by a physician and requiring specialized assistance
558.23 from another on a daily basis; and

558.24 (8) other congenital or acquired diseases creating a need for significantly increased direct
558.25 hands-on assistance and interventions in six to eight activities of daily living.

558.26 (g) "Community first services and supports" or "CFSS" means the assistance and supports
558.27 program under this section needed for accomplishing activities of daily living, instrumental
558.28 activities of daily living, and health-related tasks through hands-on assistance to accomplish
558.29 the task or constant supervision and cueing to accomplish the task, or the purchase of goods
558.30 as defined in subdivision 7, clause (3), that replace the need for human assistance.

559.1 (h) "Community first services and supports service delivery plan" or "CFSS service
559.2 delivery plan" means a written document detailing the services and supports chosen by the
559.3 participant to meet assessed needs that are within the approved CFSS service authorization,
559.4 as determined in subdivision 8. Services and supports are based on the coordinated service
559.5 and support plan identified in section 256S.10.

559.6 (i) "Consultation services" means a Minnesota health care program enrolled provider
559.7 organization that provides assistance to the participant in making informed choices about
559.8 CFSS services in general and self-directed tasks in particular, and in developing a
559.9 person-centered CFSS service delivery plan to achieve quality service outcomes.

559.10 (j) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

559.11 (k) "Dependency" in activities of daily living means a person requires hands-on assistance
559.12 or constant supervision and cueing to accomplish one or more of the activities of daily living
559.13 every day or on the days during the week that the activity is performed; however, a child
559.14 may not be found to be dependent in an activity of daily living if, because of the child's age,
559.15 an adult would either perform the activity for the child or assist the child with the activity
559.16 and the assistance needed is the assistance appropriate for a typical child of the same age.

559.17 (l) "Extended CFSS" means CFSS services and supports provided under CFSS that are
559.18 included in the CFSS service delivery plan through one of the home and community-based
559.19 services waivers and as approved and authorized under chapter 256S and sections 256B.092,
559.20 subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state
559.21 plan CFSS services for participants.

559.22 (m) "Financial management services provider" or "FMS provider" means a qualified
559.23 organization required for participants using the budget model under subdivision 13 that is
559.24 an enrolled provider with the department to provide vendor fiscal/employer agent financial
559.25 management services (FMS).

559.26 (n) "Health-related procedures and tasks" means procedures and tasks related to the
559.27 specific assessed health needs of a participant that can be taught or assigned by a
559.28 state-licensed health care or mental health professional and performed by a support worker.

559.29 (o) "Instrumental activities of daily living" means activities related to living independently
559.30 in the community, including but not limited to: meal planning, preparation, and cooking;
559.31 shopping for food, clothing, or other essential items; laundry; housecleaning; assistance
559.32 with medications; managing finances; communicating needs and preferences during activities;
559.33 arranging supports; and assistance with traveling around and participating in the community.

560.1 (p) "Lead agency" has the meaning given in section 256B.0911, subdivision 1a, paragraph
560.2 (e).

560.3 (q) "Legal representative" means parent of a minor, a court-appointed guardian, or
560.4 another representative with legal authority to make decisions about services and supports
560.5 for the participant. Other representatives with legal authority to make decisions include but
560.6 are not limited to a health care agent or an attorney-in-fact authorized through a health care
560.7 directive or power of attorney.

560.8 (r) "Level I behavior" means physical aggression ~~towards~~ toward self or others or
560.9 destruction of property that requires the immediate response of another person.

560.10 (s) "Medication assistance" means providing verbal or visual reminders to take regularly
560.11 scheduled medication, and includes any of the following supports listed in clauses (1) to
560.12 (3) and other types of assistance, except that a support worker may not determine medication
560.13 dose or time for medication or inject medications into veins, muscles, or skin:

560.14 (1) under the direction of the participant or the participant's representative, bringing
560.15 medications to the participant including medications given through a nebulizer, opening a
560.16 container of previously set-up medications, emptying the container into the participant's
560.17 hand, opening and giving the medication in the original container to the participant, or
560.18 bringing to the participant liquids or food to accompany the medication;

560.19 (2) organizing medications as directed by the participant or the participant's representative;
560.20 and

560.21 (3) providing verbal or visual reminders to perform regularly scheduled medications.

560.22 (t) "Participant" means a person who is eligible for CFSS.

560.23 (u) "Participant's representative" means a parent, family member, advocate, or other
560.24 adult authorized by the participant or participant's legal representative, if any, to serve as a
560.25 representative in connection with the provision of CFSS. This authorization must be in
560.26 writing or by another method that clearly indicates the participant's free choice and may be
560.27 withdrawn at any time. The participant's representative must have no financial interest in
560.28 the provision of any services included in the participant's CFSS service delivery plan and
560.29 must be capable of providing the support necessary to assist the participant in the use of
560.30 CFSS. If through the assessment process described in subdivision 5 a participant is
560.31 determined to be in need of a participant's representative, one must be selected. If the
560.32 participant is unable to assist in the selection of a participant's representative, the legal
560.33 representative shall appoint one. Two persons may be designated as a participant's

561.1 representative for reasons such as divided households and court-ordered custodies. Duties
561.2 of a participant's representatives may include:

561.3 (1) being available while services are provided in a method agreed upon by the participant
561.4 or the participant's legal representative and documented in the participant's CFSS service
561.5 delivery plan;

561.6 (2) monitoring CFSS services to ensure the participant's CFSS service delivery plan is
561.7 being followed; and

561.8 (3) reviewing and signing CFSS time sheets after services are provided to provide
561.9 verification of the CFSS services.

561.10 (v) "Person-centered planning process" means a process that is directed by the participant
561.11 to plan for CFSS services and supports.

561.12 (w) "Service budget" means the authorized dollar amount used for the budget model or
561.13 for the purchase of goods.

561.14 (x) "Shared services" means the provision of CFSS services by the same CFSS support
561.15 worker to two or three participants who voluntarily enter into an agreement to receive
561.16 services at the same time and in the same setting by the same employer.

561.17 (y) "Support worker" means a qualified and trained employee of the agency-provider
561.18 as required by subdivision 11b or of the participant employer under the budget model as
561.19 required by subdivision 14 who has direct contact with the participant and provides services
561.20 as specified within the participant's CFSS service delivery plan.

561.21 (z) "Unit" means the increment of service based on hours or minutes identified in the
561.22 service agreement.

561.23 (aa) "Vendor fiscal employer agent" means an agency that provides financial management
561.24 services.

561.25 (bb) "Wages and benefits" means the hourly wages and salaries, the employer's share
561.26 of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation,
561.27 mileage reimbursement, health and dental insurance, life insurance, disability insurance,
561.28 long-term care insurance, uniform allowance, contributions to employee retirement accounts,
561.29 or other forms of employee compensation and benefits.

561.30 (cc) "Worker training and development" means services provided according to subdivision
561.31 18a for developing workers' skills as required by the participant's individual CFSS service
561.32 delivery plan that are arranged for or provided by the agency-provider or purchased by the

562.1 participant employer. These services include training, education, direct observation and
562.2 supervision, and evaluation and coaching of job skills and tasks, including supervision of
562.3 health-related tasks or behavioral supports.

562.4 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
562.5 whichever is later. The commissioner of human services must notify the revisor of statutes
562.6 when federal approval is obtained.

562.7 Sec. 26. **[256B.851] COMMUNITY FIRST SERVICES AND SUPPORTS; PAYMENT**
562.8 **RATES.**

562.9 Subdivision 1. **Application.** (a) The payment methodologies in this section apply to:

562.10 (1) community first services and supports (CFSS), extended CFSS, and enhanced rate
562.11 CFSS under section 256B.85; and

562.12 (2) personal care assistance services under section 256B.0625, subdivisions 19a and
562.13 19c; extended personal care assistance service as defined in section 256B.0659, subdivision
562.14 1; and enhanced rate personal care assistance services under section 256B.0659, subdivision
562.15 17a.

562.16 (b) This section does not change existing personal care assistance program or community
562.17 first services and supports policies and procedures.

562.18 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
562.19 meanings given in section 256B.85, subdivision 2, and as follows.

562.20 (b) "Commissioner" means the commissioner of human services.

562.21 (c) "Component value" means an underlying factor that is built into the rate methodology
562.22 to calculate service rates and is part of the cost of providing services.

562.23 (d) "Payment rate" or "rate" means reimbursement to an eligible provider for services
562.24 provided to a qualified individual based on an approved service authorization.

562.25 Subd. 3. **Payment rates; base wage index.** When initially establishing the base wage
562.26 component values, the commissioner must use the Minnesota-specific median wage for the
562.27 standard occupational classification (SOC) codes published by the Bureau of Labor Statistics
562.28 in the edition of the Occupational Handbook available January 1, 2021. The commissioner
562.29 must calculate the base wage component values as follows for:

562.30 (1) personal care assistance services, CFSS, extended personal care assistance services,
562.31 and extended CFSS. The base wage component value equals the median wage for personal
562.32 care aide (SOC code 31-1120);

563.1 (2) enhanced rate personal care assistance services and enhanced rate CFSS. The base
563.2 wage component value equals the product of median wage for personal care aide (SOC
563.3 code 31-1120) and the value of the enhanced rate under section 256B.0659, subdivision
563.4 17a; and

563.5 (3) qualified professional services and CFSS worker training and development. The base
563.6 wage component value equals the sum of 70 percent of the median wage for registered nurse
563.7 (SOC code 29-1141), 15 percent of the median wage for health care social worker (SOC
563.8 code 21-1099), and 15 percent of the median wage for social and human service assistant
563.9 (SOC code 21-1093).

563.10 Subd. 4. **Payment rates; total wage index.** (a) The commissioner must multiply the
563.11 base wage component values in subdivision 3 by one plus the appropriate competitive
563.12 workforce factor. The product is the total wage component value.

563.13 (b) For personal care assistance services, CFSS, extended personal care assistance
563.14 services, extended CFSS, enhanced rate personal care assistance services, and enhanced
563.15 rate CFSS, the initial competitive workforce factor is 4.7 percent.

563.16 (c) For qualified professional services and CFSS worker training and development, the
563.17 competitive workforce factor is zero percent.

563.18 (d) On August 1, 2024, and every two years thereafter, the commissioner shall report
563.19 recommendations to the chairs and ranking minority members of the legislative committees
563.20 and divisions with jurisdiction over health and human services policy and finance an update
563.21 of the competitive workforce factors in this subdivision using the most recently available
563.22 data. The commissioner shall make adjustments to the competitive workforce factor toward
563.23 the percent difference between: (1) the median wage for personal care aide (SOC code
563.24 31-1120); and (2) the weighted average wage for all other SOC codes with the same Bureau
563.25 of Labor Statistics classifications for education, experience, and training required for job
563.26 competency.

563.27 (e) The commissioner shall recommend an increase or decrease of the competitive
563.28 workforce factor from its previous value by no more than three percentage points. If, after
563.29 a biennial adjustment, the competitive workforce factor is less than or equal to zero, the
563.30 competitive workforce factor shall be zero.

563.31 Subd. 5. **Payment rates; component values.** (a) The commissioner must use the
563.32 following component values:

563.33 (1) employee vacation, sick, and training factor, 8.71 percent;

564.1 (2) employer taxes and workers' compensation factor, 11.56 percent;

564.2 (3) employee benefits factor, 12.04 percent;

564.3 (4) client programming and supports factor, 2.30 percent;

564.4 (5) program plan support factor, 7.00 percent;

564.5 (6) general business and administrative expenses factor, 13.25 percent;

564.6 (7) program administration expenses factor, 2.90 percent; and

564.7 (8) absence and utilization factor, 3.90 percent.

564.8 (b) For purposes of implementation, the commissioner shall use the following
564.9 implementation components:

564.10 (1) personal care assistance services and CFSS: 75.45 percent;

564.11 (2) enhanced rate personal care assistance services and enhanced rate CFSS: 75.45
564.12 percent; and

564.13 (3) qualified professional services and CFSS worker training and development: 75.45
564.14 percent.

564.15 Subd. 6. **Payment rates; rate determination.** (a) The commissioner must determine
564.16 the rate for personal care assistance services, CFSS, extended personal care assistance
564.17 services, extended CFSS, enhanced rate personal care assistance services, enhanced rate
564.18 CFSS, qualified professional services, and CFSS worker training and development as
564.19 follows:

564.20 (1) multiply the appropriate total wage component value calculated in subdivision 4 by
564.21 one plus the employee vacation, sick, and training factor in subdivision 5;

564.22 (2) for program plan support, multiply the result of clause (1) by one plus the program
564.23 plan support factor in subdivision 5;

564.24 (3) for employee-related expenses, add the employer taxes and workers' compensation
564.25 factor in subdivision 5 and the employee benefits factor in subdivision 5. The sum is
564.26 employee-related expenses. Multiply the product of clause (2) by one plus the value for
564.27 employee-related expenses;

564.28 (4) for client programming and supports, multiply the product of clause (3) by one plus
564.29 the client programming and supports factor in subdivision 5;

565.1 (5) for administrative expenses, add the general business and administrative expenses
565.2 factor in subdivision 5, the program administration expenses factor in subdivision 5, and
565.3 the absence and utilization factor in subdivision 5;

565.4 (6) divide the result of clause (4) by one minus the result of clause (5). The quotient is
565.5 the hourly rate;

565.6 (7) multiply the hourly rate by the appropriate implementation component under
565.7 subdivision 5. This is the adjusted hourly rate; and

565.8 (8) divide the adjusted hourly rate by four. The quotient is the total adjusted payment
565.9 rate.

565.10 (b) The commissioner must publish the total adjusted payment rates.

565.11 Subd. 7. **Personal care provider agency; required reporting and analysis of cost**
565.12 **data.** (a) The commissioner shall evaluate on an ongoing basis whether the base wage
565.13 component values and component values in this section appropriately address the cost to
565.14 provide the service. The commissioner shall make recommendations to adjust the rate
565.15 methodology as indicated by the evaluation. As determined by the commissioner and in
565.16 consultation with stakeholders, agencies enrolled to provide services with rates determined
565.17 under this section must submit requested cost data to the commissioner. The commissioner
565.18 may request cost data, including but not limited to:

565.19 (1) worker wage costs;

565.20 (2) benefits paid;

565.21 (3) supervisor wage costs;

565.22 (4) executive wage costs;

565.23 (5) vacation, sick, and training time paid;

565.24 (6) taxes, workers' compensation, and unemployment insurance costs paid;

565.25 (7) administrative costs paid;

565.26 (8) program costs paid;

565.27 (9) transportation costs paid;

565.28 (10) staff vacancy rates; and

565.29 (11) other data relating to costs required to provide services requested by the
565.30 commissioner.

566.1 (b) At least once in any three-year period, a provider must submit the required cost data
566.2 for a fiscal year that ended not more than 18 months prior to the submission date. The
566.3 commissioner must provide each provider a 90-day notice prior to its submission due date.
566.4 If a provider fails to submit required cost data, the commissioner must provide notice to a
566.5 provider that has not provided required cost data 30 days after the required submission date
566.6 and a second notice to a provider that has not provided required cost data 60 days after the
566.7 required submission date. The commissioner must temporarily suspend payments to a
566.8 provider if the commissioner has not received required cost data 90 days after the required
566.9 submission date. The commissioner must make withheld payments when the required cost
566.10 data is received by the commissioner.

566.11 (c) The commissioner must conduct a random validation of data submitted under this
566.12 subdivision to ensure data accuracy. The commissioner shall analyze cost documentation
566.13 in paragraph (a) and provide recommendations for adjustments to cost components.

566.14 (d) The commissioner shall analyze cost documentation in paragraph (a) and may submit
566.15 recommendations on component values, updated base wage component values, and
566.16 competitive workforce factors to the chair and ranking minority members of the legislative
566.17 committees and divisions with jurisdiction over human services policy and finance every
566.18 two years beginning August 1, 2026. The commissioner shall release cost data in an aggregate
566.19 form, and cost data from individual providers shall not be released except as provided for
566.20 in current law.

566.21 (e) The commissioner, in consultation with stakeholders, must develop and implement
566.22 a process for providing training and technical assistance necessary to support provider
566.23 submission of cost data required under this subdivision.

566.24 Subd. 8. **Payment rates; reports required.** (a) The commissioner must assess the
566.25 standard component values and publish evaluation findings and recommended changes to
566.26 the rate methodology in a report to the legislature by August 1, 2026.

566.27 (b) The commissioner must assess the long-term impacts of the rate methodology
566.28 implementation on staff providing services with rates determined under this section, including
566.29 but not limited to measuring changes in wages, benefits provided, hours worked, and
566.30 retention. The commissioner must publish evaluation findings in a report to the legislature
566.31 by August 1, 2028, and once every two years thereafter.

566.32 Subd. 9. **Self-directed services workforce.** Nothing in this section limits the
566.33 commissioner's authority over terms and conditions for individual providers in covered
566.34 programs as defined in section 256B.0711. The commissioner's authority over terms and

567.1 conditions for individual providers in covered programs remains subject to the state's
567.2 obligations to meet and negotiate under chapter 179A, as modified and made applicable to
567.3 individual providers under section 179A.54, and to agreements with any exclusive
567.4 representative of individual providers, as authorized by chapter 179A, as modified and made
567.5 applicable to individual providers under section 179A.54. A change in the rate for services
567.6 within the covered programs defined in section 256B.0711 does not constitute a change in
567.7 a term or condition for individual providers in covered programs and is not subject to the
567.8 state's obligation to meet and negotiate under chapter 179A, except that, notwithstanding
567.9 any other law to the contrary, the state shall meet and negotiate with the exclusive
567.10 representative of individual providers over wage and benefit increases made possible by
567.11 rate increases provided between January 1, 2023 and June 30, 2023. Any resulting tentative
567.12 agreement shall be submitted to the legislature to be accepted or rejected in accordance with
567.13 sections 3.855 and 179A.22.

567.14 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
567.15 whichever is later. The commissioner of human services must notify the revisor of statutes
567.16 when federal approval is obtained.

567.17 Sec. 27. Minnesota Statutes 2020, section 256I.04, subdivision 3, is amended to read:

567.18 Subd. 3. **Moratorium on development of housing support beds.** (a) Agencies shall
567.19 not enter into agreements for new housing support beds with total rates in excess of the
567.20 MSA equivalent rate except:

567.21 (1) for establishments licensed under chapter 245D provided the facility is needed to
567.22 meet the census reduction targets for persons with developmental disabilities at regional
567.23 treatment centers;

567.24 (2) up to 80 beds in a single, specialized facility located in Hennepin County that will
567.25 provide housing for chronic inebriates who are repetitive users of detoxification centers and
567.26 are refused placement in emergency shelters because of their state of intoxication, and
567.27 planning for the specialized facility must have been initiated before July 1, 1991, in
567.28 anticipation of receiving a grant from the Housing Finance Agency under section 462A.05,
567.29 subdivision 20a, paragraph (b);

567.30 (3) notwithstanding the provisions of subdivision 2a, for up to ~~226~~ 500 supportive
567.31 housing units in Anoka, Carver, Dakota, Hennepin, ~~or~~ Ramsey, Scott, or Washington County
567.32 for homeless adults with a mental illness, a history of substance abuse, or human
567.33 immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this
567.34 section, "homeless adult" means a person who is living on the street or in a shelter ~~or~~

568.1 ~~discharged from a regional treatment center, community hospital, or residential treatment~~
568.2 ~~program and~~, has no appropriate housing available, and lacks the resources and support
568.3 necessary to access appropriate housing. ~~At least 70 percent of the supportive housing units~~
568.4 ~~must serve homeless adults with mental illness, substance abuse problems, or human~~
568.5 ~~immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or,~~
568.6 ~~within the previous six months, have been discharged from a regional treatment center, or~~
568.7 ~~a state-contracted psychiatric bed in a community hospital, or a residential mental health~~
568.8 ~~or chemical dependency treatment program.~~ If a person meets the requirements of subdivision
568.9 1, paragraph (a) or (b), and receives a federal or state housing subsidy, the housing support
568.10 rate for that person is limited to the supplementary rate under section 256I.05, subdivision
568.11 1a~~, and is determined by subtracting the amount of the person's countable income that~~
568.12 ~~exceeds the MSA equivalent rate from the housing support supplementary service rate~~. A
568.13 resident in a demonstration project site who no longer participates in the demonstration
568.14 program shall retain eligibility for a housing support payment in an amount determined
568.15 under section 256I.06, subdivision 8, using the MSA equivalent rate~~. Service funding under~~
568.16 ~~section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are~~
568.17 ~~available and the services can be provided through a managed care entity. If federal matching~~
568.18 ~~funds are not available, then service funding will continue under section 256I.05, subdivision~~
568.19 ~~1a~~;

568.20 (4) for an additional two beds, resulting in a total of 32 beds, for a facility located in
568.21 Hennepin County providing services for recovering and chemically dependent men that has
568.22 had a housing support contract with the county and has been licensed as a board and lodge
568.23 facility with special services since 1980;

568.24 (5) for a housing support provider located in the city of St. Cloud, or a county contiguous
568.25 to the city of St. Cloud, that operates a 40-bed facility, that received financing through the
568.26 Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves
568.27 chemically dependent clientele, providing 24-hour-a-day supervision;

568.28 (6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent
568.29 persons, operated by a housing support provider that currently operates a 304-bed facility
568.30 in Minneapolis, and a 44-bed facility in Duluth;

568.31 (7) for a housing support provider that operates two ten-bed facilities, one located in
568.32 Hennepin County and one located in Ramsey County, that provide community support and
568.33 24-hour-a-day supervision to serve the mental health needs of individuals who have
568.34 chronically lived unsheltered; and

569.1 (8) for a facility authorized for recipients of housing support in Hennepin County with
569.2 a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility
569.3 and that until August 1, 2007, operated as a licensed chemical dependency treatment program.

569.4 (b) An agency may enter into a housing support agreement for beds with rates in excess
569.5 of the MSA equivalent rate in addition to those currently covered under a housing support
569.6 agreement if the additional beds are only a replacement of beds with rates in excess of the
569.7 MSA equivalent rate which have been made available due to closure of a setting, a change
569.8 of licensure or certification which removes the beds from housing support payment, or as
569.9 a result of the downsizing of a setting authorized for recipients of housing support. The
569.10 transfer of available beds from one agency to another can only occur by the agreement of
569.11 both agencies.

569.12 (c) The appropriation for this subdivision must include administrative funding equal to
569.13 the cost of two full-time equivalent employees to process eligibility. The commissioner
569.14 must disburse administrative funding to the fiscal agent for the counties under this
569.15 subdivision.

569.16 Sec. 28. Minnesota Statutes 2020, section 256I.05, subdivision 1a, is amended to read:

569.17 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04,
569.18 subdivision 3, the ~~county~~ agency may negotiate a payment not to exceed $426.37 for other
569.19 services necessary to provide room and board if the residence is licensed by or registered
569.20 by the Department of Health, or licensed by the Department of Human Services to provide
569.21 services in addition to room and board, and if the provider of services is not also concurrently
569.22 receiving funding for services for a recipient under a home and community-based waiver
569.23 under title XIX of the federal Social Security Act; or funding from the medical assistance
569.24 program under section 256B.0659, for personal care services for residents in the setting; or
569.25 residing in a setting which receives funding under section 245.73. If funding is available
569.26 for other necessary services through a home and community-based waiver, or personal care
569.27 services under section 256B.0659, then the housing support rate is limited to the rate set in
569.28 subdivision 1. Unless otherwise provided in law, in no case may the supplementary service
569.29 rate exceed $426.37. The registration and licensure requirement does not apply to
569.30 establishments which are exempt from state licensure because they are located on Indian
569.31 reservations and for which the tribe has prescribed health and safety requirements. Service
569.32 payments under this section may be prohibited under rules to prevent the supplanting of
569.33 federal funds with state funds. The commissioner shall pursue the feasibility of obtaining
569.34 the approval of the Secretary of Health and Human Services to provide home and

570.1 community-based waiver services under title XIX of the federal Social Security Act for
570.2 residents who are not eligible for an existing home and community-based waiver due to a
570.3 primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if
570.4 it is determined to be cost-effective.

570.5 (b) The commissioner is authorized to make cost-neutral transfers from the housing
570.6 support fund for beds under this section to other funding programs administered by the
570.7 department after consultation with the ~~county or counties~~ agency in which the affected beds
570.8 are located. The commissioner may also make cost-neutral transfers from the housing support
570.9 fund to ~~county human service~~ agencies for beds permanently removed from the housing
570.10 support census under a plan submitted by the ~~county~~ agency and approved by the
570.11 commissioner. The commissioner shall report the amount of any transfers under this provision
570.12 annually to the legislature.

570.13 (c) ~~Counties~~ Agencies must not negotiate supplementary service rates with providers of
570.14 housing support that are licensed as board and lodging with special services and that do not
570.15 encourage a policy of sobriety on their premises and make referrals to available community
570.16 services for volunteer and employment opportunities for residents.

570.17 **EFFECTIVE DATE.** This section is effective the day following final enactment.

570.18 Sec. 29. Minnesota Statutes 2020, section 256I.05, subdivision 1c, is amended to read:

570.19 Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for housing
570.20 support above those in effect on June 30, 1993, except as provided in paragraphs (a) to (f).

570.21 (a) An agency may increase the rates for room and board to the MSA equivalent rate
570.22 for those settings whose current rate is below the MSA equivalent rate.

570.23 (b) An agency may increase the rates for residents in adult foster care whose difficulty
570.24 of care has increased. The total housing support rate for these residents must not exceed the
570.25 maximum rate specified in subdivisions 1 and 1a. Agencies must not include nor increase
570.26 difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding
570.27 by home and community-based waiver programs under title XIX of the Social Security Act.

570.28 (c) The room and board rates will be increased each year when the MSA equivalent rate
570.29 is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less
570.30 the amount of the increase in the medical assistance personal needs allowance under section
570.31 256B.35.

570.32 (d) When housing support pays for an individual's room and board, or other costs
570.33 necessary to provide room and board, the rate payable to the residence must continue for

571.1 up to 18 calendar days per incident that the person is temporarily absent from the residence,
571.2 not to exceed 60 days in a calendar year, if the absence or absences are reported in advance
571.3 to the county agency's social service staff. Advance reporting is not required for emergency
571.4 absences due to crisis, illness, or injury. For purposes of maintaining housing while
571.5 temporarily absent due to residential behavioral health treatment or health care treatment
571.6 that requires admission to an inpatient hospital, nursing facility, or other health care facility,
571.7 the room and board rate for an individual is payable beyond an 18-calendar-day absence
571.8 period, not to exceed 150 days in a calendar year.

571.9 (e) For facilities meeting substantial change criteria within the prior year. Substantial
571.10 change criteria exists if the establishment experiences a 25 percent increase or decrease in
571.11 the total number of its beds, if the net cost of capital additions or improvements is in excess
571.12 of 15 percent of the current market value of the residence, or if the residence physically
571.13 moves, or changes its licensure, and incurs a resulting increase in operation and property
571.14 costs.

571.15 (f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid
571.16 for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who
571.17 reside in residences that are licensed by the commissioner of health as a boarding care home,
571.18 but are not certified for the purposes of the medical assistance program. However, an increase
571.19 under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical
571.20 assistance reimbursement rate for nursing home resident class A, in the geographic grouping
571.21 in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to
571.22 9549.0058.

571.23 Sec. 30. Minnesota Statutes 2020, section 256I.05, subdivision 11, is amended to read:

571.24 Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a
571.25 cost-neutral transfer of funding from the housing support fund to ~~county human service~~
571.26 ~~agencies~~ the agency for emergency shelter beds removed from the housing support census
571.27 under a biennial plan submitted by the ~~county~~ agency and approved by the commissioner.
571.28 The plan must describe: (1) anticipated and actual outcomes for persons experiencing
571.29 homelessness in emergency shelters; (2) improved efficiencies in administration; (3)
571.30 requirements for individual eligibility; and (4) plans for quality assurance monitoring and
571.31 quality assurance outcomes. The commissioner shall review the ~~county~~ agency plan to
571.32 monitor implementation and outcomes at least biennially, and more frequently if the
571.33 commissioner deems necessary.

572.1 (b) The funding under paragraph (a) may be used for the provision of room and board
572.2 or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must
572.3 meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding must be allocated
572.4 annually, and the room and board portion of the allocation shall be adjusted according to
572.5 the percentage change in the housing support room and board rate. The room and board
572.6 portion of the allocation shall be determined at the time of transfer. The commissioner or
572.7 ~~county~~ agency may return beds to the housing support fund with 180 days' notice, including
572.8 financial reconciliation.

572.9 **EFFECTIVE DATE.** This section is effective the day following final enactment.

572.10 Sec. 31. Minnesota Statutes 2020, section 256S.18, subdivision 7, is amended to read:

572.11 Subd. 7. **Monthly case mix budget cap exception.** The commissioner shall approve an
572.12 exception to the monthly case mix budget cap in ~~paragraph (a)~~ subdivision 3 to account for
572.13 the additional cost of providing enhanced rate personal care assistance services under section
572.14 256B.0659 or enhanced rate community first services and supports under section 256B.85.
572.15 ~~The exception shall not exceed 107.5 percent of the budget otherwise available to the~~
572.16 ~~individual.~~ The commissioner must calculate the difference between the rate for personal
572.17 care assistance services and enhanced rate personal care assistance services. The additional
572.18 budget amount approved under an exception must not exceed this difference. The exception
572.19 must be reapproved on an annual basis at the time of a participant's annual reassessment.

572.20 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
572.21 whichever is later. The commissioner of human services must notify the revisor of statutes
572.22 when federal approval is obtained.

572.23 Sec. 32. Minnesota Statutes 2020, section 256S.20, subdivision 1, is amended to read:

572.24 Subdivision 1. **Customized living services provider requirements.** ~~Only a provider~~
572.25 ~~licensed by the Department of Health as a comprehensive home care provider may provide~~
572.26 (a) To deliver customized living services or 24-hour customized living services~~.~~, a provider
572.27 must:

572.28 (1) be licensed as an assisted living facility under chapter 144G; or

572.29 (2) be licensed as a comprehensive home care provider under chapter 144A and be
572.30 delivering services: (i) in a setting defined under section 144G.08, subdivision 7, clauses
572.31 (11) to (13); or (ii) in an affordable housing setting under section 144G.08, subdivision 7,
572.32 clause (10), that is delivering authorized customized living services to a person in the setting

573.1 on or before June 30, 2022. A licensed home care provider is subject to section 256B.0651,
573.2 subdivision 14.

573.3 (b) Settings under paragraph (a), clause (2), must comply with section 256S.2003.

573.4 **EFFECTIVE DATE.** This section is effective August 1, 2021.

573.5 Sec. 33. **[256S.2003] CUSTOMIZED LIVING SERVICES; REQUIREMENTS OF**
573.6 **PROVIDERS IN DESIGNATED SETTINGS.**

573.7 Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have
573.8 the meanings given.

573.9 (b) "Designated provider" means a home care provider licensed under chapter 144A that
573.10 provides customized living services to some or all of the residents of a designated setting
573.11 and that is either the setting itself or another entity with which the setting has a contract or
573.12 business relationship.

573.13 (c) "Designated setting" means a setting defined under section 256S.20, subdivision 1,
573.14 paragraph (a), clause (2).

573.15 (d) "Resident" means a person receiving customized living services in a designated
573.16 setting.

573.17 Subd. 2. **Attestation of compliance with requirements.** Upon enrollment with the
573.18 department to provide customized living services, a designated provider of customized
573.19 living services must submit an attestation that the provider is in compliance with subdivisions
573.20 3 to 8.

573.21 Subd. 3. **Contracts.** (a) Every designated provider must execute a written contract with
573.22 a resident or the resident's representative and must operate in accordance with the terms of
573.23 the contract. The resident or the resident's representative must be given a complete copy of
573.24 the contract and all supporting documents and attachments and any changes whenever
573.25 changes are made.

573.26 (b) The contract must include at least the following elements in itself or through
573.27 supporting documents or attachments:

573.28 (1) the name, street address, and mailing address of the designated provider;

573.29 (2) the name and mailing address of the owner or owners of the designated provider
573.30 and, if the owner or owners are not natural persons, identification of the type of business
573.31 entity of the owner or owners;

574.1 (3) the name and mailing address of the managing agent, through management agreement
574.2 or lease agreement, of the designated provider, if different from the owner or owners;

574.3 (4) the name and address of at least one natural person who is authorized to accept service
574.4 of process on behalf of the owner or owners and managing agent;

574.5 (5) a statement identifying the designated provider's home care license number;

574.6 (6) the term of the contract;

574.7 (7) an itemization and description of the services to be provided to the resident;

574.8 (8) a conspicuous notice informing the resident of the policy concerning the conditions
574.9 under which and the process through which the contract may be modified, amended, or
574.10 terminated;

574.11 (9) a description of the designated provider's complaint resolution process available to
574.12 residents including the toll-free complaint line for the Office of Ombudsman for Long-Term
574.13 Care;

574.14 (10) the resident's designated representative, if any;

574.15 (11) the designated provider's referral procedures if the contract is terminated;

574.16 (12) a statement regarding the ability of a resident to receive services from service
574.17 providers with whom the designated provider does not have an arrangement;

574.18 (13) a statement regarding the availability of public funds for payment for residence or
574.19 services; and

574.20 (14) a statement regarding the availability of and contact information for long-term care
574.21 consultation services under section 256B.0911 in the county in which the establishment is
574.22 located.

574.23 (c) The contract must include a statement regarding:

574.24 (1) the ability of a resident to furnish and decorate the resident's unit within the terms
574.25 of the lease;

574.26 (2) a resident's right to access food at any time;

574.27 (3) a resident's right to choose the resident's visitors and times of visits;

574.28 (4) a resident's right to choose a roommate if sharing a unit; and

574.29 (5) a resident's right to have and use a lockable door to the resident's unit. The designated
574.30 setting must provide the locks on the unit. Only a staff member with a specific need to enter

575.1 the unit shall have keys, and advance notice must be given to the resident before entrance,
575.2 when possible.

575.3 (d) A restriction of a resident's rights under this subdivision is allowed only if determined
575.4 necessary for health and safety reasons identified by the home care provider's registered
575.5 nurse in an initial assessment or reassessment, as defined under section 144A.4791,
575.6 subdivision 8, and documented in the written service plan under section 144A.4791,
575.7 subdivision 9. Any restrictions of those rights for people served under this chapter and
575.8 section 256B.49 must be documented in the resident's coordinated service and support plan,
575.9 as defined under sections 256B.49, subdivision 15, and 256S.10.

575.10 (e) The contract and related documents executed by each resident or resident's
575.11 representative must be maintained by the designated provider in files from the date of
575.12 execution until three years after the contract is terminated.

575.13 Subd. 4. **Training in dementia.** (a) If a designated provider has a special program or
575.14 special care unit for residents with Alzheimer's disease or other dementias or advertises,
575.15 markets, or otherwise promotes the provision of services for persons with Alzheimer's
575.16 disease or other dementias, whether in a segregated or general unit, employees of the provider
575.17 must meet the following training requirements:

575.18 (1) supervisors of direct-care staff must have at least eight hours of initial training on
575.19 topics specified under paragraph (b) within 120 working hours of the employment start
575.20 date, and must have at least two hours of training on topics related to dementia care for each
575.21 12 months of employment thereafter;

575.22 (2) direct-care employees must have completed at least eight hours of initial training on
575.23 topics specified under paragraph (b) within 160 working hours of the employment start
575.24 date. Until this initial training is complete, an employee must not provide direct care unless
575.25 there is another employee on site who has completed the initial eight hours of training on
575.26 topics related to dementia care and who can act as a resource and assist if issues arise. A
575.27 trainer of the requirements under paragraph (b), or a supervisor meeting the requirements
575.28 in clause (1), must be available for consultation with the new employee until the training
575.29 requirement is complete. Direct-care employees must have at least two hours of training on
575.30 topics related to dementia care for each 12 months of employment thereafter;

575.31 (3) staff who do not provide direct care, including maintenance, housekeeping, and food
575.32 service staff, must have at least four hours of initial training on topics specified under
575.33 paragraph (b) within 160 working hours of the employment start date, and must have at

576.1 least two hours of training on topics related to dementia care for each 12 months of
576.2 employment thereafter; and

576.3 (4) new employees may satisfy the initial training requirements under clauses (1) to (3)
576.4 by producing written proof of previously completed required training within the past 18
576.5 months.

576.6 (b) Areas of required training include:

576.7 (1) an explanation of Alzheimer's disease and related disorders;

576.8 (2) assistance with activities of daily living;

576.9 (3) problem solving with challenging behaviors; and

576.10 (4) communication skills.

576.11 (c) The provider must provide to residents and prospective residents in written or
576.12 electronic form a description of the training program, the categories of employees trained,
576.13 the frequency of training, and the basic topics covered.

576.14 Subd. 5. **Restraints.** Residents must be free from any physical or chemical restraints
576.15 imposed for purposes of discipline or convenience.

576.16 Subd. 6. **Termination of contract.** A designated provider must include with notice of
576.17 termination of contract information about how to contact the ombudsman for long-term
576.18 care, including the address and telephone number, along with a statement of how to request
576.19 problem-solving assistance.

576.20 Subd. 7. **Manager requirements.** (a) The person primarily responsible for oversight
576.21 and management of the designated provider, as designated by the owner, must obtain at
576.22 least 30 hours of continuing education every two years of employment as the manager in
576.23 topics relevant to the operations of the facility and the needs of its tenants. Continuing
576.24 education earned to maintain a professional license, such as a nursing home administrator
576.25 license, nursing license, social worker license, or real estate license, can be used to complete
576.26 this requirement.

576.27 (b) New managers may satisfy the initial dementia training requirements by producing
576.28 written proof of previously completed required training within the past 18 months.

576.29 Subd. 8. **Emergency planning.** (a) Each designated provider must meet the following
576.30 requirements:

577.1 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses
577.2 elements of sheltering in-place, identifies temporary relocation sites, and details staff
577.3 assignments in the event of a disaster or an emergency;

577.4 (2) prominently post an emergency disaster plan;

577.5 (3) provide building emergency exit diagrams to all residents upon signing a contract;

577.6 (4) post emergency exit diagrams on each floor; and

577.7 (5) have a written policy and procedure regarding missing residents.

577.8 (b) Each designated provider must provide emergency and disaster training to all staff
577.9 during the initial staff orientation and annually thereafter and must make emergency and
577.10 disaster training available to all residents annually. Staff who have not received emergency
577.11 and disaster training are allowed to work only when trained staff are also working on site.

577.12 (c) Each designated provider location must conduct and document a fire drill or other
577.13 emergency drill at least once every six months. To the extent possible, drills must be
577.14 coordinated with local fire departments or other community emergency resources.

577.15 Subd. 9. **Other laws.** Each designated provider must comply with chapter 504B, and
577.16 must obtain and maintain all other licenses, permits, registrations, or other required
577.17 governmental approvals. A designated provider is not required to obtain a lodging license
577.18 under chapter 157 and related rules.

577.19 **EFFECTIVE DATE.** This section is effective August 1, 2021.

577.20 Sec. 34. Laws 2020, Fifth Special Session chapter 3, article 10, section 3, is amended to
577.21 read:

577.22 Sec. 3. **TEMPORARY PERSONAL CARE ASSISTANCE COMPENSATION FOR**
577.23 **SERVICES PROVIDED BY A PARENT OR SPOUSE.**

577.24 (a) Notwithstanding Minnesota Statutes, section 256B.0659, subdivisions 3, paragraph
577.25 (a), clause (1); 11, paragraph (c); and 19, paragraph (b), clause (3), during a peacetime
577.26 emergency declared by the governor under Minnesota Statutes, section 12.31, subdivision
577.27 2, for an outbreak of COVID-19, a parent, stepparent, or legal guardian of a minor who is
577.28 a personal care assistance recipient or a spouse of a personal care assistance recipient may
577.29 provide and be paid for providing personal care assistance services.

577.30 (b) This section expires ~~February 7, 2021~~ upon the expiration of the COVID-19 public
577.31 health emergency declared by the United States Secretary of Health and Human Services.

578.1 **EFFECTIVE DATE; REVIVAL AND REENACTMENT.** This section is effective
578.2 the day following final enactment, or upon federal approval, whichever is later, and Laws
578.3 2020, Fifth Special Session chapter 3, article 10, section 3, is revived and reenacted as of
578.4 that date.

578.5 Sec. 35. **SELF-DIRECTED WORKER CONTRACT RATIFICATION.**

578.6 The labor agreement between the state of Minnesota and the Service Employees
578.7 International Union Healthcare Minnesota, submitted to the Legislative Coordinating
578.8 Commission on March 1, 2021, is ratified.

578.9 Sec. 36. **DIRECTION TO THE COMMISSIONER; CUSTOMIZED LIVING**
578.10 **REPORT.**

578.11 (a) By January 15, 2022, the commissioner of human services shall submit a report to
578.12 the chairs and ranking minority members of the legislative committees with jurisdiction
578.13 over human services policy and finance. The report must include the commissioner's:

578.14 (1) assessment of the prevalence of customized living services provided under Minnesota
578.15 Statutes, section 256B.49, supplanting the provision of residential services and supports
578.16 licensed under Minnesota Statutes, chapter 245D, and provided in settings licensed under
578.17 Minnesota Statutes, chapter 245A;

578.18 (2) recommendations regarding the continuation of the moratorium on home and
578.19 community-based services customized living settings under Minnesota Statutes, section
578.20 256B.49, subdivision 28;

578.21 (3) other policy recommendations to ensure that customized living services are being
578.22 provided in a manner consistent with the policy objectives of the foster care licensing
578.23 moratorium under Minnesota Statutes, section 245A.03, subdivision 7; and

578.24 (4) recommendations for needed statutory changes to implement the transition from
578.25 existing four-person or fewer customized living settings to corporate adult foster care or
578.26 community residential settings.

578.27 (b) The commissioner of health shall provide the commissioner of human services with
578.28 the required data to complete the report in paragraph (a) and implement the moratorium on
578.29 home and community-based services customized living settings under Minnesota Statutes,
578.30 section 256B.49, subdivision 28. The data must include, at a minimum, each registered
578.31 housing with services establishment under Minnesota Statutes, chapter 144D, enrolled as
578.32 a customized living setting to deliver customized living services as defined under the brain

579.1 injury or community access for disability inclusion waiver plans under Minnesota Statutes,
579.2 section 256B.49.

579.3 Sec. 37. **DIRECTION TO COMMISSIONER; PROVIDER STANDARDS FOR**
579.4 **CUSTOMIZED LIVING SERVICES IN DESIGNATED SETTINGS.**

579.5 The commissioner of human services shall review policies and provider standards for
579.6 customized living services provided in settings identified in Minnesota Statutes, section
579.7 256S.20, subdivision 1, paragraph (a), clause (2), in consultation with stakeholders. The
579.8 commissioner may provide recommendations to the chairs and ranking minority members
579.9 of the legislative committees and divisions with jurisdiction over customized living services
579.10 by February 15, 2022, regarding appropriate regulatory oversight and payment policies for
579.11 customized living services delivered in these settings.

579.12 Sec. 38. **GOVERNOR'S COUNCIL ON AN AGE-FRIENDLY MINNESOTA.**

579.13 The Governor's Council on an Age-Friendly Minnesota, established in Executive Order
579.14 19-38, shall: (1) work to advance age-friendly policies; and (2) coordinate state, local, and
579.15 private partners' collaborative work on emergency preparedness, with a focus on older
579.16 adults, communities, and persons in zip codes most impacted by the COVID-19 pandemic.
579.17 The Governor's Council on an Age-Friendly Minnesota is extended and expires October 1,
579.18 2022.

579.19 Sec. 39. **RATE INCREASE FOR DIRECT SUPPORT SERVICES WORKFORCE.**

579.20 (a) Effective October 1, 2021, or upon federal approval, whichever is later, if the labor
579.21 agreement between the state of Minnesota and the Service Employees International Union
579.22 Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved pursuant to
579.23 Minnesota Statutes, section 3.855, the commissioner of human services shall increase:

579.24 (1) reimbursement rates, individual budgets, grants, or allocations by 4.14 percent for
579.25 services under paragraph (b) provided on or after October 1, 2021, or upon federal approval,
579.26 whichever is later, to implement the minimum hourly wage, holiday, and paid time off
579.27 provisions of that agreement;

579.28 (2) reimbursement rates, individual budgets, grants, or allocations by 2.95 percent for
579.29 services under paragraph (b) provided on or after July 1, 2022, or upon federal approval,
579.30 whichever is later, to implement the minimum hourly wage, holiday, and paid time off
579.31 provisions of that agreement;

580.1 (3) individual budgets, grants, or allocations by 1.58 percent for services under paragraph
580.2 (c) provided on or after October 1, 2021, or upon federal approval, whichever is later, to
580.3 implement the minimum hourly wage, holiday, and paid time off provisions of that
580.4 agreement; and

580.5 (4) individual budgets, grants, or allocations by .81 percent for services under paragraph
580.6 (c) provided on or after July 1, 2022, or upon federal approval, whichever is later, to
580.7 implement the minimum hourly wage, holiday, and paid time off provisions of that
580.8 agreement.

580.9 (b) The rate changes described in paragraph (a), clauses (1) and (2), apply to direct
580.10 support services provided through a covered program, as defined in Minnesota Statutes,
580.11 section 256B.0711, subdivision 1, with the exception of consumer-directed community
580.12 supports available under programs established pursuant to home and community-based
580.13 service waivers authorized under section 1915(c) of the federal Social Security Act and
580.14 Minnesota Statutes, including but not limited to chapter 256S and sections 256B.092 and
580.15 256B.49, and under the alternative care program under Minnesota Statutes, section
580.16 256B.0913.

580.17 (c) The funding changes described in paragraph (a), clauses (3) and (4), apply to
580.18 consumer-directed community supports available under programs established pursuant to
580.19 home and community-based service waivers authorized under section 1915(c) of the federal
580.20 Social Security Act, and Minnesota Statutes, including but not limited to chapter 256S and
580.21 sections 256B.092 and 256B.49, and under the alternative care program under Minnesota
580.22 Statutes, section 256B.0913.

580.23 Sec. 40. **WAIVER REIMAGINE PHASE II.**

580.24 (a) The commissioner of human services must implement a two-home and
580.25 community-based services waiver program structure, as authorized under section 1915(c)
580.26 of the federal Social Security Act, that serves persons who are determined by a certified
580.27 assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral
580.28 hospital, or an intermediate care facility for persons with developmental disabilities.

580.29 (b) The commissioner of human services must implement an individualized budget
580.30 methodology, as authorized under section 1915(c) of the federal Social Security Act, that
580.31 serves persons who are determined by a certified assessor to require the levels of care
580.32 provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care
580.33 facility for persons with developmental disabilities.

581.1 (c) The commissioner of human services may seek all federal authority necessary to
581.2 implement this section.

581.3 **EFFECTIVE DATE.** This section is effective September 1, 2024, or 90 days after
581.4 federal approval, whichever is later. The commissioner of human services shall notify the
581.5 revisor of statutes when federal approval is obtained.

581.6 Sec. 41. **REPEALER.**

581.7 (a) Minnesota Statutes 2020, section 256B.097, subdivisions 1, 2, 3, 4, 5, and 6, are
581.8 repealed effective July 1, 2021.

581.9 (b) Minnesota Statutes 2020, sections 256B.0916, subdivisions 2, 3, 4, 5, 8, 11, and 12;
581.10 and 256B.49, subdivisions 26 and 27, are repealed effective January 1, 2023, or upon federal
581.11 approval, whichever is later. The commissioner of human services shall notify the revisor
581.12 of statutes when federal approval is obtained.

581.13 (c) Minnesota Statutes 2020, section 256S.20, subdivision 2, is repealed effective August
581.14 1, 2021.

581.15 **ARTICLE 15**
581.16 **COMMUNITY SUPPORTS POLICY**

581.17 Section 1. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

581.18 Subd. 6. **Service standards.** The standards in this subdivision apply to intensive
581.19 nonresidential rehabilitative mental health services.

581.20 (a) The treatment team must use team treatment, not an individual treatment model.

581.21 (b) Services must be available at times that meet client needs.

581.22 (c) Services must be age-appropriate and meet the specific needs of the client.

581.23 (d) The initial functional assessment must be completed within ten days of intake and
581.24 updated at least every six months or prior to discharge from the service, whichever comes
581.25 first.

581.26 (e) The treatment team must complete an individual treatment plan for each client and
581.27 the individual treatment plan must:

581.28 (1) be based on the information in the client's diagnostic assessment and baselines;

582.1 (2) identify goals and objectives of treatment, a treatment strategy, a schedule for
582.2 accomplishing treatment goals and objectives, and the individuals responsible for providing
582.3 treatment services and supports;

582.4 (3) be developed after completion of the client's diagnostic assessment by a mental health
582.5 professional or clinical trainee and before the provision of children's therapeutic services
582.6 and supports;

582.7 (4) be developed through a child-centered, family-driven, culturally appropriate planning
582.8 process, including allowing parents and guardians to observe or participate in individual
582.9 and family treatment services, assessments, and treatment planning;

582.10 (5) be reviewed at least once every six months and revised to document treatment progress
582.11 on each treatment objective and next goals or, if progress is not documented, to document
582.12 changes in treatment;

582.13 (6) be signed by the clinical supervisor and by the client or by the client's parent or other
582.14 person authorized by statute to consent to mental health services for the client. A client's
582.15 parent may approve the client's individual treatment plan by secure electronic signature or
582.16 by documented oral approval that is later verified by written signature;

582.17 (7) be completed in consultation with the client's current therapist and key providers and
582.18 provide for ongoing consultation with the client's current therapist to ensure therapeutic
582.19 continuity and to facilitate the client's return to the community. For clients under the age of
582.20 18, the treatment team must consult with parents and guardians in developing the treatment
582.21 plan;

582.22 (8) if a need for substance use disorder treatment is indicated by validated assessment:

582.23 (i) identify goals, objectives, and strategies of substance use disorder treatment; develop
582.24 a schedule for accomplishing treatment goals and objectives; and identify the individuals
582.25 responsible for providing treatment services and supports;

582.26 (ii) be reviewed at least once every 90 days and revised, if necessary;

582.27 (9) be signed by the clinical supervisor and by the client and, if the client is a minor, by
582.28 the client's parent or other person authorized by statute to consent to mental health treatment
582.29 and substance use disorder treatment for the client; and

582.30 (10) provide for the client's transition out of intensive nonresidential rehabilitative mental
582.31 health services by defining the team's actions to assist the client and subsequent providers
582.32 in the transition to less intensive or "stepped down" services.

583.1 (f) The treatment team shall actively and assertively engage the client's family members
583.2 and significant others by establishing communication and collaboration with the family and
583.3 significant others and educating the family and significant others about the client's mental
583.4 illness, symptom management, and the family's role in treatment, unless the team knows or
583.5 has reason to suspect that the client has suffered or faces a threat of suffering any physical
583.6 or mental injury, abuse, or neglect from a family member or significant other.

583.7 (g) For a client age 18 or older, the treatment team may disclose to a family member,
583.8 other relative, or a close personal friend of the client, or other person identified by the client,
583.9 the protected health information directly relevant to such person's involvement with the
583.10 client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the
583.11 client is present, the treatment team shall obtain the client's agreement, provide the client
583.12 with an opportunity to object, or reasonably infer from the circumstances, based on the
583.13 exercise of professional judgment, that the client does not object. If the client is not present
583.14 or is unable, by incapacity or emergency circumstances, to agree or object, the treatment
583.15 team may, in the exercise of professional judgment, determine whether the disclosure is in
583.16 the best interests of the client and, if so, disclose only the protected health information that
583.17 is directly relevant to the family member's, relative's, friend's, or client-identified person's
583.18 involvement with the client's health care. The client may orally agree or object to the
583.19 disclosure and may prohibit or restrict disclosure to specific individuals.

583.20 (h) The treatment team shall provide interventions to promote positive interpersonal
583.21 relationships.

583.22 Sec. 2. Minnesota Statutes 2020, section 256B.69, subdivision 5a, is amended to read:

583.23 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and
583.24 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner
583.25 may issue separate contracts with requirements specific to services to medical assistance
583.26 recipients age 65 and older.

583.27 (b) A prepaid health plan providing covered health services for eligible persons pursuant
583.28 to chapters 256B and 256L is responsible for complying with the terms of its contract with
583.29 the commissioner. Requirements applicable to managed care programs under chapters 256B
583.30 and 256L established after the effective date of a contract with the commissioner take effect
583.31 when the contract is next issued or renewed.

583.32 (c) The commissioner shall withhold five percent of managed care plan payments under
583.33 this section and county-based purchasing plan payments under section 256B.692 for the
583.34 prepaid medical assistance program pending completion of performance targets. Each

584.1 performance target must be quantifiable, objective, measurable, and reasonably attainable,
584.2 except in the case of a performance target based on a federal or state law or rule. Criteria
584.3 for assessment of each performance target must be outlined in writing prior to the contract
584.4 effective date. Clinical or utilization performance targets and their related criteria must
584.5 consider evidence-based research and reasonable interventions when available or applicable
584.6 to the populations served, and must be developed with input from external clinical experts
584.7 and stakeholders, including managed care plans, county-based purchasing plans, and
584.8 providers. The managed care or county-based purchasing plan must demonstrate, to the
584.9 commissioner's satisfaction, that the data submitted regarding attainment of the performance
584.10 target is accurate. The commissioner shall periodically change the administrative measures
584.11 used as performance targets in order to improve plan performance across a broader range
584.12 of administrative services. The performance targets must include measurement of plan
584.13 efforts to contain spending on health care services and administrative activities. The
584.14 commissioner may adopt plan-specific performance targets that take into account factors
584.15 affecting only one plan, including characteristics of the plan's enrollee population. The
584.16 withheld funds must be returned no sooner than July of the following year if performance
584.17 targets in the contract are achieved. The commissioner may exclude special demonstration
584.18 projects under subdivision 23.

584.19 (d) The commissioner shall require that managed care plans use the assessment and
584.20 authorization processes, forms, timelines, standards, documentation, and data reporting
584.21 requirements, protocols, billing processes, and policies consistent with medical assistance
584.22 fee-for-service or the Department of Human Services contract requirements for all personal
584.23 care assistance services under section 256B.0659 and community first services and supports
584.24 under section 256B.85.

584.25 (e) Effective for services rendered on or after January 1, 2012, the commissioner shall
584.26 include as part of the performance targets described in paragraph (c) a reduction in the health
584.27 plan's emergency department utilization rate for medical assistance and MinnesotaCare
584.28 enrollees, as determined by the commissioner. For 2012, the reduction shall be based on
584.29 the health plan's utilization in 2009. To earn the return of the withhold each subsequent
584.30 year, the managed care plan or county-based purchasing plan must achieve a qualifying
584.31 reduction of no less than ten percent of the plan's emergency department utilization rate for
584.32 medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described
584.33 in subdivisions 23 and 28, compared to the previous measurement year until the final
584.34 performance target is reached. When measuring performance, the commissioner must
584.35 consider the difference in health risk in a managed care or county-based purchasing plan's

585.1 membership in the baseline year compared to the measurement year, and work with the
585.2 managed care or county-based purchasing plan to account for differences that they agree
585.3 are significant.

585.4 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
585.5 the following calendar year if the managed care plan or county-based purchasing plan
585.6 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate
585.7 was achieved. The commissioner shall structure the withhold so that the commissioner
585.8 returns a portion of the withheld funds in amounts commensurate with achieved reductions
585.9 in utilization less than the targeted amount.

585.10 The withhold described in this paragraph shall continue for each consecutive contract
585.11 period until the plan's emergency room utilization rate for state health care program enrollees
585.12 is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance
585.13 and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the
585.14 health plans in meeting this performance target and shall accept payment withholds that
585.15 may be returned to the hospitals if the performance target is achieved.

585.16 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall
585.17 include as part of the performance targets described in paragraph (c) a reduction in the plan's
585.18 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as
585.19 determined by the commissioner. To earn the return of the withhold each year, the managed
585.20 care plan or county-based purchasing plan must achieve a qualifying reduction of no less
585.21 than five percent of the plan's hospital admission rate for medical assistance and
585.22 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
585.23 28, compared to the previous calendar year until the final performance target is reached.
585.24 When measuring performance, the commissioner must consider the difference in health risk
585.25 in a managed care or county-based purchasing plan's membership in the baseline year
585.26 compared to the measurement year, and work with the managed care or county-based
585.27 purchasing plan to account for differences that they agree are significant.

585.28 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
585.29 the following calendar year if the managed care plan or county-based purchasing plan
585.30 demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization
585.31 rate was achieved. The commissioner shall structure the withhold so that the commissioner
585.32 returns a portion of the withheld funds in amounts commensurate with achieved reductions
585.33 in utilization less than the targeted amount.

586.1 The withhold described in this paragraph shall continue until there is a 25 percent
586.2 reduction in the hospital admission rate compared to the hospital admission rates in calendar
586.3 year 2011, as determined by the commissioner. The hospital admissions in this performance
586.4 target do not include the admissions applicable to the subsequent hospital admission
586.5 performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting
586.6 this performance target and shall accept payment withholds that may be returned to the
586.7 hospitals if the performance target is achieved.

586.8 (g) Effective for services rendered on or after January 1, 2012, the commissioner shall
586.9 include as part of the performance targets described in paragraph (c) a reduction in the plan's
586.10 hospitalization admission rates for subsequent hospitalizations within 30 days of a previous
586.11 hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare
586.12 enrollees, as determined by the commissioner. To earn the return of the withhold each year,
586.13 the managed care plan or county-based purchasing plan must achieve a qualifying reduction
586.14 of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees,
586.15 excluding enrollees in programs described in subdivisions 23 and 28, of no less than five
586.16 percent compared to the previous calendar year until the final performance target is reached.

586.17 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
586.18 the following calendar year if the managed care plan or county-based purchasing plan
586.19 demonstrates to the satisfaction of the commissioner that a qualifying reduction in the
586.20 subsequent hospitalization rate was achieved. The commissioner shall structure the withhold
586.21 so that the commissioner returns a portion of the withheld funds in amounts commensurate
586.22 with achieved reductions in utilization less than the targeted amount.

586.23 The withhold described in this paragraph must continue for each consecutive contract
586.24 period until the plan's subsequent hospitalization rate for medical assistance and
586.25 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
586.26 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year
586.27 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall
586.28 accept payment withholds that must be returned to the hospitals if the performance target
586.29 is achieved.

586.30 (h) Effective for services rendered on or after January 1, 2013, through December 31,
586.31 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
586.32 this section and county-based purchasing plan payments under section 256B.692 for the
586.33 prepaid medical assistance program. The withheld funds must be returned no sooner than
586.34 July 1 and no later than July 31 of the following year. The commissioner may exclude
586.35 special demonstration projects under subdivision 23.

587.1 (i) Effective for services rendered on or after January 1, 2014, the commissioner shall
587.2 withhold three percent of managed care plan payments under this section and county-based
587.3 purchasing plan payments under section 256B.692 for the prepaid medical assistance
587.4 program. The withheld funds must be returned no sooner than July 1 and no later than July
587.5 31 of the following year. The commissioner may exclude special demonstration projects
587.6 under subdivision 23.

587.7 (j) A managed care plan or a county-based purchasing plan under section 256B.692 may
587.8 include as admitted assets under section 62D.044 any amount withheld under this section
587.9 that is reasonably expected to be returned.

587.10 (k) Contracts between the commissioner and a prepaid health plan are exempt from the
587.11 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
587.12 7.

587.13 (l) The return of the withhold under paragraphs (h) and (i) is not subject to the
587.14 requirements of paragraph (c).

587.15 (m) Managed care plans and county-based purchasing plans shall maintain current and
587.16 fully executed agreements for all subcontractors, including bargaining groups, for
587.17 administrative services that are expensed to the state's public health care programs.
587.18 Subcontractor agreements determined to be material, as defined by the commissioner after
587.19 taking into account state contracting and relevant statutory requirements, must be in the
587.20 form of a written instrument or electronic document containing the elements of offer,
587.21 acceptance, consideration, payment terms, scope, duration of the contract, and how the
587.22 subcontractor services relate to state public health care programs. Upon request, the
587.23 commissioner shall have access to all subcontractor documentation under this paragraph.
587.24 Nothing in this paragraph shall allow release of information that is nonpublic data pursuant
587.25 to section 13.02.

587.26 Sec. 3. Minnesota Statutes 2020, section 256B.85, subdivision 1, is amended to read:

587.27 Subdivision 1. **Basis and scope.** (a) Upon federal approval, the commissioner shall
587.28 establish a state plan option for the provision of home and community-based personal
587.29 assistance service and supports called "community first services and supports (CFSS)."

587.30 (b) CFSS is a participant-controlled method of selecting and providing services and
587.31 supports that allows the participant maximum control of the services and supports.
587.32 Participants may choose the degree to which they direct and manage their supports by
587.33 choosing to have a significant and meaningful role in the management of services and

supports including by directly employing support workers with the necessary supports to perform that function.

(c) CFSS is available statewide to eligible people to assist with accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task; and to assist with acquiring, maintaining, and enhancing the skills necessary to accomplish ADLs, IADLs, and health-related procedures and tasks. CFSS allows payment for the participant for certain supports and goods such as environmental modifications and technology that are intended to replace or decrease the need for human assistance.

(d) Upon federal approval, CFSS will replace the personal care assistance program under sections 256.476, 256B.0625, subdivisions 19a and 19c, and 256B.0659.

(e) For the purposes of this section, notwithstanding the provisions of section 144A.43, subdivision 3, supports purchased under CFSS are not considered home care services.

Sec. 4. Minnesota Statutes 2020, section 256B.85, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Activities of daily living" or "ADLs" means ~~eating, toileting, grooming, dressing, bathing, mobility, positioning, and transferring.~~:

(1) dressing, including assistance with choosing, applying, and changing clothing and applying special appliances, wraps, or clothing;

(2) grooming, including assistance with basic hair care, oral care, shaving, applying cosmetics and deodorant, and care of eyeglasses and hearing aids. Grooming includes nail care, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

(4) eating, including assistance with hand washing and applying orthotics required for eating, transfers, or feeding;

(5) transfers, including assistance with transferring the participant from one seating or reclining area to another;

(6) mobility, including assistance with ambulation and use of a wheelchair. Mobility does not include providing transportation for a participant;

589.1 (7) positioning, including assistance with positioning or turning a participant for necessary
589.2 care and comfort; and

589.3 (8) toileting, including assistance with bowel or bladder elimination and care, transfers,
589.4 mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing
589.5 the perineal area, inspection of the skin, and adjusting clothing.

589.6 (c) "Agency-provider model" means a method of CFSS under which a qualified agency
589.7 provides services and supports through the agency's own employees and policies. The agency
589.8 must allow the participant to have a significant role in the selection and dismissal of support
589.9 workers of their choice for the delivery of their specific services and supports.

589.10 (d) "Behavior" means a description of a need for services and supports used to determine
589.11 the home care rating and additional service units. The presence of Level I behavior is used
589.12 to determine the home care rating.

589.13 (e) "Budget model" means a service delivery method of CFSS that allows the use of a
589.14 service budget and assistance from a financial management services (FMS) provider for a
589.15 participant to directly employ support workers and purchase supports and goods.

589.16 (f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that
589.17 has been ordered by a physician, advanced practice registered nurse, or physician's assistant
589.18 and is specified in a community support plan, including:

589.19 (1) tube feedings requiring:

589.20 (i) a gastrojejunostomy tube; or

589.21 (ii) continuous tube feeding lasting longer than 12 hours per day;

589.22 (2) wounds described as:

589.23 (i) stage III or stage IV;

589.24 (ii) multiple wounds;

589.25 (iii) requiring sterile or clean dressing changes or a wound vac; or

589.26 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized
589.27 care;

589.28 (3) parenteral therapy described as:

589.29 (i) IV therapy more than two times per week lasting longer than four hours for each
589.30 treatment; or

589.31 (ii) total parenteral nutrition (TPN) daily;

590.1 (4) respiratory interventions, including:

590.2 (i) oxygen required more than eight hours per day;

590.3 (ii) respiratory vest more than one time per day;

590.4 (iii) bronchial drainage treatments more than two times per day;

590.5 (iv) sterile or clean suctioning more than six times per day;

590.6 (v) dependence on another to apply respiratory ventilation augmentation devices such
590.7 as BiPAP and CPAP; and

590.8 (vi) ventilator dependence under section 256B.0651;

590.9 (5) insertion and maintenance of catheter, including:

590.10 (i) sterile catheter changes more than one time per month;

590.11 (ii) clean intermittent catheterization, and including self-catheterization more than six
590.12 times per day; or

590.13 (iii) bladder irrigations;

590.14 (6) bowel program more than two times per week requiring more than 30 minutes to
590.15 perform each time;

590.16 (7) neurological intervention, including:

590.17 (i) seizures more than two times per week and requiring significant physical assistance
590.18 to maintain safety; or

590.19 (ii) swallowing disorders diagnosed by a physician, advanced practice registered nurse,
590.20 or physician's assistant and requiring specialized assistance from another on a daily basis;
590.21 and

590.22 (8) other congenital or acquired diseases creating a need for significantly increased direct
590.23 hands-on assistance and interventions in six to eight activities of daily living.

590.24 (g) "Community first services and supports" or "CFSS" means the assistance and supports
590.25 program under this section needed for accomplishing activities of daily living, instrumental
590.26 activities of daily living, and health-related tasks through hands-on assistance to accomplish
590.27 the task or constant supervision and cueing to accomplish the task, or the purchase of goods
590.28 as defined in subdivision 7, clause (3), that replace the need for human assistance.

590.29 (h) "Community first services and supports service delivery plan" or "CFSS service
590.30 delivery plan" means a written document detailing the services and supports chosen by the

591.1 participant to meet assessed needs that are within the approved CFSS service authorization,
591.2 as determined in subdivision 8. Services and supports are based on the coordinated service
591.3 and support plan identified in ~~section~~ sections 256B.092, subdivision 1b, and 256S.10.

591.4 (i) "Consultation services" means a Minnesota health care program enrolled provider
591.5 organization that provides assistance to the participant in making informed choices about
591.6 CFSS services in general and self-directed tasks in particular, and in developing a
591.7 person-centered CFSS service delivery plan to achieve quality service outcomes.

591.8 (j) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

591.9 (k) "Dependency" in activities of daily living means a person requires hands-on assistance
591.10 or constant supervision and cueing to accomplish one or more of the activities of daily living
591.11 every day or on the days during the week that the activity is performed; however, a child
591.12 ~~may~~ must not be found to be dependent in an activity of daily living if, because of the child's
591.13 age, an adult would either perform the activity for the child or assist the child with the
591.14 activity and the assistance needed is the assistance appropriate for a typical child of the
591.15 same age.

591.16 (l) "Extended CFSS" means CFSS services and supports provided under CFSS that are
591.17 included in the CFSS service delivery plan through one of the home and community-based
591.18 services waivers and as approved and authorized under chapter 256S and sections 256B.092,
591.19 subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state
591.20 plan CFSS services for participants. Extended CFSS excludes the purchase of goods.

591.21 (m) "Financial management services provider" or "FMS provider" means a qualified
591.22 organization required for participants using the budget model under subdivision 13 that is
591.23 an enrolled provider with the department to provide vendor fiscal/employer agent financial
591.24 management services (FMS).

591.25 (n) "Health-related procedures and tasks" means procedures and tasks related to the
591.26 specific assessed health needs of a participant that can be taught or assigned by a
591.27 state-licensed health care or mental health professional and performed by a support worker.

591.28 (o) "Instrumental activities of daily living" means activities related to living independently
591.29 in the community, including but not limited to: meal planning, preparation, and cooking;
591.30 shopping for food, clothing, or other essential items; laundry; housecleaning; assistance
591.31 with medications; managing finances; communicating needs and preferences during activities;
591.32 arranging supports; and assistance with traveling around and participating in the community.

592.1 (p) "Lead agency" has the meaning given in section 256B.0911, subdivision 1a, paragraph
592.2 (e).

592.3 (q) "Legal representative" means parent of a minor, a court-appointed guardian, or
592.4 another representative with legal authority to make decisions about services and supports
592.5 for the participant. Other representatives with legal authority to make decisions include but
592.6 are not limited to a health care agent or an attorney-in-fact authorized through a health care
592.7 directive or power of attorney.

592.8 (r) "Level I behavior" means physical aggression towards self or others or destruction
592.9 of property that requires the immediate response of another person.

592.10 (s) "Medication assistance" means providing verbal or visual reminders to take regularly
592.11 scheduled medication, and includes any of the following supports listed in clauses (1) to
592.12 (3) and other types of assistance, except that a support worker ~~may~~ must not determine
592.13 medication dose or time for medication or inject medications into veins, muscles, or skin:

592.14 (1) under the direction of the participant or the participant's representative, bringing
592.15 medications to the participant including medications given through a nebulizer, opening a
592.16 container of previously set-up medications, emptying the container into the participant's
592.17 hand, opening and giving the medication in the original container to the participant, or
592.18 bringing to the participant liquids or food to accompany the medication;

592.19 (2) organizing medications as directed by the participant or the participant's representative;
592.20 and

592.21 (3) providing verbal or visual reminders to perform regularly scheduled medications.

592.22 (t) "Participant" means a person who is eligible for CFSS.

592.23 (u) "Participant's representative" means a parent, family member, advocate, or other
592.24 adult authorized by the participant or participant's legal representative, if any, to serve as a
592.25 representative in connection with the provision of CFSS. ~~This authorization must be in~~
592.26 ~~writing or by another method that clearly indicates the participant's free choice and may be~~
592.27 ~~withdrawn at any time. The participant's representative must have no financial interest in~~
592.28 ~~the provision of any services included in the participant's CFSS service delivery plan and~~
592.29 ~~must be capable of providing the support necessary to assist the participant in the use of~~
592.30 ~~CFSS. If through the assessment process described in subdivision 5 a participant is~~
592.31 ~~determined to be in need of a participant's representative, one must be selected.~~ If the
592.32 participant is unable to assist in the selection of a participant's representative, the legal
592.33 representative shall appoint one. ~~Two persons may be designated as a participant's~~

593.1 ~~representative for reasons such as divided households and court-ordered custodies. Duties~~
593.2 ~~of a participant's representatives may include:~~

593.3 ~~(1) being available while services are provided in a method agreed upon by the participant~~
593.4 ~~or the participant's legal representative and documented in the participant's CFSS service~~
593.5 ~~delivery plan;~~

593.6 ~~(2) monitoring CFSS services to ensure the participant's CFSS service delivery plan is~~
593.7 ~~being followed; and~~

593.8 ~~(3) reviewing and signing CFSS time sheets after services are provided to provide~~
593.9 ~~verification of the CFSS services.~~

593.10 (v) "Person-centered planning process" means a process that is directed by the participant
593.11 to plan for CFSS services and supports.

593.12 (w) "Service budget" means the authorized dollar amount used for the budget model or
593.13 for the purchase of goods.

593.14 (x) "Shared services" means the provision of CFSS services by the same CFSS support
593.15 worker to two or three participants who voluntarily enter into ~~an~~ a written agreement to
593.16 receive services at the same time ~~and~~, in the same setting ~~by~~, and through the same ~~employer~~
593.17 agency-provider or FMS provider.

593.18 (y) "Support worker" means a qualified and trained employee of the agency-provider
593.19 as required by subdivision 11b or of the participant employer under the budget model as
593.20 required by subdivision 14 who has direct contact with the participant and provides services
593.21 as specified within the participant's CFSS service delivery plan.

593.22 (z) "Unit" means the increment of service based on hours or minutes identified in the
593.23 service agreement.

593.24 (aa) "Vendor fiscal employer agent" means an agency that provides financial management
593.25 services.

593.26 (bb) "Wages and benefits" means the hourly wages and salaries, the employer's share
593.27 of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation,
593.28 mileage reimbursement, health and dental insurance, life insurance, disability insurance,
593.29 long-term care insurance, uniform allowance, contributions to employee retirement accounts,
593.30 or other forms of employee compensation and benefits.

593.31 (cc) "Worker training and development" means services provided according to subdivision
593.32 18a for developing workers' skills as required by the participant's individual CFSS service

594.1 delivery plan that are arranged for or provided by the agency-provider or purchased by the
594.2 participant employer. These services include training, education, direct observation and
594.3 supervision, and evaluation and coaching of job skills and tasks, including supervision of
594.4 health-related tasks or behavioral supports.

594.5 Sec. 5. Minnesota Statutes 2020, section 256B.85, subdivision 3, is amended to read:

594.6 Subd. 3. **Eligibility.** (a) CFSS is available to a person who ~~meets one of the following~~:

594.7 ~~(1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056,~~
594.8 ~~or 256B.057, subdivisions 5 and 9;~~

594.9 (1) is determined eligible for medical assistance under this chapter, excluding those
594.10 under section 256B.057, subdivisions 3, 3a, 3b, and 4;

594.11 (2) is a participant in the alternative care program under section 256B.0913;

594.12 (3) is a waiver participant as defined under chapter 256S or section 256B.092, 256B.093,
594.13 or 256B.49; or

594.14 (4) has medical services identified in a person's individualized education program and
594.15 is eligible for services as determined in section 256B.0625, subdivision 26.

594.16 (b) In addition to meeting the eligibility criteria in paragraph (a), a person must also
594.17 meet all of the following:

594.18 (1) require assistance and be determined dependent in one activity of daily living or
594.19 Level I behavior based on assessment under section 256B.0911; and

594.20 (2) is not a participant under a family support grant under section 252.32.

594.21 (c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision
594.22 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible
594.23 for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as
594.24 determined under section 256B.0911.

594.25 Sec. 6. Minnesota Statutes 2020, section 256B.85, subdivision 4, is amended to read:

594.26 Subd. 4. **Eligibility for other services.** Selection of CFSS by a participant must not
594.27 restrict access to other medically necessary care and services furnished under the state plan
594.28 benefit or other services available through the alternative care program.

594.29 Sec. 7. Minnesota Statutes 2020, section 256B.85, subdivision 5, is amended to read:

594.30 Subd. 5. **Assessment requirements.** (a) The assessment of functional need must:

595.1 (1) be conducted by a certified assessor according to the criteria established in section
595.2 256B.0911, subdivision 3a;

595.3 (2) be conducted face-to-face, initially and at least annually thereafter, or when there is
595.4 a significant change in the participant's condition or a change in the need for services and
595.5 supports, or at the request of the participant when the participant experiences a change in
595.6 condition or needs a change in the services or supports; and

595.7 (3) be completed using the format established by the commissioner.

595.8 (b) The results of the assessment and any recommendations and authorizations for CFSS
595.9 must be determined and communicated in writing by the lead agency's ~~certified~~ assessor as
595.10 defined in section 256B.0911 to the participant ~~and the agency-provider or FMS provider~~
595.11 ~~chosen by the participant~~ or the participant's representative and chosen CFSS providers
595.12 within ~~40 calendar~~ ten business days and must include the participant's right to appeal the
595.13 assessment under section 256.045, subdivision 3.

595.14 (c) The lead agency assessor may authorize a temporary authorization for CFSS services
595.15 to be provided under the agency-provider model. The lead agency assessor may authorize
595.16 a temporary authorization for CFSS services to be provided under the agency-provider
595.17 model without using the assessment process described in this subdivision. Authorization
595.18 for a temporary level of CFSS services under the agency-provider model is limited to the
595.19 time specified by the commissioner, but shall not exceed 45 days. The level of services
595.20 authorized under this paragraph shall have no bearing on a future authorization. ~~Participants~~
595.21 ~~approved for a temporary authorization shall access the consultation service~~ For CFSS
595.22 services needed beyond the 45-day temporary authorization, the lead agency must conduct
595.23 an assessment as described in this subdivision and participants must use consultation services
595.24 to complete their orientation and selection of a service model.

595.25 Sec. 8. Minnesota Statutes 2020, section 256B.85, subdivision 6, is amended to read:

595.26 Subd. 6. **Community first services and supports service delivery plan.** (a) The CFSS
595.27 service delivery plan must be developed and evaluated through a person-centered planning
595.28 process by the participant, or the participant's representative or legal representative who
595.29 may be assisted by a consultation services provider. The CFSS service delivery plan must
595.30 reflect the services and supports that are important to the participant and for the participant
595.31 to meet the needs assessed by the certified assessor and identified in the coordinated service
595.32 and support plan identified in ~~section~~ sections 256B.092, subdivision 1b, and 256S.10. The
595.33 CFSS service delivery plan must be reviewed by the participant, the consultation services
595.34 provider, and the agency-provider or FMS provider prior to starting services and at least

596.1 annually upon reassessment, or when there is a significant change in the participant's
596.2 condition, or a change in the need for services and supports.

596.3 (b) The commissioner shall establish the format and criteria for the CFSS service delivery
596.4 plan.

596.5 (c) The CFSS service delivery plan must be person-centered and:

596.6 (1) specify the consultation services provider, agency-provider, or FMS provider selected
596.7 by the participant;

596.8 (2) reflect the setting in which the participant resides that is chosen by the participant;

596.9 (3) reflect the participant's strengths and preferences;

596.10 (4) include the methods and supports used to address the needs as identified through an
596.11 assessment of functional needs;

596.12 (5) include the participant's identified goals and desired outcomes;

596.13 (6) reflect the services and supports, paid and unpaid, that will assist the participant to
596.14 achieve identified goals, including the costs of the services and supports, and the providers
596.15 of those services and supports, including natural supports;

596.16 (7) identify the amount and frequency of face-to-face supports and amount and frequency
596.17 of remote supports and technology that will be used;

596.18 (8) identify risk factors and measures in place to minimize them, including individualized
596.19 backup plans;

596.20 (9) be understandable to the participant and the individuals providing support;

596.21 (10) identify the individual or entity responsible for monitoring the plan;

596.22 (11) be finalized and agreed to in writing by the participant and signed by ~~all~~ individuals
596.23 and providers responsible for its implementation;

596.24 (12) be distributed to the participant and other people involved in the plan;

596.25 (13) prevent the provision of unnecessary or inappropriate care;

596.26 (14) include a detailed budget for expenditures for budget model participants or
596.27 participants under the agency-provider model if purchasing goods; and

596.28 (15) include a plan for worker training and development provided according to
596.29 subdivision 18a detailing what service components will be used, when the service components

597.1 will be used, how they will be provided, and how these service components relate to the
597.2 participant's individual needs and CFSS support worker services.

597.3 (d) The CFSS service delivery plan must describe the units or dollar amount available
597.4 to the participant. The total units of agency-provider services or the service budget amount
597.5 for the budget model include both annual totals and a monthly average amount that cover
597.6 the number of months of the service agreement. The amount used each month may vary,
597.7 but additional funds must not be provided above the annual service authorization amount,
597.8 determined according to subdivision 8, unless a change in condition is assessed and
597.9 authorized by the certified assessor and documented in the coordinated service and support
597.10 plan and CFSS service delivery plan.

597.11 (e) In assisting with the development or modification of the CFSS service delivery plan
597.12 during the authorization time period, the consultation services provider shall:

597.13 (1) consult with the FMS provider on the spending budget when applicable; and

597.14 (2) consult with the participant or participant's representative, agency-provider, and case
597.15 manager~~/~~ or care coordinator.

597.16 (f) The CFSS service delivery plan must be approved by the consultation services provider
597.17 for participants without a case manager or care coordinator who is responsible for authorizing
597.18 services. A case manager or care coordinator must approve the plan for a waiver or alternative
597.19 care program participant.

597.20 Sec. 9. Minnesota Statutes 2020, section 256B.85, subdivision 7, is amended to read:

597.21 Subd. 7. **Community first services and supports; covered services.** Services and
597.22 supports covered under CFSS include:

597.23 (1) assistance to accomplish activities of daily living (ADLs), instrumental activities of
597.24 daily living (IADLs), and health-related procedures and tasks through hands-on assistance
597.25 to accomplish the task or constant supervision and cueing to accomplish the task;

597.26 (2) assistance to acquire, maintain, or enhance the skills necessary for the participant to
597.27 accomplish activities of daily living, instrumental activities of daily living, or health-related
597.28 tasks;

597.29 (3) expenditures for items, services, supports, environmental modifications, or goods,
597.30 including assistive technology. These expenditures must:

597.31 (i) relate to a need identified in a participant's CFSS service delivery plan; and

598.1 (ii) increase independence or substitute for human assistance, to the extent that
598.2 expenditures would otherwise be made for human assistance for the participant's assessed
598.3 needs;

598.4 (4) observation and redirection for behavior or symptoms where there is a need for
598.5 assistance;

598.6 (5) back-up systems or mechanisms, such as the use of pagers or other electronic devices,
598.7 to ensure continuity of the participant's services and supports;

598.8 (6) services provided by a consultation services provider as defined under subdivision
598.9 17, that is under contract with the department and enrolled as a Minnesota health care
598.10 program provider;

598.11 (7) services provided by an FMS provider as defined under subdivision 13a, that is an
598.12 enrolled provider with the department;

598.13 (8) CFSS services provided by a support worker who is a parent, stepparent, or legal
598.14 guardian of a participant under age 18, or who is the participant's spouse. These support
598.15 workers shall not:

598.16 (i) provide any medical assistance home and community-based services in excess of 40
598.17 hours per seven-day period regardless of the number of parents providing services,
598.18 combination of parents and spouses providing services, or number of children who receive
598.19 medical assistance services; and

598.20 (ii) have a wage that exceeds the current rate for a CFSS support worker including the
598.21 wage, benefits, and payroll taxes; and

598.22 (9) worker training and development services as described in subdivision 18a.

598.23 Sec. 10. Minnesota Statutes 2020, section 256B.85, subdivision 8, is amended to read:

598.24 Subd. 8. **Determination of CFSS service authorization amount.** (a) All community
598.25 first services and supports must be authorized by the commissioner or the commissioner's
598.26 designee before services begin. The authorization for CFSS must be completed as soon as
598.27 possible following an assessment but no later than 40 calendar days from the date of the
598.28 assessment.

598.29 (b) The amount of CFSS authorized must be based on the participant's home care rating
598.30 described in paragraphs (d) and (e) and any additional service units for which the participant
598.31 qualifies as described in paragraph (f).

599.1 (c) The home care rating shall be determined by the commissioner or the commissioner's
599.2 designee based on information submitted to the commissioner identifying the following for
599.3 a participant:

599.4 (1) the total number of dependencies of activities of daily living;

599.5 (2) the presence of complex health-related needs; and

599.6 (3) the presence of Level I behavior.

599.7 (d) The methodology to determine the total service units for CFSS for each home care
599.8 rating is based on the median paid units per day for each home care rating from fiscal year
599.9 2007 data for the PCA program.

599.10 (e) Each home care rating is designated by the letters P through Z and EN and has the
599.11 following base number of service units assigned:

599.12 (1) P home care rating requires Level I behavior or one to three dependencies in ADLs
599.13 and qualifies the person for five service units;

599.14 (2) Q home care rating requires Level I behavior and one to three dependencies in ADLs
599.15 and qualifies the person for six service units;

599.16 (3) R home care rating requires a complex health-related need and one to three
599.17 dependencies in ADLs and qualifies the person for seven service units;

599.18 (4) S home care rating requires four to six dependencies in ADLs and qualifies the person
599.19 for ten service units;

599.20 (5) T home care rating requires four to six dependencies in ADLs and Level I behavior
599.21 and qualifies the person for 11 service units;

599.22 (6) U home care rating requires four to six dependencies in ADLs and a complex
599.23 health-related need and qualifies the person for 14 service units;

599.24 (7) V home care rating requires seven to eight dependencies in ADLs and qualifies the
599.25 person for 17 service units;

599.26 (8) W home care rating requires seven to eight dependencies in ADLs and Level I
599.27 behavior and qualifies the person for 20 service units;

599.28 (9) Z home care rating requires seven to eight dependencies in ADLs and a complex
599.29 health-related need and qualifies the person for 30 service units; and

599.30 (10) EN home care rating includes ventilator dependency as defined in section 256B.0651,
599.31 subdivision 1, paragraph (g). A person who meets the definition of ventilator-dependent

600.1 and the EN home care rating and utilize a combination of CFSS and home care nursing
600.2 services is limited to a total of 96 service units per day for those services in combination.
600.3 Additional units may be authorized when a person's assessment indicates a need for two
600.4 staff to perform activities. Additional time is limited to 16 service units per day.

600.5 (f) Additional service units are provided through the assessment and identification of
600.6 the following:

600.7 (1) 30 additional minutes per day for a dependency in each critical activity of daily
600.8 living;

600.9 (2) 30 additional minutes per day for each complex health-related need; and

600.10 (3) 30 additional minutes per day ~~when the~~ for each behavior under this clause that
600.11 requires assistance at least four times per week ~~for one or more of the following behaviors~~:

600.12 (i) level I behavior that requires the immediate response of another person;

600.13 (ii) increased vulnerability due to cognitive deficits or socially inappropriate behavior;
600.14 or

600.15 (iii) increased need for assistance for participants who are verbally aggressive or resistive
600.16 to care so that the time needed to perform activities of daily living is increased.

600.17 (g) The service budget for budget model participants shall be based on:

600.18 (1) assessed units as determined by the home care rating; and

600.19 (2) an adjustment needed for administrative expenses.

600.20 Sec. 11. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision
600.21 to read:

600.22 Subd. 8a. **Authorization; exceptions.** All CFSS services must be authorized by the
600.23 commissioner or the commissioner's designee as described in subdivision 8 except when:

600.24 (1) the lead agency temporarily authorizes services in the agency-provider model as
600.25 described in subdivision 5, paragraph (c);

600.26 (2) CFSS services in the agency-provider model were required to treat an emergency
600.27 medical condition that if not immediately treated could cause a participant serious physical
600.28 or mental disability, continuation of severe pain, or death. The CFSS agency provider must
600.29 request retroactive authorization from the lead agency no later than five working days after
600.30 providing the initial emergency service. The CFSS agency provider must be able to
600.31 substantiate the emergency through documentation such as reports, notes, and admission

601.1 or discharge histories. A lead agency must follow the authorization process in subdivision
601.2 5 after the lead agency receives the request for authorization from the agency provider;

601.3 (3) the lead agency authorizes a temporary increase to the amount of services authorized
601.4 in the agency or budget model to accommodate the participant's temporary higher need for
601.5 services. Authorization for a temporary level of CFSS services is limited to the time specified
601.6 by the commissioner, but shall not exceed 45 days. The level of services authorized under
601.7 this clause shall have no bearing on a future authorization;

601.8 (4) a participant's medical assistance eligibility has lapsed, is then retroactively reinstated,
601.9 and an authorization for CFSS services is completed based on the date of a current
601.10 assessment, eligibility, and request for authorization;

601.11 (5) a third-party payer for CFSS services has denied or adjusted a payment. Authorization
601.12 requests must be submitted by the provider within 20 working days of the notice of denial
601.13 or adjustment. A copy of the notice must be included with the request;

601.14 (6) the commissioner has determined that a lead agency or state human services agency
601.15 has made an error; or

601.16 (7) a participant enrolled in managed care experiences a temporary disenrollment from
601.17 a health plan, in which case the commissioner shall accept the current health plan
601.18 authorization for CFSS services for up to 60 days. The request must be received within the
601.19 first 30 days of the disenrollment. If the recipient's reenrollment in managed care is after
601.20 the 60 days and before 90 days, the provider shall request an additional 30-day extension
601.21 of the current health plan authorization, for a total limit of 90 days from the time of
601.22 disenrollment.

601.23 Sec. 12. Minnesota Statutes 2020, section 256B.85, subdivision 9, is amended to read:

601.24 Subd. 9. **Noncovered services.** (a) Services or supports that are not eligible for payment
601.25 under this section include those that:

601.26 (1) are not authorized by the certified assessor or included in the CFSS service delivery
601.27 plan;

601.28 (2) are provided prior to the authorization of services and the approval of the CFSS
601.29 service delivery plan;

601.30 (3) are duplicative of other paid services in the CFSS service delivery plan;

602.1 (4) supplant natural unpaid supports that appropriately meet a need in the CFSS service
602.2 delivery plan, are provided voluntarily to the participant, and are selected by the participant
602.3 in lieu of other services and supports;

602.4 (5) are not effective means to meet the participant's needs; and

602.5 (6) are available through other funding sources, including~~,~~ but not limited to~~,~~ funding
602.6 through title IV-E of the Social Security Act.

602.7 (b) Additional services, goods, or supports that are not covered include:

602.8 (1) those that are not for the direct benefit of the participant, except that services for
602.9 caregivers such as training to improve the ability to provide CFSS are considered to directly
602.10 benefit the participant if chosen by the participant and approved in the support plan;

602.11 (2) any fees incurred by the participant, such as Minnesota health care programs fees
602.12 and co-pays, legal fees, or costs related to advocate agencies;

602.13 (3) insurance, except for insurance costs related to employee coverage;

602.14 (4) room and board costs for the participant;

602.15 (5) services, supports, or goods that are not related to the assessed needs;

602.16 (6) special education and related services provided under the Individuals with Disabilities
602.17 Education Act and vocational rehabilitation services provided under the Rehabilitation Act
602.18 of 1973;

602.19 (7) assistive technology devices and assistive technology services other than those for
602.20 back-up systems or mechanisms to ensure continuity of service and supports listed in
602.21 subdivision 7;

602.22 (8) medical supplies and equipment covered under medical assistance;

602.23 (9) environmental modifications, except as specified in subdivision 7;

602.24 (10) expenses for travel, lodging, or meals related to training the participant or the
602.25 participant's representative or legal representative;

602.26 (11) experimental treatments;

602.27 (12) any service or good covered by other state plan services, including prescription and
602.28 over-the-counter medications, compounds, and solutions and related fees, including premiums
602.29 and co-payments;

602.30 (13) membership dues or costs, except when the service is necessary and appropriate to
602.31 treat a health condition or to improve or maintain the adult participant's health condition.

603.1 The condition must be identified in the participant's CFSS service delivery plan and
603.2 monitored by a Minnesota health care program enrolled physician, advanced practice
603.3 registered nurse, or physician's assistant;

603.4 (14) vacation expenses other than the cost of direct services;

603.5 (15) vehicle maintenance or modifications not related to the disability, health condition,
603.6 or physical need;

603.7 (16) tickets and related costs to attend sporting or other recreational or entertainment
603.8 events;

603.9 (17) services provided and billed by a provider who is not an enrolled CFSS provider;

603.10 (18) CFSS provided by a participant's representative or paid legal guardian;

603.11 (19) services that are used solely as a child care or babysitting service;

603.12 (20) services that are the responsibility or in the daily rate of a residential or program
603.13 license holder under the terms of a service agreement and administrative rules;

603.14 (21) sterile procedures;

603.15 (22) giving of injections into veins, muscles, or skin;

603.16 (23) homemaker services that are not an integral part of the assessed CFSS service;

603.17 (24) home maintenance or chore services;

603.18 (25) home care services, including hospice services if elected by the participant, covered
603.19 by Medicare or any other insurance held by the participant;

603.20 (26) services to other members of the participant's household;

603.21 (27) services not specified as covered under medical assistance as CFSS;

603.22 (28) application of restraints or implementation of deprivation procedures;

603.23 (29) assessments by CFSS provider organizations or by independently enrolled registered
603.24 nurses;

603.25 (30) services provided in lieu of legally required staffing in a residential or child care
603.26 setting; ~~and~~

603.27 (31) services provided by ~~the residential or program~~ a foster care license holder ~~in a~~
603.28 ~~residence for more than four participants.~~ except when the home of the person receiving
603.29 services is the licensed foster care provider's primary residence;

604.1 (32) services that are the responsibility of the foster care provider under the terms of the
604.2 foster care placement agreement, assessment under sections 256N.24 and 260C.4411, and
604.3 administrative rules under sections 256N.24 and 260C.4411;

604.4 (33) services in a setting that has a licensed capacity greater than six, unless all conditions
604.5 for a variance under section 245A.04, subdivision 9a, are satisfied for a sibling, as defined
604.6 in section 260C.007, subdivision 32;

604.7 (34) services from a provider who owns or otherwise controls the living arrangement,
604.8 except when the provider of services is related by blood, marriage, or adoption or when the
604.9 provider is a licensed foster care provider who is not prohibited from providing services
604.10 under clauses (31) to (33);

604.11 (35) instrumental activities of daily living for children younger than 18 years of age,
604.12 except when immediate attention is needed for health or hygiene reasons integral to an
604.13 assessed need for assistance with activities of daily living, health-related procedures, and
604.14 tasks or behaviors; or

604.15 (36) services provided to a resident of a nursing facility, hospital, intermediate care
604.16 facility, or health care facility licensed by the commissioner of health.

604.17 Sec. 13. Minnesota Statutes 2020, section 256B.85, subdivision 10, is amended to read:

604.18 Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a)
604.19 Agency-providers identified in subdivision 11 and FMS providers identified in subdivision
604.20 13a shall:

604.21 (1) enroll as a medical assistance Minnesota health care programs provider and meet all
604.22 applicable provider standards and requirements including completion of required provider
604.23 training as determined by the commissioner;

604.24 (2) demonstrate compliance with federal and state laws and policies for CFSS as
604.25 determined by the commissioner;

604.26 (3) comply with background study requirements under chapter 245C and maintain
604.27 documentation of background study requests and results;

604.28 (4) verify and maintain records of all services and expenditures by the participant,
604.29 including hours worked by support workers;

604.30 (5) not engage in any agency-initiated direct contact or marketing in person, by telephone,
604.31 or other electronic means to potential participants, guardians, family members, or participants'
604.32 representatives;

605.1 (6) directly provide services and not use a subcontractor or reporting agent;

605.2 (7) meet the financial requirements established by the commissioner for financial
605.3 solvency;

605.4 (8) have never had a lead agency contract or provider agreement discontinued due to
605.5 fraud, or have never had an owner, board member, or manager fail a state or FBI-based
605.6 criminal background check while enrolled or seeking enrollment as a Minnesota health care
605.7 programs provider; and

605.8 (9) have an office located in Minnesota.

605.9 (b) In conducting general duties, agency-providers and FMS providers shall:

605.10 (1) pay support workers based upon actual hours of services provided;

605.11 (2) pay for worker training and development services based upon actual hours of services
605.12 provided or the unit cost of the training session purchased;

605.13 (3) withhold and pay all applicable federal and state payroll taxes;

605.14 (4) make arrangements and pay unemployment insurance, taxes, workers' compensation,
605.15 liability insurance, and other benefits, if any;

605.16 (5) enter into a written agreement with the participant, participant's representative, or
605.17 legal representative that assigns roles and responsibilities to be performed before services,
605.18 supports, or goods are provided and that meets the requirements of subdivisions 20a, 20b,
605.19 and 20c for agency-providers;

605.20 (6) report maltreatment as required under section 626.557 and chapter 260E;

605.21 (7) comply with the labor market reporting requirements described in section 256B.4912,
605.22 subdivision 1a;

605.23 (8) comply with any data requests from the department consistent with the Minnesota
605.24 Government Data Practices Act under chapter 13; ~~and~~

605.25 (9) maintain documentation for the requirements under subdivision 16, paragraph (e),
605.26 clause (2), to qualify for an enhanced rate under this section~~.~~; and

605.27 (10) request reassessments 60 days before the end of the current authorization for CFSS
605.28 on forms provided by the commissioner.

606.1 Sec. 14. Minnesota Statutes 2020, section 256B.85, subdivision 11, is amended to read:

606.2 Subd. 11. **Agency-provider model.** (a) The agency-provider model includes services
606.3 provided by support workers and staff providing worker training and development services
606.4 who are employed by an agency-provider that meets the criteria established by the
606.5 commissioner, including required training.

606.6 (b) The agency-provider shall allow the participant to have a significant role in the
606.7 selection and dismissal of the support workers for the delivery of the services and supports
606.8 specified in the participant's CFSS service delivery plan. The agency must make a reasonable
606.9 effort to fulfill the participant's request for the participant's preferred worker.

606.10 (c) A participant may use authorized units of CFSS services as needed within a service
606.11 agreement that is not greater than 12 months. Using authorized units in a flexible manner
606.12 in either the agency-provider model or the budget model does not increase the total amount
606.13 of services and supports authorized for a participant or included in the participant's CFSS
606.14 service delivery plan.

606.15 (d) A participant may share CFSS services. Two or three CFSS participants may share
606.16 services at the same time provided by the same support worker.

606.17 (e) The agency-provider must use a minimum of 72.5 percent of the revenue generated
606.18 by the medical assistance payment for CFSS for support worker wages and benefits, except
606.19 all of the revenue generated by a medical assistance rate increase due to a collective
606.20 bargaining agreement under section 179A.54 must be used for support worker wages and
606.21 benefits. The agency-provider must document how this requirement is being met. The
606.22 revenue generated by the worker training and development services and the reasonable costs
606.23 associated with the worker training and development services must not be used in making
606.24 this calculation.

606.25 (f) The agency-provider model must be used by ~~individuals~~ participants who are restricted
606.26 by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to
606.27 9505.2245.

606.28 (g) Participants purchasing goods under this model, along with support worker services,
606.29 must:

606.30 (1) specify the goods in the CFSS service delivery plan and detailed budget for
606.31 expenditures that must be approved by the consultation services provider, case manager, or
606.32 care coordinator; and

606.33 (2) use the FMS provider for the billing and payment of such goods.

Sec. 15. Minnesota Statutes 2020, section 256B.85, subdivision 11b, is amended to read:

Subd. 11b. **Agency-provider model; support worker competency.** (a) The agency-provider must ensure that support workers are competent to meet the participant's assessed needs, goals, and additional requirements as written in the CFSS service delivery plan. ~~Within 30 days of any support worker beginning to provide services for a participant,~~ The agency-provider must evaluate the competency of the worker through direct observation of the support worker's performance of the job functions in a setting where the participant is using CFSS~~.~~ within 30 days of:

(1) any support worker beginning to provide services for a participant; or

(2) any support worker beginning to provide shared services.

(b) The agency-provider must verify and maintain evidence of support worker competency, including documentation of the support worker's:

(1) education and experience relevant to the job responsibilities assigned to the support worker and the needs of the participant;

(2) relevant training received from sources other than the agency-provider;

(3) orientation and instruction to implement services and supports to participant needs and preferences as identified in the CFSS service delivery plan; ~~and~~

(4) orientation and instruction delivered by an individual competent to perform, teach, or assign the health-related tasks for tracheostomy suctioning and services to participants on ventilator support, including equipment operation and maintenance; and

~~(4)~~ (5) periodic performance reviews completed by the agency-provider at least annually, including any evaluations required under subdivision 11a, paragraph (a). If a support worker is a minor, all evaluations of worker competency must be completed in person and in a setting where the participant is using CFSS.

(c) The agency-provider must develop a worker training and development plan with the participant to ensure support worker competency. The worker training and development plan must be updated when:

(1) the support worker begins providing services;

(2) the support worker begins providing shared services;

~~(2)~~ (3) there is any change in condition or a modification to the CFSS service delivery plan; or

608.1 ~~(3)~~ (4) a performance review indicates that additional training is needed.

608.2 Sec. 16. Minnesota Statutes 2020, section 256B.85, subdivision 12, is amended to read:

608.3 Subd. 12. **Requirements for enrollment of CFSS agency-providers.** (a) All CFSS
608.4 agency-providers must provide, at the time of enrollment, reenrollment, and revalidation
608.5 as a CFSS agency-provider in a format determined by the commissioner, information and
608.6 documentation that includes~~,~~ but is not limited to~~,~~ the following:

608.7 (1) the CFSS agency-provider's current contact information including address, telephone
608.8 number, and e-mail address;

608.9 (2) proof of surety bond coverage. Upon new enrollment, or if the agency-provider's
608.10 Medicaid revenue in the previous calendar year is less than or equal to $300,000, the
608.11 agency-provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid
608.12 revenue in the previous calendar year is greater than $300,000, the agency-provider must
608.13 purchase a surety bond of $100,000. The surety bond must be in a form approved by the
608.14 commissioner, must be renewed annually, and must allow for recovery of costs and fees in
608.15 pursuing a claim on the bond;

608.16 (3) proof of fidelity bond coverage in the amount of $20,000 per provider location;

608.17 (4) proof of workers' compensation insurance coverage;

608.18 (5) proof of liability insurance;

608.19 (6) a ~~description~~ copy of the CFSS agency-provider's ~~organization~~ organizational chart
608.20 identifying the names and roles of all owners, managing employees, staff, board of directors,
608.21 and ~~the~~ additional documentation reporting any affiliations of the directors and owners to
608.22 other service providers;

608.23 (7) ~~a copy of~~ proof that the CFSS ~~agency-provider's~~ agency-provider has written policies
608.24 and procedures including: hiring of employees; training requirements; service delivery; and
608.25 employee and consumer safety, including the process for notification and resolution of
608.26 participant grievances, incident response, identification and prevention of communicable
608.27 diseases, and employee misconduct;

608.28 (8) ~~copies of all other forms~~ proof that the CFSS agency-provider ~~uses in the course of~~
608.29 ~~daily business including, but not limited to~~ has all of the following forms and documents:

608.30 (i) a copy of the CFSS agency-provider's time sheet; and

608.31 (ii) a copy of the participant's individual CFSS service delivery plan;

(9) a list of all training and classes that the CFSS agency-provider requires of its staff providing CFSS services;

(10) documentation that the CFSS agency-provider and staff have successfully completed all the training required by this section;

(11) documentation of the agency-provider's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that are used or could be used for providing home care services;

(13) documentation that the agency-provider will use at least the following percentages of revenue generated from the medical assistance rate paid for CFSS services for CFSS support worker wages and benefits: 72.5 percent of revenue from CFSS providers, except 100 percent of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services shall not be used in making this calculation; and

(14) documentation that the agency-provider does not burden participants' free exercise of their right to choose service providers by requiring CFSS support workers to sign an agreement not to work with any particular CFSS participant or for another CFSS agency-provider after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) CFSS agency-providers shall provide to the commissioner the information specified in paragraph (a).

(c) All CFSS agency-providers shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a CFSS agency-provider do not need to repeat the required training if they are hired by another agency~~, if~~ and they have completed the training within the past three years. CFSS agency-provider billing staff shall complete training about CFSS program financial management. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency.

~~(d) The commissioner shall send annual review notifications to agency-providers 30 days prior to renewal. The notification must:~~

~~(1) list the materials and information the agency-provider is required to submit;~~

~~(2) provide instructions on submitting information to the commissioner; and~~

~~(3) provide a due date by which the commissioner must receive the requested information. Agency-providers shall submit all required documentation for annual review within 30 days of notification from the commissioner. If an agency-provider fails to submit all the required documentation, the commissioner may take action under subdivision 23a.~~

(d) Agency-providers shall submit all required documentation in this section within 30 days of notification from the commissioner. If an agency-provider fails to submit all the required documentation, the commissioner may take action under subdivision 23a.

Sec. 17. Minnesota Statutes 2020, section 256B.85, subdivision 12b, is amended to read:

Subd. 12b. **CFSS agency-provider requirements; notice regarding termination of services.** (a) An agency-provider must provide written notice when it intends to terminate services with a participant at least ~~ten~~ 30 calendar days before the proposed service termination is to become effective, except in cases where:

(1) the participant engages in conduct that significantly alters the terms of the CFSS service delivery plan with the agency-provider;

(2) the participant or other persons at the setting where services are being provided engage in conduct that creates an imminent risk of harm to the support worker or other agency-provider staff; or

(3) an emergency or a significant change in the participant's condition occurs within a 24-hour period that results in the participant's service needs exceeding the participant's identified needs in the current CFSS service delivery plan so that the agency-provider cannot safely meet the participant's needs.

(b) When a participant initiates a request to terminate CFSS services with the agency-provider, the agency-provider must give the participant a written ~~acknowledgement~~ acknowledgment of the participant's service termination request that includes the date the request was received by the agency-provider and the requested date of termination.

(c) The agency-provider must participate in a coordinated transfer of the participant to a new agency-provider to ensure continuity of care.

611.1 Sec. 18. Minnesota Statutes 2020, section 256B.85, subdivision 13, is amended to read:

611.2 Subd. 13. **Budget model.** (a) Under the budget model participants exercise responsibility
611.3 and control over the services and supports described and budgeted within the CFSS service
611.4 delivery plan. Participants must use services specified in subdivision 13a provided by an
611.5 FMS provider. Under this model, participants may use their approved service budget
611.6 allocation to:

611.7 (1) directly employ support workers, and pay wages, federal and state payroll taxes, and
611.8 premiums for workers' compensation, liability, and health insurance coverage; and

611.9 (2) obtain supports and goods as defined in subdivision 7.

611.10 (b) Participants who are unable to fulfill any of the functions listed in paragraph (a) may
611.11 authorize a legal representative or participant's representative to do so on their behalf.

611.12 (c) If two or more participants using the budget model live in the same household and
611.13 have the same worker, the participants must use the same FMS provider.

611.14 (d) If the FMS provider advises that there is a joint employer in the budget model, all
611.15 participants associated with that joint employer must use the same FMS provider.

611.16 ~~(c)~~ (e) The commissioner shall disenroll or exclude participants from the budget model
611.17 and transfer them to the agency-provider model under, but not limited to, the following
611.18 circumstances:

611.19 (1) when a participant has been restricted by the Minnesota restricted recipient program,
611.20 in which case the participant may be excluded for a specified time period under Minnesota
611.21 Rules, parts 9505.2160 to 9505.2245;

611.22 (2) when a participant exits the budget model during the participant's service plan year.
611.23 Upon transfer, the participant shall not access the budget model for the remainder of that
611.24 service plan year; or

611.25 (3) when the department determines that the participant or participant's representative
611.26 or legal representative is unable to fulfill the responsibilities under the budget model, as
611.27 specified in subdivision 14.

611.28 ~~(d)~~ (f) A participant may appeal in writing to the department under section 256.045,
611.29 subdivision 3, to contest the department's decision under paragraph ~~(c)~~ (e), clause (3), to
611.30 disenroll or exclude the participant from the budget model.

612.1 Sec. 19. Minnesota Statutes 2020, section 256B.85, subdivision 13a, is amended to read:

612.2 Subd. 13a. **Financial management services.** (a) Services provided by an FMS provider
612.3 include but are not limited to: filing and payment of federal and state payroll taxes on behalf
612.4 of the participant; initiating and complying with background study requirements under
612.5 chapter 245C and maintaining documentation of background study requests and results;
612.6 billing for approved CFSS services with authorized funds; monitoring expenditures;
612.7 accounting for and disbursing CFSS funds; providing assistance in obtaining and filing for
612.8 liability, workers' compensation, and unemployment coverage; and providing participant
612.9 instruction and technical assistance to the participant in fulfilling employer-related
612.10 requirements in accordance with section 3504 of the Internal Revenue Code and related
612.11 regulations and interpretations, including Code of Federal Regulations, title 26, section
612.12 31.3504-1.

612.13 (b) Agency-provider services shall not be provided by the FMS provider.

612.14 (c) The FMS provider shall provide service functions as determined by the commissioner
612.15 for budget model participants that include but are not limited to:

612.16 (1) assistance with the development of the detailed budget for expenditures portion of
612.17 the CFSS service delivery plan as requested by the consultation services provider or
612.18 participant;

612.19 (2) data recording and reporting of participant spending;

612.20 (3) other duties established by the department, including with respect to providing
612.21 assistance to the participant, participant's representative, or legal representative in performing
612.22 employer responsibilities regarding support workers. The support worker shall not be
612.23 considered the employee of the FMS provider; and

612.24 (4) billing, payment, and accounting of approved expenditures for goods.

612.25 (d) The FMS provider shall obtain an assurance statement from the participant employer
612.26 agreeing to follow state and federal regulations and CFSS policies regarding employment
612.27 of support workers.

612.28 (e) The FMS provider shall:

612.29 (1) not limit or restrict the participant's choice of service or support providers or service
612.30 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.

614.1 Sec. 20. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision
614.2 to read:

614.3 Subd. 14a. **Participant's representative responsibilities.** (a) If a participant is unable
614.4 to direct the participant's own care, the participant must use a participant's representative
614.5 to receive CFSS services. A participant's representative is required if:

614.6 (1) the person is under 18 years of age;

614.7 (2) the person has a court-appointed guardian; or

614.8 (3) an assessment according to section 256B.0659, subdivision 3a, determines that the
614.9 participant is in need of a participant's representative.

614.10 (b) A participant's representative must:

614.11 (1) be at least 18 years of age;

614.12 (2) actively participate in planning and directing CFSS services;

614.13 (3) have sufficient knowledge of the participant's circumstances to use CFSS services
614.14 consistent with the participant's health and safety needs identified in the participant's service
614.15 delivery plan;

614.16 (4) not have a financial interest in the provision of any services included in the
614.17 participant's CFSS service delivery plan; and

614.18 (5) be capable of providing the support necessary to assist the participant in the use of
614.19 CFSS services.

614.20 (c) A participant's representative must not be the:

614.21 (1) support worker;

614.22 (2) worker training and development service provider;

614.23 (3) agency-provider staff, unless related to the participant by blood, marriage, or adoption;

614.24 (4) consultation service provider, unless related to the participant by blood, marriage,
614.25 or adoption;

614.26 (5) FMS staff, unless related to the participant by blood, marriage, or adoption;

614.27 (6) FMS owner or manager; or

614.28 (7) lead agency staff acting as part of employment.

615.1 (d) A licensed family foster parent who lives with the participant may be the participant's
615.2 representative if the family foster parent meets the other participant's representative
615.3 requirements.

615.4 (e) There may be two persons designated as the participant's representative, including
615.5 instances of divided households and court-ordered custodies. Each person named as the
615.6 participant's representative must meet the program criteria and responsibilities.

615.7 (f) The participant or the participant's legal representative shall appoint a participant's
615.8 representative. The participant's representative must be identified at the time of assessment
615.9 and listed on the participant's service agreement and CFSS service delivery plan.

615.10 (g) A participant's representative must enter into a written agreement with an
615.11 agency-provider or FMS on a form determined by the commissioner and maintained in the
615.12 participant's file, to:

615.13 (1) be available while care is provided using a method agreed upon by the participant
615.14 or the participant's legal representative and documented in the participant's service delivery
615.15 plan;

615.16 (2) monitor CFSS services to ensure the participant's service delivery plan is followed;

615.17 (3) review and sign support worker time sheets after services are provided to verify the
615.18 provision of services;

615.19 (4) review and sign vendor paperwork to verify receipt of goods; and

615.20 (5) in the budget model, review and sign documentation to verify worker training and
615.21 development expenditures.

615.22 (h) A participant's representative may delegate responsibility to another adult who is not
615.23 the support worker during a temporary absence of at least 24 hours but not more than six
615.24 months. To delegate responsibility, the participant's representative must:

615.25 (1) ensure that the delegate serving as the participant's representative satisfies the
615.26 requirements of the participant's representative;

615.27 (2) ensure that the delegate performs the functions of the participant's representative;

615.28 (3) communicate to the CFSS agency-provider or FMS provider about the need for a
615.29 delegate by updating the written agreement to include the name of the delegate and the
615.30 delegate's contact information; and

615.31 (4) ensure that the delegate protects the participant's privacy according to federal and
615.32 state data privacy laws.

616.1 (i) The designation of a participant's representative remains in place until:

616.2 (1) the participant revokes the designation;

616.3 (2) the participant's representative withdraws the designation or becomes unable to fulfill
616.4 the duties;

616.5 (3) the legal authority to act as a participant's representative changes; or

616.6 (4) the participant's representative is disqualified.

616.7 (j) A lead agency may disqualify a participant's representative who engages in conduct
616.8 that creates an imminent risk of harm to the participant, the support workers, or other staff.
616.9 A participant's representative who fails to provide support required by the participant must
616.10 be referred to the common entry point.

616.11 Sec. 21. Minnesota Statutes 2020, section 256B.85, subdivision 15, is amended to read:

616.12 Subd. 15. **Documentation of support services provided; time sheets.** (a) CFSS services
616.13 provided to a participant by a support worker employed by either an agency-provider or the
616.14 participant employer must be documented daily by each support worker, on a time sheet.
616.15 Time sheets may be created, submitted, and maintained electronically. Time sheets must
616.16 be submitted by the support worker at least once per month to the:

616.17 (1) agency-provider when the participant is using the agency-provider model. The
616.18 agency-provider must maintain a record of the time sheet and provide a copy of the time
616.19 sheet to the participant; or

616.20 (2) participant and the participant's FMS provider when the participant is using the
616.21 budget model. The participant and the FMS provider must maintain a record of the time
616.22 sheet.

616.23 (b) The documentation on the time sheet must correspond to the participant's assessed
616.24 needs within the scope of CFSS covered services. The accuracy of the time sheets must be
616.25 verified by the:

616.26 (1) agency-provider when the participant is using the agency-provider model; or

616.27 (2) participant employer and the participant's FMS provider when the participant is using
616.28 the budget model.

616.29 (c) The time sheet must document the time the support worker provides services to the
616.30 participant. The following elements must be included in the time sheet:

616.31 (1) the support worker's full name and individual provider number;

(2) the agency-provider's name and telephone numbers, when responsible for the CFSS service delivery plan;

(3) the participant's full name;

(4) the dates within the pay period established by the agency-provider or FMS provider, including month, day, and year, and arrival and departure times with a.m. or p.m. notations for days worked within the established pay period;

(5) the covered services provided to the participant on each date of service;

(6) ~~a~~ the signature ~~line for~~ of the participant or the participant's representative and a statement that the participant's or participant's representative's signature is verification of the time sheet's accuracy;

(7) the ~~personal~~ signature of the support worker;

(8) any shared care provided, if applicable;

(9) a statement that it is a federal crime to provide false information on CFSS billings for medical assistance payments; and

(10) dates and location of participant stays in a hospital, care facility, or incarceration occurring within the established pay period.

Sec. 22. Minnesota Statutes 2020, section 256B.85, subdivision 17a, is amended to read:

Subd. 17a. **Consultation services provider qualifications and requirements.** Consultation services providers must meet the following qualifications and requirements:

(1) meet the requirements under subdivision 10, paragraph (a), excluding clauses (4) and (5);

(2) are under contract with the department;

(3) are not the FMS provider, the lead agency, or the CFSS or home and community-based services waiver vendor or agency-provider to the participant;

(4) meet the service standards as established by the commissioner;

(5) have proof of surety bond coverage. Upon new enrollment, or if the consultation service provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the consultation service provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the consultation service provider must purchase a surety bond of $100,000. The surety bond

618.1 must be in a form approved by the commissioner, must be renewed annually, and must
618.2 allow for recovery of costs and fees in pursuing a claim on the bond;

618.3 ~~(5)~~ (6) employ lead professional staff with a minimum of ~~three~~ two years of experience
618.4 in providing services such as support planning, support broker, case management or care
618.5 coordination, or consultation services and consumer education to participants using a
618.6 self-directed program using FMS under medical assistance;

618.7 (7) report maltreatment as required under chapter 260E and section 626.557;

618.8 ~~(6)~~ (8) comply with medical assistance provider requirements;

618.9 ~~(7)~~ (9) understand the CFSS program and its policies;

618.10 ~~(8)~~ (10) are knowledgeable about self-directed principles and the application of the
618.11 person-centered planning process;

618.12 ~~(9)~~ (11) have general knowledge of the FMS provider duties and the vendor
618.13 fiscal/employer agent model, including all applicable federal, state, and local laws and
618.14 regulations regarding tax, labor, employment, and liability and workers' compensation
618.15 coverage for household workers; and

618.16 ~~(10)~~ (12) have all employees, including lead professional staff, staff in management and
618.17 supervisory positions, and owners of the agency who are active in the day-to-day management
618.18 and operations of the agency, complete training as specified in the contract with the
618.19 department.

618.20 Sec. 23. Minnesota Statutes 2020, section 256B.85, subdivision 18a, is amended to read:

618.21 Subd. 18a. **Worker training and development services.** (a) The commissioner shall
618.22 develop the scope of tasks and functions, service standards, and service limits for worker
618.23 training and development services.

618.24 (b) Worker training and development costs are in addition to the participant's assessed
618.25 service units or service budget. Services provided according to this subdivision must:

618.26 (1) help support workers obtain and expand the skills and knowledge necessary to ensure
618.27 competency in providing quality services as needed and defined in the participant's CFSS
618.28 service delivery plan and as required under subdivisions 11b and 14;

618.29 (2) be provided or arranged for by the agency-provider under subdivision 11, or purchased
618.30 by the participant employer under the budget model as identified in subdivision 13; ~~and~~

(3) be delivered by an individual competent to perform, teach, or assign the tasks, including health-related tasks, identified in the plan through education, training, and work experience relevant to the person's assessed needs; and

~~(3)~~ (4) be described in the participant's CFSS service delivery plan and documented in the participant's file.

(c) Services covered under worker training and development shall include:

(1) support worker training on the participant's individual assessed needs and condition, provided individually or in a group setting by a skilled and knowledgeable trainer beyond any training the participant or participant's representative provides;

(2) tuition for professional classes and workshops for the participant's support workers that relate to the participant's assessed needs and condition;

(3) direct observation, monitoring, coaching, and documentation of support worker job skills and tasks, beyond any training the participant or participant's representative provides, including supervision of health-related tasks or behavioral supports that is conducted by an appropriate professional based on the participant's assessed needs. These services must be provided at the start of services or the start of a new support worker except as provided in paragraph (d) and must be specified in the participant's CFSS service delivery plan; and

(4) the activities to evaluate CFSS services and ensure support worker competency described in subdivisions 11a and 11b.

(d) The services in paragraph (c), clause (3), are not required to be provided for a new support worker providing services for a participant due to staffing failures, unless the support worker is expected to provide ongoing backup staffing coverage.

(e) Worker training and development services shall not include:

(1) general agency training, worker orientation, or training on CFSS self-directed models;

(2) payment for preparation or development time for the trainer or presenter;

(3) payment of the support worker's salary or compensation during the training;

(4) training or supervision provided by the participant, the participant's support worker, or the participant's informal supports, including the participant's representative; or

(5) services in excess of ~~96 units~~ the rate set by the commissioner per annual service agreement, unless approved by the department.

Sec. 24. Minnesota Statutes 2020, section 256B.85, subdivision 20b, is amended to read:

Subd. 20b. **Service-related rights under an agency-provider.** A participant receiving CFSS from an agency-provider has service-related rights to:

(1) participate in and approve the initial development and ongoing modification and evaluation of CFSS services provided to the participant;

(2) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(3) before services are initiated, be told the limits to the services available from the agency-provider, including the agency-provider's knowledge, skill, and ability to meet the participant's needs identified in the CFSS service delivery plan;

(4) a coordinated transfer of services when there will be a change in the agency-provider;

(5) before services are initiated, be told what the agency-provider charges for the services;

(6) before services are initiated, be told to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the participant may be responsible for paying;

(7) receive services from an individual who is competent and trained, who has professional certification or licensure, as required, and who meets additional qualifications identified in the participant's CFSS service delivery plan;

(8) have the participant's preferences for support workers identified and documented, and have those preferences met when possible; and

(9) before services are initiated, be told the choices that are available from the agency-provider for meeting the participant's assessed needs identified in the CFSS service delivery plan, including but not limited to which support worker staff will be providing services ~~and~~, the proposed frequency and schedule of visits, and any agreements for shared services.

Sec. 25. Minnesota Statutes 2020, section 256B.85, subdivision 23, is amended to read:

Subd. 23. **Commissioner's access.** (a) When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the agency-provider, consultation services provider, or FMS provider's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. ~~Denying the commissioner access to records is cause for immediate suspension of payment and terminating~~ If the ~~agency-provider's~~

~~enrollment or~~ agency-provider, FMS ~~provider's enrollment~~ provider, or consultation services provider denies the commissioner access to records, the provider's payment may be immediately suspended or the provider's enrollment may be terminated according to section 256B.064 ~~or terminating the consultation services provider contract~~.

(b) The commissioner has the authority to request proof of compliance with laws, rules, and policies from agency-providers, consultation services providers, FMS providers, and participants.

(c) When relevant to an investigation conducted by the commissioner, the commissioner must be given access to the business office, documents, and records of the agency-provider, consultation services provider, or FMS provider, including records maintained in electronic format; participants served by the program; and staff during regular business hours. The commissioner must be given access without prior notice and as often as the commissioner considers necessary if the commissioner is investigating an alleged violation of applicable laws or rules. The commissioner may request and shall receive assistance from lead agencies and other state, county, and municipal agencies and departments. The commissioner's access includes being allowed to photocopy, photograph, and make audio and video recordings at the commissioner's expense.

Sec. 26. Minnesota Statutes 2020, section 256B.85, subdivision 23a, is amended to read:

Subd. 23a. **Sanctions; information for participants upon termination of services.** (a) The commissioner may withhold payment from the provider or suspend or terminate the provider enrollment number if the provider fails to comply fully with applicable laws or rules. The provider has the right to appeal the decision of the commissioner under section 256B.064.

(b) Notwithstanding subdivision 13, paragraph (c), if a participant employer fails to comply fully with applicable laws or rules, the commissioner may disenroll the participant from the budget model. A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision to disenroll the participant from the budget model.

(c) Agency-providers of CFSS services or FMS providers must provide each participant with a copy of participant protections in subdivision 20c at least 30 days prior to terminating services to a participant, if the termination results from sanctions under this subdivision or section 256B.064, such as a payment withhold or a suspension or termination of the provider enrollment number. If a CFSS agency-provider ~~or~~, FMS provider, or consultation services provider determines it is unable to continue providing services to a participant because of

622.1 an action under this subdivision or section 256B.064, the agency-provider ~~or~~, FMS provider,
622.2 or consultation services provider must notify the participant, the participant's representative,
622.3 and the commissioner 30 days prior to terminating services to the participant, and must
622.4 assist the commissioner and lead agency in supporting the participant in transitioning to
622.5 another CFSS agency-provider ~~or~~, FMS provider, or consultation services provider of the
622.6 participant's choice.

622.7 (d) In the event the commissioner withholds payment from a CFSS agency-provider ~~or~~,
622.8 FMS provider, or consultation services provider, or suspends or terminates a provider
622.9 enrollment number of a CFSS agency-provider ~~or~~, FMS provider, or consultation services
622.10 provider under this subdivision or section 256B.064, the commissioner may inform the
622.11 Office of Ombudsman for Long-Term Care and the lead agencies for all participants with
622.12 active service agreements with the agency-provider ~~or~~, FMS provider, or consultation
622.13 services provider. At the commissioner's request, the lead agencies must contact participants
622.14 to ensure that the participants are continuing to receive needed care, and that the participants
622.15 have been given free choice of agency-provider ~~or~~, FMS provider, or consultation services
622.16 provider if they transfer to another CFSS agency-provider ~~or~~, FMS provider, or consultation
622.17 services provider. In addition, the commissioner or the commissioner's delegate may directly
622.18 notify participants who receive care from the agency-provider ~~or~~, FMS provider, or
622.19 consultation services provider that payments have been or will be withheld or that the
622.20 provider's participation in medical assistance has been or will be suspended or terminated,
622.21 if the commissioner determines that the notification is necessary to protect the welfare of
622.22 the participants.

622.23 **ARTICLE 16**

622.24 **MISCELLANEOUS**

622.25 Section 1. **[3.9215] OMBUDSPERSON FOR AMERICAN INDIAN FAMILIES.**

622.26 Subdivision 1. **Scope.** In recognition of the sovereign status of Indian Tribes and the
622.27 unique laws and standards involved in protecting Indian children, this section creates the
622.28 Office of the Ombudsperson for American Indian Families and gives the ombudsperson the
622.29 powers and duties necessary to effectively carry out the functions of the office.

622.30 Subd. 2. **Creation.** The ombudsperson shall operate independently from and in
622.31 collaboration with the Indian Affairs Council and the American Indian Child Welfare
622.32 Advisory Council under section 260.835.

623.1 Subd. 3. **Selection; qualifications.** The ombudsperson shall be selected by the American
623.2 Indian community-specific board established in section 3.9216. The ombudsperson serves
623.3 in the unclassified service at the pleasure of the community-specific board and may be
623.4 removed only for just cause. Each ombudsperson must be selected without regard to political
623.5 affiliation and shall be a person highly competent and qualified to analyze questions of law,
623.6 administration, and public policy regarding the protection and placement of children. In
623.7 addition, the ombudsperson must be experienced in working collaboratively with the
623.8 American Indian and Alaskan Native communities or nations and knowledgeable about the
623.9 needs of those communities, the Indian Child Welfare Act and Minnesota Indian Family
623.10 Preservation Act, and best practices regarding prevention, cultural resources, and historical
623.11 trauma. No individual may serve as the ombudsperson for American Indian families while
623.12 holding any other public office.

623.13 Subd. 4. **Appropriation.** Money appropriated for the ombudsperson for American Indian
623.14 families from the general fund or the special fund authorized by section 256.01, subdivision
623.15 2, paragraph (o), is under the control of the ombudsperson. The amount necessary for the
623.16 ombudsperson to carry out the duties in this section is annually appropriated from the general
623.17 fund to the ombudsperson. This appropriation is available until expended and is in addition
623.18 to the appropriation under section 257.0769, subdivision 1, paragraph (a).

623.19 Subd. 5. **Definitions.** (a) For the purposes of this section, the following terms have the
623.20 meanings given them.

623.21 (b) "Agency" means the local district courts or a designated county social service agency
623.22 as defined in section 256G.02, subdivision 7, engaged in providing child protection and
623.23 placement services for children. Agency also means any individual, service, organization,
623.24 or program providing child protection, placement, or adoption services in coordination with
623.25 or under contract with any other entity specified in this subdivision, including guardians ad
623.26 litem.

623.27 (c) "American Indian" refers to individuals who are members of federally recognized
623.28 Tribes, eligible for membership in a federally recognized Tribe, or children or grandchildren
623.29 of a member of a federally recognized Tribe. American Indian is a political status established
623.30 through treaty rights between the federal government and Tribes. Each Tribe has a unique
623.31 culture and practices specific to the Tribe.

623.32 (d) "Facility" means any entity required to be licensed under chapter 245A.

623.33 (e) "Indian custodian" has the meaning given in United States Code, title 25, section
623.34 1903.

624.1 Subd. 6. **Organization.** (a) The ombudsperson may select, appoint, and compensate
624.2 assistants and employees that the ombudsperson finds necessary to discharge responsibilities.
624.3 All employees, except the secretarial and clerical staff, serve at the pleasure of the
624.4 ombudsperson in the unclassified service. The ombudsperson and full-time staff are members
624.5 of the Minnesota State Retirement Association.

624.6 (b) The ombudsperson may delegate to staff members or members of the American
624.7 Indian Community-Specific Board under section 3.9216 any of the ombudsperson's authority
624.8 or duties except the duty of formally making recommendations to an administrative agency
624.9 or reports to the Office of the Governor or to the legislature.

624.10 Subd. 7. **Duties and powers.** (a) The ombudsperson has the duties listed in this paragraph.

624.11 (1) The ombudsperson shall monitor agency compliance with all laws governing child
624.12 protection and placement, public education, and housing issues related to child protection
624.13 that impact American Indian children and their families. In particular, the ombudsperson
624.14 shall monitor agency compliance with sections 260.751 to 260.835; section 260C.193,
624.15 subdivision 3; and section 260C.215.

624.16 (2) The ombudsperson shall work with local state courts to ensure that:

624.17 (i) court officials, public policy makers, and service providers are trained in cultural
624.18 competency. The ombudsperson shall document and monitor court activities to heighten
624.19 awareness of diverse belief systems and family relationships;

624.20 (ii) qualified expert witnesses from the appropriate American Indian community,
624.21 including Tribal advocates, are used as court advocates and are consulted in placement
624.22 decisions that involve American Indian children; and

624.23 (iii) guardians ad litem and other individuals from American Indian communities are
624.24 recruited, trained, and used in court proceedings to advocate on behalf of American Indian
624.25 children.

624.26 (3) The ombudsperson shall primarily work on behalf of American Indian children and
624.27 families, but shall also work on behalf of any Minnesota children and families as the
624.28 ombudsperson deems necessary and appropriate.

624.29 (b) The ombudsperson has the authority to investigate decisions, acts, and other matters
624.30 of an agency, program, or facility providing protection or placement services to American
624.31 Indian children. In carrying out this authority and the duties in paragraph (a), the
624.32 ombudsperson has the power to:

624.33 (1) prescribe the methods by which complaints are made, reviewed, and acted upon;

625.1 (2) determine the scope and manner of investigations;

625.2 (3) investigate, upon a complaint or upon personal initiative, any action of any agency;

625.3 (4) request and be given access to any information in the possession of any agency
625.4 deemed necessary for the discharge of responsibilities. The ombudsperson is authorized to
625.5 set reasonable deadlines within which an agency must respond to requests for information.
625.6 Data obtained from any agency under this clause retains the classification that the data has
625.7 under section 13.02 and the ombudsperson shall maintain and disseminate the data according
625.8 to chapter 13;

625.9 (5) examine the records and documents of an agency;

625.10 (6) enter and inspect, during normal business hours, premises within the control of an
625.11 agency; and

625.12 (7) subpoena any agency personnel to appear, testify, or produce documentation or other
625.13 evidence that the ombudsperson deems relevant to a particular matter under investigation,
625.14 and petition the appropriate state court to seek enforcement of the subpoena. Any witness
625.15 at a hearing or for an investigation has the same privileges of a witness in the courts or under
625.16 the laws of this state. The ombudsperson may compel individuals who are not agency
625.17 personnel to testify or produce evidence according to procedures developed by the advisory
625.18 board.

625.19 (c) The ombudsperson may apply for grants and accept gifts, donations, and
625.20 appropriations for training relating to the duties of the ombudsperson. Grants, gifts, donations,
625.21 and appropriations received by the ombudsperson shall be used for training. The
625.22 ombudsperson may seek and apply for grants to develop new programs and initiatives and
625.23 to continue existing programs and initiatives. These funds may not be used for operating
625.24 expenses for the Office of the Ombudsperson for American Indian Families.

625.25 Subd. 8. **Matters appropriate for review.** (a) In selecting matters for review, an
625.26 ombudsperson should give particular attention to actions of an agency, facility, or program
625.27 that:

625.28 (1) may be contrary to law or rule;

625.29 (2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an
625.30 agency, facility, or program;

625.31 (3) may result in abuse or neglect of a child;

626.1 (4) may disregard the rights of a child or another individual served by an agency or
626.2 facility; or

626.3 (5) may be unclear or inadequately explained, when reasons should have been revealed.

626.4 (b) The ombudsperson shall, in selecting matters for review, inform other interested
626.5 agencies in order to avoid duplicating other investigations or regulatory efforts, including
626.6 activities undertaken by a Tribal organization under the authority of sections 260.751 to
626.7 260.835.

626.8 Subd. 9. **Complaints.** The ombudsperson may receive a complaint from any source
626.9 concerning an action of an agency, facility, or program. After completing a review, the
626.10 ombudsperson shall inform the complainant, agency, facility, or program. Services to a
626.11 child shall not be unfavorably altered as a result of an investigation or complaint. An agency,
626.12 facility, or program shall not retaliate or take adverse action, as defined in section 260E.07,
626.13 against an individual who, in good faith, makes a complaint or assists in an investigation.

626.14 Subd. 10. **Recommendations to agency.** (a) If, after reviewing a complaint or conducting
626.15 an investigation and considering the response of an agency, facility, or program and any
626.16 other pertinent material, the ombudsperson determines that the complaint has merit or that
626.17 the investigation reveals a problem, the ombudsperson may recommend that the agency,
626.18 facility, or program:

626.19 (1) consider the matter further;

626.20 (2) modify or cancel its actions;

626.21 (3) alter a rule, order, or internal policy;

626.22 (4) explain more fully the action in question; or

626.23 (5) take other action as authorized under section 257.0762.

626.24 (b) At the ombudsperson's request, the agency, facility, or program shall, within a
626.25 reasonable time, inform the ombudsperson about the action taken on the recommendation
626.26 or the reasons for not complying with the recommendation.

626.27 (c) Data obtained from any agency under this section retains the classification that the
626.28 data has under section 13.02, and the ombudsperson shall maintain and disseminate the data
626.29 according to chapter 13.

626.30 Subd. 11. **Recommendations and public reports.** (a) The ombudsperson may send
626.31 conclusions and suggestions concerning any reviewed matter to the governor and shall
626.32 provide copies of all reports to the advisory board and to the groups specified in section

627.1 257.0768, subdivision 1. Before making public a conclusion or recommendation that
627.2 expressly or implicitly criticizes an agency, facility, program, or any person, the
627.3 ombudsperson shall inform the governor and the affected agency, facility, program, or
627.4 person concerning the conclusion or recommendation. When sending a conclusion or
627.5 recommendation to the governor that is adverse to an agency, facility, program, or any
627.6 person, the ombudsperson shall include any statement of reasonable length made by that
627.7 agency, facility, program, or person in defense or mitigation of the ombudsperson's
627.8 conclusion or recommendation.

627.9 (b) In addition to conclusions or recommendations that the ombudsperson makes to the
627.10 governor on an ad hoc basis, the ombudsperson shall, at the end of each year, report to the
627.11 governor concerning the exercise of the ombudsperson's functions during the preceding
627.12 year.

627.13 Subd. 12. **Civil actions.** The ombudsperson and designees are not civilly liable for any
627.14 action taken under this section if the action was taken in good faith, was within the scope
627.15 of the ombudsperson's authority, and did not constitute willful or reckless misconduct.

627.16 Subd. 13. **Use of funds.** Any funds received by the ombudsperson from any source may
627.17 be used to compensate members of the American Indian community-specific board for
627.18 reasonable and necessary expenses incurred in aiding and assisting the ombudsperson in
627.19 programs and initiatives.

627.20 Sec. 2. **[3.9216] AMERICAN INDIAN COMMUNITY-SPECIFIC BOARD.**

627.21 Subdivision 1. **Membership.** The board consists of five members who are members of
627.22 a federally recognized Tribe or members of the American Indian community. The chair of
627.23 the Indian Affairs Council shall appoint the members of the board. In making appointments,
627.24 the chair must consult with other members of the council.

627.25 Subd. 2. **Compensation.** Members do not receive compensation but are entitled to
627.26 receive reimbursement for reasonable and necessary expenses incurred doing board-related
627.27 work, including travel for meetings, trainings, and presentations. Board members may also
627.28 receive per diem payments in a manner and amount prescribed by the board.

627.29 Subd. 3. **Meetings.** The board shall meet regularly at the request of the appointing chair,
627.30 board chair, or ombudsperson. The board must meet at least quarterly. The appointing chair,
627.31 board chair, or ombudsperson may also call special or emergency meetings as necessary.

628.1 Subd. 4. **Removal and vacancy.** (a) A member may be removed by the appointing
628.2 authority at any time, either for cause, as described in paragraph (b), or after missing three
628.3 consecutive meetings, as described in paragraph (c).

628.4 (b) If a removal is for cause, the member must be given notice and an opportunity for a
628.5 hearing before removal.

628.6 (c) After a member misses two consecutive meetings, and before the next meeting, the
628.7 board chair shall notify the member in writing that the member may be removed if the
628.8 member misses the next meeting. If a member misses three consecutive meetings, the board
628.9 chair must notify the appointing authority.

628.10 (d) If there is a vacancy on the board, the appointing authority shall appoint a person to
628.11 fill the vacancy for the remainder of the unexpired term.

628.12 Subd. 5. **Duties.** (a) The board shall appoint the Ombudsperson for American Indian
628.13 Families and shall advise and assist the ombudsperson in various ways, including, but not
628.14 limited to:

628.15 (1) selecting matters for attention;

628.16 (2) developing policies, plans, and programs to carry out the ombudsperson's functions
628.17 and powers;

628.18 (3) attending policy meetings when requested by the ombudsperson;

628.19 (4) establishing protocols for working with American Indian communities;

628.20 (5) developing procedures for the ombudsperson's use of the subpoena power to compel
628.21 testimony and evidence from individuals who are not agency personnel; and

628.22 (6) making reports and recommendations for changes designed to improve standards of
628.23 competence, efficiency, justice, and protection of rights.

628.24 (b) The board shall not make individual case recommendations.

628.25 Subd. 6. **Grants, gifts, donations, and appropriations.** The board may apply for grants
628.26 for the purpose of training and educating the American Indian community on child protection
628.27 issues involving American Indian families. The board may also accept gifts, donations, and
628.28 appropriations for training and education. Grants, gifts, donations, and appropriations
628.29 received by the board shall be used for training and education purposes. The board may
628.30 seek and apply for grants to develop new programs and initiatives and to continue existing
628.31 programs and initiatives. These funds may also be used to reimburse board members for
628.32 reasonable and necessary expenses incurred in aiding and assisting the Office of the

629.1 Ombudsperson for American Indian Families in Office of the Ombudsperson for American
629.2 Indian Families programs and initiatives, but may not be used for operating expenses for
629.3 the Office of Ombudsperson for American Indian Families.

629.4 Subd. 7. **Terms and expiration.** The terms and expiration of board membership are
629.5 governed by section 15.0575.

629.6 Sec. 3. **[119B.195] RETAINING EARLY EDUCATORS THROUGH ATTAINING**
629.7 **INCENTIVES NOW (REETAIN) GRANT PROGRAM.**

629.8 Subdivision 1. **Establishment; purpose.** The retaining early educators through attaining
629.9 incentives now (REETAIN) grant program is established to provide competitive grants to
629.10 incentivize well-trained child care professionals to remain in the workforce. The overall
629.11 goal of the REETAIN grant program is to create more consistent care for children over time.

629.12 Subd. 2. **Administration.** The commissioner shall administer the REETAIN grant
629.13 program through a grant to a nonprofit with the demonstrated ability to manage benefit
629.14 programs for child care professionals. Up to ten percent of grant money may be used for
629.15 administration of the grant program.

629.16 Subd. 3. **Application.** Applicants must apply for the REETAIN grant program using
629.17 the forms and according to timelines established by the commissioner.

629.18 Subd. 4. **Eligibility.** (a) To be eligible for a grant, an applicant must:

629.19 (1) be licensed to provide child care or work for a licensed child care program;

629.20 (2) work directly with children at least 30 hours per week;

629.21 (3) have worked in the applicant's current position for at least 12 months;

629.22 (4) agree to work in the early childhood care and education field for at least 12 months
629.23 upon receiving a grant under this section;

629.24 (5) have a career lattice step of five or higher;

629.25 (6) have a current membership with the Minnesota quality improvement and registry
629.26 tool;

629.27 (7) not be a current teacher education and compensation helps scholarship recipient; and

629.28 (8) meet any other requirements determined by the commissioner.

629.29 (b) Grant recipients must sign a contract agreeing to remain in the early childhood care
629.30 and education field for 12 months.

630.1 Subd. 5. **Grant awards.** Grant awards must be made annually and may be made up to
630.2 an amount per recipient determined by the commissioner. Grant recipients may use grant
630.3 money for program supplies, training, or personal expenses.

630.4 Subd. 6. **Report.** By January 1 each year, the commissioner must report to the legislative
630.5 committees with jurisdiction over child care about the number of grants awarded to recipients
630.6 and outcomes of the grant program since the last report.

630.7 Sec. 4. Minnesota Statutes 2020, section 136A.128, subdivision 2, is amended to read:

630.8 Subd. 2. **Program components.** (a) The nonprofit organization must use the grant for:

630.9 (1) tuition scholarships up to ~~$5,000~~ $10,000 per year for courses leading to the nationally
630.10 recognized child development associate credential or college-level courses leading to an
630.11 associate's degree or bachelor's degree in early childhood development and school-age care;
630.12 and

630.13 (2) education incentives of a minimum of ~~$100~~ $250 to participants in the tuition
630.14 scholarship program if they complete a year of working in the early care and education
630.15 field.

630.16 (b) Applicants for the scholarship must be employed by a licensed early childhood or
630.17 child care program and working directly with children, a licensed family child care provider,
630.18 employed by a public prekindergarten program, or an employee in a school-age program
630.19 exempt from licensing under section 245A.03, subdivision 2, paragraph (a), clause (12).
630.20 Lower wage earners must be given priority in awarding the tuition scholarships. Scholarship
630.21 recipients must contribute at least ten percent of the total scholarship and must be sponsored
630.22 by their employers, who must also contribute ~~ten~~ at least five percent of the total scholarship.
630.23 Scholarship recipients who are self-employed must contribute 20 percent of the total
630.24 scholarship.

630.25 Sec. 5. Minnesota Statutes 2020, section 136A.128, subdivision 4, is amended to read:

630.26 Subd. 4. **Administration.** A nonprofit organization that receives a grant under this
630.27 section may use ~~five~~ ten percent of the grant amount to administer the program.

630.28 Sec. 6. Minnesota Statutes 2020, section 256.041, is amended to read:

630.29 **256.041 CULTURAL AND ETHNIC COMMUNITIES LEADERSHIP COUNCIL.**

630.30 Subdivision 1. **Establishment; purpose.** (a) There is hereby established the Cultural
630.31 and Ethnic Communities Leadership Council for the Department of Human Services. The

631.1 purpose of the council is to advise the commissioner of human services on ~~reducing~~
631.2 implementing strategies to reduce inequities and disparities that particularly affect racial
631.3 and ethnic groups in Minnesota.

631.4 (b) This council is comprised of racially and ethnically diverse community leaders
631.5 including American Indians who are residents of Minnesota facing the compounded
631.6 challenges of systemic inequities. Members include people who are refugees, immigrants,
631.7 and LGBTQ+; people who have disabilities; and people who live in rural Minnesota.

631.8 Subd. 2. **Members.** (a) The council must consist of:

631.9 (1) the chairs and ranking minority members of the committees in the house of
631.10 representatives and the senate with jurisdiction over human services; and

631.11 (2) no fewer than 15 and no more than 25 members appointed by and serving at the
631.12 pleasure of the commissioner of human services, in consultation with county, tribal, cultural,
631.13 and ethnic communities; diverse program participants; ~~and~~ parent representatives from these
631.14 communities; and cultural and ethnic communities leadership council members.

631.15 (b) In making appointments under this section, the commissioner shall give priority
631.16 consideration to public members of the legislative councils of color established under ~~chapter~~
631.17 ~~3~~ section 15.0145.

631.18 (c) Members must be appointed to allow for representation of the following groups:

631.19 (1) racial and ethnic minority groups;

631.20 (2) the American Indian community, which must be represented by two members;

631.21 (3) culturally and linguistically specific advocacy groups and service providers;

631.22 (4) human services program participants;

631.23 (5) public and private institutions;

631.24 (6) parents of human services program participants;

631.25 (7) members of the faith community;

631.26 (8) Department of Human Services employees; and

631.27 (9) any other group the commissioner deems appropriate to facilitate the goals and duties
631.28 of the council.

631.29 Subd. 3. **Guidelines.** The commissioner shall direct the development of guidelines
631.30 defining the membership of the council; setting out definitions; and developing duties of

the commissioner, the council, and council members regarding racial and ethnic disparities reduction. The guidelines must be developed in consultation with:

(1) the chairs of relevant committees; and

(2) county, tribal, and cultural communities and program participants from these communities.

Subd. 4. **Chair.** The commissioner shall accept recommendations from the council to appoint a chair or chairs.

~~Subd. 5.~~ ~~**Terms for first appointees.**~~ ~~The initial members appointed shall serve until January 15, 2016.~~

Subd. 6. **Terms.** A term shall be for two years and appointees may be reappointed to serve two additional terms. The commissioner shall make appointments to replace members vacating their positions ~~by January 15 of each year~~ in a timely manner, no more than three months after the council reviews panel recommendations.

Subd. 7. **Duties of commissioner.** (a) The commissioner of human services or the commissioner's designee shall:

(1) maintain and actively engage with the council established in this section;

(2) supervise and coordinate policies for persons from racial, ethnic, cultural, linguistic, and tribal communities who experience disparities in access and outcomes;

(3) identify human services rules or statutes affecting persons from racial, ethnic, cultural, linguistic, and tribal communities that may need to be revised;

(4) investigate and implement ~~cost-effective~~ equitable and culturally responsive models of service delivery ~~such as~~ including careful ~~adaptation~~ adoption of ~~clinically~~ proven services ~~that constitute one strategy for increasing~~ to increase the number of culturally relevant services available to currently underserved populations; ~~and~~

(5) based on recommendations of the council, review identified department policies that maintain racial, ethnic, cultural, linguistic, and tribal disparities~~, and~~; make adjustments to ensure those disparities are not perpetuated~~.~~; and advise the department on progress and accountability measures for addressing inequities;

(6) in partnership with the council, renew and implement equity policy with action plans and resources necessary to implement the action plans;

(7) support interagency collaboration to advance equity;

633.1 (8) address the council at least twice annually on the state of equity within the department;
633.2 and

633.3 (9) support member participation in the council, including participation in educational
633.4 and community engagement events across Minnesota that address equity in human services.

633.5 (b) The commissioner of human services or the commissioner's designee shall consult
633.6 with the council and receive recommendations from the council when meeting the
633.7 requirements in this subdivision.

633.8 Subd. 8. **Duties of council.** The council shall:

633.9 (1) recommend to the commissioner for review ~~identified policies in the~~ Department of
633.10 Human Services policy, budgetary, and operational decisions and practices that ~~maintain~~
633.11 impact racial, ethnic, cultural, linguistic, and tribal disparities;

633.12 (2) with community input, advance legislative proposals to improve racial and health
633.13 equity outcomes;

633.14 (3) identify issues regarding inequities and disparities by engaging diverse populations
633.15 in human services programs;

633.16 ~~(3)~~ (4) engage in mutual learning essential for achieving human services parity and
633.17 optimal wellness for service recipients;

633.18 ~~(4)~~ (5) raise awareness about human services disparities to the legislature and media;

633.19 ~~(5)~~ (6) provide technical assistance and consultation support to counties, private nonprofit
633.20 agencies, and other service providers to build their capacity to provide equitable human
633.21 services for persons from racial, ethnic, cultural, linguistic, and tribal communities who
633.22 experience disparities in access and outcomes;

633.23 ~~(6)~~ (7) provide technical assistance to promote statewide development of culturally and
633.24 linguistically appropriate, accessible, and cost-effective human services and related policies;

633.25 ~~(7) provide~~ (8) recommend and monitor training and outreach to facilitate access to
633.26 culturally and linguistically appropriate, accessible, and cost-effective human services to
633.27 prevent disparities;

633.28 ~~(8) facilitate culturally appropriate and culturally sensitive admissions, continued services,~~
633.29 ~~discharges, and utilization review for human services agencies and institutions;~~

633.30 (9) form work groups to help carry out the duties of the council that include, but are not
633.31 limited to, persons who provide and receive services and representatives of advocacy groups,

634.1 and provide the work groups with clear guidelines, standardized parameters, and tasks for
634.2 the work groups to accomplish;

634.3 (10) promote information sharing in the human services community and statewide; and

634.4 (11) by February 15 ~~each year~~ in the second year of the biennium, prepare and submit
634.5 to the chairs and ranking minority members of the committees in the house of representatives
634.6 and the senate with jurisdiction over human services a report that summarizes the activities
634.7 of the council, identifies the major problems and issues confronting racial and ethnic groups
634.8 in accessing human services, makes recommendations to address issues, and lists the specific
634.9 objectives that the council seeks to attain during the next biennium, and recommendations
634.10 to strengthen equity, diversity, and inclusion within the department. The report must ~~also~~
634.11 ~~include a list of programs, groups, and grants used to reduce disparities, and statistically~~
634.12 ~~valid reports of outcomes on the reduction of the disparities.~~ identify racial and ethnic groups'
634.13 difficulty in accessing human services and make recommendations to address the issues.
634.14 The report must include any updated Department of Human Services equity policy,
634.15 implementation plans, equity initiatives, and the council's progress.

634.16 Subd. 9. **Duties of council members.** The members of the council shall:

634.17 (1) attend ~~and~~ scheduled meetings with no more than three absences per year, participate
634.18 in scheduled meetings, and be prepared by reviewing meeting notes;

634.19 (2) maintain open communication channels with respective constituencies;

634.20 (3) identify and communicate issues and risks that could impact the timely completion
634.21 of tasks;

634.22 (4) collaborate on inequity and disparity reduction efforts;

634.23 (5) communicate updates of the council's work progress and status on the Department
634.24 of Human Services website; ~~and~~

634.25 (6) participate in any activities the council or chair deems appropriate and necessary to
634.26 facilitate the goals and duties of the council~~.~~; and

634.27 (7) participate in work groups to carry out council duties.

634.28 Subd. 10. **Expiration.** The council ~~expires on June 30, 2022~~ shall expire when racial
634.29 and ethnic-based disparities no longer exist in the state of Minnesota.

634.30 Subd. 11. **Compensation.** Compensation for members of the council is governed by
634.31 section 15.059, subdivision 3.

635.1 Sec. 7. Minnesota Statutes 2020, section 257.0755, subdivision 1, is amended to read:

635.2 Subdivision 1. **Creation.** Each ombudsperson shall operate independently from but in
635.3 collaboration with the community-specific board that appointed the ombudsperson under
635.4 section 257.0768: ~~the Indian Affairs Council,~~ the Minnesota Council on Latino Affairs, the
635.5 Council for Minnesotans of African Heritage, and the Council on Asian-Pacific Minnesotans.

635.6 Sec. 8. Minnesota Statutes 2020, section 257.076, subdivision 3, is amended to read:

635.7 Subd. 3. **Communities of color.** "Communities of color" means the following: ~~American~~
635.8 ~~Indian,~~ Hispanic-Latino, Asian-Pacific, African, and African-American communities.

635.9 Sec. 9. Minnesota Statutes 2020, section 257.076, subdivision 5, is amended to read:

635.10 Subd. 5. **Family of color.** "Family of color" means any family with a child under the
635.11 age of 18 who is identified by one or both parents or another trusted adult to be of ~~American~~
635.12 ~~Indian,~~ Hispanic-Latino, Asian-Pacific, African, or African-American descent.

635.13 Sec. 10. Minnesota Statutes 2020, section 257.0768, subdivision 1, is amended to read:

635.14 Subdivision 1. **Membership.** ~~Four~~ Three community-specific boards are created. Each
635.15 board consists of five members. The chair of each of the following groups shall appoint the
635.16 board for the community represented by the group: ~~the Indian Affairs Council;~~ the Minnesota
635.17 Council on Latino Affairs; the Council for Minnesotans of African Heritage; and the Council
635.18 on Asian-Pacific Minnesotans. In making appointments, the chair must consult with other
635.19 members of the council.

635.20 Sec. 11. Minnesota Statutes 2020, section 257.0768, subdivision 6, is amended to read:

635.21 Subd. 6. **Joint meetings.** The members of the ~~four~~ three community-specific boards
635.22 shall meet jointly at least four times each year to advise the ombudspersons on overall
635.23 policies, plans, protocols, and programs for the office.

635.24 Sec. 12. Minnesota Statutes 2020, section 257.0769, is amended to read:

635.25 **257.0769 FUNDING FOR THE OMBUDSPERSON PROGRAM.**

635.26 Subdivision 1. **Appropriations.** (a) ~~money is appropriated from~~ $23,000 from the special
635.27 fund authorized by section 256.01, subdivision 2, paragraph (o), is annually appropriated
635.28 to the ~~Indian Affairs Council~~ Office of Ombudsperson for American Indian Families for
635.29 the ~~purposes~~ purpose of ~~sections 257.0755 to 257.0768~~ section 3.9215.

636.1 (b) ~~money is appropriated from~~ $69,000 from the special fund authorized by section
636.2 256.01, subdivision 2, paragraph (o), is annually appropriated to the ~~Minnesota Council on~~
636.3 ~~Latino Affairs~~ Office of Ombudsperson for Families for the purposes of sections 257.0755
636.4 to 257.0768.

636.5 ~~(c) Money is appropriated from the special fund authorized by section 256.01, subdivision~~
636.6 ~~2, paragraph (o), to the Council for Minnesotans of African Heritage for the purposes of~~
636.7 ~~sections 257.0755 to 257.0768.~~

636.8 ~~(d) Money is appropriated from the special fund authorized by section 256.01, subdivision~~
636.9 ~~2, paragraph (o), to the Council on Asian-Pacific Minnesotans for the purposes of sections~~
636.10 ~~257.0755 to 257.0768.~~

636.11 Subd. 2. **Title IV-E reimbursement.** The commissioner shall obtain federal title IV-E
636.12 financial participation for eligible activity by the ombudsperson for families under section
636.13 257.0755 and the ombudsperson for American Indian families under section 3.9215. The
636.14 ombudsperson for families and the ombudsperson for American Indian families shall maintain
636.15 and transmit to the Department of Human Services documentation that is necessary in order
636.16 to obtain federal funds.

636.17 Sec. 13. **TRANSFER OF MONEY.**

636.18 Before the end of fiscal year 2021, the Office of the Ombudsperson for Families must
636.19 transfer to the Office of the Ombudsperson for American Indian Families any remaining
636.20 money designated for use by the Ombudsperson for American Indian Families. This section
636.21 is cost-neutral.

636.22 Sec. 14. **CHILDREN WITH DISABILITIES INCLUSIVE CHILD CARE ACCESS**
636.23 **EXPANSION GRANT PROGRAM.**

636.24 Subdivision 1. **Establishment.** (a) The commissioner of human services shall establish
636.25 a competitive grant program to expand access to licensed family child care providers or
636.26 licensed child care centers for children with disabilities including medical complexities.
636.27 The commissioner shall award grants to counties or Tribes, including at least one county
636.28 from the seven-county metropolitan area and at least one county or Tribe outside the
636.29 seven-county metropolitan area, and grant funds shall be used to enable child care providers
636.30 to develop an inclusive child care setting and offer care to children with disabilities and
636.31 children without disabilities. Grants shall be awarded to at least two applicants beginning
636.32 no later than December 1, 2021.

637.1 (b) For purposes of this section, "child with a disability" means a child who has a
637.2 substantial delay or has an identifiable physical, medical, emotional, or mental condition
637.3 that hinders development.

637.4 (c) For purposes of this section, "inclusive child care setting" means child care provided
637.5 in a manner that serves children with disabilities in the same setting as children without
637.6 disabilities.

637.7 Subd. 2. **Commissioner's duties.** To administer the grant program, the commissioner
637.8 shall:

637.9 (1) consult with relevant stakeholders to develop a request for proposals that at least
637.10 requires grant applicants to identify the items or services and estimated accompanying costs,
637.11 where possible, needed to expand access to inclusive child care settings for children with
637.12 disabilities;

637.13 (2) develop procedures for data collection, qualitative and quantitative measurement of
637.14 grant program outcomes, and reporting requirements for grant recipients;

637.15 (3) convene a working group of grant recipients, partner child care providers, and
637.16 participating families to assess progress on grant activities, share best practices, and collect
637.17 and review data on grant activities; and

637.18 (4) by February 1, 2023, provide a report to the chairs and ranking minority members
637.19 of the legislative committees with jurisdiction over early childhood programs on the activities
637.20 and outcomes of the grant program with legislative recommendations for implementing
637.21 inclusive child care settings statewide. The report shall be made available to the public.

637.22 Subd. 3. **Grant activities.** Grant recipients shall use grant funds for the cost of facility
637.23 modifications, resources, or services necessary to expand access to inclusive child care
637.24 settings for children with disabilities, including:

637.25 (1) onetime needs to equip a child care setting to serve children with disabilities, including
637.26 but not limited to environmental modifications; accessibility modifications; sensory
637.27 adaptation; training materials and staff time for training, including for substitutes; or
637.28 equipment purchases, including durable medical equipment;

637.29 (2) ongoing medical- or disability-related services for children with disabilities in
637.30 inclusive child care settings, including but not limited to mental health supports; inclusion
637.31 specialist services; home care nursing; behavioral supports; coaching or training for staff
637.32 and substitutes; substitute teaching time; or additional child care staff, an enhanced rate, or
637.33 another mechanism to increase staff-to-child ratio; and

638.1 (3) other expenses determined by the grant recipient and each partner child care provider
638.2 to be necessary to establish an inclusive child care setting and serve children with disabilities
638.3 at the provider's location.

638.4 Subd. 4. **Requirements for grant recipients.** Upon receipt of grant funds and throughout
638.5 the grant period, grant recipients shall:

638.6 (1) partner with at least two but no more than five child care providers, each of which
638.7 must meet one of the following criteria:

638.8 (i) serve 29 or fewer children, including at least two children with a disability who are
638.9 not a family member of the child care provider if the participating child care provider is a
638.10 family child care provider; or

638.11 (ii) serve more than 30 children, including at least three children with a disability;

638.12 (2) develop and follow a process to ensure that grant funding is used to support children
638.13 with disabilities who, without the additional supports made available through the grant,
638.14 would have difficulty accessing an inclusive child care setting;

638.15 (3) pursue funding for ongoing services needed for children with disabilities in inclusive
638.16 child care settings, such as Medicaid or private health insurance coverage; additional grant
638.17 funding; or other funding sources;

638.18 (4) explore and seek opportunities to use existing federal funds to provide ongoing
638.19 support to family child care providers or child care centers serving children with disabilities.
638.20 Grant recipients shall seek to minimize family financial obligations for child care for a child
638.21 with disabilities beyond what child care would cost for a child without disabilities; and

638.22 (5) identify and utilize training resources for child care providers, where available and
638.23 applicable, for at least one of the grant recipient's partner child care providers.

638.24 Subd. 5. **Reporting.** Grant recipients shall report to the commissioner every six months,
638.25 in a manner specified by the commissioner, on the following:

638.26 (1) the number, type, and cost of additional supports needed to serve children with
638.27 disabilities in inclusive child care settings;

638.28 (2) best practices for billing;

638.29 (3) availability and use of funding sources other than through the grant program;

638.30 (4) processes for identifying families of children with disabilities who could benefit
638.31 from grant activities and connecting them with a child care provider interested in serving
638.32 them;

639.1 (5) processes and eligibility criteria used to determine whether a child is a child with a
639.2 disability and means of prioritizing grant funding to serve children with significant support
639.3 needs associated with their disability; and

639.4 (6) any other information deemed relevant by the commissioner.

639.5 Sec. 15. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; FAMILY**
639.6 **CHILD CARE SHARED SERVICES INNOVATION GRANTS.**

639.7 The commissioner of human services shall establish a grant program to test strategies
639.8 by which family child care providers may share services and thereby achieve economies of
639.9 scale. The commissioner shall report the results of the grant program to the legislative
639.10 committees with jurisdiction over early care and education programs.

639.11 Sec. 16. **REPORT ON PARTICIPATION IN EARLY CHILDHOOD PROGRAMS**
639.12 **BY CHILDREN IN FOSTER CARE.**

639.13 Subdivision 1. **Reporting requirement.** (a) The commissioner of human services shall
639.14 report on the participation in early care and education programs by children under age six
639.15 who have experienced foster care, as defined in Minnesota Statutes, section 260C.007,
639.16 subdivision 18, at any time during the reporting period.

639.17 (b) For purposes of this section, "early care and education program" means Early Head
639.18 Start and Head Start under the federal Improving Head Start for School Readiness Act of
639.19 2007; special education programs under Minnesota Statutes, chapter 125A; early learning
639.20 scholarships under Minnesota Statutes, section 124D.165; school readiness under Minnesota
639.21 Statutes, sections 124D.15 and 124D.16; school readiness plus under Laws 2017, First
639.22 Special Session chapter 5, article 8, section 9; voluntary prekindergarten under Minnesota
639.23 Statutes, section 124D.151; child care assistance under Minnesota Statutes, chapter 119B;
639.24 and other programs as determined by the commissioner.

639.25 Subd. 2. **Report content.** (a) The report shall provide counts and rates of participation
639.26 in the early care and education program by each child's race, ethnicity, age, and county of
639.27 residence. The report shall use the most current administrative data and systems, including
639.28 the Early Childhood Longitudinal Data System, and include recommendations for collecting
639.29 any other administrative data listed in this paragraph that is not currently available.

639.30 (b) The report shall include recommendations to:

639.31 (1) provide the data described in paragraph (a) on an annual basis as part of the report
639.32 required under Minnesota Statutes, section 257.0725;

640.1 (2) facilitate children's continued participation in early care and education programs
640.2 after reunification, adoption, or transfer of permanent legal and physical custody; and

640.3 (3) regularly report measures of early childhood well-being for children who have
640.4 experienced foster care. "Measures of early childhood well-being" include administrative
640.5 data from developmental screenings, school readiness assessments, well-child medical visits,
640.6 and other sources as determined by the commissioner, in consultation with the commissioners
640.7 of health, education, and management and budget, county social service and public health
640.8 agencies, and school districts.

640.9 (c) The report shall include an implementation plan to increase the rates of participation
640.10 among children and their foster families in early care and education programs, including
640.11 processes for referrals and follow-up. The plan shall be developed in collaboration with
640.12 affected communities and families, incorporating their experiences and feedback.
640.13 Representatives from county public health agencies; county social service agencies, including
640.14 child protection services; early childhood care and education providers; the judiciary; and
640.15 school districts must collaborate on the plan's development and implementation strategy.

640.16 (d) The report shall identify barriers to be addressed to ensure that early care and
640.17 education programs are responsive to the cultural, logistical, and racial equity concerns and
640.18 needs of children's foster families and families of origin and the report shall identify methods
640.19 to ensure that the experiences and feedback from children's foster families and families of
640.20 origin are included in the ongoing implementation of early care and education programs.

640.21 Subd. 3. **Submission to legislature.** By June 30, 2022, the commissioner shall submit
640.22 an interim progress report, including identification of potential administrative data sources
640.23 and barriers and a listing of plan development participants, and by December 1, 2022, the
640.24 commissioner shall submit the final report required under this section to the legislative
640.25 committees with jurisdiction over early care and education programs.

640.26 Sec. 17. **REVISOR INSTRUCTION.**

640.27 The revisor of statutes shall renumber Minnesota Statutes, section 136A.128, in Minnesota
640.28 Statutes, chapter 119B. The revisor shall also make necessary cross-reference changes
640.29 consistent with the renumbering.

641.1 ARTICLE 17

641.2 MENTAL HEALTH UNIFORM SERVICE STANDARDS

641.3 Section 1. **[245I.01] PURPOSE AND CITATION.**

641.4 Subdivision 1. **Citation.** This chapter may be cited as the "Mental Health Uniform
641.5 Service Standards Act."

641.6 Subd. 2. **Purpose.** In accordance with sections 245.461 and 245.487, the purpose of this
641.7 chapter is to create a system of mental health care that is unified, accountable, and
641.8 comprehensive, and to promote the recovery and resiliency of Minnesotans who have mental
641.9 illnesses. The state's public policy is to support Minnesotans' access to quality outpatient
641.10 and residential mental health services. Further, the state's public policy is to protect the
641.11 health and safety, rights, and well-being of Minnesotans receiving mental health services.

641.12 Sec. 2. **[245I.011] APPLICABILITY.**

641.13 Subdivision 1. **License requirements.** A license holder under this chapter must comply
641.14 with the requirements in chapters 245A, 245C, and 260E; section 626.557; and Minnesota
641.15 Rules, chapter 9544.

641.16 Subd. 2. **Variances.** (a) The commissioner may grant a variance to an applicant, license
641.17 holder, or certification holder as long as the variance does not affect the staff qualifications
641.18 or the health or safety of any person in a licensed or certified program and the applicant,
641.19 license holder, or certification holder meets the following conditions:

641.20 (1) an applicant, license holder, or certification holder must request the variance on a
641.21 form approved by the commissioner and in a manner prescribed by the commissioner;

641.22 (2) the request for a variance must include the:

641.23 (i) reasons that the applicant, license holder, or certification holder cannot comply with
641.24 a requirement as stated in the law; and

641.25 (ii) alternative equivalent measures that the applicant, license holder, or certification
641.26 holder will follow to comply with the intent of the law; and

641.27 (3) the request for a variance must state the period of time when the variance is requested.

641.28 (b) The commissioner may grant a permanent variance when the conditions under which
641.29 the applicant, license holder, or certification holder requested the variance do not affect the
641.30 health or safety of any person whom the licensed or certified program serves, and when the
641.31 conditions of the variance do not compromise the qualifications of staff who provide services

642.1 to clients. A permanent variance expires when the conditions that warranted the variance
642.2 change in any way. Any applicant, license holder, or certification holder must inform the
642.3 commissioner of any changes to the conditions that warranted the permanent variance. If
642.4 an applicant, license holder, or certification holder fails to advise the commissioner of
642.5 changes to the conditions that warranted the variance, the commissioner must revoke the
642.6 permanent variance and may impose other sanctions under sections 245A.06 and 245A.07.

642.7 (c) The commissioner's decision to grant or deny a variance request is final and not
642.8 subject to appeal under the provisions of chapter 14.

642.9 Subd. 3. **Certification required.** (a) An individual, organization, or government entity
642.10 that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause
642.11 (19), and chooses to be identified as a certified mental health clinic must:

642.12 (1) be a mental health clinic that is certified under section 245I.20;

642.13 (2) comply with all of the responsibilities assigned to a license holder by this chapter
642.14 except subdivision 1; and

642.15 (3) comply with all of the responsibilities assigned to a certification holder by chapter
642.16 245A.

642.17 (b) An individual, organization, or government entity described by this subdivision must
642.18 obtain a criminal background study for each staff person or volunteer who provides direct
642.19 contact services to clients.

642.20 Subd. 4. **License required.** An individual, organization, or government entity providing
642.21 intensive residential treatment services or residential crisis stabilization to adults must be
642.22 licensed under section 245I.23. An entity with an adult foster care license providing
642.23 residential crisis stabilization is exempt from licensure under section 245I.23.

642.24 Subd. 5. **Programs certified under chapter 256B.** (a) An individual, organization, or
642.25 government entity certified under the following sections must comply with all of the
642.26 responsibilities assigned to a license holder under this chapter except subdivision 1:

642.27 (1) an assertive community treatment provider under section 256B.0622, subdivision
642.28 3a;

642.29 (2) an adult rehabilitative mental health services provider under section 256B.0623;

642.30 (3) a mobile crisis team under section 256B.0624;

642.31 (4) a children's therapeutic services and supports provider under section 256B.0943;

642.32 (5) an intensive treatment in foster care provider under section 256B.0946; and

643.1 (6) an intensive nonresidential rehabilitative mental health services provider under section
643.2 256B.0947.

643.3 (b) An individual, organization, or government entity certified under the sections listed
643.4 in paragraph (a), clauses (1) to (6), must obtain a criminal background study for each staff
643.5 person and volunteer providing direct contact services to a client.

643.6 Sec. 3. **[245I.02] DEFINITIONS.**

643.7 Subdivision 1. **Scope.** For purposes of this chapter, the terms in this section have the
643.8 meanings given.

643.9 Subd. 2. **Approval.** "Approval" means the documented review of, opportunity to request
643.10 changes to, and agreement with a treatment document. An individual may demonstrate
643.11 approval with a written signature, secure electronic signature, or documented oral approval.

643.12 Subd. 3. **Behavioral sciences or related fields.** "Behavioral sciences or related fields"
643.13 means an education from an accredited college or university in social work, psychology,
643.14 sociology, community counseling, family social science, child development, child
643.15 psychology, community mental health, addiction counseling, counseling and guidance,
643.16 special education, nursing, and other similar fields approved by the commissioner.

643.17 Subd. 4. **Business day.** "Business day" means a weekday on which government offices
643.18 are open for business. Business day does not include state or federal holidays, Saturdays,
643.19 or Sundays.

643.20 Subd. 5. **Case manager.** "Case manager" means a client's case manager according to
643.21 section 256B.0596; 256B.0621; 256B.0625, subdivision 20; 256B.092, subdivision 1a;
643.22 256B.0924; 256B.093, subdivision 3a; 256B.094; or 256B.49.

643.23 Subd. 6. **Certified rehabilitation specialist.** "Certified rehabilitation specialist" means
643.24 a staff person who meets the qualifications of section 245I.04, subdivision 8.

643.25 Subd. 7. **Child.** "Child" means a client under the age of 18.

643.26 Subd. 8. **Client.** "Client" means a person who is seeking or receiving services regulated
643.27 by this chapter. For the purpose of a client's consent to services, client includes a parent,
643.28 guardian, or other individual legally authorized to consent on behalf of a client to services.

643.29 Subd. 9. **Clinical trainee.** "Clinical trainee" means a staff person who is qualified
643.30 according to section 245I.04, subdivision 6.

643.31 Subd. 10. **Commissioner.** "Commissioner" means the commissioner of human services
643.32 or the commissioner's designee.

644.1 Subd. 11. **Co-occurring substance use disorder treatment.** "Co-occurring substance
644.2 use disorder treatment" means the treatment of a person who has a co-occurring mental
644.3 illness and substance use disorder. Co-occurring substance use disorder treatment is
644.4 characterized by stage-wise comprehensive treatment, treatment goal setting, and flexibility
644.5 for clients at each stage of treatment. Co-occurring substance use disorder treatment includes
644.6 assessing and tracking each client's stage of change readiness and treatment using a treatment
644.7 approach based on a client's stage of change, such as motivational interviewing when working
644.8 with a client at an earlier stage of change readiness and a cognitive behavioral approach
644.9 and relapse prevention to work with a client at a later stage of change; and facilitating a
644.10 client's access to community supports.

644.11 Subd. 12. **Crisis plan.** "Crisis plan" means a plan to prevent and de-escalate a client's
644.12 future crisis situation, with the goal of preventing future crises for the client and the client's
644.13 family and other natural supports. Crisis plan includes a crisis plan developed according to
644.14 section 245.4871, subdivision 9a.

644.15 Subd. 13. **Critical incident.** "Critical incident" means an occurrence involving a client
644.16 that requires a license holder to respond in a manner that is not part of the license holder's
644.17 ordinary daily routine. Critical incident includes a client's suicide, attempted suicide, or
644.18 homicide; a client's death; an injury to a client or other person that is life-threatening or
644.19 requires medical treatment; a fire that requires a fire department's response; alleged
644.20 maltreatment of a client; an assault of a client; an assault by a client; or other situation that
644.21 requires a response by law enforcement, the fire department, an ambulance, or another
644.22 emergency response provider.

644.23 Subd. 14. **Diagnostic assessment.** "Diagnostic assessment" means the evaluation and
644.24 report of a client's potential diagnoses that a mental health professional or clinical trainee
644.25 completes under section 245I.10, subdivisions 4 to 6.

644.26 Subd. 15. **Direct contact.** "Direct contact" has the meaning given in section 245C.02,
644.27 subdivision 11.

644.28 Subd. 16. **Family and other natural supports.** "Family and other natural supports"
644.29 means the people whom a client identifies as having a high degree of importance to the
644.30 client. Family and other natural supports also means people that the client identifies as being
644.31 important to the client's mental health treatment, regardless of whether the person is related
644.32 to the client or lives in the same household as the client.

644.33 Subd. 17. **Functional assessment.** "Functional assessment" means the assessment of a
644.34 client's current level of functioning relative to functioning that is appropriate for someone

645.1 the client's age. For a client five years of age or younger, a functional assessment is the
645.2 Early Childhood Service Intensity Instrument (ESCII). For a client six to 17 years of age,
645.3 a functional assessment is the Child and Adolescent Service Intensity Instrument (CASII).
645.4 For a client 18 years of age or older, a functional assessment is the functional assessment
645.5 described in section 245I.10, subdivision 9.

645.6 Subd. 18. **Individual abuse prevention plan.** "Individual abuse prevention plan" means
645.7 a plan according to section 245A.65, subdivision 2, paragraph (b), and section 626.557,
645.8 subdivision 14.

645.9 Subd. 19. **Level of care assessment.** "Level of care assessment" means the level of care
645.10 decision support tool appropriate to the client's age. For a client five years of age or younger,
645.11 a level of care assessment is the Early Childhood Service Intensity Instrument (ESCII). For
645.12 a client six to 17 years of age, a level of care assessment is the Child and Adolescent Service
645.13 Intensity Instrument (CASII). For a client 18 years of age or older, a level of care assessment
645.14 is the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS).

645.15 Subd. 20. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

645.16 Subd. 21. **License holder.** "License holder" has the meaning given in section 245A.02,
645.17 subdivision 9.

645.18 Subd. 22. **Licensed prescriber.** "Licensed prescriber" means an individual who is
645.19 authorized to prescribe legend drugs under section 151.37.

645.20 Subd. 23. **Mental health behavioral aide.** "Mental health behavioral aide" means a
645.21 staff person who is qualified under section 245I.04, subdivision 16.

645.22 Subd. 24. **Mental health certified family peer specialist.** "Mental health certified
645.23 family peer specialist" means a staff person who is qualified under section 245I.04,
645.24 subdivision 12.

645.25 Subd. 25. **Mental health certified peer specialist.** "Mental health certified peer
645.26 specialist" means a staff person who is qualified under section 245I.04, subdivision 10.

645.27 Subd. 26. **Mental health practitioner.** "Mental health practitioner" means a staff person
645.28 who is qualified under section 245I.04, subdivision 4.

645.29 Subd. 27. **Mental health professional.** "Mental health professional" means a staff person
645.30 who is qualified under section 245I.04, subdivision 2.

645.31 Subd. 28. **Mental health rehabilitation worker.** "Mental health rehabilitation worker"
645.32 means a staff person who is qualified under section 245I.04, subdivision 14.

646.1 Subd. 29. **Mental illness.** "Mental illness" means any of the conditions included in the
646.2 most recent editions of the DC: 0-5 Diagnostic Classification of Mental Health and
646.3 Development Disorders of Infancy and Early Childhood published by Zero to Three or the
646.4 Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric
646.5 Association.

646.6 Subd. 30. **Organization.** "Organization" has the meaning given in section 245A.02,
646.7 subdivision 10c.

646.8 Subd. 31. **Personnel file.** "Personnel file" means a set of records under section 245I.07,
646.9 paragraph (a). Personnel files excludes information related to a person's employment that
646.10 is not included in section 245I.07.

646.11 Subd. 32. **Registered nurse.** "Registered nurse" means a staff person who is qualified
646.12 under section 148.171, subdivision 20.

646.13 Subd. 33. **Rehabilitative mental health services.** "Rehabilitative mental health services"
646.14 means mental health services provided to an adult client that enable the client to develop
646.15 and achieve psychiatric stability, social competencies, personal and emotional adjustment,
646.16 independent living skills, family roles, and community skills when symptoms of mental
646.17 illness has impaired any of the client's abilities in these areas.

646.18 Subd. 34. **Residential program.** "Residential program" has the meaning given in section
646.19 245A.02, subdivision 14.

646.20 Subd. 35. **Signature.** "Signature" means a written signature or an electronic signature
646.21 defined in section 325L.02, paragraph (h).

646.22 Subd. 36. **Staff person.** "Staff person" means an individual who works under a license
646.23 holder's direction or under a contract with a license holder. Staff person includes an intern,
646.24 consultant, contractor, individual who works part-time, and an individual who does not
646.25 provide direct contact services to clients. Staff person includes a volunteer who provides
646.26 treatment services to a client or a volunteer whom the license holder regards as a staff person
646.27 for the purpose of meeting staffing or service delivery requirements. A staff person must
646.28 be 18 years of age or older.

646.29 Subd. 37. **Strengths.** "Strengths" means a person's inner characteristics, virtues, external
646.30 relationships, activities, and connections to resources that contribute to a client's resilience
646.31 and core competencies. A person can build on strengths to support recovery.

646.32 Subd. 38. **Trauma.** "Trauma" means an event, series of events, or set of circumstances
646.33 that is experienced by an individual as physically or emotionally harmful or life-threatening

647.1 that has lasting adverse effects on the individual's functioning and mental, physical, social,
647.2 emotional, or spiritual well-being. Trauma includes group traumatic experiences. Group
647.3 traumatic experiences are emotional or psychological harm that a group experiences. Group
647.4 traumatic experiences can be transmitted across generations within a community and are
647.5 often associated with racial and ethnic population groups who suffer major intergenerational
647.6 losses.

647.7 Subd. 39. **Treatment plan.** "Treatment plan" means services that a license holder
647.8 formulates to respond to a client's needs and goals. A treatment plan includes individual
647.9 treatment plans under section 245I.10, subdivisions 7 and 8; initial treatment plans under
647.10 section 245I.23, subdivision 7; and crisis treatment plans under sections 245I.23, subdivision
647.11 8, and 256B.0624, subdivision 11.

647.12 Subd. 40. **Treatment supervision.** "Treatment supervision" means a mental health
647.13 professional's or certified rehabilitation specialist's oversight, direction, and evaluation of
647.14 a staff person providing services to a client according to section 245I.06.

647.15 Subd. 41. **Volunteer.** "Volunteer" means an individual who, under the direction of the
647.16 license holder, provides services to or facilitates an activity for a client without compensation.

647.17 Sec. 4. **[245I.03] REQUIRED POLICIES AND PROCEDURES.**

647.18 Subdivision 1. **Generally.** A license holder must establish, enforce, and maintain policies
647.19 and procedures to comply with the requirements of this chapter and chapters 245A, 245C,
647.20 and 260E; sections 626.557 and 626.5572; and Minnesota Rules, chapter 9544. The license
647.21 holder must make all policies and procedures available in writing to each staff person. The
647.22 license holder must complete and document a review of policies and procedures every two
647.23 years and update policies and procedures as necessary. Each policy and procedure must
647.24 identify the date that it was initiated and the dates of all revisions. The license holder must
647.25 clearly communicate any policy and procedural change to each staff person and provide
647.26 necessary training to each staff person to implement any policy and procedural change.

647.27 Subd. 2. **Health and safety.** A license holder must have policies and procedures to
647.28 ensure the health and safety of each staff person and client during the provision of services,
647.29 including policies and procedures for services based in community settings.

647.30 Subd. 3. **Client rights.** A license holder must have policies and procedures to ensure
647.31 that each staff person complies with the client rights and protections requirements in section
647.32 245I.12.

648.1 Subd. 4. **Behavioral emergencies.** (a) A license holder must have procedures that each
648.2 staff person follows when responding to a client who exhibits behavior that threatens the
648.3 immediate safety of the client or others. A license holder's behavioral emergency procedures
648.4 must incorporate person-centered planning and trauma-informed care.

648.5 (b) A license holder's behavioral emergency procedures must include:

648.6 (1) a plan designed to prevent the client from inflicting self-harm and harming others;

648.7 (2) contact information for emergency resources that a staff person must use when the
648.8 license holder's behavioral emergency procedures are unsuccessful in controlling a client's
648.9 behavior;

648.10 (3) the types of behavioral emergency procedures that a staff person may use;

648.11 (4) the specific circumstances under which the program may use behavioral emergency
648.12 procedures; and

648.13 (5) the staff persons whom the license holder authorizes to implement behavioral
648.14 emergency procedures.

648.15 (c) The license holder's behavioral emergency procedures must not include secluding
648.16 or restraining a client except as allowed under section 245.8261.

648.17 (d) Staff persons must not use behavioral emergency procedures to enforce program
648.18 rules or for the convenience of staff persons. Behavioral emergency procedures must not
648.19 be part of any client's treatment plan. A staff person may not use behavioral emergency
648.20 procedures except in response to a client's current behavior that threatens the immediate
648.21 safety of the client or others.

648.22 Subd. 5. **Health services and medications.** If a license holder is licensed as a residential
648.23 program, stores or administers client medications, or observes clients self-administer
648.24 medications, the license holder must ensure that a staff person who is a registered nurse or
648.25 licensed prescriber reviews and approves of the license holder's policies and procedures to
648.26 comply with the health services and medications requirements in section 245I.11, the training
648.27 requirements in section 245I.05, subdivision 6, and the documentation requirements in
648.28 section 245I.08, subdivision 5.

648.29 Subd. 6. **Reporting maltreatment.** A license holder must have policies and procedures
648.30 for reporting a staff person's suspected maltreatment, abuse, or neglect of a client according
648.31 to chapter 260E and section 626.557.

649.1 Subd. 7. **Critical incidents.** If a license holder is licensed as a residential program, the
649.2 license holder must have policies and procedures for reporting and maintaining records of
649.3 critical incidents according to section 245I.13.

649.4 Subd. 8. **Personnel.** A license holder must have personnel policies and procedures that:

649.5 (1) include a chart or description of the organizational structure of the program that
649.6 indicates positions and lines of authority;

649.7 (2) ensure that it will not adversely affect a staff person's retention, promotion, job
649.8 assignment, or pay when a staff person communicates in good faith with the Department
649.9 of Human Services, the Office of Ombudsman for Mental Health and Developmental
649.10 Disabilities, the Department of Health, a health-related licensing board, a law enforcement
649.11 agency, or a local agency investigating a complaint regarding a client's rights, health, or
649.12 safety;

649.13 (3) prohibit a staff person from having sexual contact with a client in violation of chapter
649.14 604, sections 609.344 or 609.345;

649.15 (4) prohibit a staff person from neglecting, abusing, or maltreating a client as described
649.16 in chapter 260E and sections 626.557 and 626.5572;

649.17 (5) include the drug and alcohol policy described in section 245A.04, subdivision 1,
649.18 paragraph (c);

649.19 (6) describe the process for disciplinary action, suspension, or dismissal of a staff person
649.20 for violating a policy provision described in clauses (3) to (5);

649.21 (7) describe the license holder's response to a staff person who violates other program
649.22 policies or who has a behavioral problem that interferes with providing treatment services
649.23 to clients; and

649.24 (8) describe each staff person's position that includes the staff person's responsibilities,
649.25 authority to execute the responsibilities, and qualifications for the position.

649.26 Subd. 9. **Volunteers.** A license holder must have policies and procedures for using
649.27 volunteers, including when a license holder must submit a background study for a volunteer,
649.28 and the specific tasks that a volunteer may perform.

649.29 Subd. 10. **Data privacy.** (a) A license holder must have policies and procedures that
649.30 comply with all applicable state and federal law. A license holder's use of electronic record
649.31 keeping or electronic signatures does not alter a license holder's obligations to comply with
649.32 applicable state and federal law.

650.1 (b) A license holder must have policies and procedures for a staff person to promptly
650.2 document a client's revocation of consent to disclose the client's health record. The license
650.3 holder must verify that the license holder has permission to disclose a client's health record
650.4 before releasing any client data.

650.5 Sec. 5. **[245I.04] PROVIDER QUALIFICATIONS AND SCOPE OF PRACTICE.**

650.6 Subdivision 1. **Tribal providers.** For purposes of this section, a tribal entity may
650.7 credential an individual according to section 256B.02, subdivision 7, paragraphs (b) and
650.8 (c).

650.9 Subd. 2. **Mental health professional qualifications.** The following individuals may
650.10 provide services to a client as a mental health professional:

650.11 (1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified
650.12 as a: (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and
650.13 mental health nursing by a national certification organization; or (ii) nurse practitioner in
650.14 adult or family psychiatric and mental health nursing by a national nurse certification
650.15 organization;

650.16 (2) a licensed independent clinical social worker as defined in section 148E.050,
650.17 subdivision 5;

650.18 (3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;

650.19 (4) a physician licensed under chapter 147 if the physician is: (i) certified by the American
650.20 Board of Psychiatry and Neurology; (ii) certified by the American Osteopathic Board of
650.21 Neurology and Psychiatry; or (iii) eligible for board certification in psychiatry;

650.22 (5) a marriage and family therapist licensed under sections 148B.29 to 148B.392; or

650.23 (6) a licensed professional clinical counselor licensed under section 148B.5301.

650.24 Subd. 3. **Mental health professional scope of practice.** A mental health professional
650.25 must maintain a valid license with the mental health professional's governing health-related
650.26 licensing board and must only provide services to a client within the scope of practice
650.27 determined by the applicable health-related licensing board.

650.28 Subd. 4. **Mental health practitioner qualifications.** (a) An individual who is qualified
650.29 in at least one of the ways described in paragraph (b) to (d) may serve as a mental health
650.30 practitioner.

651.1 (b) An individual is qualified as a mental health practitioner through relevant coursework
651.2 if the individual completes at least 30 semester hours or 45 quarter hours in behavioral
651.3 sciences or related fields and:

651.4 (1) has at least 2,000 hours of experience providing services to individuals with:

651.5 (i) a mental illness or a substance use disorder; or

651.6 (ii) a traumatic brain injury or a developmental disability, and completes the additional
651.7 training described in section 245I.05, subdivision 3, paragraph (c), before providing direct
651.8 contact services to a client;

651.9 (2) is fluent in the non-English language of the ethnic group to which at least 50 percent
651.10 of the individual's clients belong, and completes the additional training described in section
651.11 245I.05, subdivision 3, paragraph (c), before providing direct contact services to a client;

651.12 (3) is working in a day treatment program under section 256B.0671, subdivision 3, or
651.13 256B.0943; or

651.14 (4) has completed a practicum or internship that (i) required direct interaction with adult
651.15 clients or child clients, and (ii) was focused on behavioral sciences or related fields.

651.16 (c) An individual is qualified as a mental health practitioner through work experience
651.17 if the individual:

651.18 (1) has at least 4,000 hours of experience in the delivery of services to individuals with:

651.19 (i) a mental illness or a substance use disorder; or

651.20 (ii) a traumatic brain injury or a developmental disability, and completes the additional
651.21 training described in section 245I.05, subdivision 3, paragraph (c), before providing direct
651.22 contact services to clients; or

651.23 (2) receives treatment supervision at least once per week until meeting the requirement
651.24 in clause (1) of 4,000 hours of experience and has at least 2,000 hours of experience providing
651.25 services to individuals with:

651.26 (i) a mental illness or a substance use disorder; or

651.27 (ii) a traumatic brain injury or a developmental disability, and completes the additional
651.28 training described in section 245I.05, subdivision 3, paragraph (c), before providing direct
651.29 contact services to clients.

651.30 (d) An individual is qualified as a mental health practitioner if the individual has a
651.31 master's or other graduate degree in behavioral sciences or related fields.

652.1 Subd. 5. **Mental health practitioner scope of practice.** (a) A mental health practitioner
652.2 under the treatment supervision of a mental health professional or certified rehabilitation
652.3 specialist may provide an adult client with client education, rehabilitative mental health
652.4 services, functional assessments, level of care assessments, and treatment plans. A mental
652.5 health practitioner under the treatment supervision of a mental health professional may
652.6 provide skill-building services to a child client and complete treatment plans for a child
652.7 client.

652.8 (b) A mental health practitioner must not provide treatment supervision to other staff
652.9 persons. A mental health practitioner may provide direction to mental health rehabilitation
652.10 workers and mental health behavioral aides.

652.11 (c) A mental health practitioner who provides services to clients according to section
652.12 256B.0624 or 256B.0944 may perform crisis assessments and interventions for a client.

652.13 Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who: (1)
652.14 is enrolled in an accredited graduate program of study to prepare the staff person for
652.15 independent licensure as a mental health professional and who is participating in a practicum
652.16 or internship with the license holder through the individual's graduate program; or (2) has
652.17 completed an accredited graduate program of study to prepare the staff person for independent
652.18 licensure as a mental health professional and who is in compliance with the requirements
652.19 of the applicable health-related licensing board, including requirements for supervised
652.20 practice.

652.21 (b) A clinical trainee is responsible for notifying and applying to a health-related licensing
652.22 board to ensure that the trainee meets the requirements of the health-related licensing board.
652.23 As permitted by a health-related licensing board, treatment supervision under this chapter
652.24 may be integrated into a plan to meet the supervisory requirements of the health-related
652.25 licensing board but does not supersede those requirements.

652.26 Subd. 7. **Clinical trainee scope of practice.** (a) A clinical trainee under the treatment
652.27 supervision of a mental health professional may provide a client with psychotherapy, client
652.28 education, rehabilitative mental health services, diagnostic assessments, functional
652.29 assessments, level of care assessments, and treatment plans.

652.30 (b) A clinical trainee must not provide treatment supervision to other staff persons. A
652.31 clinical trainee may provide direction to mental health behavioral aides and mental health
652.32 rehabilitation workers.

652.33 (c) A psychological clinical trainee under the treatment supervision of a psychologist
652.34 may perform psychological testing of clients.

653.1 (d) A clinical trainee must not provide services to clients that violate any practice act of
653.2 a health-related licensing board, including failure to obtain licensure if licensure is required.

653.3 Subd. 8. **Certified rehabilitation specialist qualifications.** A certified rehabilitation
653.4 specialist must have:

653.5 (1) a master's degree from an accredited college or university in behavioral sciences or
653.6 related fields;

653.7 (2) at least 4,000 hours of post-master's supervised experience providing mental health
653.8 services to clients; and

653.9 (3) a valid national certification as a certified rehabilitation counselor or certified
653.10 psychosocial rehabilitation practitioner.

653.11 Subd. 9. **Certified rehabilitation specialist scope of practice.** (a) A certified
653.12 rehabilitation specialist may provide an adult client with client education, rehabilitative
653.13 mental health services, functional assessments, level of care assessments, and treatment
653.14 plans.

653.15 (b) A certified rehabilitation specialist may provide treatment supervision to a mental
653.16 health certified peer specialist, mental health practitioner, and mental health rehabilitation
653.17 worker.

653.18 Subd. 10. **Mental health certified peer specialist qualifications.** A mental health
653.19 certified peer specialist must:

653.20 (1) have been diagnosed with a mental illness;

653.21 (2) be a current or former mental health services client; and

653.22 (3) have a valid certification as a mental health certified peer specialist under section
653.23 256B.0615.

653.24 Subd. 11. **Mental health certified peer specialist scope of practice.** A mental health
653.25 certified peer specialist under the treatment supervision of a mental health professional or
653.26 certified rehabilitation specialist must:

653.27 (1) provide individualized peer support to each client;

653.28 (2) promote a client's recovery goals, self-sufficiency, self-advocacy, and development
653.29 of natural supports; and

653.30 (3) support a client's maintenance of skills that the client has learned from other services.

654.1 Subd. 12. **Mental health certified family peer specialist qualifications.** A mental
654.2 health certified family peer specialist must:

654.3 (1) have raised or be currently raising a child with a mental illness;

654.4 (2) have experience navigating the children's mental health system; and

654.5 (3) have a valid certification as a mental health certified family peer specialist under
654.6 section 256B.0616.

654.7 Subd. 13. **Mental health certified family peer specialist scope of practice.** A mental
654.8 health certified family peer specialist under the treatment supervision of a mental health
654.9 professional must provide services to increase the child's ability to function in the child's
654.10 home, school, and community. The mental health certified family peer specialist must:

654.11 (1) provide family peer support to build on a client's family's strengths and help the
654.12 family achieve desired outcomes;

654.13 (2) provide nonadversarial advocacy to a child client and the child's family that
654.14 encourages partnership and promotes the child's positive change and growth;

654.15 (3) support families in advocating for culturally appropriate services for a child in each
654.16 treatment setting;

654.17 (4) promote resiliency, self-advocacy, and development of natural supports;

654.18 (5) support maintenance of skills learned from other services;

654.19 (6) establish and lead parent support groups;

654.20 (7) assist parents in developing coping and problem-solving skills; and

654.21 (8) educate parents about mental illnesses and community resources, including resources
654.22 that connect parents with similar experiences to one another.

654.23 Subd. 14. **Mental health rehabilitation worker qualifications.** (a) A mental health
654.24 rehabilitation worker must:

654.25 (1) have a high school diploma or equivalent; and

654.26 (2) meet one of the following qualification requirements:

654.27 (i) be fluent in the non-English language or competent in the culture of the ethnic group
654.28 to which at least 20 percent of the mental health rehabilitation worker's clients belong;

654.29 (ii) have an associate of arts degree;

655.1 (iii) have two years of full-time postsecondary education or a total of 15 semester hours
655.2 or 23 quarter hours in behavioral sciences or related fields;

655.3 (iv) be a registered nurse;

655.4 (v) have, within the previous ten years, three years of personal life experience with
655.5 mental illness;

655.6 (vi) have, within the previous ten years, three years of life experience as a primary
655.7 caregiver to an adult with a mental illness, traumatic brain injury, substance use disorder,
655.8 or developmental disability; or

655.9 (vii) have, within the previous ten years, 2,000 hours of work experience providing
655.10 health and human services to individuals.

655.11 (b) A mental health rehabilitation worker who is scheduled as an overnight staff person
655.12 and works alone is exempt from the additional qualification requirements in paragraph (a),
655.13 clause (2).

655.14 Subd. 15. **Mental health rehabilitation worker scope of practice.** A mental health
655.15 rehabilitation worker under the treatment supervision of a mental health professional or
655.16 certified rehabilitation specialist may provide rehabilitative mental health services to an
655.17 adult client according to the client's treatment plan.

655.18 Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health
655.19 behavioral aide must have: (1) a high school diploma or equivalent; or (2) two years of
655.20 experience as a primary caregiver to a child with mental illness within the previous ten
655.21 years.

655.22 (b) A level 2 mental health behavioral aide must: (1) have an associate or bachelor's
655.23 degree; or (2) be certified by a program under section 256B.0943, subdivision 8a.

655.24 Subd. 17. **Mental health behavioral aide scope of practice.** While under the treatment
655.25 supervision of a mental health professional, a mental health behavioral aide may practice
655.26 psychosocial skills with a child client according to the child's treatment plan and individual
655.27 behavior plan that a mental health professional, clinical trainee, or mental health practitioner
655.28 has previously taught to the child.

655.29 Sec. 6. **[245I.05] TRAINING REQUIRED.**

655.30 Subdivision 1. **Training plan.** A license holder must develop a training plan to ensure
655.31 that staff persons receive ongoing training according to this section. The training plan must
655.32 include:

656.1 (1) a formal process to evaluate the training needs of each staff person. An annual
656.2 performance evaluation of a staff person satisfies this requirement;

656.3 (2) a description of how the license holder conducts ongoing training of each staff person,
656.4 including whether ongoing training is based on a staff person's hire date or a specified annual
656.5 cycle determined by the program;

656.6 (3) a description of how the license holder verifies and documents each staff person's
656.7 previous training experience. A license holder may consider a staff person to have met a
656.8 training requirement in subdivision 3, paragraph (d) or (e), if the staff person has received
656.9 equivalent postsecondary education in the previous four years or training experience in the
656.10 previous two years; and

656.11 (4) a description of how the license holder determines when a staff person needs
656.12 additional training, including when the license holder will provide additional training.

656.13 Subd. 2. **Documentation of training.** (a) The license holder must provide training to
656.14 each staff person according to the training plan and must document that the license holder
656.15 provided the training to each staff person. The license holder must document the following
656.16 information for each staff person's training:

656.17 (1) the topics of the training;

656.18 (2) the name of the trainee;

656.19 (3) the name and credentials of the trainer;

656.20 (4) the license holder's method of evaluating the trainee's competency upon completion
656.21 of training;

656.22 (5) the date of the training; and

656.23 (6) the length of training in hours and minutes.

656.24 (b) Documentation of a staff person's continuing education credit accepted by the
656.25 governing health-related licensing board is sufficient to document training for purposes of
656.26 this subdivision.

656.27 Subd. 3. **Initial training.** (a) A staff person must receive training about:

656.28 (1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and

656.29 (2) the maltreatment of minor reporting requirements and definitions in chapter 260E
656.30 within 72 hours of first providing direct contact services to a client.

657.1 (b) Before providing direct contact services to a client, a staff person must receive training
657.2 about:

657.3 (1) client rights and protections under section 245I.12;

657.4 (2) the Minnesota Health Records Act, including client confidentiality, family engagement
657.5 under section 144.294, and client privacy;

657.6 (3) emergency procedures that the staff person must follow when responding to a fire,
657.7 inclement weather, a report of a missing person, and a behavioral or medical emergency;

657.8 (4) specific activities and job functions for which the staff person is responsible, including
657.9 the license holder's program policies and procedures applicable to the staff person's position;

657.10 (5) professional boundaries that the staff person must maintain; and

657.11 (6) specific needs of each client to whom the staff person will be providing direct contact
657.12 services, including each client's developmental status, cognitive functioning, physical and
657.13 mental abilities.

657.14 (c) Before providing direct contact services to a client, a mental health rehabilitation
657.15 worker, mental health behavioral aide, or mental health practitioner qualified under section
657.16 245I.04, subdivision 4, must receive 30 hours of training about:

657.17 (1) mental illnesses;

657.18 (2) client recovery and resiliency;

657.19 (3) mental health de-escalation techniques;

657.20 (4) co-occurring mental illness and substance use disorders; and

657.21 (5) psychotropic medications and medication side effects.

657.22 (d) Within 90 days of first providing direct contact services to an adult client, a clinical
657.23 trainee, mental health practitioner, mental health certified peer specialist, or mental health
657.24 rehabilitation worker must receive training about:

657.25 (1) trauma-informed care and secondary trauma;

657.26 (2) person-centered individual treatment plans, including seeking partnerships with
657.27 family and other natural supports;

657.28 (3) co-occurring substance use disorders; and

657.29 (4) culturally responsive treatment practices.

658.1 (e) Within 90 days of first providing direct contact services to a child client, a clinical
658.2 trainee, mental health practitioner, mental health certified family peer specialist, mental
658.3 health certified peer specialist, or mental health behavioral aide must receive training about
658.4 the topics in clauses (1) to (5). This training must address the developmental characteristics
658.5 of each child served by the license holder and address the needs of each child in the context
658.6 of the child's family, support system, and culture. Training topics must include:

658.7 (1) trauma-informed care and secondary trauma, including adverse childhood experiences
658.8 (ACEs);

658.9 (2) family-centered treatment plan development, including seeking partnership with a
658.10 child client's family and other natural supports;

658.11 (3) mental illness and co-occurring substance use disorders in family systems;

658.12 (4) culturally responsive treatment practices; and

658.13 (5) child development, including cognitive functioning, and physical and mental abilities.

658.14 (f) For a mental health behavioral aide, the training under paragraph (e) must include
658.15 parent team training using a curriculum approved by the commissioner.

658.16 Subd. 4. **Ongoing training.** (a) A license holder must ensure that staff persons who
658.17 provide direct contact services to clients receive annual training about the topics in
658.18 subdivision 3, paragraphs (a) and (b), clauses (1) to (3).

658.19 (b) A license holder must ensure that each staff person who is qualified under section
658.20 245I.04 who is not a mental health professional receives 30 hours of training every two
658.21 years. The training topics must be based on the program's needs and the staff person's areas
658.22 of competency.

658.23 Subd. 5. **Additional training for medication administration.** (a) Prior to administering
658.24 medications to a client under delegated authority or observing a client self-administer
658.25 medications, a staff person who is not a licensed prescriber, registered nurse, or licensed
658.26 practical nurse qualified under section 148.171, subdivision 8, must receive training about
658.27 psychotropic medications, side effects, and medication management.

658.28 (b) Prior to administering medications to a client under delegated authority, a staff person
658.29 must successfully complete a:

658.30 (1) medication administration training program for unlicensed personnel through an
658.31 accredited Minnesota postsecondary educational institution with completion of the course
658.32 documented in writing and placed in the staff person's personnel file; or

659.1 (2) formalized training program taught by a registered nurse or licensed prescriber that
659.2 is offered by the license holder. A staff person's successful completion of the formalized
659.3 training program must include direct observation of the staff person to determine the staff
659.4 person's areas of competency.

659.5 Sec. 7. **[245I.06] TREATMENT SUPERVISION.**

659.6 Subdivision 1. **Generally.** (a) A license holder must ensure that a mental health
659.7 professional or certified rehabilitation specialist provides treatment supervision to each staff
659.8 person who provides services to a client and who is not a mental health professional or
659.9 certified rehabilitation specialist. When providing treatment supervision, a treatment
659.10 supervisor must follow a staff person's written treatment supervision plan.

659.11 (b) Treatment supervision must focus on each client's treatment needs and the ability of
659.12 the staff person under treatment supervision to provide services to each client, including
659.13 the following topics related to the staff person's current caseload:

659.14 (1) a review and evaluation of the interventions that the staff person delivers to each
659.15 client;

659.16 (2) instruction on alternative strategies if a client is not achieving treatment goals;

659.17 (3) a review and evaluation of each client's assessments, treatment plans, and progress
659.18 notes for accuracy and appropriateness;

659.19 (4) instruction on the cultural norms or values of the clients and communities that the
659.20 license holder serves and the impact that a client's culture has on providing treatment;

659.21 (5) evaluation of and feedback regarding a direct service staff person's areas of
659.22 competency; and

659.23 (6) coaching, teaching, and practicing skills with a staff person.

659.24 (c) A treatment supervisor must provide treatment supervision to a staff person using
659.25 methods that allow for immediate feedback, including in-person, telephone, and interactive
659.26 video supervision.

659.27 (d) A treatment supervisor's responsibility for a staff person receiving treatment
659.28 supervision is limited to the services provided by the associated license holder. If a staff
659.29 person receiving treatment supervision is employed by multiple license holders, each license
659.30 holder is responsible for providing treatment supervision related to the treatment of the
659.31 license holder's clients.

660.1 Subd. 2. **Treatment supervision planning.** (a) A treatment supervisor and the staff
660.2 person supervised by the treatment supervisor must develop a written treatment supervision
660.3 plan. The license holder must ensure that a new staff person's treatment supervision plan is
660.4 completed and implemented by a treatment supervisor and the new staff person within 30
660.5 days of the new staff person's first day of employment. The license holder must review and
660.6 update each staff person's treatment supervision plan annually.

660.7 (b) Each staff person's treatment supervision plan must include:

660.8 (1) the name and qualifications of the staff person receiving treatment supervision;

660.9 (2) the names and licensures of the treatment supervisors who are supervising the staff
660.10 person;

660.11 (3) how frequently the treatment supervisors must provide treatment supervision to the
660.12 staff person; and

660.13 (4) the staff person's authorized scope of practice, including a description of the client
660.14 population that the staff person serves, and a description of the treatment methods and
660.15 modalities that the staff person may use to provide services to clients.

660.16 Subd. 3. **Treatment supervision and direct observation of mental health**
660.17 **rehabilitation workers and mental health behavioral aides.** (a) A mental health behavioral
660.18 aide or a mental health rehabilitation worker must receive direct observation from a mental
660.19 health professional, clinical trainee, certified rehabilitation specialist, or mental health
660.20 practitioner while the mental health behavioral aide or mental health rehabilitation worker
660.21 provides treatment services to clients, no less than twice per month for the first six months
660.22 of employment and once per month thereafter. The staff person performing the direct
660.23 observation must approve of the progress note for the observed treatment service.

660.24 (b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision
660.25 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work
660.26 must at a minimum consist of:

660.27 (1) monthly individual supervision; and

660.28 (2) direct observation twice per month.

660.29 Sec. 8. **[245I.07] PERSONNEL FILES.**

660.30 (a) For each staff person, a license holder must maintain a personnel file that includes:

661.1 (1) verification of the staff person's qualifications required for the position including
661.2 training, education, practicum or internship agreement, licensure, and any other required
661.3 qualifications;

661.4 (2) documentation related to the staff person's background study;

661.5 (3) the hiring date of the staff person;

661.6 (4) a description of the staff person's job responsibilities with the license holder;

661.7 (5) the date that the staff person's specific duties and responsibilities became effective,
661.8 including the date that the staff person began having direct contact with clients;

661.9 (6) documentation of the staff person's training as required by section 245I.05, subdivision
661.10 2;

661.11 (7) a verification copy of license renewals that the staff person completed during the
661.12 staff person's employment;

661.13 (8) annual job performance evaluations; and

661.14 (9) if applicable, the staff person's alleged and substantiated violations of the license
661.15 holder's policies under section 245I.03, subdivision 8, clauses (3) to (7), and the license
661.16 holder's response.

661.17 (b) The license holder must ensure that all personnel files are readily accessible for the
661.18 commissioner's review. The license holder is not required to keep personnel files in a single
661.19 location.

661.20 Sec. 9. **[245I.08] DOCUMENTATION STANDARDS.**

661.21 Subdivision 1. **Generally.** A license holder must ensure that all documentation required
661.22 by this chapter complies with this section.

661.23 Subd. 2. **Documentation standards.** A license holder must ensure that all documentation
661.24 required by this chapter:

661.25 (1) is legible;

661.26 (2) identifies the applicable client and staff person on each page; and

661.27 (3) is signed and dated by the staff persons who provided services to the client or
661.28 completed the documentation, including the staff persons' credentials.

661.29 Subd. 3. **Documenting approval.** A license holder must ensure that all diagnostic
661.30 assessments, functional assessments, level of care assessments, and treatment plans completed

662.1 by a clinical trainee or mental health practitioner contain documentation of approval by a
662.2 treatment supervisor within five business days of initial completion by the staff person under
662.3 treatment supervision.

662.4 Subd. 4. **Progress notes.** A license holder must use a progress note to document each
662.5 occurrence of a mental health service that a staff person provides to a client. A progress
662.6 note must include the following:

662.7 (1) the type of service;

662.8 (2) the date of service;

662.9 (3) the start and stop time of the service unless the license holder is licensed as a
662.10 residential program;

662.11 (4) the location of the service;

662.12 (5) the scope of the service, including: (i) the targeted goal and objective; (ii) the
662.13 intervention that the staff person provided to the client and the methods that the staff person
662.14 used; (iii) the client's response to the intervention; (iv) the staff person's plan to take future
662.15 actions, including changes in treatment that the staff person will implement if the intervention
662.16 was ineffective; and (v) the service modality;

662.17 (6) the signature, printed name, and credentials of the staff person who provided the
662.18 service to the client;

662.19 (7) the mental health provider travel documentation required by section 256B.0625, if
662.20 applicable; and

662.21 (8) significant observations by the staff person, if applicable, including: (i) the client's
662.22 current risk factors; (ii) emergency interventions by staff persons; (iii) consultations with
662.23 or referrals to other professionals, family, or significant others; and (iv) changes in the
662.24 client's mental or physical symptoms.

662.25 Subd. 5. **Medication administration record.** If a license holder administers or observes
662.26 a client self-administer medications, the license holder must maintain a medication
662.27 administration record for each client that contains the following, as applicable:

662.28 (1) the client's date of birth;

662.29 (2) the client's allergies;

662.30 (3) all medication orders for the client, including client-specific orders for
662.31 over-the-counter medications and approved condition-specific protocols;

663.1 (4) the name of each ordered medication, date of each medication's expiration, each
663.2 medication's dosage frequency, method of administration, and time;

663.3 (5) the licensed prescriber's name and telephone number;

663.4 (6) the date of initiation;

663.5 (7) the signature, printed name, and credentials of the staff person who administered the
663.6 medication or observed the client self-administer the medication; and

663.7 (8) the reason that the license holder did not administer the client's prescribed medication
663.8 or observe the client self-administer the client's prescribed medication.

663.9 Sec. 10. **[245I.09] CLIENT FILES.**

663.10 Subdivision 1. **Generally.** (a) A license holder must maintain a file for each client that
663.11 contains the client's current and accurate records. The license holder must store each client
663.12 file on the premises where the license holder provides or coordinates services for the client.
663.13 The license holder must ensure that all client files are readily accessible for the
663.14 commissioner's review. The license holder is not required to keep client files in a single
663.15 location.

663.16 (b) The license holder must protect client records against loss, tampering, or unauthorized
663.17 disclosure of confidential client data according to the Minnesota Government Data Practices
663.18 Act, chapter 13; the privacy provisions of the Minnesota health care programs provider
663.19 agreement; the Health Insurance Portability and Accountability Act of 1996 (HIPAA),
663.20 Public Law 104-191; and the Minnesota Health Records Act, sections 144.291 to 144.298.

663.21 Subd. 2. **Record retention.** A license holder must retain client records of a discharged
663.22 client for a minimum of five years from the date of the client's discharge. A license holder
663.23 who ceases to provide treatment services to a client must retain the client's records for a
663.24 minimum of five years from the date that the license holder stopped providing services to
663.25 the client and must notify the commissioner of the location of the client records and the
663.26 name of the individual responsible for storing and maintaining the client records.

663.27 Subd. 3. **Contents.** A license holder must retain a clear and complete record of the
663.28 information that the license holder receives regarding a client, and of the services that the
663.29 license holder provides to the client. If applicable, each client's file must include the following
663.30 information:

663.31 (1) the client's screenings, assessments, and testing;

663.32 (2) the client's treatment plans and reviews of the client's treatment plan;

664.1 (3) the client's individual abuse prevention plans;

664.2 (4) the client's health care directive under section 145C.01, subdivision 5a, and the
664.3 client's emergency contacts;

664.4 (5) the client's crisis plans;

664.5 (6) the client's consents for releases of information and documentation of the client's
664.6 releases of information;

664.7 (7) the client's significant medical and health-related information;

664.8 (8) a record of each communication that a staff person has with the client's other mental
664.9 health providers and persons interested in the client, including the client's case manager,
664.10 family members, primary caregiver, legal representatives, court representatives,
664.11 representatives from the correctional system, or school administration;

664.12 (9) written information by the client that the client requests to include in the client's file;
664.13 and

664.14 (10) the date of the client's discharge from the license holder's program, the reason that
664.15 the license holder discontinued services for the client, and the client's discharge summaries.

664.16 Sec. 11. **[245I.10] ASSESSMENT AND TREATMENT PLANNING.**

664.17 Subdivision 1. **Definitions.** (a) "Diagnostic formulation" means a written analysis and
664.18 explanation of a client's clinical assessment to develop a hypothesis about the cause and
664.19 nature of a client's presenting problems and to identify the most suitable approach for treating
664.20 the client.

664.21 (b) "Responsivity factors" means the factors other than the diagnostic formulation that
664.22 may modify a client's treatment needs. This includes a client's learning style, abilities,
664.23 cognitive functioning, cultural background, and personal circumstances. When documenting
664.24 a client's responsivity factors a mental health professional or clinical trainee must include
664.25 an analysis of how a client's strengths are reflected in the license holder's plan to deliver
664.26 services to the client.

664.27 Subd. 2. **Generally.** (a) A license holder must use a client's diagnostic assessment or
664.28 crisis assessment to determine a client's eligibility for mental health services, except as
664.29 provided in this section.

664.30 (b) Prior to completing a client's initial diagnostic assessment, a license holder may
664.31 provide a client with the following services:

665.1 (1) an explanation of findings;

665.2 (2) neuropsychological testing, neuropsychological assessment, and psychological
665.3 testing;

665.4 (3) any combination of psychotherapy sessions, family psychotherapy sessions, and
665.5 family psychoeducation sessions not to exceed three sessions;

665.6 (4) crisis assessment services according to section 256B.0624; and

665.7 (5) ten days of intensive residential treatment services according to the assessment and
665.8 treatment planning standards in section 245.23, subdivision 7.

665.9 (c) Based on the client's needs that a crisis assessment identifies under section 256B.0624,
665.10 a license holder may provide a client with the following services:

665.11 (1) crisis intervention and stabilization services under section 245I.23 or 256B.0624;
665.12 and

665.13 (2) any combination of psychotherapy sessions, group psychotherapy sessions, family
665.14 psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions
665.15 within a 12-month period without prior authorization.

665.16 (d) Based on the client's needs in the client's brief diagnostic assessment, a license holder
665.17 may provide a client with any combination of psychotherapy sessions, group psychotherapy
665.18 sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed
665.19 ten sessions within a 12-month period without prior authorization for any new client or for
665.20 an existing client who the license holder projects will need fewer than ten sessions during
665.21 the next 12 months.

665.22 (e) Based on the client's needs that a hospital's medical history and presentation
665.23 examination identifies, a license holder may provide a client with:

665.24 (1) any combination of psychotherapy sessions, group psychotherapy sessions, family
665.25 psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions
665.26 within a 12-month period without prior authorization for any new client or for an existing
665.27 client who the license holder projects will need fewer than ten sessions during the next 12
665.28 months; and

665.29 (2) up to five days of day treatment services or partial hospitalization.

665.30 (f) A license holder must complete a new standard diagnostic assessment of a client:

665.31 (1) when the client requires services of a greater number or intensity than the services
665.32 that paragraphs (b) to (e) describe;

666.1 (2) at least annually following the client's initial diagnostic assessment if the client needs
666.2 additional mental health services and the client does not meet the criteria for a brief
666.3 assessment;

666.4 (3) when the client's mental health condition has changed markedly since the client's
666.5 most recent diagnostic assessment; or

666.6 (4) when the client's current mental health condition does not meet the criteria of the
666.7 client's current diagnosis.

666.8 (g) For an existing client, the license holder must ensure that a new standard diagnostic
666.9 assessment includes a written update containing all significant new or changed information
666.10 about the client, and an update regarding what information has not significantly changed,
666.11 including a discussion with the client about changes in the client's life situation, functioning,
666.12 presenting problems, and progress with achieving treatment goals since the client's last
666.13 diagnostic assessment was completed.

666.14 Subd. 3. **Continuity of services.** (a) For any client with a diagnostic assessment
666.15 completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before the effective date
666.16 of this section, the diagnostic assessment is valid for authorizing the client's treatment and
666.17 billing for one calendar year after the date that the assessment was completed.

666.18 (b) For any client with an individual treatment plan completed under section 256B.0622,
666.19 256B.0623, 256B.0943, 256B.0946, or 256B.0947 or Minnesota Rules, parts 9505.0370 to
666.20 9505.0372, the client's treatment plan is valid for authorizing treatment and billing until the
666.21 treatment plan's expiration date.

666.22 (c) This subdivision expires July 1, 2023.

666.23 Subd. 4. **Diagnostic assessment.** A client's diagnostic assessment must: (1) identify at
666.24 least one mental health diagnosis for which the client meets the diagnostic criteria and
666.25 recommend mental health services to develop the client's mental health services and treatment
666.26 plan; or (2) include a finding that the client does not meet the criteria for a mental health
666.27 disorder.

666.28 Subd. 5. **Brief diagnostic assessment; required elements.** (a) Only a mental health
666.29 professional or clinical trainee may complete a brief diagnostic assessment of a client. A
666.30 license holder may only use a brief diagnostic assessment for a client who is six years of
666.31 age or older.

666.32 (b) When conducting a brief diagnostic assessment of a client, the assessor must complete
666.33 a face-to-face interview with the client and a written evaluation of the client. The assessor

667.1 must gather and document initial components of the client's standard diagnostic assessment,
667.2 including the client's:

667.3 (1) age;

667.4 (2) description of symptoms, including the reason for the client's referral;

667.5 (3) history of mental health treatment;

667.6 (4) cultural influences on the client; and

667.7 (5) mental status examination.

667.8 (c) Based on the initial components of the assessment, the assessor must develop a
667.9 provisional diagnostic formulation about the client. The assessor may use the client's
667.10 provisional diagnostic formulation to address the client's immediate needs and presenting
667.11 problems.

667.12 (d) A mental health professional or clinical trainee may use treatment sessions with the
667.13 client authorized by a brief diagnostic assessment to gather additional information about
667.14 the client to complete the client's standard diagnostic assessment if the number of sessions
667.15 will exceed the coverage limits in subdivision 2.

667.16 Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health
667.17 professional or a clinical trainee may complete a standard diagnostic assessment of a client.
667.18 A standard diagnostic assessment of a client must include a face-to-face interview with a
667.19 client and a written evaluation of the client. The assessor must complete a client's standard
667.20 diagnostic assessment within the client's cultural context.

667.21 (b) When completing a standard diagnostic assessment of a client, the assessor must
667.22 gather and document information about the client's current life situation, including the
667.23 following information:

667.24 (1) the client's age;

667.25 (2) the client's current living situation, including the client's housing status and household
667.26 members;

667.27 (3) the status of the client's basic needs;

667.28 (4) the client's education level and employment status;

667.29 (5) the client's current medications;

667.30 (6) any immediate risks to the client's health and safety;

667.31 (7) the client's perceptions of the client's condition;

668.1 (8) the client's description of the client's symptoms, including the reason for the client's
668.2 referral;

668.3 (9) the client's history of mental health treatment; and

668.4 (10) cultural influences on the client.

668.5 (c) If the assessor cannot obtain the information that this subdivision requires without
668.6 retraumatizing the client or harming the client's willingness to engage in treatment, the
668.7 assessor must identify which topics will require further assessment during the course of the
668.8 client's treatment. The assessor must gather and document information related to the following
668.9 topics:

668.10 (1) the client's relationship with the client's family and other significant personal
668.11 relationships, including the client's evaluation of the quality of each relationship;

668.12 (2) the client's strengths and resources, including the extent and quality of the client's
668.13 social networks;

668.14 (3) important developmental incidents in the client's life;

668.15 (4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

668.16 (5) the client's history of or exposure to alcohol and drug usage and treatment; and

668.17 (6) the client's health history and the client's family health history, including the client's
668.18 physical, chemical, and mental health history.

668.19 (d) When completing a standard diagnostic assessment of a client, an assessor must use
668.20 a recognized diagnostic framework.

668.21 (1) When completing a standard diagnostic assessment of a client who is five years of
668.22 age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic
668.23 Classification of Mental Health and Development Disorders of Infancy and Early Childhood
668.24 published by Zero to Three.

668.25 (2) When completing a standard diagnostic assessment of a client who is six years of
668.26 age or older, the assessor must use the current edition of the Diagnostic and Statistical
668.27 Manual of Mental Disorders published by the American Psychiatric Association.

668.28 (3) When completing a standard diagnostic assessment of a client who is five years of
668.29 age or younger, an assessor must administer the Early Childhood Service Intensity Instrument
668.30 (ECSII) to the client and include the results in the client's assessment.

669.1 (4) When completing a standard diagnostic assessment of a client who is six to 17 years
669.2 of age, an assessor must administer the Child and Adolescent Service Intensity Instrument
669.3 (CASII) to the client and include the results in the client's assessment.

669.4 (5) When completing a standard diagnostic assessment of a client who is 18 years of
669.5 age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria
669.6 in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders
669.7 published by the American Psychiatric Association to screen and assess the client for a
669.8 substance use disorder.

669.9 (e) When completing a standard diagnostic assessment of a client, the assessor must
669.10 include and document the following components of the assessment:

669.11 (1) the client's mental status examination;

669.12 (2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources;
669.13 vulnerabilities; safety needs, including client information that supports the assessor's findings
669.14 after applying a recognized diagnostic framework from paragraph (d); and any differential
669.15 diagnosis of the client;

669.16 (3) an explanation of: (i) how the assessor diagnosed the client using the information
669.17 from the client's interview, assessment, psychological testing, and collateral information
669.18 about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths;
669.19 and (v) the client's responsivity factors.

669.20 (f) When completing a standard diagnostic assessment of a client, the assessor must
669.21 consult the client and the client's family about which services that the client and the family
669.22 prefer to treat the client. The assessor must make referrals for the client as to services required
669.23 by law.

669.24 Subd. 7. **Individual treatment plan.** A license holder must follow each client's written
669.25 individual treatment plan when providing services to the client with the following exceptions:

669.26 (1) services that do not require that a license holder completes a standard diagnostic
669.27 assessment of a client before providing services to the client;

669.28 (2) when developing a service plan; and

669.29 (3) when a client re-engages in services under subdivision 8, paragraph (b).

669.30 Subd. 8. **Individual treatment plan; required elements.** (a) After completing a client's
669.31 diagnostic assessment and before providing services to the client, the license holder must
669.32 complete the client's individual treatment plan. The license holder must:

670.1 (1) base the client's individual treatment plan on the client's diagnostic assessment and
670.2 baseline measurements;

670.3 (2) for a child client, use a child-centered, family-driven, and culturally appropriate
670.4 planning process that allows the child's parents and guardians to observe and participate in
670.5 the child's individual and family treatment services, assessments, and treatment planning;

670.6 (3) for an adult client, use a person-centered, culturally appropriate planning process
670.7 that allows the client's family and other natural supports to observe and participate in the
670.8 client's treatment services, assessments, and treatment planning;

670.9 (4) identify the client's treatment goals, measureable treatment objectives, a schedule
670.10 for accomplishing the client's treatment goals and objectives, a treatment strategy, and the
670.11 individuals responsible for providing treatment services and supports to the client. The
670.12 license holder must have a treatment strategy to engage the client in treatment if the client:

670.13 (i) has a history of not engaging in treatment; and

670.14 (ii) is ordered by a court to participate in treatment services or to take neuroleptic
670.15 medications;

670.16 (5) identify the participants involved in the client's treatment planning. The client must
670.17 be a participant in the client's treatment planning. If applicable, the license holder must
670.18 document the reasons that the license holder did not involve the client's family or other
670.19 natural supports in the client's treatment planning;

670.20 (6) review the client's individual treatment plan every 180 days and update the client's
670.21 individual treatment plan with the client's treatment progress, new treatment objectives and
670.22 goals or, if the client has not made treatment progress, changes in the license holder's
670.23 approach to treatment; and

670.24 (7) ensure that the client approves of the client's individual treatment plan unless a court
670.25 orders the client's treatment plan under chapter 253B.

670.26 (b) If the client disagrees with the client's treatment plan, the license holder must
670.27 document in the client file the reasons why the client does not agree with the treatment plan.
670.28 If the license holder cannot obtain the client's approval of the treatment plan, a mental health
670.29 professional must make efforts to obtain approval from a person who is authorized to consent
670.30 on the client's behalf within 30 days after the client's previous individual treatment plan
670.31 expired. A license holder may not deny a client service during this time period solely because
670.32 the license holder could not obtain the client's approval of the client's individual treatment

671.1 plan. A license holder may continue to bill for the client's otherwise eligible services when
671.2 the client re-engages in services.

671.3 Subd. 9. **Functional assessment; required elements.** When a license holder is
671.4 completing a functional assessment for an adult client, the license holder must:

671.5 (1) complete a functional assessment of the client after completing the client's diagnostic
671.6 assessment;

671.7 (2) use a collaborative process that allows the client and the client's family and other
671.8 natural supports, the client's referral sources, and the client's providers to provide information
671.9 about how the client's symptoms of mental illness impact the client's functioning;

671.10 (3) if applicable, document the reasons that the license holder did not contact the client's
671.11 family and other natural supports;

671.12 (4) assess and document how the client's symptoms of mental illness impact the client's
671.13 functioning in the following areas:

671.14 (i) the client's mental health symptoms;

671.15 (ii) the client's mental health service needs;

671.16 (iii) the client's substance use;

671.17 (iv) the client's vocational and educational functioning;

671.18 (v) the client's social functioning, including the use of leisure time;

671.19 (vi) the client's interpersonal functioning, including relationships with the client's family
671.20 and other natural supports;

671.21 (vii) the client's ability to provide self-care and live independently;

671.22 (viii) the client's medical and dental health;

671.23 (ix) the client's financial assistance needs; and

671.24 (x) the client's housing and transportation needs;

671.25 (5) include a narrative summarizing the client's strengths, resources, and all areas of
671.26 functional impairment;

671.27 (6) complete the client's functional assessment before the client's initial individual
671.28 treatment plan unless a service specifies otherwise; and

672.1 (7) update the client's functional assessment with the client's current functioning whenever
672.2 there is a significant change in the client's functioning or at least every 180 days, unless a
672.3 service specifies otherwise.

672.4 Sec. 12. **[245I.11] HEALTH SERVICES AND MEDICATIONS.**

672.5 Subdivision 1. **Generally.** If a license holder is licensed as a residential program, stores
672.6 or administers client medications, or observes clients self-administer medications, the license
672.7 holder must ensure that a staff person who is a registered nurse or licensed prescriber is
672.8 responsible for overseeing storage and administration of client medications and observing
672.9 as a client self-administers medications, including training according to section 245I.05,
672.10 subdivision 6, and documenting the occurrence according to section 245I.08, subdivision
672.11 5.

672.12 Subd. 2. **Health services.** If a license holder is licensed as a residential program, the
672.13 license holder must:

672.14 (1) ensure that a client is screened for health issues within 72 hours of the client's
672.15 admission;

672.16 (2) monitor the physical health needs of each client on an ongoing basis;

672.17 (3) offer referrals to clients and coordinate each client's care with psychiatric and medical
672.18 services;

672.19 (4) identify circumstances in which a staff person must notify a registered nurse or
672.20 licensed prescriber of any of a client's health concerns and the process for providing
672.21 notification of client health concerns; and

672.22 (5) identify the circumstances in which the license holder must obtain medical care for
672.23 a client and the process for obtaining medical care for a client.

672.24 Subd. 3. **Storing and accounting for medications.** (a) If a license holder stores client
672.25 medications, the license holder must:

672.26 (1) store client medications in original containers in a locked location;

672.27 (2) store refrigerated client medications in special trays or containers that are separate
672.28 from food;

672.29 (3) store client medications marked "for external use only" in a compartment that is
672.30 separate from other client medications;

673.1 (4) store Schedule II to IV drugs listed in section 152.02, subdivisions 3 to 5, in a
673.2 compartment that is locked separately from other medications;

673.3 (5) ensure that only authorized staff persons have access to stored client medications;

673.4 (6) follow a documentation procedure on each shift to account for all scheduled drugs;
673.5 and

673.6 (7) record each incident when a staff person accepts a supply of client medications and
673.7 destroy discontinued, outdated, or deteriorated client medications.

673.8 (b) If a license holder is licensed as a residential program, the license holder must allow
673.9 clients who self-administer medications to keep a private medication supply. The license
673.10 holder must ensure that the client stores all private medication in a locked container in the
673.11 client's private living area, unless the private medication supply poses a health and safety
673.12 risk to any clients. A client must not maintain a private medication supply of a prescription
673.13 medication without a written medication order from a licensed prescriber and a prescription
673.14 label that includes the client's name.

673.15 Subd. 4. **Medication orders.** (a) If a license holder stores, prescribes, or administers
673.16 medications or observes a client self-administer medications, the license holder must:

673.17 (1) ensure that a licensed prescriber writes all orders to accept, administer, or discontinue
673.18 client medications;

673.19 (2) accept nonwritten orders to administer client medications in emergency circumstances
673.20 only;

673.21 (3) establish a timeline and process for obtaining a written order with the licensed
673.22 prescriber's signature when the license holder accepts a nonwritten order to administer client
673.23 medications;

673.24 (4) obtain prescription medication renewals from a licensed prescriber for each client
673.25 every 90 days for psychotropic medications and annually for all other medications; and

673.26 (5) maintain the client's right to privacy and dignity.

673.27 (b) If a license holder employs a licensed prescriber, the license holder must inform the
673.28 client about potential medication effects and side effects and obtain and document the client's
673.29 informed consent before the licensed prescriber prescribes a medication.

673.30 Subd. 5. **Medication administration.** If a license holder is licensed as a residential
673.31 program, the license holder must:

674.1 (1) assess and document each client's ability to self-administer medication. In the
674.2 assessment, the license holder must evaluate the client's ability to: (i) comply with prescribed
674.3 medication regimens; and (ii) store the client's medications safely and in a manner that
674.4 protects other individuals in the facility. Through the assessment process, the license holder
674.5 must assist the client in developing the skills necessary to safely self-administer medication;

674.6 (2) monitor the effectiveness of medications, side effects of medications, and adverse
674.7 reactions to medications for each client. The license holder must address and document any
674.8 concerns about a client's medications;

674.9 (3) ensure that no staff person or client gives a legend drug supply for one client to
674.10 another client;

674.11 (4) have policies and procedures for: (i) keeping a record of each client's medication
674.12 orders; (ii) keeping a record of any incident of deferring a client's medications; (iii)
674.13 documenting any incident when a client's medication is omitted; and (iv) documenting when
674.14 a client refuses to take medications as prescribed; and

674.15 (5) document and track medication errors, document whether the license holder notified
674.16 anyone about the medication error, determine if the license holder must take any follow-up
674.17 actions, and identify the staff persons who are responsible for taking follow-up actions.

674.18 Sec. 13. **[245I.12] CLIENT RIGHTS AND PROTECTIONS.**

674.19 Subdivision 1. **Client rights.** A license holder must ensure that all clients have the
674.20 following rights:

674.21 (1) the rights listed in the health care bill of rights in section 144.651;

674.22 (2) the right to be free from discrimination based on age, race, color, creed, religion,
674.23 national origin, gender, marital status, disability, sexual orientation, and status with regard
674.24 to public assistance. The license holder must follow all applicable state and federal laws
674.25 including the Minnesota Human Rights Act, chapter 363A; and

674.26 (3) the right to be informed prior to a photograph or audio or video recording being made
674.27 of the client. The client has the right to refuse to allow any recording or photograph of the
674.28 client that is not for the purposes of identification or supervision by the license holder.

674.29 Subd. 2. **Restrictions to client rights.** If the license holder restricts a client's right, the
674.30 license holder must document in the client file a mental health professional's approval of
674.31 the restriction and the reasons for the restriction.

675.1 Subd. 3. **Notice of rights.** The license holder must give a copy of the client's rights
675.2 according to this section to each client on the day of the client's admission. The license
675.3 holder must document that the license holder gave a copy of the client's rights to each client
675.4 on the day of the client's admission according to this section. The license holder must post
675.5 a copy of the client rights in an area visible or accessible to all clients. The license holder
675.6 must include the client rights in Minnesota Rules, chapter 9544, for applicable clients.

675.7 Subd. 4. **Client property.** (a) The license holder must meet the requirements of section
675.8 245A.04, subdivision 13.

675.9 (b) If the license holder is unable to obtain a client's signature acknowledging the receipt
675.10 or disbursement of the client's funds or property required by section 245A.04, subdivision
675.11 13, paragraph (c), clause (1), two staff persons must sign documentation acknowledging
675.12 that the staff persons witnessed the client's receipt or disbursement of the client's funds or
675.13 property.

675.14 (c) The license holder must return all of the client's funds and other property to the client
675.15 except for the following items:

675.16 (1) illicit drugs, drug paraphernalia, and drug containers that are subject to forfeiture
675.17 under section 609.5316. The license holder must give illicit drugs, drug paraphernalia, and
675.18 drug containers to a local law enforcement agency or destroy the items; and

675.19 (2) weapons, explosives, and other property that may cause serious harm to the client
675.20 or others. The license holder may give a client's weapons and explosives to a local law
675.21 enforcement agency. The license holder must notify the client that a local law enforcement
675.22 agency has the client's property and that the client has the right to reclaim the property if
675.23 the client has a legal right to possess the item.

675.24 (d) If a client leaves the license holder's program but abandons the client's funds or
675.25 property, the license holder must retain and store the client's funds or property, including
675.26 medications, for a minimum of 30 days after the client's discharge from the program.

675.27 Subd. 5. **Client grievances.** (a) The license holder must have a grievance procedure
675.28 that:

675.29 (1) describes to clients how the license holder will meet the requirements in this
675.30 subdivision; and

675.31 (2) contains the current public contact information of the Department of Human Services,
675.32 Licensing Division; the Office of Ombudsman for Mental Health and Developmental

676.1 Disabilities; the Department of Health, Office of Health Facilities Complaints; and all
676.2 applicable health-related licensing boards.

676.3 (b) On the day of each client's admission, the license holder must explain the grievance
676.4 procedure to the client.

676.5 (c) The license holder must:

676.6 (1) post the grievance procedure in a place visible to clients and provide a copy of the
676.7 grievance procedure upon request;

676.8 (2) allow clients, former clients, and their authorized representatives to submit a grievance
676.9 to the license holder;

676.10 (3) within three business days of receiving a client's grievance, acknowledge in writing
676.11 that the license holder received the client's grievance. If applicable, the license holder must
676.12 include a notice of the client's separate appeal rights for a managed care organization's
676.13 reduction, termination, or denial of a covered service;

676.14 (4) within 15 business days of receiving a client's grievance, provide a written final
676.15 response to the client's grievance containing the license holder's official response to the
676.16 grievance; and

676.17 (5) allow the client to bring a grievance to the person with the highest level of authority
676.18 in the program.

676.19 Sec. 14. **[245I.13] CRITICAL INCIDENTS.**

676.20 If a license holder is licensed as a residential program, the license holder must report all
676.21 critical incidents to the commissioner within ten days of learning of the incident on a form
676.22 approved by the commissioner. The license holder must keep a record of critical incidents
676.23 in a central location that is readily accessible to the commissioner for review upon the
676.24 commissioner's request for a minimum of two licensing periods.

676.25 Sec. 15. **[245I.20] MENTAL HEALTH CLINIC.**

676.26 Subdivision 1. **Purpose.** Certified mental health clinics provide clinical services for the
676.27 treatment of mental illnesses with a treatment team that reflects multiple disciplines and
676.28 areas of expertise.

676.29 Subd. 2. **Definitions.** (a) "Clinical services" means services provided to a client to
676.30 diagnose, describe, predict, and explain the client's status relative to a condition or problem
676.31 as described in the: (1) current edition of the Diagnostic and Statistical Manual of Mental

677.1 Disorders published by the American Psychiatric Association; or (2) current edition of the
677.2 DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy
677.3 and Early Childhood published by Zero to Three. Where necessary, clinical services includes
677.4 services to treat a client to reduce the client's impairment due to the client's condition.
677.5 Clinical services also includes individual treatment planning, case review, record-keeping
677.6 required for a client's treatment, and treatment supervision. For the purposes of this section,
677.7 clinical services excludes services delivered to a client under a separate license and services
677.8 listed under section 245I.011, subdivision 5.

677.9 (b) "Competent" means having professional education, training, continuing education,
677.10 consultation, supervision, experience, or a combination thereof necessary to demonstrate
677.11 sufficient knowledge of and proficiency in a specific clinical service.

677.12 (c) "Discipline" means a branch of professional knowledge or skill acquired through a
677.13 specific course of study, training, and supervised practice. Discipline is usually documented
677.14 by a specific educational degree, licensure, or certification of proficiency. Examples of the
677.15 mental health disciplines include but are not limited to psychiatry, psychology, clinical
677.16 social work, marriage and family therapy, clinical counseling, and psychiatric nursing.

677.17 (d) "Treatment team" means the mental health professionals, mental health practitioners,
677.18 and clinical trainees who provide clinical services to clients.

677.19 Subd. 3. **Organizational structure.** (a) A mental health clinic location must be an entire
677.20 facility or a clearly identified unit within a facility that is administratively and clinically
677.21 separate from the rest of the facility. The mental health clinic location may provide services
677.22 other than clinical services to clients, including medical services, substance use disorder
677.23 services, social services, training, and education.

677.24 (b) The certification holder must notify the commissioner of all mental health clinic
677.25 locations. If there is more than one mental health clinic location, the certification holder
677.26 must designate one location as the main location and all of the other locations as satellite
677.27 locations. The main location as a unit and the clinic as a whole must comply with the
677.28 minimum staffing standards in subdivision 4.

677.29 (c) The certification holder must ensure that each satellite location:

677.30 (1) adheres to the same policies and procedures as the main location;

677.31 (2) provides treatment team members with face-to-face or telephone access to a mental
677.32 health professional for the purposes of supervision whenever the satellite location is open.
677.33 The certification holder must maintain a schedule of the mental health professionals who

678.1 will be available and the contact information for each available mental health professional.
678.2 The schedule must be current and readily available to treatment team members; and

678.3 (3) enables clients to access all of the mental health clinic's clinical services and treatment
678.4 team members, as needed.

678.5 Subd. 4. **Minimum staffing standards.** (a) A certification holder's treatment team must
678.6 consist of at least four mental health professionals. At least two of the mental health
678.7 professionals must be employed by or under contract with the mental health clinic for a
678.8 minimum of 35 hours per week each. Each of the two mental health professionals must
678.9 specialize in a different mental health discipline.

678.10 (b) The treatment team must include:

678.11 (1) a physician qualified as a mental health professional according to section 245I.04,
678.12 subdivision 2, clause (4), or a nurse qualified as a mental health professional according to
678.13 section 245I.04, subdivision 2, clause (1); and

678.14 (2) a psychologist qualified as a mental health professional according to section 245I.04,
678.15 subdivision 2, clause (3).

678.16 (c) The staff persons fulfilling the requirement in paragraph (b) must provide clinical
678.17 services at least:

678.18 (1) eight hours every two weeks if the mental health clinic has over 25.0 full-time
678.19 equivalent treatment team members;

678.20 (2) eight hours each month if the mental health clinic has 15.1 to 25.0 full-time equivalent
678.21 treatment team members;

678.22 (3) four hours each month if the mental health clinic has 5.1 to 15.0 full-time equivalent
678.23 treatment team members; or

678.24 (4) two hours each month if the mental health clinic has 2.0 to 5.0 full-time equivalent
678.25 treatment team members or only provides in-home services to clients.

678.26 (d) The certification holder must maintain a record that demonstrates compliance with
678.27 this subdivision.

678.28 Subd. 5. **Treatment supervision specified.** (a) A mental health professional must remain
678.29 responsible for each client's case. The certification holder must document the name of the
678.30 mental health professional responsible for each case and the dates that the mental health
678.31 professional is responsible for the client's case from beginning date to end date. The
678.32 certification holder must assign each client's case for assessment, diagnosis, and treatment

679.1 services to a treatment team member who is competent in the assigned clinical service, the
679.2 recommended treatment strategy, and in treating the client's characteristics.

679.3 (b) Treatment supervision of mental health practitioners and clinical trainees required
679.4 by section 245I.06 must include case reviews as described in this paragraph. Every two
679.5 months, a mental health professional must complete a case review of each client assigned
679.6 to the mental health professional when the client is receiving clinical services from a mental
679.7 health practitioner or clinical trainee. The case review must include a consultation process
679.8 that thoroughly examines the client's condition and treatment, including: (1) a review of the
679.9 client's reason for seeking treatment, diagnoses and assessments, and the individual treatment
679.10 plan; (2) a review of the appropriateness, duration, and outcome of treatment provided to
679.11 the client; and (3) treatment recommendations.

679.12 Subd. 6. **Additional policy and procedure requirements.** (a) In addition to the policies
679.13 and procedures required by section 245I.03, the certification holder must establish, enforce,
679.14 and maintain the policies and procedures required by this subdivision.

679.15 (b) The certification holder must have a clinical evaluation procedure to identify and
679.16 document each treatment team member's areas of competence.

679.17 (c) The certification holder must have policies and procedures for client intake and case
679.18 assignment that:

679.19 (1) outline the client intake process;

679.20 (2) describe how the mental health clinic determines the appropriateness of accepting a
679.21 client into treatment by reviewing the client's condition and need for treatment, the clinical
679.22 services that the mental health clinic offers to clients, and other available resources; and

679.23 (3) contain a process for assigning a client's case to a mental health professional who is
679.24 responsible for the client's case and other treatment team members.

679.25 Subd. 7. **Referrals.** If necessary treatment for a client or treatment desired by a client
679.26 is not available at the mental health clinic, the certification holder must facilitate appropriate
679.27 referrals for the client. When making a referral for a client, the treatment team member must
679.28 document a discussion with the client that includes: (1) the reason for the client's referral;
679.29 (2) potential treatment resources for the client; and (3) the client's response to receiving a
679.30 referral.

679.31 Subd. 8. **Emergency service.** For the certification holder's telephone numbers that clients
679.32 regularly access, the certification holder must include the contact information for the area's

680.1 mental health crisis services as part of the certification holder's message when a live operator
680.2 is not available to answer clients' calls.

680.3 Subd. 9. **Quality assurance and improvement plan.** (a) At a minimum, a certification
680.4 holder must develop a written quality assurance and improvement plan that includes a plan
680.5 for:

680.6 (1) encouraging ongoing consultation among members of the treatment team;

680.7 (2) obtaining and evaluating feedback about services from clients, family and other
680.8 natural supports, referral sources, and staff persons;

680.9 (3) measuring and evaluating client outcomes;

680.10 (4) reviewing client suicide deaths and suicide attempts;

680.11 (5) examining the quality of clinical service delivery to clients; and

680.12 (6) self-monitoring of compliance with this chapter.

680.13 (b) At least annually, the certification holder must review, evaluate, and update the
680.14 quality assurance and improvement plan. The review must: (1) include documentation of
680.15 the actions that the certification holder will take as a result of information obtained from
680.16 monitoring activities in the plan; and (2) establish goals for improved service delivery to
680.17 clients for the next year.

680.18 Subd. 10. **Application procedures.** (a) The applicant for certification must submit any
680.19 documents that the commissioner requires on forms approved by the commissioner.

680.20 (b) Upon submitting an application for certification, an applicant must pay the application
680.21 fee required by section 245A.10, subdivision 3.

680.22 (c) The commissioner must act on an application within 90 working days of receiving
680.23 a completed application.

680.24 (d) When the commissioner receives an application for initial certification that is
680.25 incomplete because the applicant failed to submit required documents or is deficient because
680.26 the submitted documents do not meet certification requirements, the commissioner must
680.27 provide the applicant with written notice that the application is incomplete or deficient. In
680.28 the notice, the commissioner must identify the particular documents that are missing or
680.29 deficient and give the applicant 45 days to submit a second application that is complete. An
680.30 applicant's failure to submit a complete application within 45 days after receiving notice
680.31 from the commissioner is a basis for certification denial.

681.1 (e) The commissioner must give notice of a denial to an applicant when the commissioner
681.2 has made the decision to deny the certification application. In the notice of denial, the
681.3 commissioner must state the reasons for the denial in plain language. The commissioner
681.4 must send or deliver the notice of denial to an applicant by certified mail or personal service.
681.5 In the notice of denial, the commissioner must state the reasons that the commissioner denied
681.6 the application and must inform the applicant of the applicant's right to request a contested
681.7 case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The
681.8 applicant may appeal the denial by notifying the commissioner in writing by certified mail
681.9 or personal service. If mailed, the appeal must be postmarked and sent to the commissioner
681.10 within 20 calendar days after the applicant received the notice of denial. If an applicant
681.11 delivers an appeal by personal service, the commissioner must receive the appeal within 20
681.12 calendar days after the applicant received the notice of denial.

681.13 Subd. 11. **Commissioner's right of access.** (a) When the commissioner is exercising
681.14 the powers conferred to the commissioner by this chapter, if the mental health clinic is in
681.15 operation and the information is relevant to the commissioner's inspection or investigation,
681.16 the certification holder must provide the commissioner access to:

681.17 (1) the physical facility and grounds where the program is located;

681.18 (2) documentation and records, including electronically maintained records;

681.19 (3) clients served by the mental health clinic;

681.20 (4) staff persons of the mental health clinic; and

681.21 (5) personnel records of current and former staff of the mental health clinic.

681.22 (b) The certification holder must provide the commissioner with access to the facility
681.23 and grounds, documentation and records, clients, and staff without prior notice and as often
681.24 as the commissioner considers necessary if the commissioner is investigating alleged
681.25 maltreatment or a violation of a law or rule, or conducting an inspection. When conducting
681.26 an inspection, the commissioner may request and must receive assistance from other state,
681.27 county, and municipal governmental agencies and departments. The applicant or certification
681.28 holder must allow the commissioner, at the commissioner's expense, to photocopy,
681.29 photograph, and make audio and video recordings during an inspection.

681.30 Subd. 12. **Monitoring and inspections.** (a) The commissioner may conduct a certification
681.31 review of the certified mental health clinic every two years to determine the certification
681.32 holder's compliance with applicable rules and statutes.

682.1 (b) The commissioner must offer the certification holder a choice of dates for an
682.2 announced certification review. A certification review must occur during the clinic's normal
682.3 working hours.

682.4 (c) The commissioner must make the results of certification reviews and investigations
682.5 publicly available on the department's website.

682.6 Subd. 13. **Correction orders.** (a) If the applicant or certification holder fails to comply
682.7 with a law or rule, the commissioner may issue a correction order. The correction order
682.8 must state:

682.9 (1) the condition that constitutes a violation of the law or rule;

682.10 (2) the specific law or rule that the applicant or certification holder has violated; and

682.11 (3) the time that the applicant or certification holder is allowed to correct each violation.

682.12 (b) If the applicant or certification holder believes that the commissioner's correction
682.13 order is erroneous, the applicant or certification holder may ask the commissioner to
682.14 reconsider the part of the correction order that is allegedly erroneous. An applicant or
682.15 certification holder must make a request for reconsideration in writing. The request must
682.16 be postmarked and sent to the commissioner within 20 calendar days after the applicant or
682.17 certification holder received the correction order; and the request must:

682.18 (1) specify the part of the correction order that is allegedly erroneous;

682.19 (2) explain why the specified part is erroneous; and

682.20 (3) include documentation to support the allegation of error.

682.21 (c) A request for reconsideration does not stay any provision or requirement of the
682.22 correction order. The commissioner's disposition of a request for reconsideration is final
682.23 and not subject to appeal.

682.24 (d) If the commissioner finds that the applicant or certification holder failed to correct
682.25 the violation specified in the correction order, the commissioner may decertify the certified
682.26 mental health clinic according to subdivision 14.

682.27 (e) Nothing in this subdivision prohibits the commissioner from decertifying a mental
682.28 health clinic according to subdivision 14.

682.29 Subd. 14. **Decertification.** (a) The commissioner may decertify a mental health clinic
682.30 if a certification holder:

682.31 (1) failed to comply with an applicable law or rule; or

683.1 (2) knowingly withheld relevant information from or gave false or misleading information
683.2 to the commissioner in connection with an application for certification, during an
683.3 investigation, or regarding compliance with applicable laws or rules.

683.4 (b) When considering decertification of a mental health clinic, the commissioner must
683.5 consider the nature, chronicity, or severity of the violation of law or rule and the effect of
683.6 the violation on the health, safety, or rights of clients.

683.7 (c) If the commissioner decertifies a mental health clinic, the order of decertification
683.8 must inform the certification holder of the right to have a contested case hearing under
683.9 chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The certification holder
683.10 may appeal the decertification. The certification holder must appeal a decertification in
683.11 writing and send or deliver the appeal to the commissioner by certified mail or personal
683.12 service. If the certification holder mails the appeal, the appeal must be postmarked and sent
683.13 to the commissioner within ten calendar days after the certification holder receives the order
683.14 of decertification. If the certification holder delivers an appeal by personal service, the
683.15 commissioner must receive the appeal within ten calendar days after the certification holder
683.16 received the order. If a certification holder submits a timely appeal of an order of
683.17 decertification, the certification holder may continue to operate the program until the
683.18 commissioner issues a final order on the decertification.

683.19 (d) If the commissioner decertifies a mental health clinic pursuant to paragraph (a),
683.20 clause (1), based on a determination that the mental health clinic was responsible for
683.21 maltreatment, and if the certification holder appeals the decertification according to paragraph
683.22 (c), and appeals the maltreatment determination under section 260E.33, the final
683.23 decertification determination is stayed until the commissioner issues a final decision regarding
683.24 the maltreatment appeal.

683.25 Subd. 15. **Transfer prohibited.** A certification issued under this section is only valid
683.26 for the premises and the individual, organization, or government entity identified by the
683.27 commissioner on the certification. A certification is not transferable or assignable.

683.28 Subd. 16. **Notifications required and noncompliance.** (a) A certification holder must
683.29 notify the commissioner, in a manner prescribed by the commissioner, and obtain the
683.30 commissioner's approval before making any change to the name of the certification holder
683.31 or the location of the mental health clinic.

683.32 (b) Changes in mental health clinic organization, staffing, treatment, or quality assurance
683.33 procedures that affect the ability of the certification holder to comply with the minimum
683.34 standards of this section must be reported in writing by the certification holder to the

684.1 commissioner within 15 days of the occurrence. Review of the change must be conducted
684.2 by the commissioner. A certification holder with changes resulting in noncompliance in
684.3 minimum standards must receive written notice and may have up to 180 days to correct the
684.4 areas of noncompliance before being decertified. Interim procedures to resolve the
684.5 noncompliance on a temporary basis must be developed and submitted in writing to the
684.6 commissioner for approval within 30 days of the commissioner's determination of the
684.7 noncompliance. Not reporting an occurrence of a change that results in noncompliance
684.8 within 15 days, failure to develop an approved interim procedure within 30 days of the
684.9 determination of the noncompliance, or nonresolution of the noncompliance within 180
684.10 days will result in immediate decertification.

684.11 (c) The mental health clinic may be required to submit written information to the
684.12 department to document that the mental health clinic has maintained compliance with this
684.13 section and mental health clinic procedures.

684.14 Sec. 16. **[245I.23] INTENSIVE RESIDENTIAL TREATMENT SERVICES AND**
684.15 **RESIDENTIAL CRISIS STABILIZATION.**

684.16 Subdivision 1. **Purpose.** (a) Intensive residential treatment services is a community-based
684.17 medically monitored level of care for an adult client that uses established rehabilitative
684.18 principles to promote a client's recovery and to develop and achieve psychiatric stability,
684.19 personal and emotional adjustment, self-sufficiency, and other skills that help a client
684.20 transition to a more independent setting.

684.21 (b) Residential crisis stabilization provides structure and support to an adult client in a
684.22 community living environment when a client has experienced a mental health crisis and
684.23 needs short-term services to ensure that the client can safely return to the client's home or
684.24 precrisis living environment with additional services and supports identified in the client's
684.25 crisis assessment.

684.26 Subd. 2. **Definitions.** (a) "Program location" means a set of rooms that are each physically
684.27 self-contained and have defining walls extending from floor to ceiling. Program location
684.28 includes bedrooms, living rooms or lounge areas, bathrooms, and connecting areas.

684.29 (b) "Treatment team" means a group of staff persons who provide intensive residential
684.30 treatment services or residential crisis stabilization to clients. The treatment team includes
684.31 mental health professionals, mental health practitioners, clinical trainees, certified
684.32 rehabilitation specialists, mental health rehabilitation workers, and mental health certified
684.33 peer specialists.

685.1 Subd. 3. **Treatment services description.** The license holder must describe in writing
685.2 all treatment services that the license holder provides. The license holder must have the
685.3 description readily available for the commissioner upon the commissioner's request.

685.4 Subd. 4. **Required intensive residential treatment services.** (a) On a daily basis, the
685.5 license holder must follow a client's treatment plan to provide intensive residential treatment
685.6 services to the client to improve the client's functioning.

685.7 (b) The license holder must offer and have the capacity to directly provide the following
685.8 treatment services to each client:

685.9 (1) rehabilitative mental health services;

685.10 (2) crisis prevention planning to assist a client with:

685.11 (i) identifying and addressing patterns in the client's history and experience of the client's
685.12 mental illness; and

685.13 (ii) developing crisis prevention strategies that include de-escalation strategies that have
685.14 been effective for the client in the past;

685.15 (3) health services and administering medication;

685.16 (4) co-occurring substance use disorder treatment;

685.17 (5) engaging the client's family and other natural supports in the client's treatment and
685.18 educating the client's family and other natural supports to strengthen the client's social and
685.19 family relationships; and

685.20 (6) making referrals for the client to other service providers in the community and
685.21 supporting the client's transition from intensive residential treatment services to another
685.22 setting.

685.23 (c) The license holder must include Illness Management and Recovery (IMR), Enhanced
685.24 Illness Management and Recovery (E-IMR), or other similar interventions in the license
685.25 holder's programming as approved by the commissioner.

685.26 Subd. 5. **Required residential crisis stabilization services.** (a) On a daily basis, the
685.27 license holder must follow a client's individual crisis treatment plan to provide services to
685.28 the client in residential crisis stabilization to improve the client's functioning.

685.29 (b) The license holder must offer and have the capacity to directly provide the following
685.30 treatment services to the client:

685.31 (1) crisis stabilization services as described in section 256B.0624, subdivision 7;

686.1 (2) rehabilitative mental health services;

686.2 (3) health services and administering the client's medications; and

686.3 (4) making referrals for the client to other service providers in the community and
686.4 supporting the client's transition from residential crisis stabilization to another setting.

686.5 Subd. 6. **Optional treatment services.** (a) If the license holder offers additional treatment
686.6 services to a client, the treatment service must be:

686.7 (1) approved by the commissioner; and

686.8 (2)(i) a mental health evidence-based practice that the federal Department of Health and
686.9 Human Services Substance Abuse and Mental Health Service Administration has adopted;

686.10 (ii) a nationally recognized mental health service that substantial research has validated
686.11 as effective in helping individuals with serious mental illness achieve treatment goals; or

686.12 (iii) developed under state-sponsored research of publicly funded mental health programs
686.13 and validated to be effective for individuals, families, and communities.

686.14 (b) Before providing an optional treatment service to a client, the license holder must
686.15 provide adequate training to a staff person about providing the optional treatment service
686.16 to a client.

686.17 Subd. 7. **Intensive residential treatment services assessment and treatment**
686.18 **planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate and
686.19 document the client's immediate needs, including the client's:

686.20 (1) health and safety, including the client's need for crisis assistance;

686.21 (2) responsibilities for children, family and other natural supports, and employers; and

686.22 (3) housing and legal issues.

686.23 (b) Within 24 hours of the client's admission, the license holder must complete an initial
686.24 treatment plan for the client. The license holder must:

686.25 (1) base the client's initial treatment plan on the client's referral information and an
686.26 assessment of the client's immediate needs;

686.27 (2) consider crisis assistance strategies that have been effective for the client in the past;

686.28 (3) identify the client's initial treatment goals, measurable treatment objectives, and
686.29 specific interventions that the license holder will use to help the client engage in treatment;

687.1 (4) identify the participants involved in the client's treatment planning. The client must
687.2 be a participant; and

687.3 (5) ensure that a treatment supervisor approves of the client's initial treatment plan if a
687.4 mental health practitioner or clinical trainee completes the client's treatment plan,
687.5 notwithstanding section 245I.08, subdivision 3.

687.6 (c) According to section 245A.65, subdivision 2, paragraph (b), the license holder must
687.7 complete an individual abuse prevention plan as part of a client's initial treatment plan.

687.8 (d) Within five days of the client's admission and again within 60 days after the client's
687.9 admission, the license holder must complete a level of care assessment of the client. If the
687.10 license holder determines that a client does not need a medically monitored level of service,
687.11 a treatment supervisor must document how the client's admission to and continued services
687.12 in intensive residential treatment services are medically necessary for the client.

687.13 (e) Within ten days of a client's admission, the license holder must complete or review
687.14 and update the client's standard diagnostic assessment.

687.15 (f) Within ten days of a client's admission, the license holder must complete the client's
687.16 individual treatment plan, notwithstanding section 245I.10, subdivision 8. Within 40 days
687.17 after the client's admission and again within 70 days after the client's admission, the license
687.18 holder must update the client's individual treatment plan. The license holder must focus the
687.19 client's treatment planning on preparing the client for a successful transition from intensive
687.20 residential treatment services to another setting. In addition to the required elements of an
687.21 individual treatment plan under section 245I.10, subdivision 8, the license holder must
687.22 identify the following information in the client's individual treatment plan: (1) the client's
687.23 referrals and resources for the client's health and safety; and (2) the staff persons who are
687.24 responsible for following up with the client's referrals and resources. If the client does not
687.25 receive a referral or resource that the client needs, the license holder must document the
687.26 reason that the license holder did not make the referral or did not connect the client to a
687.27 particular resource. The license holder is responsible for determining whether additional
687.28 follow-up is required on behalf of the client.

687.29 (g) Within 30 days of the client's admission, the license holder must complete a functional
687.30 assessment of the client. Within 60 days after the client's admission, the license holder must
687.31 update the client's functional assessment to include any changes in the client's functioning
687.32 and symptoms.

687.33 (h) For a client with a current substance use disorder diagnosis and for a client whose
687.34 substance use disorder screening in the client's standard diagnostic assessment indicates the

688.1 possibility that the client has a substance use disorder, the license holder must complete a
688.2 written assessment of the client's substance use within 30 days of the client's admission. In
688.3 the substance use assessment, the license holder must: (1) evaluate the client's history of
688.4 substance use, relapses, and hospitalizations related to substance use; (2) assess the effects
688.5 of the client's substance use on the client's relationships including with family member and
688.6 others; (3) identify financial problems, health issues, housing instability, and unemployment;
688.7 (4) assess the client's legal problems, past and pending incarceration, violence, and
688.8 victimization; and (5) evaluate the client's suicide attempts, noncompliance with taking
688.9 prescribed medications, and noncompliance with psychosocial treatment.

688.10 (i) On a weekly basis, a mental health professional or certified rehabilitation specialist
688.11 must review each client's treatment plan and individual abuse prevention plan. The license
688.12 holder must document in the client's file each weekly review of the client's treatment plan
688.13 and individual abuse prevention plan.

688.14 Subd. 8. **Residential crisis stabilization assessment and treatment planning.** (a)
688.15 Within 12 hours of a client's admission, the license holder must evaluate the client and
688.16 document the client's immediate needs, including the client's:

688.17 (1) health and safety, including the client's need for crisis assistance;

688.18 (2) responsibilities for children, family and other natural supports, and employers; and

688.19 (3) housing and legal issues.

688.20 (b) Within 24 hours of a client's admission, the license holder must complete a crisis
688.21 treatment plan for the client under section 256B.0624, subdivision 11. The license holder
688.22 must base the client's crisis treatment plan on the client's referral information and an
688.23 assessment of the client's immediate needs.

688.24 (c) Section 245A.65, subdivision 2, paragraph (b), requires the license holder to complete
688.25 an individual abuse prevention plan for a client as part of the client's crisis treatment plan.

688.26 Subd. 9. **Key staff positions.** (a) The license holder must have a staff person assigned
688.27 to each of the following key staff positions at all times:

688.28 (1) a program director who qualifies as a mental health practitioner. The license holder
688.29 must designate the program director as responsible for all aspects of the operation of the
688.30 program and the program's compliance with all applicable requirements. The program
688.31 director must know and understand the implications of this chapter; chapters 245A, 245C,
688.32 and 260E; sections 626.557 and 626.5572; Minnesota Rules, chapter 9544; and all other
688.33 applicable requirements. The license holder must document in the program director's

689.1 personnel file how the program director demonstrates knowledge of these requirements.
689.2 The program director may also serve as the treatment director of the program, if qualified;

689.3 (2) a treatment director who qualifies as a mental health professional. The treatment
689.4 director must be responsible for overseeing treatment services for clients and the treatment
689.5 supervision of all staff persons; and

689.6 (3) a registered nurse who qualifies as a mental health practitioner. The registered nurse
689.7 must:

689.8 (i) work at the program location a minimum of eight hours per week;

689.9 (ii) provide monitoring and supervision of staff persons as defined in section 148.171,
689.10 subdivisions 8a and 23;

689.11 (iii) be responsible for the review and approval of health service and medication policies
689.12 and procedures under section 245I.03, subdivision 5; and

689.13 (iv) oversee the license holder's provision of health services to clients, medication storage,
689.14 and medication administration to clients.

689.15 (b) Within five business days of a change in a key staff position, the license holder must
689.16 notify the commissioner of the staffing change. The license holder must notify the
689.17 commissioner of the staffing change on a form approved by the commissioner and include
689.18 the name of the staff person now assigned to the key staff position and the staff person's
689.19 qualifications.

689.20 Subd. 10. **Minimum treatment team staffing levels and ratios.** (a) The license holder
689.21 must maintain a treatment team staffing level sufficient to:

689.22 (1) provide continuous daily coverage of all shifts;

689.23 (2) follow each client's treatment plan and meet each client's needs as identified in the
689.24 client's treatment plan;

689.25 (3) implement program requirements; and

689.26 (4) safely monitor and guide the activities of each client, taking into account the client's
689.27 level of behavioral and psychiatric stability, cultural needs, and vulnerabilities.

689.28 (b) The license holder must ensure that treatment team members:

689.29 (1) remain awake during all work hours; and

689.30 (2) are available to monitor and guide the activities of each client whenever clients are
689.31 present in the program.

690.1 (c) On each shift, the license holder must maintain a treatment team staffing ratio of at
690.2 least one treatment team member to nine clients. If the license holder is serving nine or
690.3 fewer clients, at least one treatment team member on the day shift must be a mental health
690.4 professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.
690.5 If the license holder is serving more than nine clients, at least one of the treatment team
690.6 members working during both the day and evening shifts must be a mental health
690.7 professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.

690.8 (d) If the license holder provides residential crisis stabilization to clients and is serving
690.9 at least one client in residential crisis stabilization and more than four clients in residential
690.10 crisis stabilization and intensive residential treatment services, the license holder must
690.11 maintain a treatment team staffing ratio on each shift of at least two treatment team members
690.12 during the client's first 48 hours in residential crisis stabilization.

690.13 Subd. 11. **Shift exchange.** A license holder must ensure that treatment team members
690.14 working on different shifts exchange information about a client as necessary to effectively
690.15 care for the client and to follow and update a client's treatment plan and individual abuse
690.16 prevention plan.

690.17 Subd. 12. **Daily documentation.** (a) For each day that a client is present in the program,
690.18 the license holder must provide a daily summary in the client's file that includes observations
690.19 about the client's behavior and symptoms, including any critical incidents in which the client
690.20 was involved.

690.21 (b) For each day that a client is not present in the program, the license holder must
690.22 document the reason for a client's absence in the client's file.

690.23 Subd. 13. **Access to a mental health professional, clinical trainee, certified**
690.24 **rehabilitation specialist, or mental health practitioner.** Treatment team members must
690.25 have access in person or by telephone to a mental health professional, clinical trainee,
690.26 certified rehabilitation specialist, or mental health practitioner within 30 minutes. The license
690.27 holder must maintain a schedule of mental health professionals, clinical trainees, certified
690.28 rehabilitation specialists, or mental health practitioners who will be available and contact
690.29 information to reach them. The license holder must keep the schedule current and make the
690.30 schedule readily available to treatment team members.

690.31 Subd. 14. **Weekly team meetings.** (a) The license holder must hold weekly team meetings
690.32 and ancillary meetings according to this subdivision.

690.33 (b) A mental health professional or certified rehabilitation specialist must hold at least
690.34 one team meeting each calendar week and be physically present at the team meeting. All

691.1 treatment team members, including treatment team members who work on a part-time or
691.2 intermittent basis, must participate in a minimum of one team meeting during each calendar
691.3 week when the treatment team member is working for the license holder. The license holder
691.4 must document all weekly team meetings, including the names of meeting attendees.

691.5 (c) If a treatment team member cannot participate in a weekly team meeting, the treatment
691.6 team member must participate in an ancillary meeting. A mental health professional, certified
691.7 rehabilitation specialist, clinical trainee, or mental health practitioner who participated in
691.8 the most recent weekly team meeting may lead the ancillary meeting. During the ancillary
691.9 meeting, the treatment team member leading the ancillary meeting must review the
691.10 information that was shared at the most recent weekly team meeting, including revisions
691.11 to client treatment plans and other information that the treatment supervisors exchanged
691.12 with treatment team members. The license holder must document all ancillary meetings,
691.13 including the names of meeting attendees.

691.14 Subd. 15. **Intensive residential treatment services admission criteria.** (a) An eligible
691.15 client for intensive residential treatment services is an individual who:

691.16 (1) is age 18 or older;

691.17 (2) is diagnosed with a mental illness;

691.18 (3) because of a mental illness, has a substantial disability and functional impairment
691.19 in three or more areas listed in section 245I.10, subdivision 9, clause (4), that markedly
691.20 reduce the individual's self-sufficiency;

691.21 (4) has one or more of the following: a history of recurring or prolonged inpatient
691.22 hospitalizations during the past year, significant independent living instability, homelessness,
691.23 or very frequent use of mental health and related services with poor outcomes for the
691.24 individual; and

691.25 (5) in the written opinion of a mental health professional, needs mental health services
691.26 that available community-based services cannot provide, or is likely to experience a mental
691.27 health crisis or require a more restrictive setting if the individual does not receive intensive
691.28 rehabilitative mental health services.

691.29 (b) The license holder must not limit or restrict intensive residential treatment services
691.30 to a client based solely on:

691.31 (1) the client's substance use;

691.32 (2) the county in which the client resides; or

692.1 (3) whether the client elects to receive other services for which the client may be eligible,
692.2 including case management services.

692.3 (c) This subdivision does not prohibit the license holder from restricting admissions of
692.4 individuals who present an imminent risk of harm or danger to themselves or others.

692.5 Subd. 16. **Residential crisis stabilization services admission criteria.** An eligible client
692.6 for residential crisis stabilization is an individual who is age 18 or older and meets the
692.7 eligibility criteria in section 256B.0624, subdivision 3.

692.8 Subd. 17. **Admissions referrals and determinations.** (a) The license holder must
692.9 identify the information that the license holder needs to make a determination about a
692.10 person's admission referral.

692.11 (b) The license holder must:

692.12 (1) always be available to receive referral information about a person seeking admission
692.13 to the license holder's program;

692.14 (2) respond to the referral source within eight hours of receiving a referral and, within
692.15 eight hours, communicate with the referral source about what information the license holder
692.16 needs to make a determination concerning the person's admission;

692.17 (3) consider the license holder's staffing ratio and the areas of treatment team members'
692.18 competency when determining whether the license holder is able to meet the needs of a
692.19 person seeking admission; and

692.20 (4) determine whether to admit a person within 72 hours of receiving all necessary
692.21 information from the referral source.

692.22 Subd. 18. **Discharge standards.** (a) When a license holder discharges a client from a
692.23 program, the license holder must categorize the discharge as a successful discharge,
692.24 program-initiated discharge, or non-program-initiated discharge according to the criteria in
692.25 this subdivision. The license holder must meet the standards associated with the type of
692.26 discharge according to this subdivision.

692.27 (b) To successfully discharge a client from a program, the license holder must ensure
692.28 that the following criteria are met:

692.29 (1) the client must substantially meet the client's documented treatment plan goals and
692.30 objectives;

692.31 (2) the client must complete discharge planning with the treatment team; and

693.1 (3) the client and treatment team must arrange for the client to receive continuing care
693.2 at a less intensive level of care after discharge.

693.3 (c) Prior to successfully discharging a client from a program, the license holder must
693.4 complete the client's discharge summary and provide the client with a copy of the client's
693.5 discharge summary in plain language that includes:

693.6 (1) a brief review of the client's problems and strengths during the period that the license
693.7 holder provided services to the client;

693.8 (2) the client's response to the client's treatment plan;

693.9 (3) the goals and objectives that the license holder recommends that the client addresses
693.10 during the first three months following the client's discharge from the program;

693.11 (4) the recommended actions, supports, and services that will assist the client with a
693.12 successful transition from the program to another setting;

693.13 (5) the client's crisis plan; and

693.14 (6) the client's forwarding address and telephone number.

693.15 (d) For a non-program-initiated discharge of a client from a program, the following
693.16 criteria must be met:

693.17 (1)(i) the client has withdrawn the client's consent for treatment; (ii) the license holder
693.18 has determined that the client has the capacity to make an informed decision; and (iii) the
693.19 client does not meet the criteria for an emergency hold under section 253B.051, subdivision
693.20 2;

693.21 (2) the client has left the program against staff person advice;

693.22 (3) an entity with legal authority to remove the client has decided to remove the client
693.23 from the program; or

693.24 (4) a source of payment for the services is no longer available.

693.25 (e) Within ten days of a non-program-initiated discharge of a client from a program, the
693.26 license holder must complete the client's discharge summary in plain language that includes:

693.27 (1) the reasons for the client's discharge;

693.28 (2) a description of attempts by staff persons to enable the client to continue treatment
693.29 or to consent to treatment; and

693.30 (3) recommended actions, supports, and services that will assist the client with a
693.31 successful transition from the program to another setting.

694.1 (f) For a program-initiated discharge of a client from a program, the following criteria
694.2 must be met:

694.3 (1) the client is competent but has not participated in treatment or has not followed the
694.4 program rules and regulations and the client has not participated to such a degree that the
694.5 program's level of care is ineffective or unsafe for the client, despite multiple, documented
694.6 attempts that the license holder has made to address the client's lack of participation in
694.7 treatment;

694.8 (2) the client has not made progress toward the client's treatment goals and objectives
694.9 despite the license holder's persistent efforts to engage the client in treatment, and the license
694.10 holder has no reasonable expectation that the client will make progress at the program's
694.11 level of care nor does the client require the program's level of care to maintain the current
694.12 level of functioning;

694.13 (3) a court order or the client's legal status requires the client to participate in the program
694.14 but the client has left the program against staff person advice; or

694.15 (4) the client meets criteria for a more intensive level of care and a more intensive level
694.16 of care is available to the client.

694.17 (g) Prior to a program-initiated discharge of a client from a program, the license holder
694.18 must consult the client, the client's family and other natural supports, and the client's case
694.19 manager, if applicable, to review the issues involved in the program's decision to discharge
694.20 the client from the program. During the discharge review process, which must not exceed
694.21 five working days, the license holder must determine whether the license holder, treatment
694.22 team, and any interested persons can develop additional strategies to resolve the issues
694.23 leading to the client's discharge and to permit the client to have an opportunity to continue
694.24 receiving services from the license holder. The license holder may temporarily remove a
694.25 client from the program facility during the five-day discharge review period. The license
694.26 holder must document the client's discharge review in the client's file.

694.27 (h) Prior to a program-initiated discharge of a client from the program, the license holder
694.28 must complete the client's discharge summary and provide the client with a copy of the
694.29 discharge summary in plain language that includes:

694.30 (1) the reasons for the client's discharge;

694.31 (2) the alternatives to discharge that the license holder considered or attempted to
694.32 implement;

695.1 (3) the names of each individual who is involved in the decision to discharge the client
695.2 and a description of each individual's involvement; and

695.3 (4) recommended actions, supports, and services that will assist the client with a
695.4 successful transition from the program to another setting.

695.5 Subd. 19. **Program facility.** (a) The license holder must be licensed or certified as a
695.6 board and lodging facility, supervised living facility, or a boarding care home by the
695.7 Department of Health.

695.8 (b) The license holder must have a capacity of five to 16 beds and the program must not
695.9 be declared as an institution for mental disease.

695.10 (c) The license holder must furnish each program location to meet the psychological,
695.11 emotional, and developmental needs of clients.

695.12 (d) The license holder must provide one living room or lounge area per program location.
695.13 There must be space available to provide services according to each client's treatment plan,
695.14 such as an area for learning recreation time skills and areas for learning independent living
695.15 skills, such as laundering clothes and preparing meals.

695.16 (e) The license holder must ensure that each program location allows each client to have
695.17 privacy. Each client must have privacy during assessment interviews and counseling sessions.
695.18 Each client must have a space designated for the client to see outside visitors at the program
695.19 facility.

695.20 Subd. 20. **Physical separation of services.** If the license holder offers services to
695.21 individuals who are not receiving intensive residential treatment services or residential
695.22 stabilization at the program location, the license holder must inform the commissioner and
695.23 submit a plan for approval to the commissioner about how and when the license holder will
695.24 provide services. The license holder must only provide services to clients who are not
695.25 receiving intensive residential treatment services or residential crisis stabilization in an area
695.26 that is physically separated from the area in which the license holder provides clients with
695.27 intensive residential treatment services or residential crisis stabilization.

695.28 Subd. 21. **Dividing staff time between locations.** A license holder must obtain approval
695.29 from the commissioner prior to providing intensive residential treatment services or
695.30 residential crisis stabilization to clients in more than one program location under one license
695.31 and dividing one staff person's time between program locations during the same work period.

696.1 Subd. 22. **Additional policy and procedure requirements.** (a) In addition to the policies
696.2 and procedures in section 245I.03, the license holder must establish, enforce, and maintain
696.3 the policies and procedures in this subdivision.

696.4 (b) The license holder must have policies and procedures for receiving referrals and
696.5 making admissions determinations about referred persons under subdivisions 14 to 16.

696.6 (c) The license holder must have policies and procedures for discharging clients under
696.7 subdivision 17. In the policies and procedures, the license holder must identify the staff
696.8 persons who are authorized to discharge clients from the program.

696.9 Subd. 23. **Quality assurance and improvement plan.** (a) A license holder must develop
696.10 a written quality assurance and improvement plan that includes a plan to:

696.11 (1) encourage ongoing consultation between members of the treatment team;

696.12 (2) obtain and evaluate feedback about services from clients, family and other natural
696.13 supports, referral sources, and staff persons;

696.14 (3) measure and evaluate client outcomes in the program;

696.15 (4) review critical incidents in the program;

696.16 (5) examine the quality of clinical services in the program; and

696.17 (6) self-monitor the license holder's compliance with this chapter.

696.18 (b) At least annually, the license holder must review, evaluate, and update the license
696.19 holder's quality assurance and improvement plan. The license holder's review must:

696.20 (1) document the actions that the license holder will take in response to the information
696.21 that the license holder obtains from the monitoring activities in the plan; and

696.22 (2) establish goals for improving the license holder's services to clients during the next
696.23 year.

696.24 Subd. 24. **Application.** When an applicant requests licensure to provide intensive
696.25 residential treatment services, residential crisis stabilization, or both to clients, the applicant
696.26 must submit, on forms that the commissioner provides, any documents that the commissioner
696.27 requires.

696.28 Sec. 17. **[256B.0671] COVERED MENTAL HEALTH SERVICES.**

696.29 Subdivision 1. **Definitions.** (a) "Clinical trainee" means a staff person who is qualified
696.30 under section 245I.04, subdivision 6.

697.1 (b) "Mental health practitioner" means a staff person who is qualified under section
697.2 245I.04, subdivision 4.

697.3 (c) "Mental health professional" means a staff person who is qualified under section
697.4 245I.04, subdivision 2.

697.5 Subd. 2. **Generally.** (a) An individual, organization, or government entity providing
697.6 mental health services to a client under this section must obtain a criminal background study
697.7 of each staff person or volunteer who is providing direct contact services to a client.

697.8 (b) An individual, organization, or government entity providing mental health services
697.9 to a client under this section must comply with all responsibilities that chapter 245I assigns
697.10 to a license holder, except section 245I.011, subdivision 1, unless all of the individual's,
697.11 organization's, or government entity's treatment staff are qualified as mental health
697.12 professionals.

697.13 (c) An individual, organization, or government entity providing mental health services
697.14 to a client under this section must comply with the following requirements if all of the
697.15 license holder's treatment staff are qualified as mental health professionals:

697.16 (1) provider qualifications and scopes of practice under section 245I.04;

697.17 (2) maintaining and updating personnel files under section 245I.07;

697.18 (3) documenting under section 245I.08;

697.19 (4) maintaining and updating client files under section 245I.09;

697.20 (5) completing client assessments and treatment planning under section 245I.10;

697.21 (6) providing clients with health services and medications under section 245I.11; and

697.22 (7) respecting and enforcing client rights under section 245I.12.

697.23 Subd. 3. **Adult day treatment services.** (a) Subject to federal approval, medical
697.24 assistance covers adult day treatment (ADT) services that are provided under contract with
697.25 the county board. Adult day treatment payment is subject to the conditions in paragraphs
697.26 (b) to (e). The provider must make reasonable and good faith efforts to report individual
697.27 client outcomes to the commissioner using instruments, protocols, and forms approved by
697.28 the commissioner.

697.29 (b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve
697.30 the effects of mental illness on a client to enable the client to benefit from a lower level of
697.31 care and to live and function more independently in the community. Adult day treatment
697.32 services must be provided to a client to stabilize the client's mental health and to improve

698.1 the client's independent living and socialization skills. Adult day treatment must consist of
698.2 at least one hour of group psychotherapy and must include group time focused on
698.3 rehabilitative interventions or other therapeutic services that a multidisciplinary team provides
698.4 to each client. Adult day treatment services are not a part of inpatient or residential treatment
698.5 services. The following providers may apply to become adult day treatment providers:

698.6 (1) a hospital accredited by the Joint Commission on Accreditation of Health
698.7 Organizations and licensed under sections 144.50 to 144.55;

698.8 (2) a community mental health center under section 256B.0625, subdivision 5; or

698.9 (3) an entity that is under contract with the county board to operate a program that meets
698.10 the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170
698.11 to 9505.0475.

698.12 (c) An adult day treatment (ADT) services provider must:

698.13 (1) ensure that the commissioner has approved of the organization as an adult day
698.14 treatment provider organization;

698.15 (2) ensure that a multidisciplinary team provides ADT services to a group of clients. A
698.16 mental health professional must supervise each multidisciplinary staff person who provides
698.17 ADT services;

698.18 (3) make ADT services available to the client at least two days a week for at least three
698.19 consecutive hours per day. ADT services may be longer than three hours per day, but medical
698.20 assistance may not reimburse a provider for more than 15 hours per week;

698.21 (4) provide ADT services to each client that includes group psychotherapy by a mental
698.22 health professional or clinical trainee and daily rehabilitative interventions by a mental
698.23 health professional, clinical trainee, or mental health practitioner; and

698.24 (5) include ADT services in the client's individual treatment plan, when appropriate.
698.25 The adult day treatment provider must:

698.26 (i) complete a functional assessment of each client under section 245I.10, subdivision
698.27 9;

698.28 (ii) notwithstanding section 245I.10, subdivision 8, review the client's progress and
698.29 update the individual treatment plan at least every 90 days until the client is discharged
698.30 from the program; and

698.31 (iii) include a discharge plan for the client in the client's individual treatment plan.

698.32 (d) To be eligible for adult day treatment, a client must:

699.1 (1) be 18 years of age or older;

699.2 (2) not reside in a nursing facility, hospital, institute of mental disease, or state-operated
699.3 treatment center unless the client has an active discharge plan that indicates a move to an
699.4 independent living setting within 180 days;

699.5 (3) have the capacity to engage in rehabilitative programming, skills activities, and
699.6 psychotherapy in the structured, therapeutic setting of an adult day treatment program and
699.7 demonstrate measurable improvements in functioning resulting from participation in the
699.8 adult day treatment program;

699.9 (4) have a level of care assessment under section 245I.02, subdivision 19, recommending
699.10 that the client participate in services with the level of intensity and duration of an adult day
699.11 treatment program; and

699.12 (5) have the recommendation of a mental health professional for adult day treatment
699.13 services. The mental health professional must find that adult day treatment services are
699.14 medically necessary for the client.

699.15 (e) Medical assistance does not cover the following services as adult day treatment
699.16 services:

699.17 (1) services that are primarily recreational or that are provided in a setting that is not
699.18 under medical supervision, including sports activities, exercise groups, craft hours, leisure
699.19 time, social hours, meal or snack time, trips to community activities, and tours;

699.20 (2) social or educational services that do not have or cannot reasonably be expected to
699.21 have a therapeutic outcome related to the client's mental illness;

699.22 (3) consultations with other providers or service agency staff persons about the care or
699.23 progress of a client;

699.24 (4) prevention or education programs that are provided to the community;

699.25 (5) day treatment for clients with a primary diagnosis of a substance use disorder;

699.26 (6) day treatment provided in the client's home;

699.27 (7) psychotherapy for more than two hours per day; and

699.28 (8) participation in meal preparation and eating that is not part of a clinical treatment
699.29 plan to address the client's eating disorder.

699.30 Subd. 4. **Explanation of findings.** (a) Subject to federal approval, medical assistance
699.31 covers an explanation of findings that a mental health professional or clinical trainee provides

700.1 when the provider has obtained the authorization from the client or the client's representative
700.2 to release the information.

700.3 (b) A mental health professional or clinical trainee provides an explanation of findings
700.4 to assist the client or related parties in understanding the results of the client's testing or
700.5 diagnostic assessment and the client's mental illness, and provides professional insight that
700.6 the client or related parties need to carry out a client's treatment plan. Related parties may
700.7 include the client's family and other natural supports and other service providers working
700.8 with the client.

700.9 (c) An explanation of findings is not paid for separately when a mental health professional
700.10 or clinical trainee explains the results of psychological testing or a diagnostic assessment
700.11 to the client or the client's representative as part of the client's psychological testing or a
700.12 diagnostic assessment.

700.13 Subd. 5. **Family psychoeducation services.** (a) Subject to federal approval, medical
700.14 assistance covers family psychoeducation services provided to a child up to age 21 with a
700.15 diagnosed mental health condition when identified in the child's individual treatment plan
700.16 and provided by a mental health professional or a clinical trainee who has determined it
700.17 medically necessary to involve family members in the child's care.

700.18 (b) "Family psychoeducation services" means information or demonstration provided
700.19 to an individual or family as part of an individual, family, multifamily group, or peer group
700.20 session to explain, educate, and support the child and family in understanding a child's
700.21 symptoms of mental illness, the impact on the child's development, and needed components
700.22 of treatment and skill development so that the individual, family, or group can help the child
700.23 to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental
700.24 health and long-term resilience.

700.25 Subd. 6. **Dialectical behavior therapy.** (a) Subject to federal approval, medical assistance
700.26 covers intensive mental health outpatient treatment for dialectical behavior therapy for
700.27 adults. A dialectical behavior therapy provider must make reasonable and good faith efforts
700.28 to report individual client outcomes to the commissioner using instruments and protocols
700.29 that are approved by the commissioner.

700.30 (b) "Dialectical behavior therapy" means an evidence-based treatment approach that a
700.31 mental health professional or clinical trainee provides to a client or a group of clients in an
700.32 intensive outpatient treatment program using a combination of individualized rehabilitative
700.33 and psychotherapeutic interventions. A dialectical behavior therapy program involves:

701.1 individual dialectical behavior therapy, group skills training, telephone coaching, and team
701.2 consultation meetings.

701.3 (c) To be eligible for dialectical behavior therapy, a client must:

701.4 (1) be 18 years of age or older;

701.5 (2) have mental health needs that available community-based services cannot meet or
701.6 that the client must receive concurrently with other community-based services;

701.7 (3) have either:

701.8 (i) a diagnosis of borderline personality disorder; or

701.9 (ii) multiple mental health diagnoses, exhibit behaviors characterized by impulsivity or
701.10 intentional self-harm, and be at significant risk of death, morbidity, disability, or severe
701.11 dysfunction in multiple areas of the client's life;

701.12 (4) be cognitively capable of participating in dialectical behavior therapy as an intensive
701.13 therapy program and be able and willing to follow program policies and rules to ensure the
701.14 safety of the client and others; and

701.15 (5) be at significant risk of one or more of the following if the client does not receive
701.16 dialectical behavior therapy:

701.17 (i) having a mental health crisis;

701.18 (ii) requiring a more restrictive setting such as hospitalization;

701.19 (iii) decompensating; or

701.20 (iv) engaging in intentional self-harm behavior.

701.21 (d) Individual dialectical behavior therapy combines individualized rehabilitative and
701.22 psychotherapeutic interventions to treat a client's suicidal and other dysfunctional behaviors
701.23 and to reinforce a client's use of adaptive skillful behaviors. A mental health professional
701.24 or clinical trainee must provide individual dialectical behavior therapy to a client. A mental
701.25 health professional or clinical trainee providing dialectical behavior therapy to a client must:

701.26 (1) identify, prioritize, and sequence the client's behavioral targets;

701.27 (2) treat the client's behavioral targets;

701.28 (3) assist the client in applying dialectical behavior therapy skills to the client's natural
701.29 environment through telephone coaching outside of treatment sessions;

701.30 (4) measure the client's progress toward dialectical behavior therapy targets;

702.1 (5) help the client manage mental health crises and life-threatening behaviors; and

702.2 (6) help the client learn and apply effective behaviors when working with other treatment
702.3 providers.

702.4 (e) Group skills training combines individualized psychotherapeutic and psychiatric
702.5 rehabilitative interventions conducted in a group setting to reduce the client's suicidal and
702.6 other dysfunctional coping behaviors and restore function. Group skills training must teach
702.7 the client adaptive skills in the following areas: (1) mindfulness; (2) interpersonal
702.8 effectiveness; (3) emotional regulation; and (4) distress tolerance.

702.9 (f) Group skills training must be provided by two mental health professionals or by a
702.10 mental health professional co-facilitating with a clinical trainee or a mental health practitioner.
702.11 Individual skills training must be provided by a mental health professional, a clinical trainee,
702.12 or a mental health practitioner.

702.13 (g) Before a program provides dialectical behavior therapy to a client, the commissioner
702.14 must certify the program as a dialectical behavior therapy provider. To qualify for
702.15 certification as a dialectical behavior therapy provider, a provider must:

702.16 (1) allow the commissioner to inspect the provider's program;

702.17 (2) provide evidence to the commissioner that the program's policies, procedures, and
702.18 practices meet the requirements of this subdivision and chapter 245I;

702.19 (3) be enrolled as a MHCP provider; and

702.20 (4) have a manual that outlines the program's policies, procedures, and practices that
702.21 meet the requirements of this subdivision.

702.22 Subd. 7. **Mental health clinical care consultation.** (a) Subject to federal approval,
702.23 medical assistance covers clinical care consultation for a person up to age 21 who is
702.24 diagnosed with a complex mental health condition or a mental health condition that co-occurs
702.25 with other complex and chronic conditions, when described in the person's individual
702.26 treatment plan and provided by a mental health professional or a clinical trainee.

702.27 (b) "Clinical care consultation" means communication from a treating mental health
702.28 professional to other providers or educators not under the treatment supervision of the
702.29 treating mental health professional who are working with the same client to inform, inquire,
702.30 and instruct regarding the client's symptoms; strategies for effective engagement, care, and
702.31 intervention needs; and treatment expectations across service settings and to direct and
702.32 coordinate clinical service components provided to the client and family.

703.1 Subd. 8. **Neuropsychological assessment.** (a) Subject to federal approval, medical
703.2 assistance covers a client's neuropsychological assessment.

703.3 (b) Neuropsychological assessment" means a specialized clinical assessment of the
703.4 client's underlying cognitive abilities related to thinking, reasoning, and judgment that is
703.5 conducted by a qualified neuropsychologist. A neuropsychological assessment must include
703.6 a face-to-face interview with the client, interpretation of the test results, and preparation
703.7 and completion of a report.

703.8 (c) A client is eligible for a neuropsychological assessment if the client meets at least
703.9 one of the following criteria:

703.10 (1) the client has a known or strongly suspected brain disorder based on the client's
703.11 medical history or the client's prior neurological evaluation, including a history of significant
703.12 head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative
703.13 disorder, significant exposure to neurotoxins, central nervous system infection, metabolic
703.14 or toxic encephalopathy, fetal alcohol syndrome, or congenital malformation of the brain;
703.15 or

703.16 (2) the client has cognitive or behavioral symptoms that suggest that the client has an
703.17 organic condition that cannot be readily attributed to functional psychopathology or suspected
703.18 neuropsychological impairment in addition to functional psychopathology. The client's
703.19 symptoms may include:

703.20 (i) having a poor memory or impaired problem solving;

703.21 (ii) experiencing change in mental status evidenced by lethargy, confusion, or
703.22 disorientation;

703.23 (iii) experiencing a deteriorating level of functioning;

703.24 (iv) displaying a marked change in behavior or personality;

703.25 (v) in a child or an adolescent, having significant delays in acquiring academic skill or
703.26 poor attention relative to peers;

703.27 (vi) in a child or an adolescent, having reached a significant plateau in expected
703.28 development of cognitive, social, emotional, or physical functioning relative to peers; and

703.29 (vii) in a child or an adolescent, significant inability to develop expected knowledge,
703.30 skills, or abilities to adapt to new or changing cognitive, social, emotional, or physical
703.31 demands.

703.32 (d) The neuropsychological assessment must be completed by a neuropsychologist who:

704.1 (1) was awarded a diploma by the American Board of Clinical Neuropsychology, the
704.2 American Board of Professional Neuropsychology, or the American Board of Pediatric
704.3 Neuropsychology;

704.4 (2) earned a doctoral degree in psychology from an accredited university training program
704.5 and:

704.6 (i) completed an internship or its equivalent in a clinically relevant area of professional
704.7 psychology;

704.8 (ii) completed the equivalent of two full-time years of experience and specialized training,
704.9 at least one of which is at the postdoctoral level, supervised by a clinical neuropsychologist
704.10 in the study and practice of clinical neuropsychology and related neurosciences; and

704.11 (iii) holds a current license to practice psychology independently according to sections
704.12 144.88 to 144.98;

704.13 (3) is licensed or credentialed by another state's board of psychology examiners in the
704.14 specialty of neuropsychology using requirements equivalent to requirements specified by
704.15 one of the boards named in clause (1); or

704.16 (4) was approved by the commissioner as an eligible provider of neuropsychological
704.17 assessments prior to December 31, 2010.

704.18 Subd. 9. **Neuropsychological testing.** (a) Subject to federal approval, medical assistance
704.19 covers neuropsychological testing for clients.

704.20 (b) "Neuropsychological testing" means administering standardized tests and measures
704.21 designed to evaluate the client's ability to attend to, process, interpret, comprehend,
704.22 communicate, learn, and recall information and use problem solving and judgment.

704.23 (c) Medical assistance covers neuropsychological testing of a client when the client:

704.24 (1) has a significant mental status change that is not a result of a metabolic disorder and
704.25 that has failed to respond to treatment;

704.26 (2) is a child or adolescent with a significant plateau in expected development of
704.27 cognitive, social, emotional, or physical function relative to peers;

704.28 (3) is a child or adolescent with a significant inability to develop expected knowledge,
704.29 skills, or abilities to adapt to new or changing cognitive, social, physical, or emotional
704.30 demands; or

705.1 (4) has a significant behavioral change, memory loss, or suspected neuropsychological
705.2 impairment in addition to functional psychopathology, or other organic brain injury or one
705.3 of the following:

705.4 (i) traumatic brain injury;

705.5 (ii) stroke;

705.6 (iii) brain tumor;

705.7 (iv) substance use disorder;

705.8 (v) cerebral anoxic or hypoxic episode;

705.9 (vi) central nervous system infection or other infectious disease;

705.10 (vii) neoplasms or vascular injury of the central nervous system;

705.11 (viii) neurodegenerative disorders;

705.12 (ix) demyelinating disease;

705.13 (x) extrapyramidal disease;

705.14 (xi) exposure to systemic or intrathecal agents or cranial radiation known to be associated
705.15 with cerebral dysfunction;

705.16 (xii) systemic medical conditions known to be associated with cerebral dysfunction,
705.17 including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and
705.18 related hematologic anomalies, and autoimmune disorders, including lupus, erythematosus,
705.19 or celiac disease;

705.20 (xiii) congenital genetic or metabolic disorders known to be associated with cerebral
705.21 dysfunction, including phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

705.22 (xiv) severe or prolonged nutrition or malabsorption syndromes; or

705.23 (xv) a condition presenting in a manner difficult for a clinician to distinguish between
705.24 the neurocognitive effects of a neurogenic syndrome, including dementia or encephalopathy;
705.25 and a major depressive disorder when adequate treatment for major depressive disorder has
705.26 not improved the client's neurocognitive functioning; or another disorder, including autism,
705.27 selective mutism, anxiety disorder, or reactive attachment disorder.

705.28 (d) Neuropsychological testing must be administered or clinically supervised by a
705.29 qualified neuropsychologist under subdivision 8, paragraph (c).

706.1 (e) Medical assistance does not cover neuropsychological testing of a client when the
706.2 testing is:

706.3 (1) primarily for educational purposes;

706.4 (2) primarily for vocational counseling or training;

706.5 (3) for personnel or employment testing;

706.6 (4) a routine battery of psychological tests given to the client at the client's inpatient
706.7 admission or during a client's continued inpatient stay; or

706.8 (5) for legal or forensic purposes.

706.9 Subd. 10. **Psychological testing.** (a) Subject to federal approval, medical assistance
706.10 covers psychological testing of a client.

706.11 (b) "Psychological testing" means the use of tests or other psychometric instruments to
706.12 determine the status of a client's mental, intellectual, and emotional functioning.

706.13 (c) The psychological testing must:

706.14 (1) be administered or supervised by a licensed psychologist qualified under section
706.15 245I.04, subdivision 2, clause (3), who is competent in the area of psychological testing;
706.16 and

706.17 (2) be validated in a face-to-face interview between the client and a licensed psychologist
706.18 or a clinical trainee in psychology under the treatment supervision of a licensed psychologist
706.19 under section 245I.06.

706.20 (d) A licensed psychologist must supervise the administration, scoring, and interpretation
706.21 of a client's psychological tests when a clinical psychology trainee, technician, psychometrist,
706.22 or psychological assistant or a computer-assisted psychological testing program completes
706.23 the psychological testing of the client. The report resulting from the psychological testing
706.24 must be signed by the licensed psychologist who conducts the face-to-face interview with
706.25 the client. The licensed psychologist or a staff person who is under treatment supervision
706.26 must place the client's psychological testing report in the client's record and release one
706.27 copy of the report to the client and additional copies to individuals authorized by the client
706.28 to receive the report.

706.29 Subd. 11. **Psychotherapy.** (a) Subject to federal approval, medical assistance covers
706.30 psychotherapy for a client.

706.31 (b) "Psychotherapy" means treatment of a client with mental illness that applies to the
706.32 most appropriate psychological, psychiatric, psychosocial, or interpersonal method that

707.1 conforms to prevailing community standards of professional practice to meet the mental
707.2 health needs of the client. Medical assistance covers psychotherapy if a mental health
707.3 professional or a clinical trainee provides psychotherapy to a client.

707.4 (c) "Individual psychotherapy" means psychotherapy that a mental health professional
707.5 or clinical trainee designs for a client.

707.6 (d) "Family psychotherapy" means psychotherapy that a mental health professional or
707.7 clinical trainee designs for a client and one or more of the client's family members or primary
707.8 caregiver whose participation is necessary to accomplish the client's treatment goals. Family
707.9 members or primary caregivers participating in a therapy session do not need to be eligible
707.10 for medical assistance for medical assistance to cover family psychotherapy. For purposes
707.11 of this paragraph, "primary caregiver whose participation is necessary to accomplish the
707.12 client's treatment goals" excludes shift or facility staff persons who work at the client's
707.13 residence. Medical assistance payments for family psychotherapy are limited to face-to-face
707.14 sessions during which the client is present throughout the session, unless the mental health
707.15 professional or clinical trainee believes that the client's exclusion from the family
707.16 psychotherapy session is necessary to meet the goals of the client's individual treatment
707.17 plan. If the client is excluded from a family psychotherapy session, a mental health
707.18 professional or clinical trainee must document the reason for the client's exclusion and the
707.19 length of time that the client is excluded. The mental health professional must also document
707.20 any reason that a member of the client's family is excluded from a psychotherapy session.

707.21 (e) Group psychotherapy is appropriate for a client who, because of the nature of the
707.22 client's emotional, behavioral, or social dysfunctions, can benefit from treatment in a group
707.23 setting. For a group of three to eight clients, at least one mental health professional or clinical
707.24 trainee must provide psychotherapy to the group. For a group of nine to 12 clients, a team
707.25 of at least two mental health professionals or two clinical trainees or one mental health
707.26 professional and one clinical trainee must provide psychotherapy to the group. Medical
707.27 assistance will cover group psychotherapy for a group of no more than 12 persons.

707.28 (f) A multiple-family group psychotherapy session is eligible for medical assistance if
707.29 a mental health professional or clinical trainee designs the psychotherapy session for at least
707.30 two but not more than five families. A mental health professional or clinical trainee must
707.31 design multiple-family group psychotherapy sessions to meet the treatment needs of each
707.32 client. If the client is excluded from a psychotherapy session, the mental health professional
707.33 or clinical trainee must document the reason for the client's exclusion and the length of time
707.34 that the client was excluded. The mental health professional or clinical trainee must document
707.35 any reason that a member of the client's family was excluded from a psychotherapy session.

708.1 Subd. 12. **Partial hospitalization.** (a) Subject to federal approval, medical assistance
708.2 covers a client's partial hospitalization.

708.3 (b) "Partial hospitalization" means a provider's time-limited, structured program of
708.4 psychotherapy and other therapeutic services, as defined in United States Code, title 42,
708.5 chapter 7, subchapter XVIII, part E, section 1395x(ff), that a multidisciplinary staff person
708.6 provides in an outpatient hospital facility or community mental health center that meets
708.7 Medicare requirements to provide partial hospitalization services to a client.

708.8 (c) Partial hospitalization is an appropriate alternative to inpatient hospitalization for a
708.9 client who is experiencing an acute episode of mental illness who meets the criteria for an
708.10 inpatient hospital admission under Minnesota Rules, part 9505.0520, subpart 1, and who
708.11 has family and community resources that support the client's residence in the community.
708.12 Partial hospitalization consists of multiple intensive short-term therapeutic services for a
708.13 client that a multidisciplinary staff person provides to a client to treat the client's mental
708.14 illness.

708.15 Subd. 13. **Diagnostic assessments.** Subject to federal approval, medical assistance covers
708.16 a client's diagnostic assessments that a mental health professional or clinical trainee completes
708.17 under section 245I.10.

708.18 Sec. 18. **DIRECTION TO COMMISSIONER; SINGLE COMPREHENSIVE**
708.19 **LICENSE STRUCTURE.**

708.20 The commissioner of human services, in consultation with stakeholders including
708.21 counties, tribes, managed care organizations, provider organizations, advocacy groups, and
708.22 clients and clients' families, shall develop recommendations to develop a single
708.23 comprehensive licensing structure for mental health service programs, including outpatient
708.24 and residential services for adults and children. The recommendations must prioritize
708.25 program integrity, the welfare of clients and clients' families, improved integration of mental
708.26 health and substance use disorder services, and the reduction of administrative burden on
708.27 providers.

708.28 Sec. 19. **EFFECTIVE DATE.**

708.29 This article is effective July 1, 2022, or upon federal approval, whichever is later. The
708.30 commissioner of human services shall notify the revisor of statutes when federal approval
708.31 is obtained.

ARTICLE 18
CRISIS RESPONSE SERVICES

Section 1. Minnesota Statutes 2020, section 245.469, subdivision 1, is amended to read:

Subdivision 1. **Availability of emergency services.** ~~By July 1, 1988,~~ (a) County boards must provide or contract for enough emergency services within the county to meet the needs of adults, children, and families in the county who are experiencing an emotional crisis or mental illness. ~~Clients may be required to pay a fee according to section 245.481.~~ Emergency service providers must not delay the timely provision of emergency services to a client because of the unwillingness or inability of the client to pay for services. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of ~~adults with mental illness or emotional crises~~ each client;

(2) minimize further deterioration of ~~adults with mental illness or emotional crises~~ each client;

(3) help ~~adults with mental illness or emotional crises~~ each client to obtain ongoing care and treatment; ~~and~~

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs~~.~~; and

(5) provide support, psychoeducation, and referrals to each client's family members, service providers, and other third parties on behalf of the client in need of emergency services.

(b) If a county provides engagement services under section 253B.041, the county's emergency service providers must refer clients to engagement services when the client meets the criteria for engagement services.

Sec. 2. Minnesota Statutes 2020, section 245.469, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to adults with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, ~~a~~ a clinical trainee, or mental health practitioner~~, or until January 1, 1991, a~~

~~designated person with training in human services who receives clinical supervision from a mental health professional~~.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional, clinical trainee, or mental health practitioner ~~after January 1, 1991,~~ if the county documents that:

(1) mental health professionals, clinical trainees, or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives ~~clinical~~ treatment supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services ~~reviewed by the state advisory council on mental health and then~~ approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services ~~reviewed by the state advisory council on mental health and then~~ approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

711.1 Sec. 3. Minnesota Statutes 2020, section 245.4879, subdivision 1, is amended to read:

711.2 Subdivision 1. **Availability of emergency services.** County boards must provide or
711.3 contract for ~~enough~~ mental health emergency services ~~within the county to meet the needs~~
711.4 ~~of children, and children's families when clinically appropriate, in the county who are~~
711.5 ~~experiencing an emotional crisis or emotional disturbance. The county board shall ensure~~
711.6 ~~that parents, providers, and county residents are informed about when and how to access~~
711.7 ~~emergency mental health services for children. A child or the child's parent may be required~~
711.8 ~~to pay a fee according to section 245.481. Emergency service providers shall not delay the~~
711.9 ~~timely provision of emergency service because of delays in determining this fee or because~~
711.10 ~~of the unwillingness or inability of the parent to pay the fee. Emergency services must~~
711.11 ~~include assessment, crisis intervention, and appropriate case disposition. Emergency services~~
711.12 ~~must:~~ according to section 245.469.

711.13 ~~(1) promote the safety and emotional stability of children with emotional disturbances~~
711.14 ~~or emotional crises;~~

711.15 ~~(2) minimize further deterioration of the child with emotional disturbance or emotional~~
711.16 ~~crisis;~~

711.17 ~~(3) help each child with an emotional disturbance or emotional crisis to obtain ongoing~~
711.18 ~~care and treatment; and~~

711.19 ~~(4) prevent placement in settings that are more intensive, costly, or restrictive than~~
711.20 ~~necessary and appropriate to meet the child's needs.~~

711.21 Sec. 4. Minnesota Statutes 2020, section 256B.0624, is amended to read:

711.22 **256B.0624 ~~ADULT~~ CRISIS RESPONSE SERVICES COVERED.**

711.23 Subdivision 1. **Scope.** ~~Medical assistance covers adult mental health crisis response~~
711.24 ~~services as defined in subdivision 2, paragraphs (c) to (e),~~ (a) Subject to federal approval,
711.25 ~~if provided to a recipient as defined in subdivision 3 and provided by a qualified provider~~
711.26 ~~entity as defined in this section and by a qualified individual provider working within the~~
711.27 ~~provider's scope of practice and as defined in this subdivision and identified in the recipient's~~
711.28 ~~individual crisis treatment plan as defined in subdivision 11 and if determined to be medically~~
711.29 ~~necessary~~ medical assistance covers medically necessary crisis response services when the
711.30 services are provided according to the standards in this section.

711.31 (b) Subject to federal approval, medical assistance covers medically necessary residential
711.32 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.

714.1 (i) "Mental health certified peer specialist" means a staff person who is qualified under
714.2 section 245I.04, subdivision 10.

714.3 (j) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without
714.4 the provision of crisis response services, would likely result in significantly reducing the
714.5 recipient's levels of functioning in primary activities of daily living, in an emergency situation
714.6 under section 62Q.55, or in the placement of the recipient in a more restrictive setting,
714.7 including but not limited to inpatient hospitalization.

714.8 (k) "Mental health practitioner" means a staff person who is qualified under section
714.9 245I.04, subdivision 4.

714.10 (l) "Mental health professional" means a staff person who is qualified under section
714.11 245I.04, subdivision 2.

714.12 (m) "Mental health rehabilitation worker" means a staff person who is qualified under
714.13 section 245I.04, subdivision 14.

714.14 (n) "Mobile crisis services" means screening, assessment, intervention, and community
714.15 based stabilization, excluding residential crisis stabilization, that is provided to a recipient.

714.16 Subd. 3. **Eligibility.** ~~An eligible recipient is an individual who:~~

714.17 ~~(1) is age 18 or older;~~

714.18 ~~(2) is screened as possibly experiencing a mental health crisis or emergency where a~~
714.19 ~~mental health crisis assessment is needed; and~~

714.20 ~~(3) is assessed as experiencing a mental health crisis or emergency, and mental health~~
714.21 ~~crisis intervention or crisis intervention and stabilization services are determined to be~~
714.22 ~~medically necessary.~~

714.23 (a) A recipient is eligible for crisis assessment services when the recipient has screened
714.24 positive for a potential mental health crisis during a crisis screening.

714.25 (b) A recipient is eligible for crisis intervention services and crisis stabilization services
714.26 when the recipient has been assessed during a crisis assessment to be experiencing a mental
714.27 health crisis.

714.28 Subd. 4. **Provider entity standards.** (a) A ~~provider entity is an entity that meets the~~
714.29 ~~standards listed in paragraph (c) and~~ mobile crisis provider must be:

714.30 (1) ~~is~~ a county board operated entity; ~~or~~

715.1 (2) an Indian health services facility or facility owned and operated by a tribe or tribal
715.2 organization operating under United States Code, title 325, section 450f; or

715.3 ~~(2) is~~ (3) a provider entity that is under contract with the county board in the county
715.4 where the potential crisis or emergency is occurring. To provide services under this section,
715.5 the provider entity must directly provide the services; or if services are subcontracted, the
715.6 provider entity must maintain responsibility for services and billing.

715.7 (b) A mobile crisis provider must meet the following standards:

715.8 (1) must ensure that crisis screenings, crisis assessments, and crisis intervention services
715.9 are available to a recipient 24 hours a day, seven days a week;

715.10 (2) must be able to respond to a call for services in a designated service area or according
715.11 to a written agreement with the local mental health authority for an adjacent area;

715.12 (3) must have at least one mental health professional on staff at all times and at least
715.13 one additional staff member capable of leading a crisis response in the community; and

715.14 (4) must provide the commissioner with information about the number of requests for
715.15 service, the number of people that the provider serves face-to-face, outcomes, and the
715.16 protocols that the provider uses when deciding when to respond in the community.

715.17 ~~(b)~~ (c) A provider entity that provides crisis stabilization services in a residential setting
715.18 under subdivision 7 is not required to meet the requirements of ~~paragraph~~ paragraphs (a)~~,~~
715.19 ~~clauses (1) and (2)~~ to (b), but must meet all other requirements of this subdivision.

715.20 ~~(c) The adult mental health~~ (d) A crisis ~~response~~ services provider ~~entity~~ must have the
715.21 capacity to meet and carry out the standards in section 245I.011, subdivision 5, and the
715.22 following standards:

715.23 (1) ~~has the capacity to recruit, hire, and manage and train mental health professionals,~~
715.24 ~~practitioners, and rehabilitation workers~~ ensures that staff persons provide support for a
715.25 recipient's family and natural supports, by enabling the recipient's family and natural supports
715.26 to observe and participate in the recipient's treatment, assessments, and planning services;

715.27 (2) has adequate administrative ability to ensure availability of services;

715.28 ~~(3) is able to ensure adequate preservice and in-service training;~~

715.29 ~~(4)~~ (3) is able to ensure that staff providing these services are skilled in the delivery of
715.30 mental health crisis response services to recipients;

716.1 ~~(5)~~ (4) is able to ensure that staff are ~~capable of~~ implementing culturally specific treatment
716.2 identified in the ~~individual~~ crisis treatment plan that is meaningful and appropriate as
716.3 determined by the recipient's culture, beliefs, values, and language;

716.4 ~~(6)~~ (5) is able to ensure enough flexibility to respond to the changing intervention and
716.5 care needs of a recipient as identified by the recipient or family member during the service
716.6 partnership between the recipient and providers;

716.7 ~~(7)~~ (6) is able to ensure that ~~mental health professionals and mental health practitioners~~
716.8 staff have the communication tools and procedures to communicate and consult promptly
716.9 about crisis assessment and interventions as services occur;

716.10 ~~(8)~~ (7) is able to coordinate these services with county emergency services, community
716.11 hospitals, ambulance, transportation services, social services, law enforcement, engagement
716.12 services, and mental health crisis services through regularly scheduled interagency meetings;

716.13 ~~(9) is able to ensure that mental health crisis assessment and mobile crisis intervention~~
716.14 ~~services are available 24 hours a day, seven days a week;~~

716.15 ~~(10)~~ (8) is able to ensure that services are coordinated with other ~~mental~~ behavioral
716.16 health service providers, county mental health authorities, or federally recognized American
716.17 Indian authorities and others as necessary, with the consent of the ~~adult~~ recipient or parent
716.18 or guardian. Services must also be coordinated with the recipient's case manager if the ~~adult~~
716.19 recipient is receiving case management services;

716.20 ~~(11)~~ (9) is able to ensure that crisis intervention services are provided in a manner
716.21 consistent with sections 245.461 to 245.486 and 245.487 to 245.4879;

716.22 ~~(12) is able to submit information as required by the state;~~

716.23 ~~(13) maintains staff training and personnel files;~~

716.24 (10) is able to coordinate detoxification services for the recipient according to Minnesota
716.25 Rules, parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F;

716.26 ~~(14)~~ (11) is able to establish and maintain a quality assurance and evaluation plan to
716.27 evaluate the outcomes of services and recipient satisfaction; and

716.28 ~~(15) is able to keep records as required by applicable laws;~~

716.29 ~~(16) is able to comply with all applicable laws and statutes;~~

716.30 ~~(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.

718.1 (c) The 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph
718.2 (b), must be specific to providing crisis services to children and adults and include training
718.3 about evidence-based practices identified by the commissioner of health to reduce the
718.4 recipient's risk of suicide and self-injurious behavior.

718.5 (d) Team members must be experienced in mental health crisis assessment, crisis
718.6 intervention techniques, treatment engagement strategies, working with families, and clinical
718.7 decision-making under emergency conditions and have knowledge of local services and
718.8 resources. The team must recommend and coordinate the team's services with appropriate
718.9 local resources such as the county social services agency, mental health services, and local
718.10 law enforcement when necessary.

718.11 Subd. 6. **Crisis assessment and mobile intervention treatment planning screening.** (a)
718.12 Prior to initiating mobile crisis intervention services, a screening of the potential crisis
718.13 situation must be conducted. The crisis screening may use the resources of crisis assistance
718.14 and emergency services as defined in sections 245.462, subdivision 6, and section 245.469,
718.15 subdivisions 1 and 2. The crisis screening must gather information, determine whether a
718.16 mental health crisis situation exists, identify parties involved, and determine an appropriate
718.17 response.

718.18 (b) When conducting the crisis screening of a recipient, a provider must:

718.19 (1) employ evidence-based practices to reduce the recipient's risk of suicide and
718.20 self-injurious behavior;

718.21 (2) work with the recipient to establish a plan and time frame for responding to the
718.22 recipient's mental health crisis, including responding to the recipient's immediate need for
718.23 support by telephone or text message until the provider can respond to the recipient
718.24 face-to-face;

718.25 (3) document significant factors in determining whether the recipient is experiencing a
718.26 mental health crisis, including prior requests for crisis services, a recipient's recent
718.27 presentation at an emergency department, known calls to 911 or law enforcement, or
718.28 information from third parties with knowledge of a recipient's history or current needs;

718.29 (4) accept calls from interested third parties and consider the additional needs or potential
718.30 mental health crises that the third parties may be experiencing;

718.31 (5) provide psychoeducation, including means reduction, to relevant third parties
718.32 including family members or other persons living with the recipient; and

719.1 (6) consider other available services to determine which service intervention would best
719.2 address the recipient's needs and circumstances.

719.3 (c) For the purposes of this section, the following situations indicate a positive screen
719.4 for a potential mental health crisis and the provider must prioritize providing a face-to-face
719.5 crisis assessment of the recipient, unless a provider documents specific evidence to show
719.6 why this was not possible, including insufficient staffing resources, concerns for staff or
719.7 recipient safety, or other clinical factors:

719.8 (1) the recipient presents at an emergency department or urgent care setting and the
719.9 health care team at that location requested crisis services; or

719.10 (2) a peace officer requested crisis services for a recipient who is potentially subject to
719.11 transportation under section 253B.051.

719.12 (d) A provider is not required to have direct contact with the recipient to determine that
719.13 the recipient is experiencing a potential mental health crisis. A mobile crisis provider may
719.14 gather relevant information about the recipient from a third party to establish the recipient's
719.15 need for services and potential safety factors.

719.16 Subd. 6a. **Crisis assessment.** ~~(b)~~ (a) If a ~~crisis exists~~ recipient screens positive for
719.17 potential mental health crisis, a crisis assessment must be completed. A crisis assessment
719.18 evaluates any immediate needs for which ~~emergency~~ services are needed and, as time
719.19 permits, the recipient's current life situation, health information, including current
719.20 medications, sources of stress, mental health problems and symptoms, strengths, cultural
719.21 considerations, support network, vulnerabilities, current functioning, and the recipient's
719.22 preferences as communicated directly by the recipient, or as communicated in a health care
719.23 directive as described in chapters 145C and 253B, the crisis treatment plan described under
719.24 ~~paragraph (d)~~ subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

719.25 (b) A provider must conduct a crisis assessment at the recipient's location whenever
719.26 possible.

719.27 (c) Whenever possible, the assessor must attempt to include input from the recipient and
719.28 the recipient's family and other natural supports to assess whether a crisis exists.

719.29 (d) A crisis assessment includes determining: (1) whether the recipient is willing to
719.30 voluntarily engage in treatment or (2) has an advance directive and (3) gathering the
719.31 recipient's information and history from involved family or other natural supports.

719.32 (e) A crisis assessment must include coordinated response with other health care providers
719.33 if the assessment indicates that a recipient needs detoxification, withdrawal management,

720.1 or medical stabilization in addition to crisis response services. If the recipient does not need
720.2 an acute level of care, a team must serve an otherwise eligible recipient who has a
720.3 co-occurring substance use disorder.

720.4 (f) If, after completing a crisis assessment of a recipient, a provider refers a recipient to
720.5 an intensive setting, including an emergency department, inpatient hospitalization, or
720.6 residential crisis stabilization, one of the crisis team members who completed or conferred
720.7 about the recipient's crisis assessment must immediately contact the referral entity and
720.8 consult with the triage nurse or other staff responsible for intake at the referral entity. During
720.9 the consultation, the crisis team member must convey key findings or concerns that led to
720.10 the recipient's referral. Following the immediate consultation, the provider must also send
720.11 written documentation upon completion. The provider must document if these releases
720.12 occurred with authorization by the recipient, the recipient's legal guardian, or as allowed
720.13 by section 144.293, subdivision 5.

720.14 Subd. 6b. **Crisis intervention services.** (c) (a) If the crisis assessment determines mobile
720.15 crisis intervention services are needed, the crisis intervention services must be provided
720.16 promptly. As opportunity presents during the intervention, at least two members of the
720.17 mobile crisis intervention team must confer directly or by telephone about the crisis
720.18 assessment, crisis treatment plan, and actions taken and needed. At least one of the team
720.19 members must be on site providing face-to-face crisis intervention services. If providing
720.20 on-site crisis intervention services, a clinical trainee or mental health practitioner must seek
720.21 clinical treatment supervision as required in subdivision 9.

720.22 (b) If a provider delivers crisis intervention services while the recipient is absent, the
720.23 provider must document the reason for delivering services while the recipient is absent.

720.24 (d) (c) The mobile crisis intervention team must develop an initial, brief a crisis treatment
720.25 plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention
720.26 according to subdivision 11. The plan must address the needs and problems noted in the
720.27 crisis assessment and include measurable short-term goals, cultural considerations, and
720.28 frequency and type of services to be provided to achieve the goals and reduce or eliminate
720.29 the crisis. The treatment plan must be updated as needed to reflect current goals and services.

720.30 (e) (d) The mobile crisis intervention team must document which short-term goals crisis
720.31 treatment plan goals and objectives have been met and when no further crisis intervention
720.32 services are required.

720.33 (f) (e) If the recipient's mental health crisis is stabilized, but the recipient needs a referral
720.34 to other services, the team must provide referrals to these services. If the recipient has a

721.1 case manager, planning for other services must be coordinated with the case manager. If
721.2 the recipient is unable to follow up on the referral, the team must link the recipient to the
721.3 service and follow up to ensure the recipient is receiving the service.

721.4 ~~(g)~~ (f) If the recipient's mental health crisis is stabilized and the recipient does not have
721.5 an advance directive, the case manager or crisis team shall offer to work with the recipient
721.6 to develop one.

721.7 Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided
721.8 by qualified staff of a crisis stabilization services provider entity and must meet the following
721.9 standards:

721.10 (1) a crisis ~~stabilization~~ treatment plan must be developed ~~which~~ that meets the criteria
721.11 in subdivision 11;

721.12 (2) staff must be qualified as defined in subdivision 8; ~~and~~

721.13 (3) crisis stabilization services must be delivered according to the crisis treatment plan
721.14 and include face-to-face contact with the recipient by qualified staff for further assessment,
721.15 help with referrals, updating of the crisis ~~stabilization~~ treatment plan, ~~supportive counseling,~~
721.16 skills training, and collaboration with other service providers in the community~~.~~; and

721.17 (4) if a provider delivers crisis stabilization services while the recipient is absent, the
721.18 provider must document the reason for delivering services while the recipient is absent.

721.19 ~~(b) If crisis stabilization services are provided in a supervised, licensed residential setting,~~
721.20 ~~the recipient must be contacted face-to-face daily by a qualified mental health practitioner~~
721.21 ~~or mental health professional. The program must have 24-hour-a-day residential staffing~~
721.22 ~~which may include staff who do not meet the qualifications in subdivision 8. The residential~~
721.23 ~~staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental~~
721.24 ~~health professional or practitioner.~~

721.25 ~~(c)~~ (b) If crisis stabilization services are provided in a supervised, licensed residential
721.26 setting that serves no more than four adult residents, and one or more individuals are present
721.27 at the setting to receive residential crisis stabilization ~~services~~, the residential staff must
721.28 include, for at least eight hours per day, at least one ~~individual who meets the qualifications~~
721.29 ~~in subdivision 8, paragraph (a), clause (1) or (2)~~ mental health professional, clinical trainee,
721.30 certified rehabilitation specialist, or mental health practitioner.

721.31 ~~(d) If crisis stabilization services are provided in a supervised, licensed residential setting~~
721.32 ~~that serves more than four adult residents, and one or more are recipients of crisis stabilization~~
721.33 ~~services, the residential staff must include, for 24 hours a day, at least one individual who~~

722.1 meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the
722.2 residential program, the residential program must have at least two staff working 24 hours
722.3 a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as
722.4 specified in the crisis stabilization treatment plan.

722.5 Subd. 8. **Adult Crisis stabilization staff qualifications.** (a) Adult Mental health crisis
722.6 stabilization services must be provided by qualified individual staff of a qualified provider
722.7 entity. Individual provider staff must have the following qualifications A staff member
722.8 providing crisis stabilization services to a recipient must be qualified as a:

722.9 (1) be a mental health professional as defined in section 245.462, subdivision 18, clauses
722.10 (1) to (6);

722.11 (2) be a certified rehabilitation specialist;

722.12 (3) clinical trainee;

722.13 (4) mental health practitioner as defined in section 245.462, subdivision 17. The mental
722.14 health practitioner must work under the clinical supervision of a mental health professional;

722.15 (5) mental health certified family peer specialist;

722.16 (3) be a (6) mental health certified peer specialist under section 256B.0615. The certified
722.17 peer specialist must work under the clinical supervision of a mental health professional; or

722.18 (4) be a (7) mental health rehabilitation worker who meets the criteria in section
722.19 256B.0623, subdivision 5, paragraph (a), clause (4); works under the direction of a mental
722.20 health practitioner as defined in section 245.462, subdivision 17, or under direction of a
722.21 mental health professional; and works under the clinical supervision of a mental health
722.22 professional.

722.23 (b) Mental health practitioners and mental health rehabilitation workers must have
722.24 completed at least 30 hours of training in crisis intervention and stabilization during the
722.25 past two years. The 30 hours of ongoing training required in section 245I.05, subdivision
722.26 4, paragraph (b), must be specific to providing crisis services to children and adults and
722.27 include training about evidence-based practices identified by the commissioner of health
722.28 to reduce a recipient's risk of suicide and self-injurious behavior.

722.29 Subd. 9. **Supervision.** Clinical trainees and mental health practitioners may provide
722.30 crisis assessment and mobile crisis intervention services if the following clinical treatment
722.31 supervision requirements are met:

723.1 (1) the mental health provider entity must accept full responsibility for the services
723.2 provided;

723.3 (2) the mental health professional of the provider entity~~, who is an employee or under~~
723.4 ~~contract with the provider entity,~~ must be immediately available by phone or in person for
723.5 ~~clinical~~ treatment supervision;

723.6 (3) the mental health professional is consulted, in person or by phone, during the first
723.7 three hours when a clinical trainee or mental health practitioner provides ~~on-site service~~
723.8 crisis assessment or crisis intervention services; and

723.9 (4) the mental health professional must:

723.10 (i) review and approve, as defined in section 245I.02, subdivision 2, of the tentative
723.11 crisis assessment and crisis treatment plan within 24 hours of first providing services to the
723.12 recipient, notwithstanding section 245I.08, subdivision 3; and

723.13 (ii) document the consultation required in clause (3).~~; and~~

723.14 ~~(iii) sign the crisis assessment and treatment plan within the next business day;~~

723.15 ~~(5) if the mobile crisis intervention services continue into a second calendar day, a mental~~
723.16 ~~health professional must contact the recipient face-to-face on the second day to provide~~
723.17 ~~services and update the crisis treatment plan; and~~

723.18 ~~(6) the on-site observation must be documented in the recipient's record and signed by~~
723.19 ~~the mental health professional.~~

723.20 ~~Subd. 10.~~ ~~**Recipient file.**~~ ~~Providers of mobile crisis intervention or crisis stabilization~~
723.21 ~~services must maintain a file for each recipient containing the following information:~~

723.22 ~~(1) individual crisis treatment plans signed by the recipient, mental health professional,~~
723.23 ~~and mental health practitioner who developed the crisis treatment plan, or if the recipient~~
723.24 ~~refused to sign the plan, the date and reason stated by the recipient as to why the recipient~~
723.25 ~~would not sign the plan;~~

723.26 ~~(2) signed release forms;~~

723.27 ~~(3) recipient health information and current medications;~~

723.28 ~~(4) emergency contacts for the recipient;~~

723.29 ~~(5) case records which document the date of service, place of service delivery, signature~~
723.30 ~~of the person providing the service, and the nature, extent, and units of service. Direct or~~
723.31 ~~telephone contact with the recipient's family or others should be documented;~~

724.1 ~~(6) required clinical supervision by mental health professionals;~~

724.2 ~~(7) summary of the recipient's case reviews by staff;~~

724.3 ~~(8) any written information by the recipient that the recipient wants in the file; and~~

724.4 ~~(9) an advance directive, if there is one available.~~

724.5 ~~Documentation in the file must comply with all requirements of the commissioner.~~

724.6 Subd. 11. **Crisis treatment plan.** ~~The individual crisis stabilization treatment plan must~~
724.7 ~~include, at a minimum:~~

724.8 ~~(1) a list of problems identified in the assessment;~~

724.9 ~~(2) a list of the recipient's strengths and resources;~~

724.10 ~~(3) concrete, measurable short-term goals and tasks to be achieved, including time frames~~
724.11 ~~for achievement;~~

724.12 ~~(4) specific objectives directed toward the achievement of each one of the goals;~~

724.13 ~~(5) documentation of the participants involved in the service planning. The recipient, if~~
724.14 ~~possible, must be a participant. The recipient or the recipient's legal guardian must sign the~~
724.15 ~~service plan or documentation must be provided why this was not possible. A copy of the~~
724.16 ~~plan must be given to the recipient and the recipient's legal guardian. The plan should include~~
724.17 ~~services arranged, including specific providers where applicable;~~

724.18 ~~(6) planned frequency and type of services initiated;~~

724.19 ~~(7) a crisis response action plan if a crisis should occur;~~

724.20 ~~(8) clear progress notes on outcome of goals;~~

724.21 ~~(9) a written plan must be completed within 24 hours of beginning services with the~~
724.22 ~~recipient; and~~

724.23 ~~(10) a treatment plan must be developed by a mental health professional or mental health~~
724.24 ~~practitioner under the clinical supervision of a mental health professional. The mental health~~
724.25 ~~professional must approve and sign all treatment plans.~~

724.26 (a) Within 24 hours of the recipient's admission, the provider entity must complete the
724.27 recipient's crisis treatment plan. The provider entity must:

724.28 (1) base the recipient's crisis treatment plan on the recipient's crisis assessment;

724.29 (2) consider crisis assistance strategies that have been effective for the recipient in the
724.30 past;

725.1 (3) for a child recipient, use a child-centered, family-driven, and culturally appropriate
725.2 planning process that allows the recipient's parents and guardians to observe or participate
725.3 in the recipient's individual and family treatment services, assessment, and treatment
725.4 planning;

725.5 (4) for an adult recipient, use a person-centered, culturally appropriate planning process
725.6 that allows the recipient's family and other natural supports to observe or participate in
725.7 treatment services, assessment, and treatment planning;

725.8 (5) identify the participants involved in the recipient's treatment planning. The recipient,
725.9 if possible, must be a participant;

725.10 (6) identify the recipient's initial treatment goals, measurable treatment objectives, and
725.11 specific interventions that the license holder will use to help the recipient engage in treatment;

725.12 (7) include documentation of referral to and scheduling of services, including specific
725.13 providers where applicable;

725.14 (8) ensure that the recipient or the recipient's legal guardian approves under section
725.15 245I.02, subdivision 2, of the recipient's crisis treatment plan unless a court orders the
725.16 recipient's treatment plan under chapter 253B. If the recipient or the recipient's legal guardian
725.17 disagrees with the crisis treatment plan, the license holder must document in the client file
725.18 the reasons why the recipient disagrees with the crisis treatment plan; and

725.19 (9) ensure that a treatment supervisor approves under section 245I.02, subdivision 2, of
725.20 the recipient's treatment plan within 24 hours of the recipient's admission if a mental health
725.21 practitioner or clinical trainee completes the crisis treatment plan, notwithstanding section
725.22 245I.08, subdivision 3.

725.23 (b) The provider entity must provide the recipient and the recipient's legal guardian with
725.24 a copy of the recipient's crisis treatment plan.

725.25 Subd. 12. **Excluded services.** The following services are excluded from reimbursement
725.26 under this section:

725.27 (1) room and board services;

725.28 (2) services delivered to a recipient while admitted to an inpatient hospital;

725.29 (3) recipient transportation costs may be covered under other medical assistance
725.30 provisions, but transportation services are not an adult mental health crisis response service;

725.31 (4) services provided and billed by a provider who is not enrolled under medical
725.32 assistance to provide adult mental health crisis response services;

726.1 (5) services performed by volunteers;

726.2 (6) direct billing of time spent "on call" when not delivering services to a recipient;

726.3 (7) provider service time included in case management reimbursement. When a provider
726.4 is eligible to provide more than one type of medical assistance service, the recipient must
726.5 have a choice of provider for each service, unless otherwise provided for by law;

726.6 (8) outreach services to potential recipients; ~~and~~

726.7 (9) a mental health service that is not medically necessary~~.~~;

726.8 (10) services that a residential treatment center licensed under Minnesota Rules, chapter
726.9 2960, provides to a client;

726.10 (11) partial hospitalization or day treatment; and

726.11 (12) a crisis assessment that a residential provider completes when a daily rate is paid
726.12 for the recipient's crisis stabilization.

726.13 Sec. 5. **EFFECTIVE DATE.**

726.14 This article is effective July 1, 2022, or upon federal approval, whichever is later. The
726.15 commissioner of human services shall notify the revisor of statutes when federal approval
726.16 is obtained.

726.17 **ARTICLE 19**

726.18 **MENTAL HEALTH UNIFORM SERVICE STANDARDS; CONFORMING**
726.19 **CHANGES**

726.20 Section 1. Minnesota Statutes 2020, section 62A.152, subdivision 3, is amended to read:

726.21 Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber
726.22 contracts that provide benefits for mental or nervous disorder treatments in a hospital must
726.23 provide direct reimbursement for those services if performed by a mental health professional~~,~~
726.24 ~~as defined in sections 245.462, subdivision 18, clauses (1) to (5); and 245.4871, subdivision~~
726.25 ~~27, clauses (1) to (5)~~ qualified according to section 245I.04, subdivision 2, to the extent that
726.26 the services and treatment are within the scope of mental health professional licensure.

726.27 This subdivision is intended to provide payment of benefits for mental or nervous disorder
726.28 treatments performed by a licensed mental health professional in a hospital and is not
726.29 intended to change or add benefits for those services provided in policies or contracts to
726.30 which this subdivision applies.

727.1 Sec. 2. Minnesota Statutes 2020, section 62A.3094, subdivision 1, is amended to read:

727.2 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in
727.3 paragraphs (b) to (d) have the meanings given.

727.4 (b) "Autism spectrum disorders" means the conditions as determined by criteria set forth
727.5 in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of
727.6 the American Psychiatric Association.

727.7 (c) "Medically necessary care" means health care services appropriate, in terms of type,
727.8 frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing
727.9 and preventative services. Medically necessary care must be consistent with generally
727.10 accepted practice parameters as determined by physicians and licensed psychologists who
727.11 typically manage patients who have autism spectrum disorders.

727.12 (d) "Mental health professional" means a mental health professional ~~as defined in section~~
727.13 ~~245.4871, subdivision 27~~ who is qualified according to section 245I.04, subdivision 2,
727.14 clause (1), (2), (3), (4), or (6), who has training and expertise in autism spectrum disorder
727.15 and child development.

727.16 Sec. 3. Minnesota Statutes 2020, section 62Q.096, is amended to read:

727.17 **62Q.096 CREDENTIALING OF PROVIDERS.**

727.18 If a health plan company has initially credentialed, as providers in its provider network,
727.19 individual providers employed by or under contract with an entity that:

727.20 (1) is authorized to bill under section 256B.0625, subdivision 5;

727.21 (2) ~~meets the requirements of Minnesota Rules, parts 9520.0750 to 9520.0870~~ is a mental
727.22 health clinic certified under section 245I.20;

727.23 (3) is designated an essential community provider under section 62Q.19; and

727.24 (4) is under contract with the health plan company to provide mental health services,
727.25 the health plan company must continue to credential at least the same number of providers
727.26 from that entity, as long as those providers meet the health plan company's credentialing
727.27 standards.

727.28 A health plan company shall not refuse to credential these providers on the grounds that
727.29 their provider network has a sufficient number of providers of that type.

728.1 Sec. 4. Minnesota Statutes 2020, section 144.651, subdivision 2, is amended to read:

728.2 Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is
728.3 admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for
728.4 the purpose of diagnosis or treatment bearing on the physical or mental health of that person.
728.5 For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a
728.6 person who receives health care services at an outpatient surgical center or at a birth center
728.7 licensed under section 144.615. "Patient" also means a minor who is admitted to a residential
728.8 program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and
728.9 30, "patient" also means any person who is receiving mental health treatment on an outpatient
728.10 basis or in a community support program or other community-based program. "Resident"
728.11 means a person who is admitted to a nonacute care facility including extended care facilities,
728.12 nursing homes, and boarding care homes for care required because of prolonged mental or
728.13 physical illness or disability, recovery from injury or disease, or advancing age. For purposes
728.14 of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is
728.15 admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts
728.16 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a
728.17 supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which
728.18 operates a rehabilitation program licensed under chapter 245G or 245I, or Minnesota Rules,
728.19 parts 9530.6510 to 9530.6590.

728.20 Sec. 5. Minnesota Statutes 2020, section 144D.01, subdivision 4, is amended to read:

728.21 Subd. 4. **Housing with services establishment or establishment.** (a) "Housing with
728.22 services establishment" or "establishment" means:

728.23 (1) an establishment providing sleeping accommodations to one or more adult residents,
728.24 at least 80 percent of which are 55 years of age or older, and offering or providing, for a
728.25 fee, one or more regularly scheduled health-related services or two or more regularly
728.26 scheduled supportive services, whether offered or provided directly by the establishment
728.27 or by another entity arranged for by the establishment; or

728.28 (2) an establishment that registers under section 144D.025.

728.29 (b) Housing with services establishment does not include:

728.30 (1) a nursing home licensed under chapter 144A;

728.31 (2) a hospital, certified boarding care home, or supervised living facility licensed under
728.32 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;

730.1 (5) services and residential settings licensed under chapter 245A, including adult foster
730.2 care and services and settings governed under the standards in chapter 245D;

730.3 (6) a private home in which the residents are related by kinship, law, or affinity with the
730.4 provider of services;

730.5 (7) a duly organized condominium, cooperative, and common interest community, or
730.6 owners' association of the condominium, cooperative, and common interest community
730.7 where at least 80 percent of the units that comprise the condominium, cooperative, or
730.8 common interest community are occupied by individuals who are the owners, members, or
730.9 shareholders of the units;

730.10 (8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593;

730.11 (9) a setting offering services conducted by and for the adherents of any recognized
730.12 church or religious denomination for its members exclusively through spiritual means or
730.13 by prayer for healing;

730.14 (10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with
730.15 low-income housing tax credits pursuant to United States Code, title 26, section 42, and
730.16 units financed by the Minnesota Housing Finance Agency that are intended to serve
730.17 individuals with disabilities or individuals who are homeless, except for those developments
730.18 that market or hold themselves out as assisted living facilities and provide assisted living
730.19 services;

730.20 (11) rental housing developed under United States Code, title 42, section 1437, or United
730.21 States Code, title 12, section 1701q;

730.22 (12) rental housing designated for occupancy by only elderly or elderly and disabled
730.23 residents under United States Code, title 42, section 1437e, or rental housing for qualifying
730.24 families under Code of Federal Regulations, title 24, section 983.56;

730.25 (13) rental housing funded under United States Code, title 42, chapter 89, or United
730.26 States Code, title 42, section 8011;

730.27 (14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b); or

730.28 (15) any establishment that exclusively or primarily serves as a shelter or temporary
730.29 shelter for victims of domestic or any other form of violence.

730.30 Sec. 7. Minnesota Statutes 2020, section 148B.5301, subdivision 2, is amended to read:

730.31 Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed
730.32 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)~~ <u>who is qualified according to section 245I.04, subdivision 2</u>, 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)~~ <u>245I.04, subdivision 2</u>.

(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;

732.1 (2) the supervisor is an unlicensed social worker who is employed in, and provides the
732.2 supervision in, a setting exempt from licensure by section 148E.065, and who has
732.3 qualifications equivalent to the applicable requirements specified in sections 148E.100 to
732.4 148E.115;

732.5 (3) the supervisor is a social worker engaged in authorized social work practice in Iowa,
732.6 Manitoba, North Dakota, Ontario, South Dakota, or Wisconsin, and has the qualifications
732.7 equivalent to the applicable requirements in sections 148E.100 to 148E.115; or

732.8 (4) the applicant or licensee is engaged in nonclinical authorized social work practice
732.9 outside of Minnesota and the supervisor meets the qualifications equivalent to the applicable
732.10 requirements in sections 148E.100 to 148E.115, or the supervisor is an equivalent mental
732.11 health professional, as determined by the board, who is credentialed by a state, territorial,
732.12 provincial, or foreign licensing agency; or

732.13 (5) the applicant or licensee is engaged in clinical authorized social work practice outside
732.14 of Minnesota and the supervisor meets qualifications equivalent to the applicable
732.15 requirements in section 148E.115, or the supervisor is an equivalent mental health
732.16 professional as determined by the board, who is credentialed by a state, territorial, provincial,
732.17 or foreign licensing agency.

732.18 (c) In order for the board to consider an alternate supervisor under this section, the
732.19 licensee must:

732.20 (1) request in the supervision plan and verification submitted according to section
732.21 148E.125 that an alternate supervisor conduct the supervision; and

732.22 (2) describe the proposed supervision and the name and qualifications of the proposed
732.23 alternate supervisor. The board may audit the information provided to determine compliance
732.24 with the requirements of this section.

732.25 Sec. 9. Minnesota Statutes 2020, section 148F.11, subdivision 1, is amended to read:

732.26 Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of
732.27 other professions or occupations from performing functions for which they are qualified or
732.28 licensed. This exception includes, but is not limited to: licensed physicians; registered nurses;
732.29 licensed practical nurses; licensed psychologists and licensed psychological practitioners;
732.30 members of the clergy provided such services are provided within the scope of regular
732.31 ministries; American Indian medicine men and women; licensed attorneys; probation officers;
732.32 licensed marriage and family therapists; licensed social workers; social workers employed
732.33 by city, county, or state agencies; licensed professional counselors; licensed professional

733.1 clinical counselors; licensed school counselors; registered occupational therapists or
733.2 occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders
733.3 (UMICAD) certified counselors when providing services to Native American people; city,
733.4 county, or state employees when providing assessments or case management under Minnesota
733.5 Rules, chapter 9530; and individuals defined in section 256B.0623, subdivision 5, paragraph
733.6 (a), clauses (1) ~~and (2)~~ to (6), providing ~~integrated dual diagnosis~~ co-occurring substance
733.7 use disorder treatment in adult mental health rehabilitative programs certified or licensed
733.8 by the Department of Human Services under section 245I.23, 256B.0622, or 256B.0623.

733.9 (b) Nothing in this chapter prohibits technicians and resident managers in programs
733.10 licensed by the Department of Human Services from discharging their duties as provided
733.11 in Minnesota Rules, chapter 9530.

733.12 (c) Any person who is exempt from licensure under this section must not use a title
733.13 incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug
733.14 counselor" or otherwise hold himself or herself out to the public by any title or description
733.15 stating or implying that he or she is engaged in the practice of alcohol and drug counseling,
733.16 or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless
733.17 that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice
733.18 of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the
733.19 use of one of the titles in paragraph (a).

733.20 Sec. 10. Minnesota Statutes 2020, section 245.462, subdivision 1, is amended to read:

733.21 Subdivision 1. **Definitions.** The definitions in this section apply to sections 245.461 to
733.22 ~~245.486~~ 245.4863.

733.23 Sec. 11. Minnesota Statutes 2020, section 245.462, subdivision 6, is amended to read:

733.24 Subd. 6. **Community support services program.** "Community support services program"
733.25 means services, other than inpatient or residential treatment services, provided or coordinated
733.26 by an identified program and staff under the ~~clinical~~ treatment supervision of a mental health
733.27 professional designed to help adults with serious and persistent mental illness to function
733.28 and remain in the community. A community support services program includes:

733.29 (1) client outreach,

733.30 (2) medication monitoring,

733.31 (3) assistance in independent living skills,

733.32 (4) development of employability and work-related opportunities,

734.1 (5) crisis assistance,

734.2 (6) psychosocial rehabilitation,

734.3 (7) help in applying for government benefits, and

734.4 (8) housing support services.

734.5 The community support services program must be coordinated with the case management
734.6 services specified in section 245.4711.

734.7 Sec. 12. Minnesota Statutes 2020, section 245.462, subdivision 8, is amended to read:

734.8 Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day
734.9 treatment program" means ~~a structured program of treatment and care provided to an adult~~
734.10 ~~in or by: (1) a hospital accredited by the joint commission on accreditation of health~~
734.11 ~~organizations and licensed under sections 144.50 to 144.55; (2) a community mental health~~
734.12 ~~center under section 245.62; or (3) an entity that is under contract with the county board to~~
734.13 ~~operate a program that meets the requirements of section 245.4712, subdivision 2, and~~
734.14 ~~Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group~~
734.15 ~~psychotherapy and other intensive therapeutic services that are provided at least two days~~
734.16 ~~a week by a multidisciplinary staff under the clinical supervision of a mental health~~
734.17 ~~professional. Day treatment may include education and consultation provided to families~~
734.18 ~~and other individuals as part of the treatment process. The services are aimed at stabilizing~~
734.19 ~~the adult's mental health status, providing mental health services, and developing and~~
734.20 ~~improving the adult's independent living and socialization skills. The goal of day treatment~~
734.21 ~~is to reduce or relieve mental illness and to enable the adult to live in the community. Day~~
734.22 ~~treatment services are not a part of inpatient or residential treatment services. Day treatment~~
734.23 ~~services are distinguished from day care by their structured therapeutic program of~~
734.24 ~~psychotherapy services. The commissioner may limit medical assistance reimbursement~~
734.25 ~~for day treatment to 15 hours per week per person~~ the treatment services described by section
734.26 256B.0671, subdivision 3.

734.27 Sec. 13. Minnesota Statutes 2020, section 245.462, subdivision 9, is amended to read:

734.28 Subd. 9. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" has the meaning given in
734.29 ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota~~
734.30 ~~Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a~~
734.31 ~~standard, extended, or brief diagnostic assessment, or an adult update~~ section 245I.10,
734.32 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,~~

736.1 ~~treatment strategy, a schedule for accomplishing treatment goals and objectives, and the~~
736.2 ~~individual responsible for providing treatment to the adult with mental illness~~ the formulation
736.3 of planned services that are responsive to the needs and goals of a client. An individual
736.4 treatment plan must be completed according to section 245I.10, subdivisions 7 and 8.

736.5 Sec. 15. Minnesota Statutes 2020, section 245.462, subdivision 16, is amended to read:

736.6 Subd. 16. **Mental health funds.** "Mental health funds" are funds expended under sections
736.7 245.73 and 256E.12, federal mental health block grant funds, and funds expended under
736.8 section 256D.06 to facilities licensed under section 245I.23 or Minnesota Rules, parts
736.9 9520.0500 to 9520.0670.

736.10 Sec. 16. Minnesota Statutes 2020, section 245.462, subdivision 17, is amended to read:

736.11 Subd. 17. **Mental health practitioner.** ~~(a)~~ "Mental health practitioner" means a staff
736.12 person ~~providing services to adults with mental illness or children with emotional disturbance~~
736.13 ~~who is qualified in at least one of the ways described in paragraphs (b) to (g). A mental~~
736.14 ~~health practitioner for a child client must have training working with children. A mental~~
736.15 ~~health practitioner for an adult client must have training working with adults~~ qualified
736.16 according to section 245I.04, subdivision 4.

736.17 ~~(b) For purposes of this subdivision, a practitioner is qualified through relevant~~
736.18 ~~coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in~~
736.19 ~~behavioral sciences or related fields and:~~

736.20 ~~(1) has at least 2,000 hours of supervised experience in the delivery of services to adults~~
736.21 ~~or children with:~~

736.22 ~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

736.23 ~~(ii) traumatic brain injury or developmental disabilities and completes training on mental~~
736.24 ~~illness, recovery from mental illness, mental health de-escalation techniques, co-occurring~~
736.25 ~~mental illness and substance abuse, and psychotropic medications and side effects;~~

736.26 ~~(2) is fluent in the non-English language of the ethnic group to which at least 50 percent~~
736.27 ~~of the practitioner's clients belong, completes 40 hours of training in the delivery of services~~
736.28 ~~to adults with mental illness or children with emotional disturbance, and receives clinical~~
736.29 ~~supervision from a mental health professional at least once a week until the requirement of~~
736.30 ~~2,000 hours of supervised experience is met;~~

736.31 ~~(3) is working in a day treatment program under section 245.4712, subdivision 2; or~~

737.1 ~~(4) has completed a practicum or internship that (i) requires direct interaction with adults~~
737.2 ~~or children served, and (ii) is focused on behavioral sciences or related fields.~~

737.3 ~~(c) For purposes of this subdivision, a practitioner is qualified through work experience~~
737.4 ~~if the person:~~

737.5 ~~(1) has at least 4,000 hours of supervised experience in the delivery of services to adults~~
737.6 ~~or children with:~~

737.7 ~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

737.8 ~~(ii) traumatic brain injury or developmental disabilities and completes training on mental~~
737.9 ~~illness, recovery from mental illness, mental health de-escalation techniques, co-occurring~~
737.10 ~~mental illness and substance abuse, and psychotropic medications and side effects; or~~

737.11 ~~(2) has at least 2,000 hours of supervised experience in the delivery of services to adults~~
737.12 ~~or children with:~~

737.13 ~~(i) mental illness, emotional disturbance, or substance use disorder, and receives clinical~~
737.14 ~~supervision as required by applicable statutes and rules from a mental health professional~~
737.15 ~~at least once a week until the requirement of 4,000 hours of supervised experience is met;~~
737.16 ~~or~~

737.17 ~~(ii) traumatic brain injury or developmental disabilities; completes training on mental~~
737.18 ~~illness, recovery from mental illness, mental health de-escalation techniques, co-occurring~~
737.19 ~~mental illness and substance abuse, and psychotropic medications and side effects; and~~
737.20 ~~receives clinical supervision as required by applicable statutes and rules at least once a week~~
737.21 ~~from a mental health professional until the requirement of 4,000 hours of supervised~~
737.22 ~~experience is met.~~

737.23 ~~(d) For purposes of this subdivision, a practitioner is qualified through a graduate student~~
737.24 ~~internship if the practitioner is a graduate student in behavioral sciences or related fields~~
737.25 ~~and is formally assigned by an accredited college or university to an agency or facility for~~
737.26 ~~clinical training.~~

737.27 ~~(e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's~~
737.28 ~~degree if the practitioner:~~

737.29 ~~(1) holds a master's or other graduate degree in behavioral sciences or related fields; or~~

737.30 ~~(2) holds a bachelor's degree in behavioral sciences or related fields and completes a~~
737.31 ~~practicum or internship that (i) requires direct interaction with adults or children served,~~
737.32 ~~and (ii) is focused on behavioral sciences or related fields.~~

738.1 ~~(f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical~~
738.2 ~~care if the practitioner meets the definition of vendor of medical care in section 256B.02,~~
738.3 ~~subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.~~

738.4 ~~(g) For purposes of medical assistance coverage of diagnostic assessments, explanations~~
738.5 ~~of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health~~
738.6 ~~practitioner working as a clinical trainee means that the practitioner's clinical supervision~~
738.7 ~~experience is helping the practitioner gain knowledge and skills necessary to practice~~
738.8 ~~effectively and independently. This may include supervision of direct practice, treatment~~
738.9 ~~team collaboration, continued professional learning, and job management. The practitioner~~
738.10 ~~must also:~~

738.11 ~~(1) comply with requirements for licensure or board certification as a mental health~~
738.12 ~~professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart~~
738.13 ~~5, item A, including supervised practice in the delivery of mental health services for the~~
738.14 ~~treatment of mental illness; or~~

738.15 ~~(2) be a student in a bona fide field placement or internship under a program leading to~~
738.16 ~~completion of the requirements for licensure as a mental health professional according to~~
738.17 ~~the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.~~

738.18 ~~(h) For purposes of this subdivision, "behavioral sciences or related fields" has the~~
738.19 ~~meaning given in section 256B.0623, subdivision 5, paragraph (d).~~

738.20 ~~(i) Notwithstanding the licensing requirements established by a health-related licensing~~
738.21 ~~board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other~~
738.22 ~~statute or rule.~~

738.23 Sec. 17. Minnesota Statutes 2020, section 245.462, subdivision 18, is amended to read:

738.24 Subd. 18. **Mental health professional.** "Mental health professional" means a staff person
738.25 ~~providing clinical services in the treatment of mental illness who is qualified in at least one~~
738.26 ~~of the following ways:~~ who is qualified according to section 245I.04, subdivision 2.

738.27 ~~(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to~~
738.28 ~~148.285; and:~~

738.29 ~~(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family~~
738.30 ~~psychiatric and mental health nursing by a national nurse certification organization; or~~

738.31 ~~(ii) who has a master's degree in nursing or one of the behavioral sciences or related~~
738.32 ~~fields from an accredited college or university or its equivalent, with at least 4,000 hours~~

739.1 ~~of post-master's supervised experience in the delivery of clinical services in the treatment~~
739.2 ~~of mental illness;~~

739.3 ~~(2) in clinical social work: a person licensed as an independent clinical social worker~~
739.4 ~~under chapter 148D, or a person with a master's degree in social work from an accredited~~
739.5 ~~college or university, with at least 4,000 hours of post-master's supervised experience in~~
739.6 ~~the delivery of clinical services in the treatment of mental illness;~~

739.7 ~~(3) in psychology: an individual licensed by the Board of Psychology under sections~~
739.8 ~~148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis~~
739.9 ~~and treatment of mental illness;~~

739.10 ~~(4) in psychiatry: a physician licensed under chapter 147 and certified by the American~~
739.11 ~~Board of Psychiatry and Neurology or eligible for board certification in psychiatry, or an~~
739.12 ~~osteopathic physician licensed under chapter 147 and certified by the American Osteopathic~~
739.13 ~~Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

739.14 ~~(5) in marriage and family therapy: the mental health professional must be a marriage~~
739.15 ~~and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of~~
739.16 ~~post-master's supervised experience in the delivery of clinical services in the treatment of~~
739.17 ~~mental illness;~~

739.18 ~~(6) in licensed professional clinical counseling, the mental health professional shall be~~
739.19 ~~a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours~~
739.20 ~~of post-master's supervised experience in the delivery of clinical services in the treatment~~
739.21 ~~of mental illness; or~~

739.22 ~~(7) in allied fields: a person with a master's degree from an accredited college or university~~
739.23 ~~in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's~~
739.24 ~~supervised experience in the delivery of clinical services in the treatment of mental illness.~~

739.25 Sec. 18. Minnesota Statutes 2020, section 245.462, subdivision 21, is amended to read:

739.26 Subd. 21. **Outpatient services.** "Outpatient services" means mental health services,
739.27 excluding day treatment and community support services programs, provided by or under
739.28 the ~~clinical~~ <u>treatment</u> supervision of a mental health professional to adults with mental
739.29 illness who live outside a hospital. Outpatient services include clinical activities such as
739.30 individual, group, and family therapy; individual treatment planning; diagnostic assessments;
739.31 medication management; and psychological testing.

740.1 Sec. 19. Minnesota Statutes 2020, section 245.462, subdivision 23, is amended to read:

740.2 Subd. 23. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program
740.3 under the ~~clinical~~ treatment supervision of a mental health professional, in a community
740.4 residential setting other than an acute care hospital or regional treatment center inpatient
740.5 unit, that must be licensed as a residential treatment program for adults with mental illness
740.6 under chapter 245I, Minnesota Rules, parts 9520.0500 to 9520.0670, or other rules adopted
740.7 by the commissioner.

740.8 Sec. 20. Minnesota Statutes 2020, section 245.462, is amended by adding a subdivision
740.9 to read:

740.10 Subd. 27. **Treatment supervision.** "Treatment supervision" means the treatment
740.11 supervision described by section 245I.06.

740.12 Sec. 21. Minnesota Statutes 2020, section 245.4661, subdivision 5, is amended to read:

740.13 Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with the
740.14 exception of the placement of a Minnesota specialty treatment facility as defined in paragraph
740.15 (c), must be developed under the direction of the county board, or multiple county boards
740.16 acting jointly, as the local mental health authority. The planning process for each pilot shall
740.17 include, but not be limited to, mental health consumers, families, advocates, local mental
740.18 health advisory councils, local and state providers, representatives of state and local public
740.19 employee bargaining units, and the department of human services. As part of the planning
740.20 process, the county board or boards shall designate a managing entity responsible for receipt
740.21 of funds and management of the pilot project.

740.22 (b) For Minnesota specialty treatment facilities, the commissioner shall issue a request
740.23 for proposal for regions in which a need has been identified for services.

740.24 (c) For purposes of this section, "Minnesota specialty treatment facility" is defined as
740.25 an intensive residential treatment service licensed under ~~section 256B.0622, subdivision 2,~~
740.26 ~~paragraph (b)~~ chapter 245I.

740.27 Sec. 22. Minnesota Statutes 2020, section 245.4662, subdivision 1, is amended to read:

740.28 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have
740.29 the meanings given them.

740.30 (b) "Community partnership" means a project involving the collaboration of two or more
740.31 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;

746.1 (3) an entity that is under contract with the county board to operate a program that meets
746.2 the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170
746.3 to 9505.0475; ~~or~~

746.4 (4) an entity that operates a program that meets the requirements of section 245.4884,
746.5 subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract
746.6 with an entity that is under contract with a county board~~.~~; or

746.7 (5) a program certified under section 256B.0943.

746.8 Day treatment consists of group psychotherapy and other intensive therapeutic services
746.9 that are provided for a minimum two-hour time block by a multidisciplinary staff under the
746.10 ~~clinical~~ treatment supervision of a mental health professional. Day treatment may include
746.11 education and consultation provided to families and other individuals as an extension of the
746.12 treatment process. The services are aimed at stabilizing the child's mental health status, and
746.13 developing and improving the child's daily independent living and socialization skills. Day
746.14 treatment services are distinguished from day care by their structured therapeutic program
746.15 of psychotherapy services. Day treatment services are not a part of inpatient hospital or
746.16 residential treatment services.

746.17 A day treatment service must be available to a child up to 15 hours a week throughout
746.18 the year and must be coordinated with, integrated with, or part of an education program
746.19 offered by the child's school.

746.20 Sec. 31. Minnesota Statutes 2020, section 245.4871, subdivision 11a, is amended to read:

746.21 Subd. 11a. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" has the meaning given
746.22 in ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota~~
746.23 ~~Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a~~
746.24 ~~standard, extended, or brief diagnostic assessment, or an adult update~~ section 245I.10,
746.25 subdivisions 4 to 6.

746.26 ~~(b) A brief diagnostic assessment must include a face-to-face interview with the client~~
746.27 ~~and a written evaluation of the client by a mental health professional or a clinical trainee,~~
746.28 ~~as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or~~
746.29 ~~clinical trainee must gather initial components of a standard diagnostic assessment, including~~
746.30 ~~the client's:~~

746.31 ~~(1) age;~~

746.32 ~~(2) description of symptoms, including reason for referral;~~

747.1 ~~(3) history of mental health treatment;~~

747.2 ~~(4) cultural influences and their impact on the client; and~~

747.3 ~~(5) mental status examination.~~

747.4 ~~(c) On the basis of the brief components, the professional or clinical trainee must draw~~
747.5 ~~a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's~~
747.6 ~~immediate needs or presenting problem.~~

747.7 ~~(d) Treatment sessions conducted under authorization of a brief assessment may be used~~
747.8 ~~to gather additional information necessary to complete a standard diagnostic assessment or~~
747.9 ~~an extended diagnostic assessment.~~

747.10 ~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
747.11 ~~unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible~~
747.12 ~~for psychological testing as part of the diagnostic process.~~

747.13 ~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),~~
747.14 ~~unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction~~
747.15 ~~with the diagnostic assessment process, a client is eligible for up to three individual or family~~
747.16 ~~psychotherapy sessions or family psychoeducation sessions or a combination of the above~~
747.17 ~~sessions not to exceed three sessions.~~

747.18 Sec. 32. Minnesota Statutes 2020, section 245.4871, subdivision 17, is amended to read:

747.19 Subd. 17. **Family community support services.** "Family community support services"
747.20 means services provided under the ~~clinical~~ treatment supervision of a mental health
747.21 professional and designed to help each child with severe emotional disturbance to function
747.22 and remain with the child's family in the community. Family community support services
747.23 do not include acute care hospital inpatient treatment, residential treatment services, or
747.24 regional treatment center services. Family community support services include:

747.25 (1) client outreach to each child with severe emotional disturbance and the child's family;

747.26 (2) medication monitoring where necessary;

747.27 (3) assistance in developing independent living skills;

747.28 (4) assistance in developing parenting skills necessary to address the needs of the child
747.29 with severe emotional disturbance;

747.30 (5) assistance with leisure and recreational activities;

747.31 (6) crisis ~~assistance~~ planning, including crisis placement and respite care;

748.1 (7) professional home-based family treatment;

748.2 (8) foster care with therapeutic supports;

748.3 (9) day treatment;

748.4 (10) assistance in locating respite care and special needs day care; and

748.5 (11) assistance in obtaining potential financial resources, including those benefits listed
748.6 in section 245.4884, subdivision 5.

748.7 Sec. 33. Minnesota Statutes 2020, section 245.4871, subdivision 21, is amended to read:

748.8 Subd. 21. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan~~
748.9 ~~of intervention, treatment, and services for a child with an emotional disturbance that is~~
748.10 ~~developed by a service provider under the clinical supervision of a mental health professional~~
748.11 ~~on the basis of a diagnostic assessment. An individual treatment plan for a child must be~~
748.12 ~~developed in conjunction with the family unless clinically inappropriate. The plan identifies~~
748.13 ~~goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment~~
748.14 ~~goals and objectives, and the individuals responsible for providing treatment to the child~~
748.15 ~~with an emotional disturbance~~ the formulation of planned services that are responsive to
748.16 the needs and goals of a client. An individual treatment plan must be completed according
748.17 to section 245I.10, subdivisions 7 and 8.

748.18 Sec. 34. Minnesota Statutes 2020, section 245.4871, subdivision 26, is amended to read:

748.19 Subd. 26. **Mental health practitioner.** "Mental health practitioner" ~~has the meaning~~
748.20 ~~given in section 245.462, subdivision 17~~ means a staff person who is qualified according
748.21 to section 245I.04, subdivision 4.

748.22 Sec. 35. Minnesota Statutes 2020, section 245.4871, subdivision 27, is amended to read:

748.23 Subd. 27. **Mental health professional.** "Mental health professional" means a staff person
748.24 ~~providing clinical services in the diagnosis and treatment of children's emotional disorders.~~
748.25 ~~A mental health professional must have training and experience in working with children~~
748.26 ~~consistent with the age group to which the mental health professional is assigned. A mental~~
748.27 ~~health professional must be qualified in at least one of the following ways:~~ who is qualified
748.28 according to section 245I.04, subdivision 2.

748.29 ~~(1) in psychiatric nursing, the mental health professional must be a registered nurse who~~
748.30 ~~is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in~~
748.31 ~~child and adolescent psychiatric or mental health nursing by a national nurse certification~~

749.1 ~~organization or who has a master's degree in nursing or one of the behavioral sciences or~~
749.2 ~~related fields from an accredited college or university or its equivalent, with at least 4,000~~
749.3 ~~hours of post-master's supervised experience in the delivery of clinical services in the~~
749.4 ~~treatment of mental illness;~~

749.5 ~~(2) in clinical social work, the mental health professional must be a person licensed as~~
749.6 ~~an independent clinical social worker under chapter 148D, or a person with a master's degree~~
749.7 ~~in social work from an accredited college or university, with at least 4,000 hours of~~
749.8 ~~post-master's supervised experience in the delivery of clinical services in the treatment of~~
749.9 ~~mental disorders;~~

749.10 ~~(3) in psychology, the mental health professional must be an individual licensed by the~~
749.11 ~~board of psychology under sections 148.88 to 148.98 who has stated to the board of~~
749.12 ~~psychology competencies in the diagnosis and treatment of mental disorders;~~

749.13 ~~(4) in psychiatry, the mental health professional must be a physician licensed under~~
749.14 ~~chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible~~
749.15 ~~for board certification in psychiatry or an osteopathic physician licensed under chapter 147~~
749.16 ~~and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible~~
749.17 ~~for board certification in psychiatry;~~

749.18 ~~(5) in marriage and family therapy, the mental health professional must be a marriage~~
749.19 ~~and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of~~
749.20 ~~post-master's supervised experience in the delivery of clinical services in the treatment of~~
749.21 ~~mental disorders or emotional disturbances;~~

749.22 ~~(6) in licensed professional clinical counseling, the mental health professional shall be~~
749.23 ~~a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours~~
749.24 ~~of post-master's supervised experience in the delivery of clinical services in the treatment~~
749.25 ~~of mental disorders or emotional disturbances; or~~

749.26 ~~(7) in allied fields, the mental health professional must be a person with a master's degree~~
749.27 ~~from an accredited college or university in one of the behavioral sciences or related fields,~~
749.28 ~~with at least 4,000 hours of post-master's supervised experience in the delivery of clinical~~
749.29 ~~services in the treatment of emotional disturbances.~~

749.30 Sec. 36. Minnesota Statutes 2020, section 245.4871, subdivision 29, is amended to read:

749.31 Subd. 29. **Outpatient services.** "Outpatient services" means mental health services,
749.32 excluding day treatment and community support services programs, provided by or under
749.33 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.

751.1 Sec. 40. Minnesota Statutes 2020, section 245.4871, is amended by adding a subdivision
751.2 to read:

751.3 Subd. 36. **Treatment supervision.** "Treatment supervision" means the treatment
751.4 supervision described by section 245I.06.

751.5 Sec. 41. Minnesota Statutes 2020, section 245.4876, subdivision 2, is amended to read:

751.6 Subd. 2. **Diagnostic assessment.** ~~All residential treatment facilities and acute care~~
751.7 ~~hospital inpatient treatment facilities that provide mental health services for children must~~
751.8 ~~complete a diagnostic assessment for each of their child clients within five working days~~
751.9 ~~of admission. Providers of day treatment services for children must complete a diagnostic~~
751.10 ~~assessment within five days after the child's second visit or 30 days after intake, whichever~~
751.11 ~~occurs first. In cases where a diagnostic assessment is available and has been completed~~
751.12 ~~within 180 days preceding admission, only updating is necessary. "Updating" means a~~
751.13 ~~written summary by a mental health professional of the child's current mental health status~~
751.14 ~~and service needs. If the child's mental health status has changed markedly since the child's~~
751.15 ~~most recent diagnostic assessment, a new diagnostic assessment is required. Compliance~~
751.16 ~~with the provisions of this subdivision does not ensure eligibility for medical assistance~~
751.17 ~~reimbursement under chapter 256B.~~ Providers of services governed by this section shall
751.18 complete a diagnostic assessment according to the standards of section 245I.10, subdivisions
751.19 4 to 6.

751.20 Sec. 42. Minnesota Statutes 2020, section 245.4876, subdivision 3, is amended to read:

751.21 Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment~~
751.22 ~~services, professional home-based family treatment, residential treatment, and acute care~~
751.23 ~~hospital inpatient treatment, and all regional treatment centers that provide mental health~~
751.24 ~~services for children must develop an individual treatment plan for each child client. The~~
751.25 ~~individual treatment plan must be based on a diagnostic assessment. To the extent appropriate,~~
751.26 ~~the child and the child's family shall be involved in all phases of developing and~~
751.27 ~~implementing the individual treatment plan. Providers of residential treatment, professional~~
751.28 ~~home-based family treatment, and acute care hospital inpatient treatment, and regional~~
751.29 ~~treatment centers must develop the individual treatment plan within ten working days of~~
751.30 ~~client intake or admission and must review the individual treatment plan every 90 days after~~
751.31 ~~intake, except that the administrative review of the treatment plan of a child placed in a~~
751.32 ~~residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9.~~
751.33 ~~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.

753.1 (c) Outpatient services offered by the county board to prevent placement must be at the
753.2 level of treatment appropriate to the child's diagnostic assessment.

753.3 Sec. 44. Minnesota Statutes 2020, section 245.4901, subdivision 2, is amended to read:

753.4 Subd. 2. **Eligible applicants.** An eligible applicant for school-linked mental health grants
753.5 is an entity that is:

753.6 (1) a mental health clinic certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~
753.7 section 245I.20;

753.8 (2) a community mental health center under section 256B.0625, subdivision 5;

753.9 (3) an Indian health service facility or a facility owned and operated by a tribe or tribal
753.10 organization operating under United States Code, title 25, section 5321;

753.11 (4) a provider of children's therapeutic services and supports as defined in section
753.12 256B.0943; or

753.13 (5) enrolled in medical assistance as a mental health or substance use disorder provider
753.14 agency and employs at least two full-time equivalent mental health professionals qualified
753.15 according to section ~~245I.16~~ 245I.04, subdivision 2, or two alcohol and drug counselors
753.16 licensed or exempt from licensure under chapter 148F who are qualified to provide clinical
753.17 services to children and families.

753.18 Sec. 45. Minnesota Statutes 2020, section 245.62, subdivision 2, is amended to read:

753.19 Subd. 2. **Definition.** A community mental health center is a private nonprofit corporation
753.20 or public agency approved under the ~~rules promulgated by the commissioner pursuant to~~
753.21 ~~subdivision 4~~ standards of section 256B.0625, subdivision 5.

753.22 Sec. 46. Minnesota Statutes 2020, section 245A.04, subdivision 5, is amended to read:

753.23 Subd. 5. **Commissioner's right of access.** (a) When the commissioner is exercising the
753.24 powers conferred by this chapter, ~~sections 245.69 and~~ section 626.557, and chapter 260E,
753.25 the commissioner must be given access to:

753.26 (1) the physical plant and grounds where the program is provided;

753.27 (2) documents and records, including records maintained in electronic format;

753.28 (3) persons served by the program; and

753.29 (4) staff and personnel records of current and former staff whenever the program is in
753.30 operation and the information is relevant to inspections or investigations conducted by the

754.1 commissioner. Upon request, the license holder must provide the commissioner verification
754.2 of documentation of staff work experience, training, or educational requirements.

754.3 The commissioner must be given access without prior notice and as often as the
754.4 commissioner considers necessary if the commissioner is investigating alleged maltreatment,
754.5 conducting a licensing inspection, or investigating an alleged violation of applicable laws
754.6 or rules. In conducting inspections, the commissioner may request and shall receive assistance
754.7 from other state, county, and municipal governmental agencies and departments. The
754.8 applicant or license holder shall allow the commissioner to photocopy, photograph, and
754.9 make audio and video tape recordings during the inspection of the program at the
754.10 commissioner's expense. The commissioner shall obtain a court order or the consent of the
754.11 subject of the records or the parents or legal guardian of the subject before photocopying
754.12 hospital medical records.

754.13 (b) Persons served by the program have the right to refuse to consent to be interviewed,
754.14 photographed, or audio or videotaped. Failure or refusal of an applicant or license holder
754.15 to fully comply with this subdivision is reasonable cause for the commissioner to deny the
754.16 application or immediately suspend or revoke the license.

754.17 Sec. 47. Minnesota Statutes 2020, section 245A.10, subdivision 4, is amended to read:

754.18 Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall
754.19 pay an annual nonrefundable license fee based on the following schedule:

	Licensed Capacity	Child Care Center License Fee
754.20–754.21	Licensed Capacity	Child Care Center License Fee
754.22	1 to 24 persons	$200
754.23	25 to 49 persons	$300
754.24	50 to 74 persons	$400
754.25	75 to 99 persons	$500
754.26	100 to 124 persons	$600
754.27	125 to 149 persons	$700
754.28	150 to 174 persons	$800
754.29	175 to 199 persons	$900
754.30	200 to 224 persons	$1,000
754.31	225 or more persons	$1,100

754.32 (b)(1) A program licensed to provide one or more of the home and community-based
754.33 services and supports identified under chapter 245D to persons with disabilities or age 65
754.34 and older, shall pay an annual nonrefundable license fee based on revenues derived from

755.1 the provision of services that would require licensure under chapter 245D during the calendar
755.2 year immediately preceding the year in which the license fee is paid, according to the
755.3 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

756.1 greater than $1,750,000 but less than or 756.2 equal to $2,000,000	$4,250
756.3 greater than $2,000,000 but less than or 756.4 equal to $2,500,000	$4,500
756.5 greater than $2,500,000 but less than or 756.6 equal to $3,000,000	$4,750
756.7 greater than $3,000,000 but less than or 756.8 equal to $3,500,000	$5,000
756.9 greater than $3,500,000 but less than or 756.10 equal to $4,000,000	$5,500
756.11 greater than $4,000,000 but less than or 756.12 equal to $4,500,000	$6,000
756.13 greater than $4,500,000 but less than or 756.14 equal to $5,000,000	$6,500
756.15 greater than $5,000,000 but less than or 756.16 equal to $7,500,000	$7,000
756.17 greater than $7,500,000 but less than or 756.18 equal to $10,000,000	$8,500
756.19 greater than $10,000,000 but less than or 756.20 equal to $12,500,000	$10,000
756.21 greater than $12,500,000 but less than or 756.22 equal to $15,000,000	$14,000
756.23 greater than $15,000,000	$18,000

756.24 (2) If requested, the license holder shall provide the commissioner information to verify
756.25 the license holder's annual revenues or other information as needed, including copies of
756.26 documents submitted to the Department of Revenue.

756.27 (3) At each annual renewal, a license holder may elect to pay the highest renewal fee,
756.28 and not provide annual revenue information to the commissioner.

756.29 (4) A license holder that knowingly provides the commissioner incorrect revenue amounts
756.30 for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount
756.31 of double the fee the provider should have paid.

756.32 (5) Notwithstanding clause (1), a license holder providing services under one or more
756.33 licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license
756.34 fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license
756.35 holder for all licenses held under chapter 245B for calendar year 2013. For calendar year
756.36 2017 and thereafter, the license holder shall pay an annual license fee according to clause
756.37 (1).

757.1 (c) A chemical dependency treatment program licensed under chapter 245G, to provide
757.2 chemical dependency treatment shall pay an annual nonrefundable license fee based on the
757.3 following schedule:

757.4 Licensed Capacity	License Fee
757.5 1 to 24 persons	$600
757.6 25 to 49 persons	$800
757.7 50 to 74 persons	$1,000
757.8 75 to 99 persons	$1,200
757.9 100 or more persons	$1,400

757.10 (d) A chemical dependency program licensed under Minnesota Rules, parts 9530.6510
757.11 to 9530.6590, to provide detoxification services shall pay an annual nonrefundable license
757.12 fee based on the following schedule:

757.13 Licensed Capacity	License Fee
757.14 1 to 24 persons	$760
757.15 25 to 49 persons	$960
757.16 50 or more persons	$1,160

757.17 (e) Except for child foster care, a residential facility licensed under Minnesota Rules,
757.18 chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the
757.19 following schedule:

757.20 Licensed Capacity	License Fee
757.21 1 to 24 persons	$1,000
757.22 25 to 49 persons	$1,100
757.23 50 to 74 persons	$1,200
757.24 75 to 99 persons	$1,300
757.25 100 or more persons	$1,400

757.26 (f) A residential facility licensed under section 245I.23 or Minnesota Rules, parts
757.27 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual
757.28 nonrefundable license fee based on the following schedule:

757.29 Licensed Capacity	License Fee
757.30 1 to 24 persons	$2,525
757.31 25 or more persons	$2,725

757.32 (g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400,
757.33 to serve persons with physical disabilities shall pay an annual nonrefundable license fee
757.34 based on the following schedule:

	Licensed Capacity	License Fee
758.1	Licensed Capacity	License Fee
758.2	1 to 24 persons	$450
758.3	25 to 49 persons	$650
758.4	50 to 74 persons	$850
758.5	75 to 99 persons	$1,050
758.6	100 or more persons	$1,250

758.7 (h) A program licensed to provide independent living assistance for youth under section
758.8 245A.22 shall pay an annual nonrefundable license fee of $1,500.

758.9 (i) A private agency licensed to provide foster care and adoption services under Minnesota
758.10 Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

758.11 (j) A program licensed as an adult day care center licensed under Minnesota Rules, parts
758.12 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the
758.13 following schedule:

	Licensed Capacity	License Fee
758.14	Licensed Capacity	License Fee
758.15	1 to 24 persons	$500
758.16	25 to 49 persons	$700
758.17	50 to 74 persons	$900
758.18	75 to 99 persons	$1,100
758.19	100 or more persons	$1,300

758.20 (k) A program licensed to provide treatment services to persons with sexual psychopathic
758.21 personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to
758.22 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

758.23 (l) A ~~mental health center or~~ mental health clinic ~~requesting certification for purposes~~
758.24 ~~of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750~~
758.25 ~~to 9520.0870~~ certified under section 245I.20, shall pay ~~a~~ an annual nonrefundable certification
758.26 fee of $1,550 ~~per year~~. If the ~~mental health center or~~ mental health clinic provides services
758.27 at a primary location with satellite facilities, the satellite facilities shall be certified with the
758.28 primary location without an additional charge.

758.29 Sec. 48. Minnesota Statutes 2020, section 245A.65, subdivision 2, is amended to read:

758.30 Subd. 2. **Abuse prevention plans.** All license holders shall establish and enforce ongoing
758.31 written program abuse prevention plans and individual abuse prevention plans as required
758.32 under section 626.557, subdivision 14.

759.1 (a) The scope of the program abuse prevention plan is limited to the population, physical
759.2 plant, and environment within the control of the license holder and the location where
759.3 licensed services are provided. In addition to the requirements in section 626.557, subdivision
759.4 14, the program abuse prevention plan shall meet the requirements in clauses (1) to (5).

759.5 (1) The assessment of the population shall include an evaluation of the following factors:
759.6 age, gender, mental functioning, physical and emotional health or behavior of the client;
759.7 the need for specialized programs of care for clients; the need for training of staff to meet
759.8 identified individual needs; and the knowledge a license holder may have regarding previous
759.9 abuse that is relevant to minimizing risk of abuse for clients.

759.10 (2) The assessment of the physical plant where the licensed services are provided shall
759.11 include an evaluation of the following factors: the condition and design of the building as
759.12 it relates to the safety of the clients; and the existence of areas in the building which are
759.13 difficult to supervise.

759.14 (3) The assessment of the environment for each facility and for each site when living
759.15 arrangements are provided by the agency shall include an evaluation of the following factors:
759.16 the location of the program in a particular neighborhood or community; the type of grounds
759.17 and terrain surrounding the building; the type of internal programming; and the program's
759.18 staffing patterns.

759.19 (4) The license holder shall provide an orientation to the program abuse prevention plan
759.20 for clients receiving services. If applicable, the client's legal representative must be notified
759.21 of the orientation. The license holder shall provide this orientation for each new person
759.22 within 24 hours of admission, or for persons who would benefit more from a later orientation,
759.23 the orientation may take place within 72 hours.

759.24 (5) The license holder's governing body or the governing body's delegated representative
759.25 shall review the plan at least annually using the assessment factors in the plan and any
759.26 substantiated maltreatment findings that occurred since the last review. The governing body
759.27 or the governing body's delegated representative shall revise the plan, if necessary, to reflect
759.28 the review results.

759.29 (6) A copy of the program abuse prevention plan shall be posted in a prominent location
759.30 in the program and be available upon request to mandated reporters, persons receiving
759.31 services, and legal representatives.

759.32 (b) In addition to the requirements in section 626.557, subdivision 14, the individual
759.33 abuse prevention plan shall meet the requirements in clauses (1) and (2).

760.1 (1) The plan shall include a statement of measures that will be taken to minimize the
760.2 risk of abuse to the vulnerable adult when the individual assessment required in section
760.3 626.557, subdivision 14, paragraph (b), indicates the need for measures in addition to the
760.4 specific measures identified in the program abuse prevention plan. The measures shall
760.5 include the specific actions the program will take to minimize the risk of abuse within the
760.6 scope of the licensed services, and will identify referrals made when the vulnerable adult
760.7 is susceptible to abuse outside the scope or control of the licensed services. When the
760.8 assessment indicates that the vulnerable adult does not need specific risk reduction measures
760.9 in addition to those identified in the program abuse prevention plan, the individual abuse
760.10 prevention plan shall document this determination.

760.11 (2) An individual abuse prevention plan shall be developed for each new person as part
760.12 of the initial individual program plan or service plan required under the applicable licensing
760.13 rule or statute. The review and evaluation of the individual abuse prevention plan shall be
760.14 done as part of the review of the program plan ~~or~~, service plan, or treatment plan. The person
760.15 receiving services shall participate in the development of the individual abuse prevention
760.16 plan to the full extent of the person's abilities. If applicable, the person's legal representative
760.17 shall be given the opportunity to participate with or for the person in the development of
760.18 the plan. The interdisciplinary team shall document the review of all abuse prevention plans
760.19 at least annually, using the individual assessment and any reports of abuse relating to the
760.20 person. The plan shall be revised to reflect the results of this review.

760.21 Sec. 49. Minnesota Statutes 2020, section 245D.02, subdivision 20, is amended to read:

760.22 Subd. 20. **Mental health crisis intervention team.** "Mental health crisis intervention
760.23 team" means a mental health crisis response provider as identified in section 256B.0624~~,~~
760.24 ~~subdivision 2, paragraph (d), for adults, and in section 256B.0944, subdivision 1, paragraph~~
760.25 ~~(d), for children~~.

760.26 Sec. 50. Minnesota Statutes 2020, section 256B.0615, subdivision 1, is amended to read:

760.27 Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist
760.28 services, as established in subdivision 2, subject to federal approval, if provided to recipients
760.29 who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and
760.30 are provided by a mental health certified peer specialist who has completed the training
760.31 under subdivision 5 and is qualified according to section 245I.04, subdivision 10.

Sec. 51. Minnesota Statutes 2020, section 256B.0615, subdivision 5, is amended to read:

Subd. 5. **Certified peer specialist training and certification.** The commissioner of human services shall develop a training and certification process for certified peer specialists~~, who must be at least 21 years of age~~. The candidates must have had a primary diagnosis of mental illness, be a current or former consumer of mental health services, and must demonstrate leadership and advocacy skills and a strong dedication to recovery. The training curriculum must teach participating consumers specific skills relevant to providing peer support to other consumers. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to peer support counseling.

Sec. 52. Minnesota Statutes 2020, section 256B.0616, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services, as established in subdivision 2, subject to federal approval, if provided to recipients who have an emotional disturbance or severe emotional disturbance under chapter 245, and are provided by a mental health certified family peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 12. A family peer specialist cannot provide services to the peer specialist's family.

Sec. 53. Minnesota Statutes 2020, section 256B.0616, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** Family peer support services may be ~~located in~~ provided to recipients of inpatient hospitalization, partial hospitalization, residential treatment, intensive treatment in foster care, day treatment, children's therapeutic services and supports, or crisis services.

Sec. 54. Minnesota Statutes 2020, section 256B.0616, subdivision 5, is amended to read:

Subd. 5. **Certified family peer specialist training and certification.** The commissioner shall develop a training and certification process for certified family peer specialists ~~who must be at least 21 years of age~~. The candidates must have raised or be currently raising a child with a mental illness, have had experience navigating the children's mental health system, and must demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach participating family peer specialists specific skills relevant to providing peer support to other parents. In addition to initial training and certification, the commissioner shall develop ongoing

continuing educational workshops on pertinent issues related to family peer support counseling.

Sec. 55. Minnesota Statutes 2020, section 256B.0622, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically necessary, assertive community treatment ~~for clients as defined in subdivision 2a and intensive residential treatment services for clients as defined in subdivision 3,~~ when the services are provided by an entity certified under and meeting the standards in this section.

(b) Subject to federal approval, medical assistance covers medically necessary, intensive residential treatment services when the services are provided by an entity licensed under and meeting the standards in section 245I.23.

(c) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Sec. 56. Minnesota Statutes 2020, section 256B.0622, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "ACT team" means the group of interdisciplinary mental health staff who work as a team to provide assertive community treatment.

(c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per day, seven days per week, in a community-based setting.

(d) "Individual treatment plan" means ~~the document that results from a person-centered planning process of determining real-life outcomes with clients and developing strategies to achieve those outcomes~~ a plan described by section 245I.10, subdivisions 7 and 8.

~~(e) "Assertive engagement" means the use of collaborative strategies to engage clients to receive services.~~

~~(f) "Benefits and finance support" means assisting clients in capably managing financial affairs. Services include, but are not limited to, assisting clients in applying for benefits; assisting with redetermination of benefits; providing financial crisis management; teaching~~

763.1 ~~and supporting budgeting skills and asset development; and coordinating with a client's~~
763.2 ~~representative payee, if applicable.~~

763.3 ~~(g) "Co-occurring disorder treatment" means the treatment of co-occurring mental illness~~
763.4 ~~and substance use disorders and is characterized by assertive outreach, stage-wise~~
763.5 ~~comprehensive treatment, treatment goal setting, and flexibility to work within each stage~~
763.6 ~~of treatment. Services include, but are not limited to, assessing and tracking clients' stages~~
763.7 ~~of change readiness and treatment; applying the appropriate treatment based on stages of~~
763.8 ~~change, such as outreach and motivational interviewing techniques to work with clients in~~
763.9 ~~earlier stages of change readiness and cognitive behavioral approaches and relapse prevention~~
763.10 ~~to work with clients in later stages of change; and facilitating access to community supports.~~

763.11 ~~(h)~~ (e) "Crisis assessment and intervention" means mental health crisis response services
763.12 as defined in section 256B.0624, subdivision 2~~, paragraphs (c) to (e)~~.

763.13 ~~(i) "Employment services" means assisting clients to work at jobs of their choosing.~~
763.14 ~~Services must follow the principles of the individual placement and support (IPS)~~
763.15 ~~employment model, including focusing on competitive employment; emphasizing individual~~
763.16 ~~client preferences and strengths; ensuring employment services are integrated with mental~~
763.17 ~~health services; conducting rapid job searches and systematic job development according~~
763.18 ~~to client preferences and choices; providing benefits counseling; and offering all services~~
763.19 ~~in an individualized and time-unlimited manner. Services shall also include educating clients~~
763.20 ~~about opportunities and benefits of work and school and assisting the client in learning job~~
763.21 ~~skills, navigating the work place, and managing work relationships.~~

763.22 ~~(j) "Family psychoeducation and support" means services provided to the client's family~~
763.23 ~~and other natural supports to restore and strengthen the client's unique social and family~~
763.24 ~~relationships. Services include, but are not limited to, individualized psychoeducation about~~
763.25 ~~the client's illness and the role of the family and other significant people in the therapeutic~~
763.26 ~~process; family intervention to restore contact, resolve conflict, and maintain relationships~~
763.27 ~~with family and other significant people in the client's life; ongoing communication and~~
763.28 ~~collaboration between the ACT team and the family; introduction and referral to family~~
763.29 ~~self-help programs and advocacy organizations that promote recovery and family~~
763.30 ~~engagement, individual supportive counseling, parenting training, and service coordination~~
763.31 ~~to help clients fulfill parenting responsibilities; coordinating services for the child and~~
763.32 ~~restoring relationships with children who are not in the client's custody; and coordinating~~
763.33 ~~with child welfare and family agencies, if applicable. These services must be provided with~~
763.34 ~~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.~~

765.1 ~~(s) "Physical health services" means any service or treatment to meet the physical health~~
765.2 ~~needs of the client to support the client's mental health recovery. Services include, but are~~
765.3 ~~not limited to, education on primary health issues, including wellness education; medication~~
765.4 ~~administration and monitoring; providing and coordinating medical screening and follow-up;~~
765.5 ~~scheduling routine and acute medical and dental care visits; tobacco cessation strategies;~~
765.6 ~~assisting clients in attending appointments; communicating with other providers; and~~
765.7 ~~integrating all physical and mental health treatment.~~

765.8 ~~(t)~~ (g) "Primary team member" means the person who leads and coordinates the activities
765.9 of the individual treatment team and is the individual treatment team member who has
765.10 primary responsibility for establishing and maintaining a therapeutic relationship with the
765.11 client on a continuing basis.

765.12 ~~(u) "Rehabilitative mental health services" means mental health services that are~~
765.13 ~~rehabilitative and enable the client to develop and enhance psychiatric stability, social~~
765.14 ~~competencies, personal and emotional adjustment, independent living, parenting skills, and~~
765.15 ~~community skills, when these abilities are impaired by the symptoms of mental illness.~~

765.16 ~~(v) "Symptom management" means supporting clients in identifying and targeting the~~
765.17 ~~symptoms and occurrence patterns of their mental illness and developing strategies to reduce~~
765.18 ~~the impact of those symptoms.~~

765.19 ~~(w) "Therapeutic interventions" means empirically supported techniques to address~~
765.20 ~~specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional~~
765.21 ~~dysregulation, and trauma symptoms. Interventions include empirically supported~~
765.22 ~~psychotherapies including, but not limited to, cognitive behavioral therapy, exposure therapy,~~
765.23 ~~acceptance and commitment therapy, interpersonal therapy, and motivational interviewing.~~

765.24 ~~(x) "Wellness self-management and prevention" means a combination of approaches to~~
765.25 ~~working with the client to build and apply skills related to recovery, and to support the client~~
765.26 ~~in participating in leisure and recreational activities, civic participation, and meaningful~~
765.27 ~~structure.~~

765.28 (h) "Certified rehabilitation specialist" means a staff person who is qualified according
765.29 to section 245I.04, subdivision 8.

765.30 (i) "Clinical trainee" means a staff person who is qualified according to section 245I.04,
765.31 subdivision 6.

765.32 (j) "Mental health certified peer specialist" means a staff person who is qualified
765.33 according to section 245I.04, subdivision 10.

766.1 (k) "Mental health practitioner" means a staff person who is qualified according to section
766.2 245I.04, subdivision 4.

766.3 (l) "Mental health professional" means a staff person who is qualified according to
766.4 section 245I.04, subdivision 2.

766.5 (m) "Mental health rehabilitation worker" means a staff person who is qualified according
766.6 to section 245I.04, subdivision 14.

766.7 Sec. 57. Minnesota Statutes 2020, section 256B.0622, subdivision 3a, is amended to read:

766.8 Subd. 3a. **Provider certification and contract requirements for assertive community**
766.9 **treatment.** (a) The assertive community treatment provider must:

766.10 (1) have a contract with the host county to provide assertive community treatment
766.11 services; and

766.12 (2) have each ACT team be certified by the state following the certification process and
766.13 procedures developed by the commissioner. The certification process determines whether
766.14 the ACT team meets the standards for assertive community treatment under this section ~~as~~
766.15 ~~well as~~, the standards in chapter 245I as required in section 245I.011, subdivision 5, and
766.16 minimum program fidelity standards as measured by a nationally recognized fidelity tool
766.17 approved by the commissioner. Recertification must occur at least every three years.

766.18 (b) An ACT team certified under this subdivision must meet the following standards:

766.19 (1) have capacity to recruit, hire, manage, and train required ACT team members;

766.20 (2) have adequate administrative ability to ensure availability of services;

766.21 ~~(3) ensure adequate preservice and ongoing training for staff;~~

766.22 ~~(4) ensure that staff is capable of implementing culturally specific services that are~~
766.23 ~~culturally responsive and appropriate as determined by the client's culture, beliefs, values,~~
766.24 ~~and language as identified in the individual treatment plan;~~

766.25 ~~(5)~~ (3) ensure flexibility in service delivery to respond to the changing and intermittent
766.26 care needs of a client as identified by the client and the individual treatment plan;

766.27 ~~(6) develop and maintain client files, individual treatment plans, and contact charting;~~

766.28 ~~(7) develop and maintain staff training and personnel files;~~

766.29 ~~(8) submit information as required by the state;~~

766.30 ~~(9)~~ (4) keep all necessary records required by law;

~~(10) comply with all applicable laws;~~

~~(11)~~ (5) be an enrolled Medicaid provider; and

~~(12)~~ (6) establish and maintain a quality assurance plan to determine specific service outcomes and the client's satisfaction with services~~; and~~.

~~(13) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.~~

(c) The commissioner may intervene at any time and decertify an ACT team with cause. The commissioner shall establish a process for decertification of an ACT team and shall require corrective action, medical assistance repayment, or decertification of an ACT team that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process. The decertification is subject to appeal to the state.

Sec. 58. Minnesota Statutes 2020, section 256B.0622, subdivision 4, is amended to read:

Subd. 4. **Provider entity licensure and contract requirements for intensive residential treatment services.** ~~(a) The intensive residential treatment services provider entity must:~~

~~(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;~~

~~(2) not exceed 16 beds per site; and~~

~~(3) comply with the additional standards in this section.~~

~~(b)~~ (a) The commissioner shall develop procedures for counties and providers to submit other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

~~(c)~~ (b) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

~~(d)~~ (c) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and tribal authority that serves as a local mental health authority in the proposed service area. The statement of need must specify if the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within

768.1 60 days of the receipt of the request, the commissioner shall determine the need for the
768.2 program based on the documentation submitted by the provider entity.

768.3 Sec. 59. Minnesota Statutes 2020, section 256B.0622, subdivision 7, is amended to read:

768.4 Subd. 7. **Assertive community treatment service standards.** (a) ACT teams must offer
768.5 and have the capacity to directly provide the following services:

768.6 (1) assertive engagement using collaborative strategies to encourage clients to receive
768.7 services;

768.8 (2) benefits and finance support that assists clients to capably manage financial affairs.
768.9 Services include but are not limited to assisting clients in applying for benefits, assisting
768.10 with redetermination of benefits, providing financial crisis management, teaching and
768.11 supporting budgeting skills and asset development, and coordinating with a client's
768.12 representative payee, if applicable;

768.13 (3) co-occurring substance use disorder treatment as defined in section 245I.02,
768.14 subdivision 11;

768.15 (4) crisis assessment and intervention;

768.16 (5) employment services that assist clients to work at jobs of the clients' choosing.
768.17 Services must follow the principles of the individual placement and support employment
768.18 model, including focusing on competitive employment, emphasizing individual client
768.19 preferences and strengths, ensuring employment services are integrated with mental health
768.20 services, conducting rapid job searches and systematic job development according to client
768.21 preferences and choices, providing benefits counseling, and offering all services in an
768.22 individualized and time-unlimited manner. Services must also include educating clients
768.23 about opportunities and benefits of work and school and assisting the client in learning job
768.24 skills, navigating the workplace, workplace accommodations, and managing work
768.25 relationships;

768.26 (6) family psychoeducation and support provided to the client's family and other natural
768.27 supports to restore and strengthen the client's unique social and family relationships. Services
768.28 include but are not limited to individualized psychoeducation about the client's illness and
768.29 the role of the family and other significant people in the therapeutic process; family
768.30 intervention to restore contact, resolve conflict, and maintain relationships with family and
768.31 other significant people in the client's life; ongoing communication and collaboration between
768.32 the ACT team and the family; introduction and referral to family self-help programs and
768.33 advocacy organizations that promote recovery and family engagement, individual supportive

769.1 counseling, parenting training, and service coordination to help clients fulfill parenting
769.2 responsibilities; coordinating services for the child and restoring relationships with children
769.3 who are not in the client's custody; and coordinating with child welfare and family agencies,
769.4 if applicable. These services must be provided with the client's agreement and consent;

769.5 (7) housing access support that assists clients to find, obtain, retain, and move to safe
769.6 and adequate housing of their choice. Housing access support includes but is not limited to
769.7 locating housing options with a focus on integrated independent settings; applying for
769.8 housing subsidies, programs, or resources; assisting the client in developing relationships
769.9 with local landlords; providing tenancy support and advocacy for the individual's tenancy
769.10 rights at the client's home; and assisting with relocation;

769.11 (8) medication assistance and support that assists clients in accessing medication,
769.12 developing the ability to take medications with greater independence, and providing
769.13 medication setup. Medication assistance and support includes assisting the client with the
769.14 prescription, administration, and ordering of medication by appropriate medical staff;

769.15 (9) medication education that educates clients on the role and effects of medications in
769.16 treating symptoms of mental illness and the side effects of medications;

769.17 (10) mental health certified peer specialists services according to section 256B.0615;

769.18 (11) physical health services to meet the physical health needs of the client to support
769.19 the client's mental health recovery. Services include but are not limited to education on
769.20 primary health and wellness issues, medication administration and monitoring, providing
769.21 and coordinating medical screening and follow-up, scheduling routine and acute medical
769.22 and dental care visits, tobacco cessation strategies, assisting clients in attending appointments,
769.23 communicating with other providers, and integrating all physical and mental health treatment;

769.24 (12) rehabilitative mental health services as defined in section 245I.02, subdivision 33;

769.25 (13) symptom management that supports clients in identifying and targeting the symptoms
769.26 and occurrence patterns of their mental illness and developing strategies to reduce the impact
769.27 of those symptoms;

769.28 (14) therapeutic interventions to address specific symptoms and behaviors such as
769.29 anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms. Interventions
769.30 include empirically supported psychotherapies including but not limited to cognitive
769.31 behavioral therapy, exposure therapy, acceptance and commitment therapy, interpersonal
769.32 therapy, and motivational interviewing;

770.1 (15) wellness self-management and prevention that includes a combination of approaches
770.2 to working with the client to build and apply skills related to recovery, and to support the
770.3 client in participating in leisure and recreational activities, civic participation, and meaningful
770.4 structure; and

770.5 (16) other services based on client needs as identified in a client's assertive community
770.6 treatment individual treatment plan.

770.7 (b) ACT teams must ensure the provision of all services necessary to meet a client's
770.8 needs as identified in the client's individual treatment plan.

770.9 Sec. 60. Minnesota Statutes 2020, section 256B.0622, subdivision 7a, is amended to read:

770.10 Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)
770.11 The required treatment staff qualifications and roles for an ACT team are:

770.12 (1) the team leader:

770.13 (i) shall be a ~~licensed~~ mental health professional ~~who is qualified under Minnesota Rules,~~
770.14 ~~part 9505.0371, subpart 5, item A~~. Individuals who are not licensed but who are eligible
770.15 for licensure and are otherwise qualified may also fulfill this role but must obtain full
770.16 licensure within 24 months of assuming the role of team leader;

770.17 (ii) must be an active member of the ACT team and provide some direct services to
770.18 clients;

770.19 (iii) must be a single full-time staff member, dedicated to the ACT team, who is
770.20 responsible for overseeing the administrative operations of the team, providing ~~clinical~~
770.21 ~~oversight~~ treatment supervision of services in conjunction with the psychiatrist or psychiatric
770.22 care provider, and supervising team members to ensure delivery of best and ethical practices;
770.23 and

770.24 (iv) must be available to provide overall ~~clinical oversight~~ treatment supervision to the
770.25 ACT team after regular business hours and on weekends and holidays. The team leader may
770.26 delegate this duty to another qualified member of the ACT team;

770.27 (2) the psychiatric care provider:

770.28 (i) must be a ~~licensed psychiatrist certified by the American Board of Psychiatry and~~
770.29 ~~Neurology or eligible for board certification or certified by the American Osteopathic Board~~
770.30 ~~of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who~~
770.31 ~~is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~ mental health
770.32 professional permitted to prescribe psychiatric medications as part of the mental health

771.1 professional's scope of practice. The psychiatric care provider must have demonstrated
771.2 clinical experience working with individuals with serious and persistent mental illness;

771.3 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for
771.4 screening and admitting clients; monitoring clients' treatment and team member service
771.5 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,
771.6 and health-related conditions; actively collaborating with nurses; and helping provide ~~clinical~~
771.7 treatment supervision to the team;

771.8 (iii) shall fulfill the following functions for assertive community treatment clients:
771.9 provide assessment and treatment of clients' symptoms and response to medications, including
771.10 side effects; provide brief therapy to clients; provide diagnostic and medication education
771.11 to clients, with medication decisions based on shared decision making; monitor clients'
771.12 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and
771.13 community visits;

771.14 (iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized
771.15 for mental health treatment and shall communicate directly with the client's inpatient
771.16 psychiatric care providers to ensure continuity of care;

771.17 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
771.18 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
771.19 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
771.20 supervisory, and administrative responsibilities. No more than two psychiatric care providers
771.21 may share this role;

771.22 (vi) may not provide specific roles and responsibilities by telemedicine unless approved
771.23 by the commissioner; and

771.24 (vii) shall provide psychiatric backup to the program after regular business hours and
771.25 on weekends and holidays. The psychiatric care provider may delegate this duty to another
771.26 qualified psychiatric provider;

771.27 (3) the nursing staff:

771.28 (i) shall consist of one to three registered nurses or advanced practice registered nurses,
771.29 of whom at least one has a minimum of one-year experience working with adults with
771.30 serious mental illness and a working knowledge of psychiatric medications. No more than
771.31 two individuals can share a full-time equivalent position;

771.32 (ii) are responsible for managing medication, administering and documenting medication
771.33 treatment, and managing a secure medication room; and

772.1 (iii) shall develop strategies, in collaboration with clients, to maximize taking medications
772.2 as prescribed; screen and monitor clients' mental and physical health conditions and
772.3 medication side effects; engage in health promotion, prevention, and education activities;
772.4 communicate and coordinate services with other medical providers; facilitate the development
772.5 of the individual treatment plan for clients assigned; and educate the ACT team in monitoring
772.6 psychiatric and physical health symptoms and medication side effects;

772.7 (4) the co-occurring disorder specialist:

772.8 (i) shall be a full-time equivalent co-occurring disorder specialist who has received
772.9 specific training on co-occurring disorders that is consistent with national evidence-based
772.10 practices. The training must include practical knowledge of common substances and how
772.11 they affect mental illnesses, the ability to assess substance use disorders and the client's
772.12 stage of treatment, motivational interviewing, and skills necessary to provide counseling to
772.13 clients at all different stages of change and treatment. The co-occurring disorder specialist
772.14 may also be an individual who is a licensed alcohol and drug counselor as described in
772.15 section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience,
772.16 and other requirements in section 245G.11, subdivision 5. No more than two co-occurring
772.17 disorder specialists may occupy this role; and

772.18 (ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients.
772.19 The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT
772.20 team members on co-occurring disorders;

772.21 (5) the vocational specialist:

772.22 (i) shall be a full-time vocational specialist who has at least one-year experience providing
772.23 employment services or advanced education that involved field training in vocational services
772.24 to individuals with mental illness. An individual who does not meet these qualifications
772.25 may also serve as the vocational specialist upon completing a training plan approved by the
772.26 commissioner;

772.27 (ii) shall provide or facilitate the provision of vocational services to clients. The vocational
772.28 specialist serves as a consultant and educator to fellow ACT team members on these services;
772.29 and

772.30 (iii) ~~should~~ must not refer individuals to receive any type of vocational services or linkage
772.31 by providers outside of the ACT team;

772.32 (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.

774.1 (d) Members of the ACT team must have strong clinical skills, professional qualifications,
774.2 experience, and competency to provide a full breadth of rehabilitation services. Each staff
774.3 member shall be proficient in their respective discipline and be able to work collaboratively
774.4 as a member of a multidisciplinary team to deliver the majority of the treatment,
774.5 rehabilitation, and support services clients require to fully benefit from receiving assertive
774.6 community treatment.

774.7 (e) Each ACT team member must fulfill training requirements established by the
774.8 commissioner.

774.9 Sec. 61. Minnesota Statutes 2020, section 256B.0622, subdivision 7b, is amended to read:

774.10 Subd. 7b. **Assertive community treatment program size and opportunities.** (a) Each
774.11 ACT team shall maintain an annual average caseload that does not exceed 100 clients.
774.12 Staff-to-client ratios shall be based on team size as follows:

774.13 (1) a small ACT team must:

774.14 (i) employ at least six but no more than seven full-time treatment team staff, excluding
774.15 the program assistant and the psychiatric care provider;

774.16 (ii) serve an annual average maximum of no more than 50 clients;

774.17 (iii) ensure at least one full-time equivalent position for every eight clients served;

774.18 (iv) schedule ACT team staff for at least eight-hour shift coverage on weekdays and
774.19 on-call duty to provide crisis services and deliver services after hours when staff are not
774.20 working;

774.21 (v) provide crisis services during business hours if the small ACT team does not have
774.22 sufficient staff numbers to operate an after-hours on-call system. During all other hours,
774.23 the ACT team may arrange for coverage for crisis assessment and intervention services
774.24 through a reliable crisis-intervention provider as long as there is a mechanism by which the
774.25 ACT team communicates routinely with the crisis-intervention provider and the on-call
774.26 ACT team staff are available to see clients face-to-face when necessary or if requested by
774.27 the crisis-intervention services provider;

774.28 (vi) adjust schedules and provide staff to carry out the needed service activities in the
774.29 evenings or on weekend days or holidays, when necessary;

774.30 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
774.31 provider is not regularly scheduled to work. If availability of the ACT team's psychiatric
774.32 care provider during all hours is not feasible, alternative psychiatric prescriber backup must

775.1 be arranged and a mechanism of timely communication and coordination established in
775.2 writing; and

775.3 (viii) be composed of, at minimum, one full-time team leader, at least 16 hours each
775.4 week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time
775.5 equivalent nursing, one full-time ~~substance abuse~~ co-occurring disorder specialist, one
775.6 full-time equivalent mental health certified peer specialist, one full-time vocational specialist,
775.7 one full-time program assistant, and at least one additional full-time ACT team member
775.8 who has mental health professional, certified rehabilitation specialist, clinical trainee, or
775.9 mental health practitioner status; and

775.10 (2) a midsize ACT team shall:

775.11 (i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry
775.12 time for 51 clients, with an additional two hours for every six clients added to the team, 1.5
775.13 to two full-time equivalent nursing staff, one full-time ~~substance abuse~~ co-occurring disorder
775.14 specialist, one full-time equivalent mental health certified peer specialist, one full-time
775.15 vocational specialist, one full-time program assistant, and at least 1.5 to two additional
775.16 full-time equivalent ACT members, with at least one dedicated full-time staff member with
775.17 mental health professional status. Remaining team members may have mental health
775.18 professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner
775.19 status;

775.20 (ii) employ seven or more treatment team full-time equivalents, excluding the program
775.21 assistant and the psychiatric care provider;

775.22 (iii) serve an annual average maximum caseload of 51 to 74 clients;

775.23 (iv) ensure at least one full-time equivalent position for every nine clients served;

775.24 (v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays
775.25 and six- to eight-hour shift coverage on weekends and holidays. In addition to these minimum
775.26 specifications, staff are regularly scheduled to provide the necessary services on a
775.27 client-by-client basis in the evenings and on weekends and holidays;

775.28 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver services
775.29 when staff are not working;

775.30 (vii) have the authority to arrange for coverage for crisis assessment and intervention
775.31 services through a reliable crisis-intervention provider as long as there is a mechanism by
775.32 which the ACT team communicates routinely with the crisis-intervention provider and the

776.1 on-call ACT team staff are available to see clients face-to-face when necessary or if requested
776.2 by the crisis-intervention services provider; and

776.3 (viii) arrange for and provide psychiatric backup during all hours the psychiatric care
776.4 provider is not regularly scheduled to work. If availability of the psychiatric care provider
776.5 during all hours is not feasible, alternative psychiatric prescriber backup must be arranged
776.6 and a mechanism of timely communication and coordination established in writing;

776.7 (3) a large ACT team must:

776.8 (i) be composed of, at minimum, one full-time team leader, at least 32 hours each week
776.9 per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff,
776.10 one full-time ~~substance abuse~~ co-occurring disorder specialist, one full-time equivalent
776.11 mental health certified peer specialist, one full-time vocational specialist, one full-time
776.12 program assistant, and at least two additional full-time equivalent ACT team members, with
776.13 at least one dedicated full-time staff member with mental health professional status.
776.14 Remaining team members may have mental health professional or mental health practitioner
776.15 status;

776.16 (ii) employ nine or more treatment team full-time equivalents, excluding the program
776.17 assistant and psychiatric care provider;

776.18 (iii) serve an annual average maximum caseload of 75 to 100 clients;

776.19 (iv) ensure at least one full-time equivalent position for every nine individuals served;

776.20 (v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the
776.21 second shift providing services at least 12 hours per day weekdays. For weekends and
776.22 holidays, the team must operate and schedule ACT team staff to work one eight-hour shift,
776.23 with a minimum of two staff each weekend day and every holiday;

776.24 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver services
776.25 when staff are not working; and

776.26 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
776.27 provider is not regularly scheduled to work. If availability of the ACT team psychiatric care
776.28 provider during all hours is not feasible, alternative psychiatric backup must be arranged
776.29 and a mechanism of timely communication and coordination established in writing.

776.30 (b) An ACT team of any size may have a staff-to-client ratio that is lower than the
776.31 requirements described in paragraph (a) upon approval by the commissioner, but may not
776.32 exceed a one-to-ten staff-to-client ratio.

Sec. 62. Minnesota Statutes 2020, section 256B.0622, subdivision 7d, is amended to read:

Subd. 7d. **Assertive community treatment assessment and individual treatment plan.** (a) An initial assessment~~, including a diagnostic assessment that meets the requirements of Minnesota Rules, part 9505.0372, subpart 1, and a 30-day treatment plan~~ shall be completed the day of the client's admission to assertive community treatment by the ACT team leader or the psychiatric care provider, with participation by designated ACT team members and the client. The initial assessment must include obtaining or completing a standard diagnostic assessment according to section 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader, psychiatric care provider, or other mental health professional designated by the team leader or psychiatric care provider, must update the client's diagnostic assessment at least annually.

(b) ~~An initial~~ A functional assessment must be completed ~~within ten days of intake and updated every six months for assertive community treatment, or prior to discharge from the service, whichever comes first~~ according to section 245I.10, subdivision 9.

~~(c) Within 30 days of the client's assertive community treatment admission, the ACT team shall complete an in-depth assessment of the domains listed under section 245.462, subdivision 11a.~~

~~(d)~~ Each part of the ~~in-depth~~ functional assessment areas shall be completed by each respective team specialist or an ACT team member with skill and knowledge in the area being assessed. ~~The assessments are based upon all available information, including that from client interview family and identified natural supports, and written summaries from other agencies, including police, courts, county social service agencies, outpatient facilities, and inpatient facilities, where applicable.~~

~~(e)~~ (c) Between 30 and 45 days after the client's admission to assertive community treatment, the entire ACT team must hold a comprehensive case conference, where all team members, including the psychiatric provider, present information discovered from the completed ~~in-depth~~ assessments and provide treatment recommendations. The conference must serve as the basis for the first ~~six-month~~ individual treatment plan, which must be written by the primary team member.

~~(f)~~ (d) The client's psychiatric care provider, primary team member, and individual treatment team members shall assume responsibility for preparing the written narrative of the results from the psychiatric and social functioning history timeline and the comprehensive assessment.

778.1 ~~(g)~~ (e) The primary team member and individual treatment team members shall be
778.2 assigned by the team leader in collaboration with the psychiatric care provider by the time
778.3 of the first treatment planning meeting or 30 days after admission, whichever occurs first.

778.4 ~~(h)~~ (f) Individual treatment plans must be developed through the following treatment
778.5 planning process:

778.6 (1) The individual treatment plan shall be developed in collaboration with the client and
778.7 the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT
778.8 team shall evaluate, together with each client, the client's needs, strengths, and preferences
778.9 and develop the individual treatment plan collaboratively. The ACT team shall make every
778.10 effort to ensure that the client and the client's family and natural supports, with the client's
778.11 consent, are in attendance at the treatment planning meeting, are involved in ongoing
778.12 meetings related to treatment, and have the necessary supports to fully participate. The
778.13 client's participation in the development of the individual treatment plan shall be documented.

778.14 (2) The client and the ACT team shall work together to formulate and prioritize the
778.15 issues, set goals, research approaches and interventions, and establish the plan. The plan is
778.16 individually tailored so that the treatment, rehabilitation, and support approaches and
778.17 interventions achieve optimum symptom reduction, help fulfill the personal needs and
778.18 aspirations of the client, take into account the cultural beliefs and realities of the individual,
778.19 and improve all the aspects of psychosocial functioning that are important to the client. The
778.20 process supports strengths, rehabilitation, and recovery.

778.21 (3) Each client's individual treatment plan shall identify service needs, strengths and
778.22 capacities, and barriers, and set specific and measurable short- and long-term goals for each
778.23 service need. The individual treatment plan must clearly specify the approaches and
778.24 interventions necessary for the client to achieve the individual goals, when the interventions
778.25 shall happen, and identify which ACT team member shall carry out the approaches and
778.26 interventions.

778.27 (4) The primary team member and the individual treatment team, together with the client
778.28 and the client's family and natural supports with the client's consent, are responsible for
778.29 reviewing and rewriting the treatment goals and individual treatment plan whenever there
778.30 is a major decision point in the client's course of treatment or at least every six months.

778.31 (5) The primary team member shall prepare a summary that thoroughly describes in
778.32 writing the client's and the individual treatment team's evaluation of the client's progress
778.33 and goal attainment, the effectiveness of the interventions, and the satisfaction with services

since the last individual treatment plan. The client's most recent diagnostic assessment must be included with the treatment plan summary.

(6) The individual treatment plan and review must be ~~signed~~ approved or acknowledged by the client, the primary team member, the team leader, the psychiatric care provider, and all individual treatment team members. A copy of the ~~signed~~ approved individual treatment plan ~~is~~ must be made available to the client.

Sec. 63. Minnesota Statutes 2020, section 256B.0623, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers medically necessary adult rehabilitative mental health services ~~as defined in subdivision 2, subject to federal approval, if provided to recipients as defined in subdivision 3 and provided by a qualified provider entity meeting the standards in this section and by a qualified individual provider working within the provider's scope of practice and identified in the recipient's individual treatment plan as defined in section 245.462, subdivision 14, and if determined to be medically necessary according to section 62Q.53~~ when the services are provided by an entity meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Sec. 64. Minnesota Statutes 2020, section 256B.0623, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means ~~mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services~~ the services described in section 245I.02, subdivision 33.

~~(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom~~

780.1 ~~management skills, household management skills, employment-related skills, parenting~~
780.2 ~~skills, and transition to community living services.~~

780.3 ~~(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's~~
780.4 ~~home or another community setting or in groups.~~

780.5 (b) "Medication education services" means services provided individually or in groups
780.6 which focus on educating the recipient about mental illness and symptoms; the role and
780.7 effects of medications in treating symptoms of mental illness; and the side effects of
780.8 medications. Medication education is coordinated with medication management services
780.9 and does not duplicate it. Medication education services are provided by physicians, advanced
780.10 practice registered nurses, pharmacists, physician assistants, or registered nurses.

780.11 (c) "Transition to community living services" means services which maintain continuity
780.12 of contact between the rehabilitation services provider and the recipient and which facilitate
780.13 discharge from a hospital, residential treatment program ~~under Minnesota Rules, chapter~~
780.14 ~~9505~~, board and lodging facility, or nursing home. Transition to community living services
780.15 are not intended to provide other areas of adult rehabilitative mental health services.

780.16 Sec. 65. Minnesota Statutes 2020, section 256B.0623, subdivision 3, is amended to read:

780.17 Subd. 3. **Eligibility.** An eligible recipient is an individual who:

780.18 (1) is age 18 or older;

780.19 (2) is diagnosed with a medical condition, such as mental illness or traumatic brain
780.20 injury, for which adult rehabilitative mental health services are needed;

780.21 (3) has substantial disability and functional impairment in three or more of the areas
780.22 listed in section ~~245.462, subdivision 11a~~ 245I.10, subdivision 9, clause (4), so that
780.23 self-sufficiency is markedly reduced; and

780.24 (4) has had a recent standard diagnostic assessment ~~or an adult diagnostic assessment~~
780.25 ~~update~~ by a qualified professional that documents adult rehabilitative mental health services
780.26 are medically necessary to address identified disability and functional impairments and
780.27 individual recipient goals.

780.28 Sec. 66. Minnesota Statutes 2020, section 256B.0623, subdivision 4, is amended to read:

780.29 Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the
780.30 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;~~

782.1 ~~(8)~~ (5) assist the recipient in arranging needed crisis assessment, intervention, and
782.2 stabilization services;

782.3 ~~(9)~~ (6) ensure that services are coordinated with other recipient mental health services
782.4 providers and the county mental health authority and the federally recognized American
782.5 Indian authority and necessary others after obtaining the consent of the recipient. Services
782.6 must also be coordinated with the recipient's case manager or care coordinator if the recipient
782.7 is receiving case management or care coordination services;

782.8 ~~(10) develop and maintain recipient files, individual treatment plans, and contact charting;~~

782.9 ~~(11) develop and maintain staff training and personnel files;~~

782.10 ~~(12) submit information as required by the state;~~

782.11 ~~(13) establish and maintain a quality assurance plan to evaluate the outcome of services~~
782.12 ~~provided;~~

782.13 ~~(14)~~ (7) keep all necessary records required by law;

782.14 ~~(15)~~ (8) deliver services as required by section 245.461;

782.15 ~~(16) comply with all applicable laws;~~

782.16 ~~(17)~~ (9) be an enrolled Medicaid provider; and

782.17 ~~(18)~~ (10) maintain a quality assurance plan to determine specific service outcomes and
782.18 the recipient's satisfaction with services~~; and~~.

782.19 ~~(19) develop and maintain written policies and procedures regarding service provision~~
782.20 ~~and administration of the provider entity.~~

782.21 Sec. 67. Minnesota Statutes 2020, section 256B.0623, subdivision 5, is amended to read:

782.22 Subd. 5. **Qualifications of provider staff.** ~~(a)~~ Adult rehabilitative mental health services
782.23 must be provided by qualified individual provider staff of a certified provider entity.
782.24 Individual provider staff must be qualified ~~under one of the following criteria~~ as:

782.25 (1) a mental health professional ~~as defined in section 245.462, subdivision 18, clauses~~
782.26 ~~(1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health~~
782.27 ~~professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending~~
782.28 ~~receipt of adult mental health rehabilitative services, the definition of mental health~~
782.29 ~~professional for purposes of this section includes a person who is qualified under section~~
782.30 ~~245.462, subdivision 18, clause (7), and who holds a current and valid national certification~~

783.1 ~~as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner~~
783.2 who is qualified according to section 245I.04, subdivision 2;

783.3 (2) a certified rehabilitation specialist who is qualified according to section 245I.04,
783.4 subdivision 8;

783.5 (3) a clinical trainee who is qualified according to section 245I.04, subdivision 6;

783.6 (4) a mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental~~
783.7 ~~health practitioner must work under the clinical supervision of a mental health professional~~
783.8 qualified according to section 245I.04, subdivision 4;

783.9 ~~(3)~~ (5) a mental health certified peer specialist ~~under section 256B.0615. The certified~~
783.10 ~~peer specialist must work under the clinical supervision of a mental health professional~~ who
783.11 is qualified according to section 245I.04, subdivision 10; or

783.12 ~~(4)~~ (6) a mental health rehabilitation worker who is qualified according to section 245I.04,
783.13 subdivision 14. ~~A mental health rehabilitation worker means a staff person working under~~
783.14 ~~the direction of a mental health practitioner or mental health professional and under the~~
783.15 ~~clinical supervision of a mental health professional in the implementation of rehabilitative~~
783.16 ~~mental health services as identified in the recipient's individual treatment plan who:~~

783.17 ~~(i) is at least 21 years of age;~~

783.18 ~~(ii) has a high school diploma or equivalent;~~

783.19 ~~(iii) has successfully completed 30 hours of training during the two years immediately~~
783.20 ~~prior to the date of hire, or before provision of direct services, in all of the following areas:~~
783.21 ~~recovery from mental illness, mental health de-escalation techniques, recipient rights,~~
783.22 ~~recipient-centered individual treatment planning, behavioral terminology, mental illness,~~
783.23 ~~co-occurring mental illness and substance abuse, psychotropic medications and side effects,~~
783.24 ~~functional assessment, local community resources, adult vulnerability, recipient~~
783.25 ~~confidentiality; and~~

783.26 ~~(iv) meets the qualifications in paragraph (b).~~

783.27 ~~(b) In addition to the requirements in paragraph (a), a mental health rehabilitation worker~~
783.28 ~~must also meet the qualifications in clause (1), (2), or (3):~~

783.29 ~~(1) has an associates of arts degree, two years of full-time postsecondary education, or~~
783.30 ~~a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields; is~~
783.31 ~~a registered nurse; or within the previous ten years has:~~

783.32 ~~(i) three years of personal life experience with serious mental illness;~~

~~(ii) three years of life experience as a primary caregiver to an adult with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability; or~~

~~(iii) 2,000 hours of supervised work experience in the delivery of mental health services to adults with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability;~~

~~(2)(i) is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;~~

~~(ii) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;~~

~~(iii) has 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;~~

~~(iv) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or mental health practitioner; and~~

~~(v) has 15 hours of additional continuing education on mental health topics during the first year of employment and 15 hours during every additional year of employment; or~~

~~(3) for providers of crisis residential services, intensive residential treatment services, partial hospitalization, and day treatment services:~~

~~(i) satisfies clause (2), items (ii) to (iv); and~~

~~(ii) has 40 hours of additional continuing education on mental health topics during the first year of employment.~~

~~(c) A mental health rehabilitation worker who solely acts and is scheduled as overnight staff is not required to comply with paragraph (a), clause (4), item (iv).~~

~~(d) For purposes of this subdivision, "behavioral sciences or related fields" means an education from an accredited college or university and includes but is not limited to social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, and other fields as approved by the commissioner.~~

Sec. 68. Minnesota Statutes 2020, section 256B.0623, subdivision 6, is amended to read:

Subd. 6. **Required ~~training and~~ supervision.** ~~(a) Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in~~

~~areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d).~~

~~(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).~~

~~(c) Clinical supervision may be provided by a full- or part-time qualified professional employed by or under contract with the provider entity. Clinical supervision may be provided by interactive videoconferencing according to procedures developed by the commissioner. A mental health professional providing clinical supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:~~

~~(1) review the information in the recipient's file;~~

~~(2) review and approve initial and updates of individual treatment plans;~~

(a) A treatment supervisor providing treatment supervision required by section 245I.06 must:

~~(3)~~ (1) meet with ~~mental health rehabilitation workers and practitioners, individually or in small groups,~~ staff receiving treatment supervision at least monthly to discuss treatment topics of interest ~~to the workers and practitioners;~~

~~(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss~~ and treatment plans of recipients~~, and approve by signature and document in the recipient's file any resulting plan updates~~; and

~~(5)~~ (2) meet at least monthly with the directing clinical trainee or mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing clinical trainee or mental health practitioner~~; and~~.

~~(6) be available for urgent consultation as the individual recipient needs or the situation necessitates.~~

~~(d)~~ (b) An adult rehabilitative mental health services provider entity must have a treatment director who is a ~~mental health practitioner or~~ mental health professional clinical trainee,

786.1 certified rehabilitation specialist, or mental health practitioner. The treatment director must
786.2 ~~ensure the following~~:

786.3 (1) ~~while delivering direct services to recipients, a newly hired mental health rehabilitation~~
786.4 ~~worker must be directly observed delivering services to recipients by a mental health~~
786.5 ~~practitioner or mental health professional for at least six hours per 40 hours worked during~~
786.6 ~~the first 160 hours that the mental health rehabilitation worker works~~ ensure the direct
786.7 observation of mental health rehabilitation workers required by section 245I.06, subdivision
786.8 3, is provided;

786.9 ~~(2) the mental health rehabilitation worker must receive ongoing on-site direct service~~
786.10 ~~observation by a mental health professional or mental health practitioner for at least six~~
786.11 ~~hours for every six months of employment;~~

786.12 ~~(3) progress notes are reviewed from on-site service observation prepared by the mental~~
786.13 ~~health rehabilitation worker and mental health practitioner for accuracy and consistency~~
786.14 ~~with actual recipient contact and the individual treatment plan and goals;~~

786.15 ~~(4)~~ (2) ensure immediate availability by phone or in person for consultation by a mental
786.16 health professional, certified rehabilitation specialist, clinical trainee, or a mental health
786.17 practitioner to the mental health rehabilitation ~~services~~ worker during service provision;

786.18 ~~(5) oversee the identification of changes in individual recipient treatment strategies,~~
786.19 ~~revise the plan, and communicate treatment instructions and methodologies as appropriate~~
786.20 ~~to ensure that treatment is implemented correctly;~~

786.21 ~~(6)~~ (3) model service practices which: respect the recipient, include the recipient in
786.22 planning and implementation of the individual treatment plan, recognize the recipient's
786.23 strengths, collaborate and coordinate with other involved parties and providers;

786.24 ~~(7)~~ (4) ensure that clinical trainees, mental health practitioners, and mental health
786.25 rehabilitation workers are able to effectively communicate with the recipients, significant
786.26 others, and providers; and

786.27 ~~(8)~~ (5) oversee the record of the results of ~~on-site~~ direct observation ~~and charting~~, progress
786.28 note evaluation, and corrective actions taken to modify the work of the clinical trainees,
786.29 mental health practitioners, and mental health rehabilitation workers.

786.30 ~~(e)~~ (c) A clinical trainee or mental health practitioner who is providing treatment direction
786.31 for a provider entity must receive treatment supervision at least monthly ~~from a mental~~
786.32 ~~health professional~~ to:

786.33 (1) identify and plan for general needs of the recipient population served;

787.1 (2) identify and plan to address provider entity program needs and effectiveness;

787.2 (3) identify and plan provider entity staff training and personnel needs and issues; and

787.3 (4) plan, implement, and evaluate provider entity quality improvement programs.

787.4 Sec. 69. Minnesota Statutes 2020, section 256B.0623, subdivision 9, is amended to read:

787.5 Subd. 9. **Functional assessment.** (a) Providers of adult rehabilitative mental health
787.6 services must complete a written functional assessment as defined in section 245.462,
787.7 subdivision 11a according to section 245I.10, subdivision 9, for each recipient. The functional
787.8 assessment must be completed within 30 days of intake, and reviewed and updated at least
787.9 every six months after it is developed, unless there is a significant change in the functioning
787.10 of the recipient. If there is a significant change in functioning, the assessment must be
787.11 updated. A single functional assessment can meet case management and adult rehabilitative
787.12 mental health services requirements if agreed to by the recipient. Unless the recipient refuses,
787.13 the recipient must have significant participation in the development of the functional
787.14 assessment.

787.15 (b) When a provider of adult rehabilitative mental health services completes a written
787.16 functional assessment, the provider must also complete a level of care assessment as defined
787.17 in section 245I.02, subdivision 19, for the recipient.

787.18 Sec. 70. Minnesota Statutes 2020, section 256B.0623, subdivision 12, is amended to read:

787.19 Subd. 12. **Additional requirements.** (a) Providers of adult rehabilitative mental health
787.20 services must comply with the requirements relating to referrals for case management in
787.21 section 245.467, subdivision 4.

787.22 (b) Adult rehabilitative mental health services are provided for most recipients in the
787.23 recipient's home and community. Services may also be provided at the home of a relative
787.24 or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom,
787.25 or other places in the community. Except for "transition to community services," the place
787.26 of service does not include a regional treatment center, nursing home, residential treatment
787.27 facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or section
787.28 245I.23, or an acute care hospital.

787.29 (c) Adult rehabilitative mental health services may be provided in group settings if
787.30 appropriate to each participating recipient's needs and individual treatment plan. A group
787.31 is defined as two to ten clients, at least one of whom is a recipient, who is concurrently
787.32 receiving a service which is identified in this section. The service and group must be specified

788.1 in the recipient's individual treatment plan. No more than two qualified staff may bill
788.2 Medicaid for services provided to the same group of recipients. If two adult rehabilitative
788.3 mental health workers bill for recipients in the same group session, they must each bill for
788.4 different recipients.

788.5 (d) Adult rehabilitative mental health services are appropriate if provided to enable a
788.6 recipient to retain stability and functioning, when the recipient is at risk of significant
788.7 functional decompensation or requiring more restrictive service settings without these
788.8 services.

788.9 (e) Adult rehabilitative mental health services instruct, assist, and support the recipient
788.10 in areas including: interpersonal communication skills, community resource utilization and
788.11 integration skills, crisis planning, relapse prevention skills, health care directives, budgeting
788.12 and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,
788.13 transportation skills, medication education and monitoring, mental illness symptom
788.14 management skills, household management skills, employment-related skills, parenting
788.15 skills, and transition to community living services.

788.16 (f) Community intervention, including consultation with relatives, guardians, friends,
788.17 employers, treatment providers, and other significant individuals, is appropriate when
788.18 directed exclusively to the treatment of the client.

788.19 Sec. 71. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, is amended to read:

788.20 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary
788.21 services and consultations delivered by a licensed health care provider via telemedicine in
788.22 the same manner as if the service or consultation was delivered in person. Coverage is
788.23 limited to three telemedicine services per enrollee per calendar week, except as provided
788.24 in paragraph (f). Telemedicine services shall be paid at the full allowable rate.

788.25 (b) The commissioner shall establish criteria that a health care provider must attest to
788.26 in order to demonstrate the safety or efficacy of delivering a particular service via
788.27 telemedicine. The attestation may include that the health care provider:

788.28 (1) has identified the categories or types of services the health care provider will provide
788.29 via telemedicine;

788.30 (2) has written policies and procedures specific to telemedicine services that are regularly
788.31 reviewed and updated;

788.32 (3) has policies and procedures that adequately address patient safety before, during,
788.33 and after the telemedicine service is rendered;

789.1 (4) has established protocols addressing how and when to discontinue telemedicine
789.2 services; and

789.3 (5) has an established quality assurance process related to telemedicine services.

789.4 (c) As a condition of payment, a licensed health care provider must document each
789.5 occurrence of a health service provided by telemedicine to a medical assistance enrollee.
789.6 Health care service records for services provided by telemedicine must meet the requirements
789.7 set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

789.8 (1) the type of service provided by telemedicine;

789.9 (2) the time the service began and the time the service ended, including an a.m. and p.m.
789.10 designation;

789.11 (3) the licensed health care provider's basis for determining that telemedicine is an
789.12 appropriate and effective means for delivering the service to the enrollee;

789.13 (4) the mode of transmission of the telemedicine service and records evidencing that a
789.14 particular mode of transmission was utilized;

789.15 (5) the location of the originating site and the distant site;

789.16 (6) if the claim for payment is based on a physician's telemedicine consultation with
789.17 another physician, the written opinion from the consulting physician providing the
789.18 telemedicine consultation; and

789.19 (7) compliance with the criteria attested to by the health care provider in accordance
789.20 with paragraph (b).

789.21 (d) For purposes of this subdivision, unless otherwise covered under this chapter,
789.22 "telemedicine" is defined as the delivery of health care services or consultations while the
789.23 patient is at an originating site and the licensed health care provider is at a distant site. A
789.24 communication between licensed health care providers, or a licensed health care provider
789.25 and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission
789.26 does not constitute telemedicine consultations or services. Telemedicine may be provided
789.27 by means of real-time two-way, interactive audio and visual communications, including the
789.28 application of secure video conferencing or store-and-forward technology to provide or
789.29 support health care delivery, which facilitate the assessment, diagnosis, consultation,
789.30 treatment, education, and care management of a patient's health care.

789.31 (e) For purposes of this section, "licensed health care provider" means a licensed health
789.32 care provider under section 62A.671, subdivision 6, a community paramedic as defined

790.1 under section 144E.001, subdivision 5f, ~~or~~ a clinical trainee who is qualified according to
790.2 section 245I.04, subdivision 6, a mental health practitioner ~~defined under section 245.462,~~
790.3 ~~subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a~~
790.4 ~~mental health professional~~ qualified according to section 245I.04, subdivision 4, and a
790.5 community health worker who meets the criteria under subdivision 49, paragraph (a); "health
790.6 care provider" is defined under section 62A.671, subdivision 3; and "originating site" is
790.7 defined under section 62A.671, subdivision 7.

790.8 (f) The limit on coverage of three telemedicine services per enrollee per calendar week
790.9 does not apply if:

790.10 (1) the telemedicine services provided by the licensed health care provider are for the
790.11 treatment and control of tuberculosis; and

790.12 (2) the services are provided in a manner consistent with the recommendations and best
790.13 practices specified by the Centers for Disease Control and Prevention and the commissioner
790.14 of health.

790.15 Sec. 72. Minnesota Statutes 2020, section 256B.0625, subdivision 5, is amended to read:

790.16 Subd. 5. **Community mental health center services.** Medical assistance covers
790.17 community mental health center services provided by a community mental health center
790.18 that meets the requirements in paragraphs (a) to (j).

790.19 (a) The provider ~~is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870~~ must
790.20 be certified as a mental health clinic under section 245I.20.

790.21 (b) ~~The provider provides mental health services under the clinical supervision of a~~
790.22 ~~mental health professional who is licensed for independent practice at the doctoral level or~~
790.23 ~~by a board-certified psychiatrist~~ In addition to the policies and procedures required by
790.24 section 245I.03, the provider must establish, enforce, and maintain the policies and procedures
790.25 for oversight of clinical services by a doctoral level psychologist or a board certified or
790.26 board eligible psychiatrist ~~who is eligible for board certification~~. ~~Clinical supervision has~~
790.27 ~~the meaning given in Minnesota Rules, part 9505.0370, subpart 6.~~ These policies and
790.28 procedures must be developed with the involvement of a doctoral level psychologist and a
790.29 board certified or board eligible psychiatrist, and must include:

790.30 (1) requirements for when to seek clinical consultation by doctoral level psychologist
790.31 or a board certified or board eligible psychiatrist;

790.32 (2) requirements for the involvement of a doctoral level psychologist or a board certified
790.33 or board eligible psychiatrist in the direction of clinical services; and

791.1 (3) involvement of a doctoral level psychologist or a board certified or board eligible
791.2 psychiatrist in quality improvement initiatives and review as part of a multidisciplinary care
791.3 team.

791.4 (c) The provider must be a private nonprofit corporation or a governmental agency and
791.5 have a community board of directors as specified by section 245.66.

791.6 (d) The provider must have a sliding fee scale that meets the requirements in section
791.7 245.481, and agree to serve within the limits of its capacity all individuals residing in its
791.8 service delivery area.

791.9 (e) At a minimum, the provider must provide the following outpatient mental health
791.10 services: diagnostic assessment; explanation of findings; family, group, and individual
791.11 psychotherapy, including crisis intervention psychotherapy services, ~~multiple family group~~
791.12 ~~psychotherapy~~, psychological testing, and medication management. In addition, the provider
791.13 must provide or be capable of providing upon request of the local mental health authority
791.14 day treatment services, multiple family group psychotherapy, and professional home-based
791.15 mental health services. The provider must have the capacity to provide such services to
791.16 specialized populations such as the elderly, families with children, persons who are seriously
791.17 and persistently mentally ill, and children who are seriously emotionally disturbed.

791.18 (f) The provider must be capable of providing the services specified in paragraph (e) to
791.19 individuals who are ~~diagnosed with both~~ dually diagnosed with mental illness or emotional
791.20 disturbance, and ~~chemical dependency~~ substance use disorder, and to individuals who are
791.21 dually diagnosed with a mental illness or emotional disturbance and developmental disability.

791.22 (g) The provider must provide 24-hour emergency care services or demonstrate the
791.23 capacity to assist recipients in need of such services to access such services on a 24-hour
791.24 basis.

791.25 (h) The provider must have a contract with the local mental health authority to provide
791.26 one or more of the services specified in paragraph (e).

791.27 (i) The provider must agree, upon request of the local mental health authority, to enter
791.28 into a contract with the county to provide mental health services not reimbursable under
791.29 the medical assistance program.

791.30 (j) The provider may not be enrolled with the medical assistance program as both a
791.31 hospital and a community mental health center. The community mental health center's
791.32 administrative, organizational, and financial structure must be separate and distinct from
791.33 that of the hospital.

792.1 (k) The commissioner may require the provider to annually attest that the provider meets
792.2 the requirements in this subdivision using a form that the commissioner provides.

792.3 **EFFECTIVE DATE.** Paragraphs (b), (e), (f), and (k) are effective the day following
792.4 final enactment.

792.5 Sec. 73. Minnesota Statutes 2020, section 256B.0625, subdivision 19c, is amended to
792.6 read:

792.7 Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services
792.8 provided by an individual who is qualified to provide the services according to subdivision
792.9 19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and
792.10 supervised by a qualified professional.

792.11 "Qualified professional" means a mental health professional ~~as defined in section 245.462,~~
792.12 ~~subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~; a registered
792.13 nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in
792.14 sections 148E.010 and 148E.055, or a qualified designated coordinator under section
792.15 245D.081, subdivision 2. The qualified professional shall perform the duties required in
792.16 section 256B.0659.

792.17 Sec. 74. Minnesota Statutes 2020, section 256B.0625, subdivision 28a, is amended to
792.18 read:

792.19 Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers services
792.20 performed by a licensed physician assistant if the service is otherwise covered under this
792.21 chapter as a physician service and if the service is within the scope of practice of a licensed
792.22 physician assistant as defined in section 147A.09.

792.23 (b) Licensed physician assistants, who are supervised by a physician certified by the
792.24 American Board of Psychiatry and Neurology or eligible for board certification in psychiatry,
792.25 may bill for medication management and evaluation and management services provided to
792.26 medical assistance enrollees in inpatient hospital settings, and in outpatient settings after
792.27 the licensed physician assistant completes 2,000 hours of clinical experience in the evaluation
792.28 and treatment of mental health, consistent with their authorized scope of practice, as defined
792.29 in section 147A.09, with the exception of performing psychotherapy or diagnostic
792.30 assessments or providing ~~clinical~~ treatment supervision.

Sec. 75. Minnesota Statutes 2020, section 256B.0625, subdivision 42, is amended to read:

Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part 9505.0175, subpart 28, the definition of a mental health professional ~~shall include a person who is~~ qualified ~~as specified in~~ according to section ~~245.462, subdivision 18, clauses (1) to (6); or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2, for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Sec. 76. Minnesota Statutes 2020, section 256B.0625, subdivision 48, is amended to read:

Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance covers consultation provided by a ~~psychiatrist, a psychologist, an advanced practice registered nurse certified in psychiatric mental health, a licensed independent clinical social worker, as defined in section 245.462, subdivision 18, clause (2), or a licensed marriage and family therapist, as defined in section 245.462, subdivision 18, clause (5)~~ mental health professional who is qualified according to section 245I.04, subdivision 2, except a licensed professional clinical counselor licensed under section 148B.5301, via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Sec. 77. Minnesota Statutes 2020, section 256B.0625, subdivision 49, is amended to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has~~:~~

~~(1)~~ received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum~~; or~~.

~~(2) at least five years of supervised experience with an enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.~~

~~Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.~~

794.1 (b) Community health workers must work under the supervision of a medical assistance
794.2 enrolled physician, registered nurse, advanced practice registered nurse, mental health
794.3 professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), and section~~
794.4 ~~245.4871, subdivision 27, clauses (1) to (5)~~, or dentist, or work under the supervision of a
794.5 certified public health nurse operating under the direct authority of an enrolled unit of
794.6 government.

794.7 (c) Care coordination and patient education services covered under this subdivision
794.8 include, but are not limited to, services relating to oral health and dental care.

794.9 Sec. 78. Minnesota Statutes 2020, section 256B.0625, subdivision 56a, is amended to
794.10 read:

794.11 Subd. 56a. **Officer-involved community-based care coordination.** (a) Medical
794.12 assistance covers officer-involved community-based care coordination for an individual
794.13 who:

794.14 (1) has screened positive for benefiting from treatment for a mental illness or substance
794.15 use disorder using a tool approved by the commissioner;

794.16 (2) does not require the security of a public detention facility and is not considered an
794.17 inmate of a public institution as defined in Code of Federal Regulations, title 42, section
794.18 435.1010;

794.19 (3) meets the eligibility requirements in section 256B.056; and

794.20 (4) has agreed to participate in officer-involved community-based care coordination.

794.21 (b) Officer-involved community-based care coordination means navigating services to
794.22 address a client's mental health, chemical health, social, economic, and housing needs, or
794.23 any other activity targeted at reducing the incidence of jail utilization and connecting
794.24 individuals with existing covered services available to them, including, but not limited to,
794.25 targeted case management, waiver case management, or care coordination.

794.26 (c) Officer-involved community-based care coordination must be provided by an
794.27 individual who is an employee of or is under contract with a county, or is an employee of
794.28 or under contract with an Indian health service facility or facility owned and operated by a
794.29 tribe or a tribal organization operating under Public Law 93-638 as a 638 facility to provide
794.30 officer-involved community-based care coordination and is qualified under one of the
794.31 following criteria:

795.1 (1) a ~~licensed~~ mental health professional ~~as defined in section 245.462, subdivision 18,~~
795.2 ~~clauses (1) to (6)~~;

795.3 (2) a clinical trainee who is qualified according to section 245I.04, subdivision 6, working
795.4 under the treatment supervision of a mental health professional according to section 245I.06;

795.5 (3) a mental health practitioner ~~as defined in section 245.462, subdivision 17~~ who is
795.6 qualified according to section 245I.04, subdivision 4, working under the ~~clinical~~ treatment
795.7 supervision of a mental health professional according to section 245I.06;

795.8 ~~(3)~~ (4) a mental health certified peer specialist ~~under section 256B.0615~~ who is qualified
795.9 according to section 245I.04, subdivision 10, working under the ~~clinical~~ treatment supervision
795.10 of a mental health professional according to section 245I.06;

795.11 (4) an individual qualified as an alcohol and drug counselor under section 245G.11,
795.12 subdivision 5; or

795.13 (5) a recovery peer qualified under section 245G.11, subdivision 8, working under the
795.14 supervision of an individual qualified as an alcohol and drug counselor under section
795.15 245G.11, subdivision 5.

795.16 (d) Reimbursement is allowed for up to 60 days following the initial determination of
795.17 eligibility.

795.18 (e) Providers of officer-involved community-based care coordination shall annually
795.19 report to the commissioner on the number of individuals served, and number of the
795.20 community-based services that were accessed by recipients. The commissioner shall ensure
795.21 that services and payments provided under officer-involved community-based care
795.22 coordination do not duplicate services or payments provided under section 256B.0625,
795.23 subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

795.24 (f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for
795.25 officer-involved community-based care coordination services shall be provided by the
795.26 county providing the services, from sources other than federal funds or funds used to match
795.27 other federal funds.

795.28 Sec. 79. Minnesota Statutes 2020, section 256B.0757, subdivision 4c, is amended to read:

795.29 Subd. 4c. **Behavioral health home services staff qualifications.** (a) A behavioral health
795.30 home services provider must maintain staff with required professional qualifications
795.31 appropriate to the setting.

(b) If behavioral health home services are offered in a mental health setting, the integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice Act, sections 148.171 to 148.285.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be a mental health professional ~~as defined in~~ who is qualified according to section ~~245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

(d) If behavioral health home services are offered in either a primary care setting or mental health setting, the systems navigator must be a mental health practitioner ~~as defined in~~ who is qualified according to section ~~245.462, subdivision 17~~ 245I.04, subdivision 4, or a community health worker as defined in section 256B.0625, subdivision 49.

(e) If behavioral health home services are offered in either a primary care setting or mental health setting, the qualified health home specialist must be one of the following:

(1) a mental health certified peer ~~support~~ specialist ~~as defined in~~ who is qualified according to section ~~256B.0615~~ 245I.04, subdivision 10;

(2) a mental health certified family peer ~~support~~ specialist ~~as defined in~~ who is qualified according to section ~~256B.0616~~ 245I.04, subdivision 12;

(3) a case management associate as defined in section 245.462, subdivision 4, paragraph (g), or 245.4871, subdivision 4, paragraph (j);

(4) a mental health rehabilitation worker ~~as defined in~~ who is qualified according to section ~~256B.0623, subdivision 5, clause (4)~~ 245I.04, subdivision 14;

(5) a community paramedic as defined in section 144E.28, subdivision 9;

(6) a peer recovery specialist as defined in section 245G.07, subdivision 1, clause (5); or

(7) a community health worker as defined in section 256B.0625, subdivision 49.

Sec. 80. Minnesota Statutes 2020, section 256B.0941, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, services are determined to be medically necessary according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) was referred for treatment in a psychiatric residential treatment facility by a ~~qualified~~ mental health professional ~~licensed as defined in~~ who is qualified according to section ~~245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

(b) The commissioner shall provide oversight and review the use of referrals for clients admitted to psychiatric residential treatment facilities to ensure that eligibility criteria, clinical services, and treatment planning reflect clinical, state, and federal standards for psychiatric residential treatment facility level of care. The commissioner shall coordinate the production of a statewide list of children and youth who meet the medical necessity criteria for psychiatric residential treatment facility level of care and who are awaiting admission. The commissioner and any recipient of the list shall not use the statewide list to direct admission of children and youth to specific facilities.

Sec. 81. Minnesota Statutes 2020, section 256B.0943, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed emotional disturbance, as defined in section 245.4871, subdivision 15, or a diagnosed mental illness, as defined in section 245.462, subdivision

798.1 20. The services are time-limited interventions that are delivered using various treatment
798.2 modalities and combinations of services designed to reach treatment outcomes identified
798.3 in the individual treatment plan.

798.4 ~~(b) "Clinical supervision" means the overall responsibility of the mental health~~
798.5 ~~professional for the control and direction of individualized treatment planning, service~~
798.6 ~~delivery, and treatment review for each client. A mental health professional who is an~~
798.7 ~~enrolled Minnesota health care program provider accepts full professional responsibility~~
798.8 ~~for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work,~~
798.9 ~~and oversees or directs the supervisee's work.~~

798.10 ~~(c)~~ (b) "Clinical trainee" means a ~~mental health practitioner who meets the qualifications~~
798.11 ~~specified in Minnesota Rules, part 9505.0371, subpart 5, item C~~ staff person who is qualified
798.12 according to section 245I.04, subdivision 6.

798.13 ~~(d)~~ (c) "Crisis ~~assistance~~ planning" has the meaning given in section 245.4871, subdivision
798.14 9a. ~~Crisis assistance entails the development of a written plan to assist a child's family to~~
798.15 ~~contend with a potential crisis and is distinct from the immediate provision of crisis~~
798.16 ~~intervention services.~~

798.17 ~~(e)~~ (d) "Culturally competent provider" means a provider who understands and can
798.18 utilize to a client's benefit the client's culture when providing services to the client. A provider
798.19 may be culturally competent because the provider is of the same cultural or ethnic group
798.20 as the client or the provider has developed the knowledge and skills through training and
798.21 experience to provide services to culturally diverse clients.

798.22 ~~(f)~~ (e) "Day treatment program" for children means a site-based structured mental health
798.23 program consisting of psychotherapy for three or more individuals and individual or group
798.24 skills training provided by a ~~multidisciplinary~~ team, under the ~~clinical~~ treatment supervision
798.25 of a mental health professional.

798.26 ~~(g)~~ (f) "Standard diagnostic assessment" ~~has the meaning given in Minnesota Rules, part~~
798.27 ~~9505.0372, subpart 1~~ means the assessment described in 245I.10, subdivision 6.

798.28 ~~(h)~~ (g) "Direct service time" means the time that a mental health professional, clinical
798.29 trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with
798.30 a client and the client's family or providing covered telemedicine services. Direct service
798.31 time includes time in which the provider obtains a client's history, develops a client's
798.32 treatment plan, records individual treatment outcomes, or provides service components of
798.33 children's therapeutic services and supports. Direct service time does not include time doing

799.1 work before and after providing direct services, including scheduling or maintaining clinical
799.2 records.

799.3 ~~(i)~~ <u>(h)</u> "Direction of mental health behavioral aide" means the activities of a mental
799.4 health professional<u>, clinical trainee,</u> or mental health practitioner in guiding the mental
799.5 health behavioral aide in providing services to a client. The direction of a mental health
799.6 behavioral aide must be based on the client's ~~individualized~~ <u>individual</u> treatment plan and
799.7 meet the requirements in subdivision 6, paragraph (b), clause (5).

799.8 ~~(j)~~ <u>(i)</u> "Emotional disturbance" has the meaning given in section 245.4871, subdivision
799.9 15.

799.10 ~~(k)~~ <u>(j)</u> "Individual behavioral plan" means a plan of intervention, treatment, and services
799.11 for a child written by a mental health professional <u>or a clinical trainee</u> or mental health
799.12 practitioner~~,~~ under the ~~clinical~~ <u>treatment</u> supervision of a mental health professional, to
799.13 guide the work of the mental health behavioral aide. The individual behavioral plan may
799.14 be incorporated into the child's individual treatment plan so long as the behavioral plan is
799.15 separately communicable to the mental health behavioral aide.

799.16 ~~(l)~~ <u>(k)</u> "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part~~
799.17 ~~9505.0371, subpart 7~~ <u>means the plan described in section 245I.10, subdivisions 7 and 8</u>.

799.18 ~~(m)~~ <u>(l)</u> "Mental health behavioral aide services" means medically necessary one-on-one
799.19 activities performed by a ~~trained paraprofessional qualified as provided in subdivision 7,~~
799.20 ~~paragraph (b), clause (3)~~ <u>mental health behavioral aide qualified according to section 245I.04,</u>
799.21 <u>subdivision 16</u>, to assist a child retain or generalize psychosocial skills as previously trained
799.22 by a mental health professional<u>, clinical trainee,</u> or mental health practitioner and as described
799.23 in the child's individual treatment plan and individual behavior plan. Activities involve
799.24 working directly with the child or child's family as provided in subdivision 9, paragraph
799.25 (b), clause (4).

799.26 <u>(m) "Mental health certified family peer specialist" means a staff person who is qualified</u>
799.27 <u>according to section 245I.04, subdivision 12.</u>

799.28 (n) "Mental health practitioner" ~~has the meaning given in section 245.462, subdivision~~
799.29 ~~17, except that a practitioner working in a day treatment setting may qualify as a mental~~
799.30 ~~health practitioner if the practitioner holds a bachelor's degree in one of the behavioral~~
799.31 ~~sciences or related fields from an accredited college or university, and: (1) has at least 2,000~~
799.32 ~~hours of clinically supervised experience in the delivery of mental health services to clients~~
799.33 ~~with mental illness; (2) is fluent in the language, other than English, of the cultural group~~
799.34 ~~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~~ <u>means a staff person who is qualified according to section 245I.04, subdivision 4</u>.

(o) "Mental health professional" means ~~an individual as defined in Minnesota Rules, part 9505.0370, subpart 18~~ <u>a staff person who is qualified according to section 245I.04, subdivision 2</u>.

(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 <u>and reporting the</u> standardized outcome ~~measurement instruments, determined and updated by the commissioner~~ <u>measurements in section 245I.10, subdivision 6, paragraph (d), clauses (3) and (4), and other standardized outcome measurements approved by the commissioner</u>, 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~~

801.1 ~~experienced new trauma since the diagnostic assessment was completed and needs~~
801.2 ~~psychotherapy to address issues not currently included in the child's individual treatment~~
801.3 ~~plan~~ described in section 256B.0671, subdivision 11.

801.4 (s) "Rehabilitative services" or "psychiatric rehabilitation services" means ~~a series or~~
801.5 ~~multidisciplinary combination of psychiatric and psychosocial~~ interventions to: (1) restore
801.6 a child or adolescent to an age-appropriate developmental trajectory that had been disrupted
801.7 by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with,
801.8 counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the
801.9 course of a psychiatric illness. Psychiatric rehabilitation services for children combine
801.10 coordinated psychotherapy to address internal psychological, emotional, and intellectual
801.11 processing deficits, and skills training to restore personal and social functioning. Psychiatric
801.12 rehabilitation services establish a progressive series of goals with each achievement building
801.13 upon a prior achievement. ~~Continuing progress toward goals is expected, and rehabilitative~~
801.14 ~~potential ceases when successive improvement is not observable over a period of time.~~

801.15 (t) "Skills training" means individual, family, or group training, delivered by or under
801.16 the supervision of a mental health professional, designed to facilitate the acquisition of
801.17 psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate
801.18 developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child
801.19 to self-monitor, compensate for, cope with, counteract, or replace skills deficits or
801.20 maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject
801.21 to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

801.22 (u) "Treatment supervision" means the supervision described in section 245I.06.

801.23 Sec. 82. Minnesota Statutes 2020, section 256B.0943, subdivision 2, is amended to read:

801.24 Subd. 2. **Covered service components of children's therapeutic services and**
801.25 **supports.** (a) Subject to federal approval, medical assistance covers medically necessary
801.26 children's therapeutic services and supports ~~as defined in this section that~~ when the services
801.27 are provided by an eligible provider entity certified under ~~subdivision 4 provides to a client~~
801.28 ~~eligible under subdivision 3~~ and meeting the standards in this section. The provider entity
801.29 must make reasonable and good faith efforts to report individual client outcomes to the
801.30 commissioner, using instruments and protocols approved by the commissioner.

801.31 (b) The service components of children's therapeutic services and supports are:

801.32 (1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis,
801.33 and group psychotherapy;

802.1 (2) individual, family, or group skills training provided by a mental health professional,
802.2 clinical trainee, or mental health practitioner;

802.3 (3) crisis assistance planning;

802.4 (4) mental health behavioral aide services;

802.5 (5) direction of a mental health behavioral aide;

802.6 (6) mental health service plan development; and

802.7 (7) children's day treatment.

802.8 Sec. 83. Minnesota Statutes 2020, section 256B.0943, subdivision 3, is amended to read:

802.9 Subd. 3. **Determination of client eligibility.** (a) A client's eligibility to receive children's
802.10 therapeutic services and supports under this section shall be determined based on a standard
802.11 diagnostic assessment by a mental health professional or a mental health practitioner who
802.12 meets the requirements of a clinical trainee as defined in Minnesota Rules, part 9505.0371,
802.13 subpart 5, item C, clinical trainee that is performed within one year before the initial start
802.14 of service. The standard diagnostic assessment must meet the requirements for a standard
802.15 or extended diagnostic assessment as defined in Minnesota Rules, part 9505.0372, subpart
802.16 1, items B and C, and:

802.17 (1) include current diagnoses, including any differential diagnosis, in accordance with
802.18 all criteria for a complete diagnosis and diagnostic profile as specified in the current edition
802.19 of the Diagnostic and Statistical Manual of the American Psychiatric Association, or, for
802.20 children under age five, as specified in the current edition of the Diagnostic Classification
802.21 of Mental Health Disorders of Infancy and Early Childhood;

802.22 (2) (1) determine whether a child under age 18 has a diagnosis of emotional disturbance
802.23 or, if the person is between the ages of 18 and 21, whether the person has a mental illness;

802.24 (3) (2) document children's therapeutic services and supports as medically necessary to
802.25 address an identified disability, functional impairment, and the individual client's needs and
802.26 goals; and

802.27 (4) (3) be used in the development of the individualized individual treatment plan; and.

802.28 (5) be completed annually until age 18. For individuals between age 18 and 21, unless
802.29 a client's mental health condition has changed markedly since the client's most recent
802.30 diagnostic assessment, annual updating is necessary. For the purpose of this section,
802.31 "updating" means an adult diagnostic update as defined in Minnesota Rules, part 9505.0371,
802.32 subpart 2, item E.

803.1 (b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to
803.2 five days of day treatment under this section based on a hospital's medical history and
803.3 presentation examination of the client.

803.4 Sec. 84. Minnesota Statutes 2020, section 256B.0943, subdivision 4, is amended to read:

803.5 Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial
803.6 provider entity application and certification process and recertification process to determine
803.7 whether a provider entity has an administrative and clinical infrastructure that meets the
803.8 requirements in subdivisions 5 and 6. A provider entity must be certified for the three core
803.9 rehabilitation services of psychotherapy, skills training, and crisis ~~assistance~~ planning. The
803.10 commissioner shall recertify a provider entity at least every three years. The commissioner
803.11 shall establish a process for decertification of a provider entity and shall require corrective
803.12 action, medical assistance repayment, or decertification of a provider entity that no longer
803.13 meets the requirements in this section or that fails to meet the clinical quality standards or
803.14 administrative standards provided by the commissioner in the application and certification
803.15 process.

803.16 (b) For purposes of this section, a provider entity must meet the standards in this section
803.17 and chapter 245I, as required by section 245I.011, subdivision 5, and be:

803.18 (1) an Indian health services facility or a facility owned and operated by a tribe or tribal
803.19 organization operating as a 638 facility under Public Law 93-638 certified by the state;

803.20 (2) a county-operated entity certified by the state; or

803.21 (3) a noncounty entity certified by the state.

803.22 Sec. 85. Minnesota Statutes 2020, section 256B.0943, subdivision 5, is amended to read:

803.23 Subd. 5. **Provider entity administrative infrastructure requirements.** (a) ~~To be an~~
803.24 ~~eligible provider entity under this section, a provider entity must have an administrative~~
803.25 ~~infrastructure that establishes authority and accountability for decision making and oversight~~
803.26 ~~of functions, including finance, personnel, system management, clinical practice, and~~
803.27 ~~individual treatment outcomes measurement.~~ An eligible provider entity shall demonstrate
803.28 the availability, by means of employment or contract, of at least one backup mental health
803.29 professional in the event of the primary mental health professional's absence. ~~The provider~~
803.30 ~~must have written policies and procedures that it reviews and updates every three years and~~
803.31 ~~distributes to staff initially and upon each subsequent update.~~

(b) ~~The administrative infrastructure written~~ In addition to the policies and procedures required in section 245I.03, the policies and procedures must include:

~~(1) personnel procedures, including a process for: (i) recruiting, hiring, training, and retention of culturally and linguistically competent providers; (ii) conducting a criminal background check on all direct service providers and volunteers; (iii) investigating, reporting, and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting on violations of data privacy policies that are compliant with federal and state laws; (v) utilizing volunteers, including screening applicants, training and supervising volunteers, and providing liability coverage for volunteers; and (vi) documenting that each mental health professional, mental health practitioner, or mental health behavioral aide meets the applicable provider qualification criteria, training criteria under subdivision 8, and clinical supervision or direction of a mental health behavioral aide requirements under subdivision 6;~~

~~(2)~~ (1) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws; and

~~(3)~~ (2) a client-specific treatment outcomes measurement system, including baseline measures, to measure a client's progress toward achieving mental health rehabilitation goals. ~~Effective July 1, 2017, to be eligible for medical assistance payment, a provider entity must report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner; and~~

~~(4) a process to establish and maintain individual client records. The client's records must include:~~

~~(i) the client's personal information;~~

~~(ii) forms applicable to data privacy;~~

~~(iii) the client's diagnostic assessment, updates, results of tests, individual treatment plan, and individual behavior plan, if necessary;~~

~~(iv) documentation of service delivery as specified under subdivision 6;~~

~~(v) telephone contacts;~~

~~(vi) discharge plan; and~~

~~(vii) if applicable, insurance information.~~

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

Sec. 86. Minnesota Statutes 2020, section 256B.0943, subdivision 5a, is amended to read:

Subd. 5a. **Background studies.** The requirements for background studies under ~~this~~ section 245I.011, subdivision 4, paragraph (d), may be met by a children's therapeutic services and supports services agency through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 7, and 245C.10, subdivision 8.

Sec. 87. Minnesota Statutes 2020, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, ~~individualized~~ individual treatment plans, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review, and update as necessary, the clinical policies and procedures every three years, must distribute the policies and procedures to staff initially and upon each subsequent update, and must train staff accordingly.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for meeting the requirements in this subdivision:

(1) providing or obtaining a client's standard diagnostic assessment, including a standard diagnostic assessment ~~performed by an outside or independent clinician, that identifies acute and chronic clinical disorders, co-occurring medical conditions, and sources of psychological and environmental problems, including baselines, and a functional assessment. The functional assessment component must clearly summarize the client's individual strengths and needs.~~ When required components of the standard diagnostic assessment~~, such as baseline measures,~~ are not provided in an outside or independent assessment or ~~when baseline measures~~ cannot be attained ~~in a one-session standard diagnostic assessment~~ immediately, the provider entity must determine the missing information within 30 days and amend the child's standard diagnostic assessment or incorporate the ~~baselines~~ information into the child's individual treatment plan;

(2) developing an individual treatment plan ~~that:~~;

~~(i) is based on the information in the client's diagnostic assessment and baselines;~~

~~(ii) identified goals and objectives of treatment, treatment strategy, schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;~~

806.1 ~~(iii) is developed after completion of the client's diagnostic assessment by a mental health~~
806.2 ~~professional or clinical trainee and before the provision of children's therapeutic services~~
806.3 ~~and supports;~~

806.4 ~~(iv) is developed through a child-centered, family-driven, culturally appropriate planning~~
806.5 ~~process, including allowing parents and guardians to observe or participate in individual~~
806.6 ~~and family treatment services, assessment, and treatment planning;~~

806.7 ~~(v) is reviewed at least once every 90 days and revised to document treatment progress~~
806.8 ~~on each treatment objective and next goals or, if progress is not documented, to document~~
806.9 ~~changes in treatment; and~~

806.10 ~~(vi) is signed by the clinical supervisor and by the client or by the client's parent or other~~
806.11 ~~person authorized by statute to consent to mental health services for the client. A client's~~
806.12 ~~parent may approve the client's individual treatment plan by secure electronic signature or~~
806.13 ~~by documented oral approval that is later verified by written signature;~~

806.14 (3) developing an individual behavior plan that documents ~~treatment strategies~~ and
806.15 describes interventions to be provided by the mental health behavioral aide. The individual
806.16 behavior plan must include:

806.17 (i) detailed instructions on the ~~treatment strategies to be provided~~ psychosocial skills to
806.18 be practiced;

806.19 (ii) time allocated to each ~~treatment strategy~~ intervention;

806.20 (iii) methods of documenting the child's behavior;

806.21 (iv) methods of monitoring the child's progress in reaching objectives; and

806.22 (v) goals to increase or decrease targeted behavior as identified in the individual treatment
806.23 plan;

806.24 (4) providing ~~clinical~~ treatment supervision plans for ~~mental health practitioners and~~
806.25 ~~mental health behavioral aides. A mental health professional must document the clinical~~
806.26 ~~supervision the professional provides by cosigning individual treatment plans and making~~
806.27 ~~entries in the client's record on supervisory activities. The clinical supervisor also shall~~
806.28 ~~document supervisee-specific supervision in the supervisee's personnel file. Clinical~~ staff
806.29 according to section 245I.06. Treatment supervision does not include the authority to make
806.30 or terminate court-ordered placements of the child. A ~~clinical~~ treatment supervisor must be
806.31 available for urgent consultation as required by the individual client's needs or the situation~~.~~
806.32 ~~Clinical supervision may occur individually or in a small group to discuss treatment and~~
806.33 ~~review progress toward goals. The focus of clinical supervision must be the client's treatment~~

807.1 ~~needs and progress and the mental health practitioner's or behavioral aide's ability to provide~~
807.2 ~~services~~;

807.3 (4a) meeting day treatment program conditions in items (i) ~~to (iii)~~ and (ii):

807.4 (i) the ~~clinical~~ treatment supervisor must be present and available on the premises more
807.5 than 50 percent of the time in a provider's standard working week during which the supervisee
807.6 is providing a mental health service; and

807.7 ~~(ii) the diagnosis and the client's individual treatment plan or a change in the diagnosis~~
807.8 ~~or individual treatment plan must be made by or reviewed, approved, and signed by the~~
807.9 ~~clinical supervisor; and~~

807.10 ~~(iii)~~ (ii) every 30 days, the ~~clinical~~ treatment supervisor must review and sign the record
807.11 indicating the supervisor has reviewed the client's care for all activities in the preceding
807.12 30-day period;

807.13 (4b) meeting the ~~clinical~~ treatment supervision standards in items (i) ~~to (iv)~~ and (ii) for
807.14 all other services provided under CTSS:

807.15 ~~(i) medical assistance shall reimburse for services provided by a mental health practitioner~~
807.16 ~~who is delivering services that fall within the scope of the practitioner's practice and who~~
807.17 ~~is supervised by a mental health professional who accepts full professional responsibility;~~

807.18 ~~(ii) medical assistance shall reimburse for services provided by a mental health behavioral~~
807.19 ~~aide who is delivering services that fall within the scope of the aide's practice and who is~~
807.20 ~~supervised by a mental health professional who accepts full professional responsibility and~~
807.21 ~~has an approved plan for clinical supervision of the behavioral aide. Plans must be developed~~
807.22 ~~in accordance with supervision standards defined in Minnesota Rules, part 9505.0371,~~
807.23 ~~subpart 4, items A to D;~~

807.24 ~~(iii)~~ (i) the mental health professional is required to be present at the site of service
807.25 delivery for observation as clinically appropriate when the clinical trainee, mental health
807.26 practitioner, or mental health behavioral aide is providing CTSS services; and

807.27 ~~(iv)~~ (ii) when conducted, the on-site presence of the mental health professional must be
807.28 documented in the child's record and signed by the mental health professional who accepts
807.29 full professional responsibility;

807.30 (5) providing direction to a mental health behavioral aide. For entities that employ mental
807.31 health behavioral aides, the ~~clinical~~ treatment supervisor must be employed by the provider
807.32 entity or other provider certified to provide mental health behavioral aide services to ensure
807.33 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

809.1 must assess the client's progress and ensure that services and treatment goals continue to
809.2 be necessary and appropriate to the client and the client's family or foster family. ~~Revision~~
809.3 ~~of the individual treatment plan does not require a new diagnostic assessment unless the~~
809.4 ~~client's mental health status has changed markedly. The updated treatment plan must be~~
809.5 ~~signed by the clinical supervisor and by the client, if appropriate, and by the client's parent~~
809.6 ~~or other person authorized by statute to give consent to the mental health services for the~~
809.7 ~~child.~~

809.8 Sec. 88. Minnesota Statutes 2020, section 256B.0943, subdivision 7, is amended to read:

809.9 Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team
809.10 provider working within the scope of the provider's practice or qualifications may provide
809.11 service components of children's therapeutic services and supports that are identified as
809.12 medically necessary in a client's individual treatment plan.

809.13 (b) An individual provider must be qualified as <u>a</u>:

809.14 (1) ~~a~~ mental health professional ~~as defined in subdivision 1, paragraph (o)~~; ~~or~~

809.15 (2) ~~a~~<u> clinical trainee;</u>

809.16 <u>(3)</u> mental health practitioner ~~or clinical trainee. The mental health practitioner or clinical~~
809.17 ~~trainee must work under the clinical supervision of a mental health professional~~; ~~or~~

809.18 <u>(4) mental health certified family peer specialist; or</u>

809.19 ~~(3) a~~ <u>(5)</u> mental health behavioral aide ~~working under the clinical supervision of a mental~~
809.20 ~~health professional to implement the rehabilitative mental health services previously~~
809.21 ~~introduced by a mental health professional or practitioner and identified in the client's~~
809.22 ~~individual treatment plan and individual behavior plan.~~

809.23 ~~(A) A level I mental health behavioral aide must:~~

809.24 ~~(i) be at least 18 years old;~~

809.25 ~~(ii) have a high school diploma or commissioner of education-selected high school~~
809.26 ~~equivalency certification or two years of experience as a primary caregiver to a child with~~
809.27 ~~severe emotional disturbance within the previous ten years; and~~

809.28 ~~(iii) meet preservice and continuing education requirements under subdivision 8.~~

809.29 ~~(B) A level II mental health behavioral aide must:~~

809.30 ~~(i) be at least 18 years old;~~

810.1 ~~(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering~~
810.2 ~~clinical services in the treatment of mental illness concerning children or adolescents or~~
810.3 ~~complete a certificate program established under subdivision 8a; and~~

810.4 ~~(iii) meet preservice and continuing education requirements in subdivision 8.~~

810.5 (c) A day treatment ~~multidisciplinary~~ team must include at least one mental health
810.6 professional or clinical trainee and one mental health practitioner.

810.7 Sec. 89. Minnesota Statutes 2020, section 256B.0943, subdivision 9, is amended to read:

810.8 Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified
810.9 provider entity must ensure that:

810.10 (1) ~~each individual provider's caseload size permits the provider to deliver services to~~
810.11 ~~both clients with severe, complex needs and clients with less intensive needs.~~ the provider's
810.12 caseload size should reasonably enable the provider to play an active role in service planning,
810.13 monitoring, and delivering services to meet the client's and client's family's needs, as specified
810.14 in each client's individual treatment plan;

810.15 (2) site-based programs, including day treatment programs, provide staffing and facilities
810.16 to ensure the client's health, safety, and protection of rights, and that the programs are able
810.17 to implement each client's individual treatment plan; and

810.18 (3) a day treatment program is provided to a group of clients by a ~~multidisciplinary~~ team
810.19 under the ~~clinical~~ treatment supervision of a mental health professional. The day treatment
810.20 program must be provided in and by: (i) an outpatient hospital accredited by the Joint
810.21 Commission on Accreditation of Health Organizations and licensed under sections 144.50
810.22 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that
810.23 is certified under subdivision 4 to operate a program that meets the requirements of section
810.24 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day
810.25 treatment program must stabilize the client's mental health status while developing and
810.26 improving the client's independent living and socialization skills. The goal of the day
810.27 treatment program must be to reduce or relieve the effects of mental illness and provide
810.28 training to enable the client to live in the community. The program must be available
810.29 year-round at least three to five days per week, two or three hours per day, unless the normal
810.30 five-day school week is shortened by a holiday, weather-related cancellation, or other
810.31 districtwide reduction in a school week. A child transitioning into or out of day treatment
810.32 must receive a minimum treatment of one day a week for a two-hour time block. The
810.33 two-hour time block must include at least one hour of patient and/or family or group

811.1 psychotherapy. The remainder of the structured treatment program may include patient
811.2 and/or family or group psychotherapy, and individual or group skills training, if included
811.3 in the client's individual treatment plan. Day treatment programs are not part of inpatient
811.4 or residential treatment services. When a day treatment group that meets the minimum group
811.5 size requirement temporarily falls below the minimum group size because of a member's
811.6 temporary absence, medical assistance covers a group session conducted for the group
811.7 members in attendance. A day treatment program may provide fewer than the minimally
811.8 required hours for a particular child during a billing period in which the child is transitioning
811.9 into, or out of, the program.

811.10 (b) To be eligible for medical assistance payment, a provider entity must deliver the
811.11 service components of children's therapeutic services and supports in compliance with the
811.12 following requirements:

811.13 (1) ~~patient and/or family, family, and group psychotherapy must be delivered as specified~~
811.14 ~~in Minnesota Rules, part 9505.0372, subpart 6.~~ psychotherapy to address the child's
811.15 underlying mental health disorder must be documented as part of the child's ongoing
811.16 treatment. A provider must deliver, or arrange for, medically necessary psychotherapy,
811.17 unless the child's parent or caregiver chooses not to receive it. When a provider delivering
811.18 other services to a child under this section deems it not medically necessary to provide
811.19 psychotherapy to the child for a period of 90 days or longer, the provider entity must
811.20 document the medical reasons why psychotherapy is not necessary. When a provider
811.21 determines that a child needs psychotherapy but psychotherapy cannot be delivered due to
811.22 a shortage of licensed mental health professionals in the child's community, the provider
811.23 must document the lack of access in the child's medical record;

811.24 (2) individual, family, or group skills training ~~must be provided by a mental health~~
811.25 ~~professional or a mental health practitioner who is delivering services that fall within the~~
811.26 ~~scope of the provider's practice and is supervised by a mental health professional who~~
811.27 ~~accepts full professional responsibility for the training. Skills training~~ is subject to the
811.28 following requirements:

811.29 (i) a mental health professional, clinical trainee, or mental health practitioner shall provide
811.30 skills training;

811.31 (ii) skills training delivered to a child or the child's family must be targeted to the specific
811.32 deficits or maladaptations of the child's mental health disorder and must be prescribed in
811.33 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;

813.1 (4) mental health behavioral aide services must be medically necessary treatment services,
813.2 identified in the child's individual treatment plan and individual behavior plan, ~~which are~~
813.3 ~~performed minimally by a paraprofessional qualified according to subdivision 7, paragraph~~
813.4 ~~(b), clause (3),~~ and which are designed to improve the functioning of the child in the
813.5 progressive use of developmentally appropriate psychosocial skills. Activities involve
813.6 working directly with the child, child-peer groupings, or child-family groupings to practice,
813.7 repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (t), as previously
813.8 taught by a mental health professional, clinical trainee, or mental health practitioner including:

813.9 (i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions
813.10 so that the child progressively recognizes and responds to the cues independently;

813.11 (ii) performing as a practice partner or role-play partner;

813.12 (iii) reinforcing the child's accomplishments;

813.13 (iv) generalizing skill-building activities in the child's multiple natural settings;

813.14 (v) assigning further practice activities; and

813.15 (vi) intervening as necessary to redirect the child's target behavior and to de-escalate
813.16 behavior that puts the child or other person at risk of injury.

813.17 To be eligible for medical assistance payment, mental health behavioral aide services must
813.18 be delivered to a child who has been diagnosed with an emotional disturbance or a mental
813.19 illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must
813.20 implement treatment strategies in the individual treatment plan and the individual behavior
813.21 plan as developed by the mental health professional, clinical trainee, or mental health
813.22 practitioner providing direction for the mental health behavioral aide. The mental health
813.23 behavioral aide must document the delivery of services in written progress notes. Progress
813.24 notes must reflect implementation of the treatment strategies, as performed by the mental
813.25 health behavioral aide and the child's responses to the treatment strategies;<u> and</u>

813.26 ~~(5) direction of a mental health behavioral aide must include the following:~~

813.27 ~~(i) ongoing face-to-face observation of the mental health behavioral aide delivering~~
813.28 ~~services to a child by a mental health professional or mental health practitioner for at least~~
813.29 ~~a total of one hour during every 40 hours of service provided to a child; and~~

813.30 ~~(ii) immediate accessibility of the mental health professional, clinical trainee, or mental~~
813.31 ~~health practitioner to the mental health behavioral aide during service provision;~~

~~(6)~~ (5) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to ~~review, revise, and sign~~ approve the individual treatment plan. ~~Notwithstanding Minnesota Rules, part 9505.0371, subpart 7,~~ Medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development~~; and~~.

~~(7) to be eligible for payment, a diagnostic assessment must be complete with regard to all required components, including multiple assessment appointments required for an extended diagnostic assessment and the written report. Dates of the multiple assessment appointments must be noted in the client's clinical record.~~

Sec. 90. Minnesota Statutes 2020, section 256B.0943, subdivision 11, is amended to read:

Subd. 11. **Documentation and billing.** ~~(a)~~ A provider entity must document the services it provides under this section. The provider entity must ensure that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. Billing for covered service components under subdivision 2, paragraph (b), must not include anything other than direct service time.

~~(b) An individual mental health provider must promptly document the following in a client's record after providing services to the client:~~

~~(1) each occurrence of the client's mental health service, including the date, type, start and stop times, scope of the service as described in the child's individual treatment plan, and outcome of the service compared to baselines and objectives;~~

~~(2) the name, dated signature, and credentials of the person who delivered the service;~~

~~(3) contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools. The provider must document the name and date of each contact;~~

~~(4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative, if applicable;~~

~~(5) required clinical supervision directly related to the identified client's services and needs, as appropriate, with co-signatures of the supervisor and supervisee; and~~

~~(6) the date when services are discontinued and reasons for discontinuation of services.~~

Sec. 91. Minnesota Statutes 2020, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) ~~Effective May 23, 2013, and~~ Subject to federal approval, medical assistance covers medically necessary intensive treatment services ~~described under paragraph (b) that~~ when the services are provided by a provider entity ~~eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the regulations established by a federally recognized Minnesota tribe~~ certified under and meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) Intensive treatment services to children with mental illness residing in foster family settings that comprise specific required service components provided in clauses (1) to (5) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~;

(2) crisis ~~assistance provided according to standards for children's therapeutic services and supports in section 256B.0943~~ planning;

(3) individual, family, and group psychoeducation services~~, defined in subdivision 1a, paragraph (q),~~ provided by a mental health professional or a clinical trainee;

(4) clinical care consultation~~, as defined in subdivision 1a, and~~ provided by a mental health professional or a clinical trainee; and

(5) service delivery payment requirements as provided under subdivision 4.

816.1 Sec. 92. Minnesota Statutes 2020, section 256B.0946, subdivision 1a, is amended to read:

816.2 Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the
816.3 meanings given them.

816.4 (a) "Clinical care consultation" means communication from a treating clinician to other
816.5 providers working with the same client to inform, inquire, and instruct regarding the client's
816.6 symptoms, strategies for effective engagement, care and intervention needs, and treatment
816.7 expectations across service settings, including but not limited to the client's school, social
816.8 services, day care, probation, home, primary care, medication prescribers, disabilities
816.9 services, and other mental health providers and to direct and coordinate clinical service
816.10 components provided to the client and family.

816.11 (b) "Clinical supervision" means the documented time a clinical supervisor and supervisee
816.12 spend together to discuss the supervisee's work, to review individual client cases, and for
816.13 the supervisee's professional development. It includes the documented oversight and
816.14 supervision responsibility for planning, implementation, and evaluation of services for a
816.15 client's mental health treatment.

816.16 (c) "Clinical supervisor" means the mental health professional who is responsible for
816.17 clinical supervision.

816.18 (d) (b) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371,
816.19 subpart 5, item C; means a staff person who is qualified according to section 245I.04,
816.20 subdivision 6.

816.21 (e) (c) "Crisis assistance planning" has the meaning given in section 245.4871, subdivision
816.22 9a, including the development of a plan that addresses prevention and intervention strategies
816.23 to be used in a potential crisis, but does not include actual crisis intervention.

816.24 (f) (d) "Culturally appropriate" means providing mental health services in a manner that
816.25 incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370,
816.26 subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural
816.27 strengths and resources to promote overall wellness.

816.28 (g) (e) "Culture" means the distinct ways of living and understanding the world that are
816.29 used by a group of people and are transmitted from one generation to another or adopted
816.30 by an individual.

816.31 (h) (f) "Standard diagnostic assessment" has the meaning given in Minnesota Rules, part
816.32 9505.0370, subpart 11 means the assessment described in section 245I.10, subdivision 6.

817.1 ~~(i)~~ (g) "Family" means a person who is identified by the client or the client's parent or
817.2 guardian as being important to the client's mental health treatment. Family may include,
817.3 but is not limited to, parents, foster parents, children, spouse, committed partners, former
817.4 spouses, persons related by blood or adoption, persons who are a part of the client's
817.5 permanency plan, or persons who are presently residing together as a family unit.

817.6 ~~(j)~~ (h) "Foster care" has the meaning given in section 260C.007, subdivision 18.

817.7 ~~(k)~~ (i) "Foster family setting" means the foster home in which the license holder resides.

817.8 ~~(l)~~ (j) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part~~
817.9 ~~9505.0370, subpart 15~~ means the plan described in section 245I.10, subdivisions 7 and 8.

817.10 ~~(m) "Mental health practitioner" has the meaning given in section 245.462, subdivision~~
817.11 ~~17, and a mental health practitioner working as a clinical trainee according to Minnesota~~
817.12 ~~Rules, part 9505.0371, subpart 5, item C.~~

817.13 (k) "Mental health certified family peer specialist" means a staff person who is qualified
817.14 according to section 245I.04, subdivision 12.

817.15 ~~(n)~~ (l) "Mental health professional" ~~has the meaning given in Minnesota Rules, part~~
817.16 ~~9505.0370, subpart 18~~ means a staff person who is qualified according to section 245I.04,
817.17 subdivision 2.

817.18 ~~(o)~~ (m) "Mental illness" has the meaning given in ~~Minnesota Rules, part 9505.0370,~~
817.19 ~~subpart 20~~ section 245I.02, subdivision 29.

817.20 ~~(p)~~ (n) "Parent" has the meaning given in section 260C.007, subdivision 25.

817.21 ~~(q)~~ (o) "Psychoeducation services" means information or demonstration provided to an
817.22 individual, family, or group to explain, educate, and support the individual, family, or group
817.23 in understanding a child's symptoms of mental illness, the impact on the child's development,
817.24 and needed components of treatment and skill development so that the individual, family,
817.25 or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders,
817.26 and achieve optimal mental health and long-term resilience.

817.27 ~~(r)~~ (p) "Psychotherapy" ~~has the meaning given in Minnesota Rules, part 9505.0370,~~
817.28 ~~subpart 27~~ means the treatment described in section 256B.0671, subdivision 11.

817.29 ~~(s)~~ (q) "Team consultation and treatment planning" means the coordination of treatment
817.30 plans and consultation among providers in a group concerning the treatment needs of the
817.31 child, including disseminating the child's treatment service schedule to all members of the
817.32 service team. Team members must include all mental health professionals working with the

818.1 child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and
818.2 at least two of the following: an individualized education program case manager; probation
818.3 agent; children's mental health case manager; child welfare worker, including adoption or
818.4 guardianship worker; primary care provider; foster parent; and any other member of the
818.5 child's service team.

818.6 (r) "Trauma" has the meaning given in section 245I.02, subdivision 38.

818.7 (s) "Treatment supervision" means the supervision described under section 245I.06.

818.8 Sec. 93. Minnesota Statutes 2020, section 256B.0946, subdivision 2, is amended to read:

818.9 Subd. 2. **Determination of client eligibility.** An eligible recipient is an individual, from
818.10 birth through age 20, who is currently placed in a foster home licensed under Minnesota
818.11 Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the
818.12 regulations established by a federally recognized Minnesota tribe, and has received: (1) a
818.13 standard diagnostic assessment ~~and an evaluation of level of care needed, as defined in~~
818.14 ~~paragraphs (a) and (b).~~ within 180 days before the start of service that documents that
818.15 intensive treatment services are medically necessary within a foster family setting to
818.16 ameliorate identified symptoms and functional impairments; and (2) a level of care
818.17 assessment as defined in section 245I.02, subdivision 19, that demonstrates that the individual
818.18 requires intensive intervention without 24-hour medical monitoring, and a functional
818.19 assessment as defined in section 245I.02, subdivision 17. The level of care assessment and
818.20 the functional assessment must include information gathered from the placing county, tribe,
818.21 or case manager.

818.22 ~~(a) The diagnostic assessment must:~~

818.23 ~~(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be~~
818.24 ~~conducted by a mental health professional or a clinical trainee;~~

818.25 ~~(2) determine whether or not a child meets the criteria for mental illness, as defined in~~
818.26 ~~Minnesota Rules, part 9505.0370, subpart 20;~~

818.27 ~~(3) document that intensive treatment services are medically necessary within a foster~~
818.28 ~~family setting to ameliorate identified symptoms and functional impairments;~~

818.29 ~~(4) be performed within 180 days before the start of service; and~~

818.30 ~~(5) be completed as either a standard or extended diagnostic assessment annually to~~
818.31 ~~determine continued eligibility for the service.~~

819.1 ~~(b) The evaluation of level of care must be conducted by the placing county, tribe, or~~
819.2 ~~case manager in conjunction with the diagnostic assessment as described by Minnesota~~
819.3 ~~Rules, part 9505.0372, subpart 1, item B, using a validated tool approved by the~~
819.4 ~~commissioner of human services and not subject to the rulemaking process, consistent with~~
819.5 ~~section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates~~
819.6 ~~that the child requires intensive intervention without 24-hour medical monitoring. The~~
819.7 ~~commissioner shall update the list of approved level of care tools annually and publish on~~
819.8 ~~the department's website.~~

819.9 Sec. 94. Minnesota Statutes 2020, section 256B.0946, subdivision 3, is amended to read:

819.10 Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive
819.11 children's mental health services in a foster family setting must be certified by the state and
819.12 have a service provision contract with a county board or a reservation tribal council and
819.13 must be able to demonstrate the ability to provide all of the services required in this section
819.14 and meet the standards in chapter 245I, as required in section 245I.011, subdivision 5.

819.15 (b) For purposes of this section, a provider agency must be:

819.16 (1) a county-operated entity certified by the state;

819.17 (2) an Indian Health Services facility operated by a tribe or tribal organization under
819.18 funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the
819.19 Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

819.20 (3) a noncounty entity.

819.21 (c) Certified providers that do not meet the service delivery standards required in this
819.22 section shall be subject to a decertification process.

819.23 (d) For the purposes of this section, all services delivered to a client must be provided
819.24 by a mental health professional or a clinical trainee.

819.25 Sec. 95. Minnesota Statutes 2020, section 256B.0946, subdivision 4, is amended to read:

819.26 Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under
819.27 this section, a provider must develop and practice written policies and procedures for
819.28 intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply
819.29 with the following requirements in paragraphs (b) to ~~(n)~~ (l).

820.1 ~~(b) A qualified clinical supervisor, as defined in and performing in compliance with~~
820.2 ~~Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and~~
820.3 ~~provision of services described in this section.~~

820.4 ~~(c) Each client receiving treatment services must receive an extended diagnostic~~
820.5 ~~assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30~~
820.6 ~~days of enrollment in this service unless the client has a previous extended diagnostic~~
820.7 ~~assessment that the client, parent, and mental health professional agree still accurately~~
820.8 ~~describes the client's current mental health functioning.~~

820.9 ~~(d)~~ (b) Each previous and current mental health, school, and physical health treatment
820.10 provider must be contacted to request documentation of treatment and assessments that the
820.11 eligible client has received. This information must be reviewed and incorporated into the
820.12 standard diagnostic assessment and team consultation and treatment planning review process.

820.13 ~~(e)~~ (c) Each client receiving treatment must be assessed for a trauma history, and the
820.14 client's treatment plan must document how the results of the assessment will be incorporated
820.15 into treatment.

820.16 (d) The level of care assessment as defined in section 245I.02, subdivision 19, and
820.17 functional assessment as defined in section 245I.02, subdivision 17, must be updated at
820.18 least every 90 days or prior to discharge from the service, whichever comes first.

820.19 ~~(f)~~ (e) Each client receiving treatment services must have an individual treatment plan
820.20 that is reviewed, evaluated, and ~~signed~~ approved every 90 days using the team consultation
820.21 and treatment planning process~~, as defined in subdivision 1a, paragraph (s)~~.

820.22 ~~(g)~~ (f) Clinical care consultation~~, as defined in subdivision 1a, paragraph (a),~~ must be
820.23 provided in accordance with the client's individual treatment plan.

820.24 ~~(h)~~ (g) Each client must have a crisis ~~assistance~~ plan within ten days of initiating services
820.25 and must have access to clinical phone support 24 hours per day, seven days per week,
820.26 during the course of treatment. The crisis plan must demonstrate coordination with the local
820.27 or regional mobile crisis intervention team.

820.28 ~~(i)~~ (h) Services must be delivered and documented at least three days per week, equaling
820.29 at least six hours of treatment per week, unless reduced units of service are specified on the
820.30 treatment plan as part of transition or on a discharge plan to another service or level of care.
820.31 ~~Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.~~

~~(j)~~ (i) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

~~(k)~~ (j) Treatment must be developmentally and culturally appropriate for the client.

~~(l)~~ (k) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects.

~~(m)~~ (l) Parents, siblings, foster parents, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

~~(n)~~ (m) Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

Sec. 96. Minnesota Statutes 2020, section 256B.0946, subdivision 6, is amended to read:

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of intensive treatment in foster care services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section ~~256B.0944~~ 256B.0624; ~~and~~

(7) transportation~~.~~; and

(8) mental health certified family peer specialist services under section 256B.0616.

(b) Children receiving intensive treatment in foster care services are not eligible for medical assistance reimbursement for the following services while receiving intensive treatment in foster care:

822.1 (1) psychotherapy and skills training components of children's therapeutic services and
822.2 supports under section ~~256B.0625, subdivision 35b~~ 256B.0943;

822.3 (2) mental health behavioral aide services as defined in section 256B.0943, subdivision
822.4 1, paragraph ~~(m)~~ (l);

822.5 (3) home and community-based waiver services;

822.6 (4) mental health residential treatment; and

822.7 (5) room and board costs as defined in section 256I.03, subdivision 6.

822.8 Sec. 97. Minnesota Statutes 2020, section 256B.0947, subdivision 1, is amended to read:

822.9 Subdivision 1. **Scope.** ~~Effective November 1, 2011, and~~ Subject to federal approval,
822.10 medical assistance covers medically necessary, intensive nonresidential rehabilitative mental
822.11 health services ~~as defined in subdivision 2, for recipients as defined in subdivision 3,~~ when
822.12 the services are provided by an entity meeting the standards in this section. The provider
822.13 entity must make reasonable and good faith efforts to report individual client outcomes to
822.14 the commissioner, using instruments and protocols approved by the commissioner.

822.15 Sec. 98. Minnesota Statutes 2020, section 256B.0947, subdivision 2, is amended to read:

822.16 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
822.17 given them.

822.18 (a) "Intensive nonresidential rehabilitative mental health services" means child
822.19 rehabilitative mental health services as defined in section 256B.0943, except that these
822.20 services are provided by a multidisciplinary staff using a total team approach consistent
822.21 with assertive community treatment, as adapted for youth, and are directed to recipients
822.22 ~~ages 16, 17, 18, 19, or 20 with a serious mental illness or co-occurring mental illness and~~
822.23 ~~substance abuse addiction~~ who require intensive services to prevent admission to an inpatient
822.24 psychiatric hospital or placement in a residential treatment facility or who require intensive
822.25 services to step down from inpatient or residential care to community-based care.

822.26 (b) "Co-occurring mental illness and substance ~~abuse addiction~~ use disorder" means a
822.27 dual diagnosis of at least one form of mental illness and at least one substance use disorder.
822.28 Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine
822.29 use.

822.30 (c) "Standard diagnostic assessment" ~~has the meaning given to it in Minnesota Rules,~~
822.31 ~~part 9505.0370, subpart 11. A diagnostic assessment must be provided according to~~

823.1 ~~Minnesota Rules, part 9505.0372, subpart 1, and for this section must incorporate a~~
823.2 ~~determination of the youth's necessary level of care using a standardized functional~~
823.3 ~~assessment instrument approved and periodically updated by the commissioner~~ means the
823.4 assessment described in section 245I.10, subdivision 6.

823.5 ~~(d) "Education specialist" means an individual with knowledge and experience working~~
823.6 ~~with youth regarding special education requirements and goals, special education plans,~~
823.7 ~~and coordination of educational activities with health care activities.~~

823.8 ~~(e) "Housing access support" means an ancillary activity to help an individual find,~~
823.9 ~~obtain, retain, and move to safe and adequate housing. Housing access support does not~~
823.10 ~~provide monetary assistance for rent, damage deposits, or application fees.~~

823.11 ~~(f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring~~
823.12 ~~mental illness and substance use disorders by a team of cross-trained clinicians within the~~
823.13 ~~same program, and is characterized by assertive outreach, stage-wise comprehensive~~
823.14 ~~treatment, treatment goal setting, and flexibility to work within each stage of treatment.~~

823.15 ~~(g)~~ (d) "Medication education services" means services provided individually or in
823.16 groups, which focus on:

823.17 (1) educating the client and client's family or significant nonfamilial supporters about
823.18 mental illness and symptoms;

823.19 (2) the role and effects of medications in treating symptoms of mental illness; and

823.20 (3) the side effects of medications.

823.21 Medication education is coordinated with medication management services and does not
823.22 duplicate it. Medication education services are provided by physicians, pharmacists, or
823.23 registered nurses with certification in psychiatric and mental health care.

823.24 ~~(h) "Peer specialist" means an employed team member who is a mental health certified~~
823.25 ~~peer specialist according to section 256B.0615 and also a former children's mental health~~
823.26 ~~consumer who:~~

823.27 ~~(1) provides direct services to clients including social, emotional, and instrumental~~
823.28 ~~support and outreach;~~

823.29 ~~(2) assists younger peers to identify and achieve specific life goals;~~

823.30 ~~(3) works directly with clients to promote the client's self-determination, personal~~
823.31 ~~responsibility, and empowerment;~~

824.1 ~~(4) assists youth with mental illness to regain control over their lives and their~~
824.2 ~~developmental process in order to move effectively into adulthood;~~

824.3 ~~(5) provides training and education to other team members, consumer advocacy~~
824.4 ~~organizations, and clients on resiliency and peer support; and~~

824.5 ~~(6) meets the following criteria:~~

824.6 ~~(i) is at least 22 years of age;~~

824.7 ~~(ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370,~~
824.8 ~~subpart 20, or co-occurring mental illness and substance abuse addiction;~~

824.9 ~~(iii) is a former consumer of child and adolescent mental health services, or a former or~~
824.10 ~~current consumer of adult mental health services for a period of at least two years;~~

824.11 ~~(iv) has at least a high school diploma or equivalent;~~

824.12 ~~(v) has successfully completed training requirements determined and periodically updated~~
824.13 ~~by the commissioner;~~

824.14 ~~(vi) is willing to disclose the individual's own mental health history to team members~~
824.15 ~~and clients; and~~

824.16 ~~(vii) must be free of substance use problems for at least one year.~~

824.17 (e) "Mental health professional" means a staff person who is qualified according to
824.18 section 245I.04, subdivision 2.

824.19 ~~(i)~~ (f) "Provider agency" means a for-profit or nonprofit organization established to
824.20 administer an assertive community treatment for youth team.

824.21 ~~(j)~~ (g) "Substance use disorders" means one or more of the disorders defined in the
824.22 diagnostic and statistical manual of mental disorders, current edition.

824.23 ~~(k)~~ (h) "Transition services" means:

824.24 (1) activities, materials, consultation, and coordination that ensures continuity of the
824.25 client's care in advance of and in preparation for the client's move from one stage of care
824.26 or life to another by maintaining contact with the client and assisting the client to establish
824.27 provider relationships;

824.28 (2) providing the client with knowledge and skills needed posttransition;

824.29 (3) establishing communication between sending and receiving entities;

824.30 (4) supporting a client's request for service authorization and enrollment; and

(5) establishing and enforcing procedures and schedules.

A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.

~~(l)~~ (i) "Treatment team" means all staff who provide services to recipients under this section.

~~(m)~~ (j) "Family peer specialist" means a staff person who is qualified under section 256B.0616.

Sec. 99. Minnesota Statutes 2020, section 256B.0947, subdivision 3, is amended to read:

Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

(1) is age 16, 17, 18, 19, or 20; and

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance ~~abuse addiction~~ use disorder, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a ~~level-of-care determination, using an instrument approved by the commissioner~~ level of care assessment as defined in section 245I.02, subdivision 19, that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers;

(4) has received a functional assessment as defined in section 245I.02, subdivision 17, that indicates functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system within the next two years; and

(5) has had a recent standard diagnostic assessment~~, as provided in Minnesota Rules, part 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A,~~ that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

Sec. 100. Minnesota Statutes 2020, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** ~~(a) Subject to federal approval, medical assistance covers all medically necessary intensive nonresidential rehabilitative mental health services and supports, as defined in this section, under a single daily rate per client. Services and supports must be delivered by an eligible provider under subdivision 5 to an eligible client under subdivision 3.~~

~~(b)~~ (a) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities are covered by ~~the~~ a single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

(2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph (t);

(3) crisis ~~assistance~~ planning as defined in section 245.4871, subdivision 9a~~, which includes recognition of factors precipitating a mental health crisis, identification of behaviors related to the crisis, and the development of a plan to address prevention, intervention, and follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental health crisis; crisis assistance does not mean crisis response services or crisis intervention services provided in section 256B.0944~~;

(4) medication management provided by a physician or an advanced practice registered nurse with certification in psychiatric and mental health care;

(5) mental health case management as provided in section 256B.0625, subdivision 20;

(6) medication education services as defined in this section;

(7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;

(8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;

(9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

827.1 (10) coordination with, or performance of, crisis intervention and stabilization services
827.2 as defined in section ~~256B.0944~~ 256B.0624;

827.3 ~~(11) assessment of a client's treatment progress and effectiveness of services using~~
827.4 ~~standardized outcome measures published by the commissioner;~~

827.5 ~~(12)~~ (11) transition services ~~as defined in this section~~;

827.6 ~~(13) integrated dual disorders treatment as defined in this section~~ (12) co-occurring
827.7 substance use disorder treatment as defined in section 245I.02, subdivision 11; and

827.8 ~~(14)~~ (13) housing access support that assists clients to find, obtain, retain, and move to
827.9 safe and adequate housing. Housing access support does not provide monetary assistance
827.10 for rent, damage deposits, or application fees.

827.11 ~~(c)~~ (b) The provider shall ensure and document the following by means of performing
827.12 the required function or by contracting with a qualified person or entity:

827.13 ~~(1)~~ client access to crisis intervention services, as defined in section ~~256B.0944~~
827.14 256B.0624, and available 24 hours per day and seven days per week~~;~~.

827.15 ~~(2) completion of an extended diagnostic assessment, as defined in Minnesota Rules,~~
827.16 ~~part 9505.0372, subpart 1, item C; and~~

827.17 ~~(3) determination of the client's needed level of care using an instrument approved and~~
827.18 ~~periodically updated by the commissioner.~~

827.19 Sec. 101. Minnesota Statutes 2020, section 256B.0947, subdivision 5, is amended to read:

827.20 Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services
827.21 must ~~be provided by a provider entity as provided in subdivision 4~~ meet the standards in
827.22 this section and chapter 245I as required in section 245I.011, subdivision 5.

827.23 (b) The treatment team for intensive nonresidential rehabilitative mental health services
827.24 comprises both permanently employed core team members and client-specific team members
827.25 as follows:

827.26 (1) ~~The core treatment team is an entity that operates under the direction of an~~
827.27 ~~independently licensed mental health professional, who is qualified under Minnesota Rules,~~
827.28 ~~part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility~~
827.29 ~~for clients.~~ Based on professional qualifications and client needs, clinically qualified core
827.30 team members are assigned on a rotating basis as the client's lead worker to coordinate a
827.31 client's care. The core team must comprise at least four full-time equivalent direct care staff
827.32 and must minimally include~~, but is not limited to~~:

828.1 (i) ~~an independently licensed~~ a mental health professional~~, qualified under Minnesota~~
828.2 ~~Rules, part 9505.0371, subpart 5, item A,~~ who serves as team leader to provide administrative
828.3 direction and ~~clinical~~ treatment supervision to the team;

828.4 (ii) an advanced-practice registered nurse with certification in psychiatric or mental
828.5 health care or a board-certified child and adolescent psychiatrist, either of which must be
828.6 credentialed to prescribe medications;

828.7 (iii) a licensed alcohol and drug counselor who is also trained in mental health
828.8 interventions; and

828.9 (iv) a mental health certified peer specialist ~~as defined in subdivision 2, paragraph (h)~~
828.10 who is qualified according to section 245I.04, subdivision 10, and is also a former children's
828.11 mental health consumer.

828.12 (2) The core team may also include any of the following:

828.13 (i) additional mental health professionals;

828.14 (ii) a vocational specialist;

828.15 (iii) an educational specialist with knowledge and experience working with youth on
828.16 special education requirements and goals, special education plans, and coordination of
828.17 educational activities with health care activities;

828.18 (iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

828.19 (v) a clinical trainee who is qualified according to section 245I.04, subdivision 6;

828.20 (vi) a mental health practitioner~~, as defined in section 245.4871, subdivision 26~~ qualified
828.21 according to section 245I.04, subdivision 4;

828.22 ~~(vi)~~ (vii) a case management service provider, as defined in section 245.4871, subdivision
828.23 4;

828.24 ~~(vii)~~ (viii) a housing access specialist; and

828.25 ~~(viii)~~ (ix) a family peer specialist as defined in subdivision 2, paragraph (m).

828.26 (3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc
828.27 members not employed by the team who consult on a specific client and who must accept
828.28 overall clinical direction from the treatment team for the duration of the client's placement
828.29 with the treatment team and must be paid by the provider agency at the rate for a typical
828.30 session by that provider with that client or at a rate negotiated with the client-specific
828.31 member. Client-specific treatment team members may include:

829.1 (i) the mental health professional treating the client prior to placement with the treatment
829.2 team;

829.3 (ii) the client's current substance ~~abuse~~ use counselor, if applicable;

829.4 (iii) a lead member of the client's individualized education program team or school-based
829.5 mental health provider, if applicable;

829.6 (iv) a representative from the client's health care home or primary care clinic, as needed
829.7 to ensure integration of medical and behavioral health care;

829.8 (v) the client's probation officer or other juvenile justice representative, if applicable;
829.9 and

829.10 (vi) the client's current vocational or employment counselor, if applicable.

829.11 (c) The ~~clinical~~ treatment supervisor shall be an active member of the treatment team
829.12 and shall function as a practicing clinician at least on a part-time basis. The treatment team
829.13 shall meet with the ~~clinical~~ treatment supervisor at least weekly to discuss recipients' progress
829.14 and make rapid adjustments to meet recipients' needs. The team meeting must include
829.15 client-specific case reviews and general treatment discussions among team members.
829.16 Client-specific case reviews and planning must be documented in the individual client's
829.17 treatment record.

829.18 (d) The staffing ratio must not exceed ten clients to one full-time equivalent treatment
829.19 team position.

829.20 (e) The treatment team shall serve no more than 80 clients at any one time. Should local
829.21 demand exceed the team's capacity, an additional team must be established rather than
829.22 exceed this limit.

829.23 (f) Nonclinical staff shall have prompt access in person or by telephone to a mental
829.24 health practitioner, clinical trainee, or mental health professional. The provider shall have
829.25 the capacity to promptly and appropriately respond to emergent needs and make any
829.26 necessary staffing adjustments to ensure the health and safety of clients.

829.27 (g) The intensive nonresidential rehabilitative mental health services provider shall
829.28 participate in evaluation of the assertive community treatment for youth (Youth ACT) model
829.29 as conducted by the commissioner, including the collection and reporting of data and the
829.30 reporting of performance measures as specified by contract with the commissioner.

829.31 (h) A regional treatment team may serve multiple counties.

830.1 Sec. 102. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

830.2 Subd. 6. **Service standards.** The standards in this subdivision apply to intensive
830.3 nonresidential rehabilitative mental health services.

830.4 (a) The treatment team must use team treatment, not an individual treatment model.

830.5 (b) Services must be available at times that meet client needs.

830.6 (c) Services must be age-appropriate and meet the specific needs of the client.

830.7 (d) The ~~initial functional assessment must be completed within ten days of intake and~~
830.8 level of care assessment as defined in section 245I.02, subdivision 19, and functional
830.9 assessment as defined in section 245I.02, subdivision 17, must be updated at least every ~~six~~
830.10 ~~months~~ 90 days or prior to discharge from the service, whichever comes first.

830.11 (e) The treatment team must complete an individual treatment plan ~~must~~ for each client,
830.12 according to section 245I.10, subdivisions 7 and 8, and the individual treatment plan must:

830.13 ~~(1) be based on the information in the client's diagnostic assessment and baselines;~~

830.14 ~~(2) identify goals and objectives of treatment, a treatment strategy, a schedule for~~
830.15 ~~accomplishing treatment goals and objectives, and the individuals responsible for providing~~
830.16 ~~treatment services and supports;~~

830.17 ~~(3) be developed after completion of the client's diagnostic assessment by a mental health~~
830.18 ~~professional or clinical trainee and before the provision of children's therapeutic services~~
830.19 ~~and supports;~~

830.20 ~~(4) be developed through a child-centered, family-driven, culturally appropriate planning~~
830.21 ~~process, including allowing parents and guardians to observe or participate in individual~~
830.22 ~~and family treatment services, assessments, and treatment planning;~~

830.23 ~~(5) be reviewed at least once every six months and revised to document treatment progress~~
830.24 ~~on each treatment objective and next goals or, if progress is not documented, to document~~
830.25 ~~changes in treatment;~~

830.26 ~~(6) be signed by the clinical supervisor and by the client or by the client's parent or other~~
830.27 ~~person authorized by statute to consent to mental health services for the client. A client's~~
830.28 ~~parent may approve the client's individual treatment plan by secure electronic signature or~~
830.29 ~~by documented oral approval that is later verified by written signature;~~

830.30 ~~(7)~~ (1) be completed in consultation with the client's current therapist and key providers
830.31 and provide for ongoing consultation with the client's current therapist to ensure therapeutic
830.32 continuity and to facilitate the client's return to the community. For clients under the age of

831.1 18, the treatment team must consult with parents and guardians in developing the treatment
831.2 plan;

831.3 ~~(8)~~ (2) if a need for substance use disorder treatment is indicated by validated assessment:

831.4 (i) identify goals, objectives, and strategies of substance use disorder treatment;

831.5 (ii) develop a schedule for accomplishing substance use disorder treatment goals and
831.6 objectives; and

831.7 (iii) identify the individuals responsible for providing substance use disorder treatment
831.8 services and supports;

831.9 ~~(ii) be reviewed at least once every 90 days and revised, if necessary;~~

831.10 ~~(9) be signed by the clinical supervisor and by the client and, if the client is a minor, by~~
831.11 ~~the client's parent or other person authorized by statute to consent to mental health treatment~~
831.12 ~~and substance use disorder treatment for the client; and~~

831.13 ~~(10)~~ (3) provide for the client's transition out of intensive nonresidential rehabilitative
831.14 mental health services by defining the team's actions to assist the client and subsequent
831.15 providers in the transition to less intensive or "stepped down" services~~.~~; and

831.16 (4) notwithstanding section 245I.10, subdivision 8, be reviewed at least every 90 days
831.17 and revised to document treatment progress or, if progress is not documented, to document
831.18 changes in treatment.

831.19 (f) The treatment team shall actively and assertively engage the client's family members
831.20 and significant others by establishing communication and collaboration with the family and
831.21 significant others and educating the family and significant others about the client's mental
831.22 illness, symptom management, and the family's role in treatment, unless the team knows or
831.23 has reason to suspect that the client has suffered or faces a threat of suffering any physical
831.24 or mental injury, abuse, or neglect from a family member or significant other.

831.25 (g) For a client age 18 or older, the treatment team may disclose to a family member,
831.26 other relative, or a close personal friend of the client, or other person identified by the client,
831.27 the protected health information directly relevant to such person's involvement with the
831.28 client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the
831.29 client is present, the treatment team shall obtain the client's agreement, provide the client
831.30 with an opportunity to object, or reasonably infer from the circumstances, based on the
831.31 exercise of professional judgment, that the client does not object. If the client is not present
831.32 or is unable, by incapacity or emergency circumstances, to agree or object, the treatment
831.33 team may, in the exercise of professional judgment, determine whether the disclosure is in

832.1 the best interests of the client and, if so, disclose only the protected health information that
832.2 is directly relevant to the family member's, relative's, friend's, or client-identified person's
832.3 involvement with the client's health care. The client may orally agree or object to the
832.4 disclosure and may prohibit or restrict disclosure to specific individuals.

832.5 (h) The treatment team shall provide interventions to promote positive interpersonal
832.6 relationships.

832.7 Sec. 103. Minnesota Statutes 2020, section 256B.0947, subdivision 7, is amended to read:

832.8 Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this
832.9 section must be based on one daily encounter rate per provider inclusive of the following
832.10 services received by an eligible client in a given calendar day: all rehabilitative services,
832.11 supports, and ancillary activities under this section, staff travel time to provide rehabilitative
832.12 services under this section, and crisis response services under section ~~256B.0944~~ 256B.0624.

832.13 (b) Payment must not be made to more than one entity for each client for services
832.14 provided under this section on a given day. If services under this section are provided by a
832.15 team that includes staff from more than one entity, the team shall determine how to distribute
832.16 the payment among the members.

832.17 (c) The commissioner shall establish regional cost-based rates for entities that will bill
832.18 medical assistance for nonresidential intensive rehabilitative mental health services. In
832.19 developing these rates, the commissioner shall consider:

832.20 (1) the cost for similar services in the health care trade area;

832.21 (2) actual costs incurred by entities providing the services;

832.22 (3) the intensity and frequency of services to be provided to each client;

832.23 (4) the degree to which clients will receive services other than services under this section;
832.24 and

832.25 (5) the costs of other services that will be separately reimbursed.

832.26 (d) The rate for a provider must not exceed the rate charged by that provider for the
832.27 same service to other payers.

832.28 Sec. 104. Minnesota Statutes 2020, section 256B.0949, subdivision 2, is amended to read:

832.29 Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this
832.30 subdivision.

833.1 (b) "Agency" means the legal entity that is enrolled with Minnesota health care programs
833.2 as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide
833.3 EIDBI services and that has the legal responsibility to ensure that its employees or contractors
833.4 carry out the responsibilities defined in this section. Agency includes a licensed individual
833.5 professional who practices independently and acts as an agency.

833.6 (c) "Autism spectrum disorder or a related condition" or "ASD or a related condition"
833.7 means either autism spectrum disorder (ASD) as defined in the current version of the
833.8 Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found
833.9 to be closely related to ASD, as identified under the current version of the DSM, and meets
833.10 all of the following criteria:

833.11 (1) is severe and chronic;

833.12 (2) results in impairment of adaptive behavior and function similar to that of a person
833.13 with ASD;

833.14 (3) requires treatment or services similar to those required for a person with ASD; and

833.15 (4) results in substantial functional limitations in three core developmental deficits of
833.16 ASD: social or interpersonal interaction; functional communication, including nonverbal
833.17 or social communication; and restrictive or repetitive behaviors or hyperreactivity or
833.18 hyporeactivity to sensory input; and may include deficits or a high level of support in one
833.19 or more of the following domains:

833.20 (i) behavioral challenges and self-regulation;

833.21 (ii) cognition;

833.22 (iii) learning and play;

833.23 (iv) self-care; or

833.24 (v) safety.

833.25 (d) "Person" means a person under 21 years of age.

833.26 (e) "Clinical supervision" means the overall responsibility for the control and direction
833.27 of EIDBI service delivery, including individual treatment planning, staff supervision,
833.28 individual treatment plan progress monitoring, and treatment review for each person. Clinical
833.29 supervision is provided by a qualified supervising professional (QSP) who takes full
833.30 professional responsibility for the service provided by each supervisee.

833.31 (f) "Commissioner" means the commissioner of human services, unless otherwise
833.32 specified.

834.1 (g) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive
834.2 evaluation of a person to determine medical necessity for EIDBI services based on the
834.3 requirements in subdivision 5.

834.4 (h) "Department" means the Department of Human Services, unless otherwise specified.

834.5 (i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI
834.6 benefit" means a variety of individualized, intensive treatment modalities approved and
834.7 published by the commissioner that are based in behavioral and developmental science
834.8 consistent with best practices on effectiveness.

834.9 (j) "Generalizable goals" means results or gains that are observed during a variety of
834.10 activities over time with different people, such as providers, family members, other adults,
834.11 and people, and in different environments including, but not limited to, clinics, homes,
834.12 schools, and the community.

834.13 (k) "Incident" means when any of the following occur:

834.14 (1) an illness, accident, or injury that requires first aid treatment;

834.15 (2) a bump or blow to the head; or

834.16 (3) an unusual or unexpected event that jeopardizes the safety of a person or staff,
834.17 including a person leaving the agency unattended.

834.18 (l) "Individual treatment plan" or "ITP" means the person-centered, individualized written
834.19 plan of care that integrates and coordinates person and family information from the CMDE
834.20 for a person who meets medical necessity for the EIDBI benefit. An individual treatment
834.21 plan must meet the standards in subdivision 6.

834.22 (m) "Legal representative" means the parent of a child who is under 18 years of age, a
834.23 court-appointed guardian, or other representative with legal authority to make decisions
834.24 about service for a person. For the purpose of this subdivision, "other representative with
834.25 legal authority to make decisions" includes a health care agent or an attorney-in-fact
834.26 authorized through a health care directive or power of attorney.

834.27 (n) "Mental health professional" ~~has the meaning given in~~ means a staff person who is
834.28 qualified according to section ~~245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04,
834.29 subdivision 2.

834.30 (o) "Person-centered" means a service that both responds to the identified needs, interests,
834.31 values, preferences, and desired outcomes of the person or the person's legal representative

835.1 and respects the person's history, dignity, and cultural background and allows inclusion and
835.2 participation in the person's community.

835.3 (p) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or
835.4 level III treatment provider.

835.5 Sec. 105. Minnesota Statutes 2020, section 256B.0949, subdivision 4, is amended to read:

835.6 Subd. 4. **Diagnosis.** (a) A diagnosis of ASD or a related condition must:

835.7 (1) be based upon current DSM criteria including direct observations of the person and
835.8 information from the person's legal representative or primary caregivers;

835.9 (2) be completed by either (i) a licensed physician or advanced practice registered nurse
835.10 or (ii) a mental health professional; and

835.11 (3) meet the requirements of ~~Minnesota Rules, part 9505.0372, subpart 1, items B and~~
835.12 ~~C~~ a standard diagnostic assessment according to section 245I.10, subdivision 6.

835.13 (b) Additional assessment information may be considered to complete a diagnostic
835.14 assessment including specialized tests administered through special education evaluations
835.15 and licensed school personnel, and from professionals licensed in the fields of medicine,
835.16 speech and language, psychology, occupational therapy, and physical therapy. A diagnostic
835.17 assessment may include treatment recommendations.

835.18 Sec. 106. Minnesota Statutes 2020, section 256B.0949, subdivision 5a, is amended to
835.19 read:

835.20 Subd. 5a. **Comprehensive multidisciplinary evaluation provider qualification.** A
835.21 CMDE provider must:

835.22 (1) be a licensed physician, advanced practice registered nurse, a mental health
835.23 professional, or a ~~mental health practitioner who meets the requirements of a~~ clinical trainee
835.24 ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~ who is qualified according
835.25 to section 245I.04, subdivision 6;

835.26 (2) have at least 2,000 hours of clinical experience in the evaluation and treatment of
835.27 people with ASD or a related condition or equivalent documented coursework at the graduate
835.28 level by an accredited university in the following content areas: ASD or a related condition
835.29 diagnosis, ASD or a related condition treatment strategies, and child development; and

835.30 (3) be able to diagnose, evaluate, or provide treatment within the provider's scope of
835.31 practice and professional license.

Sec. 107. Minnesota Statutes 2020, section 256B.25, subdivision 3, is amended to read:

Subd. 3. **Payment exceptions.** The limitation in subdivision 2 shall not apply to:

(1) payment of Minnesota supplemental assistance funds to recipients who reside in facilities which are involved in litigation contesting their designation as an institution for treatment of mental disease;

(2) payment or grants to a boarding care home or supervised living facility licensed by the Department of Human Services under Minnesota Rules, parts 2960.0130 to 2960.0220 ~~or~~, 2960.0580 to 2960.0700, or 9520.0500 to 9520.0670, or under chapter 245G or 245I, or payment to recipients who reside in these facilities;

(3) payments or grants to a boarding care home or supervised living facility which are ineligible for certification under United States Code, title 42, sections 1396-1396p;

(4) payments or grants otherwise specifically authorized by statute or rule.

Sec. 108. Minnesota Statutes 2020, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

~~(c) The commissioner shall establish three levels of payment for mental health diagnostic assessment, based on three levels of complexity. The aggregate payment under the tiered rates must not exceed the projected aggregate payments for mental health diagnostic assessment under the previous single rate. The new rate structure is effective January 1, 2011, or upon federal approval, whichever is later.~~

837.1 ~~(d)~~ (c) In addition to rate increases otherwise provided, the commissioner may restructure
837.2 coverage policy and rates to improve access to adult rehabilitative mental health services
837.3 under section 256B.0623 and related mental health support services under section 256B.021,
837.4 subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected
837.5 state share of increased costs due to this paragraph is transferred from adult mental health
837.6 grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent
837.7 base adjustment for subsequent fiscal years. Payments made to managed care plans and
837.8 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect
837.9 the rate changes described in this paragraph.

837.10 ~~(e)~~ (d) Any ratables effective before July 1, 2015, do not apply to early intensive
837.11 developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

837.12 Sec. 109. Minnesota Statutes 2020, section 256B.763, is amended to read:

837.13 **256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.**

837.14 (a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment
837.15 rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

837.16 (1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

837.17 (2) community mental health centers under section 256B.0625, subdivision 5; and

837.18 (3) mental health clinics ~~and centers~~ certified under ~~Minnesota Rules, parts 9520.0750~~
837.19 ~~to 9520.0870~~ section 245I.20, or hospital outpatient psychiatric departments that are
837.20 designated as essential community providers under section 62Q.19.

837.21 (b) This increase applies to group skills training when provided as a component of
837.22 children's therapeutic services and support, psychotherapy, medication management,
837.23 evaluation and management, diagnostic assessment, explanation of findings, psychological
837.24 testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

837.25 (c) This increase does not apply to rates that are governed by section 256B.0625,
837.26 subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated
837.27 with the county, rates that are established by the federal government, or rates that increased
837.28 between January 1, 2004, and January 1, 2005.

837.29 (d) The commissioner shall adjust rates paid to prepaid health plans under contract with
837.30 the commissioner to reflect the rate increases provided in paragraphs (a), (e), and (f). The
837.31 prepaid health plan must pass this rate increase to the providers identified in paragraphs (a),
837.32 (e), (f), and (g).

(e) Payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007, for:

(1) medication education services provided on or after January 1, 2008, by adult rehabilitative mental health services providers certified under section 256B.0623; and

(2) mental health behavioral aide services provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943 and not already included in paragraph (a), payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007.

(g) Payment rates shall be increased by 2.3 percent over the rates in effect on December 31, 2007, for individual and family skills training provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(h) For services described in paragraphs (b), (e), and (g) and rendered on or after July 1, 2017, payment rates for mental health clinics ~~and centers~~ certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20, that are not designated as essential community providers under section 62Q.19 shall be equal to payment rates for mental health clinics ~~and centers~~ certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20, that are designated as essential community providers under section 62Q.19. In order to receive increased payment rates under this paragraph, a provider must demonstrate a commitment to serve low-income and underserved populations by:

(1) charging for services on a sliding-fee schedule based on current poverty income guidelines; and

(2) not restricting access or services because of a client's financial limitation.

Sec. 110. Minnesota Statutes 2020, section 256P.01, subdivision 6a, is amended to read:

Subd. 6a. **Qualified professional.** (a) For illness, injury, or incapacity, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse, physical therapist, occupational therapist, or licensed chiropractor, according to their scope of practice.

(b) For developmental disability, learning disability, and intelligence testing, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse, licensed independent clinical social worker, licensed psychologist, certified school

839.1 psychologist, or certified psychometrist working under the supervision of a licensed
839.2 psychologist.

839.3 (c) For mental health, a "qualified professional" means a licensed physician, advanced
839.4 practice registered nurse, or qualified mental health professional under section ~~245.462,~~
839.5 ~~subdivision 18, clauses (1) to (6)~~ 245I.04, subdivision 2.

839.6 (d) For substance use disorder, a "qualified professional" means a licensed physician, a
839.7 qualified mental health professional under section 245.462, subdivision 18, clauses (1) to
839.8 (6), or an individual as defined in section 245G.11, subdivision 3, 4, or 5.

839.9 Sec. 111. Minnesota Statutes 2020, section 295.50, subdivision 9b, is amended to read:

839.10 Subd. 9b. **Patient services.** (a) "Patient services" means inpatient and outpatient services
839.11 and other goods and services provided by hospitals, surgical centers, or health care providers.
839.12 They include the following health care goods and services provided to a patient or consumer:

839.13 (1) bed and board;

839.14 (2) nursing services and other related services;

839.15 (3) use of hospitals, surgical centers, or health care provider facilities;

839.16 (4) medical social services;

839.17 (5) drugs, biologicals, supplies, appliances, and equipment;

839.18 (6) other diagnostic or therapeutic items or services;

839.19 (7) medical or surgical services;

839.20 (8) items and services furnished to ambulatory patients not requiring emergency care;
839.21 and

839.22 (9) emergency services.

839.23 (b) "Patient services" does not include:

839.24 (1) services provided to nursing homes licensed under chapter 144A;

839.25 (2) examinations for purposes of utilization reviews, insurance claims or eligibility,
839.26 litigation, and employment, including reviews of medical records for those purposes;

839.27 (3) services provided to and by community residential mental health facilities licensed
839.28 under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, and to and by
839.29 residential treatment programs for children with severe emotional disturbance licensed or
839.30 certified under chapter 245A;

840.1 (4) services provided under the following programs: day treatment services as defined
840.2 in section 245.462, subdivision 8; assertive community treatment as described in section
840.3 256B.0622; adult rehabilitative mental health services as described in section 256B.0623;
840.4 ~~adult~~ crisis response services as described in section 256B.0624; <u>and</u> children's therapeutic
840.5 services and supports as described in section 256B.0943; ~~and children's mental health crisis~~
840.6 ~~response services as described in section 256B.0944;~~

840.7 (5) services provided to and by community mental health centers as defined in section
840.8 245.62, subdivision 2;

840.9 (6) services provided to and by assisted living programs and congregate housing
840.10 programs;

840.11 (7) hospice care services;

840.12 (8) home and community-based waivered services under chapter 256S and sections
840.13 256B.49 and 256B.501;

840.14 (9) targeted case management services under sections 256B.0621; 256B.0625,
840.15 subdivisions 20, 20a, 33, and 44; and 256B.094; and

840.16 (10) services provided to the following: supervised living facilities for persons with
840.17 developmental disabilities licensed under Minnesota Rules, parts 4665.0100 to 4665.9900;
840.18 housing with services establishments required to be registered under chapter 144D; board
840.19 and lodging establishments providing only custodial services that are licensed under chapter
840.20 157 and registered under section 157.17 to provide supportive services or health supervision
840.21 services; adult foster homes as defined in Minnesota Rules, part 9555.5105; day training
840.22 and habilitation services for adults with developmental disabilities as defined in section
840.23 252.41, subdivision 3; boarding care homes as defined in Minnesota Rules, part 4655.0100;
840.24 adult day care services as defined in section 245A.02, subdivision 2a; and home health
840.25 agencies as defined in Minnesota Rules, part 9505.0175, subpart 15, or licensed under
840.26 chapter 144A.

840.27 Sec. 112. Minnesota Statutes 2020, section 325F.721, subdivision 1, is amended to read:

840.28 Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have
840.29 the meanings given them.

840.30 (b) "Covered setting" means an unlicensed setting providing sleeping accommodations
840.31 to one or more adult residents, at least 80 percent of which are 55 years of age or older, and
840.32 offering or providing, for a fee, supportive services. For the purposes of this section, covered
840.33 setting does not mean:

841.1 (1) emergency shelter, transitional housing, or any other residential units serving
841.2 exclusively or primarily homeless individuals, as defined under section 116L.361;

841.3 (2) a nursing home licensed under chapter 144A;

841.4 (3) a hospital, certified boarding care, or supervised living facility licensed under sections
841.5 144.50 to 144.56;

841.6 (4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts
841.7 9520.0500 to 9520.0670, or under chapter 245D ~~or~~, 245G, or 245I;

841.8 (5) services and residential settings licensed under chapter 245A, including adult foster
841.9 care and services and settings governed under the standards in chapter 245D;

841.10 (6) private homes in which the residents are related by kinship, law, or affinity with the
841.11 providers of services;

841.12 (7) a duly organized condominium, cooperative, and common interest community, or
841.13 owners' association of the condominium, cooperative, and common interest community
841.14 where at least 80 percent of the units that comprise the condominium, cooperative, or
841.15 common interest community are occupied by individuals who are the owners, members, or
841.16 shareholders of the units;

841.17 (8) temporary family health care dwellings as defined in sections 394.307 and 462.3593;

841.18 (9) settings offering services conducted by and for the adherents of any recognized
841.19 church or religious denomination for its members exclusively through spiritual means or
841.20 by prayer for healing;

841.21 (10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with
841.22 low-income housing tax credits pursuant to United States Code, title 26, section 42, and
841.23 units financed by the Minnesota Housing Finance Agency that are intended to serve
841.24 individuals with disabilities or individuals who are homeless, except for those developments
841.25 that market or hold themselves out as assisted living facilities and provide assisted living
841.26 services;

841.27 (11) rental housing developed under United States Code, title 42, section 1437, or United
841.28 States Code, title 12, section 1701q;

841.29 (12) rental housing designated for occupancy by only elderly or elderly and disabled
841.30 residents under United States Code, title 42, section 1437e, or rental housing for qualifying
841.31 families under Code of Federal Regulations, title 24, section 983.56;

842.1 (13) rental housing funded under United States Code, title 42, chapter 89, or United
842.2 States Code, title 42, section 8011; or

842.3 (14) an assisted living facility licensed under chapter 144G.

842.4 (c) "'I'm okay' check services" means providing a service to, by any means, check on
842.5 the safety of a resident.

842.6 (d) "Resident" means a person entering into written contract for housing and services
842.7 with a covered setting.

842.8 (e) "Supportive services" means:

842.9 (1) assistance with laundry, shopping, and household chores;

842.10 (2) housekeeping services;

842.11 (3) provision of meals or assistance with meals or food preparation;

842.12 (4) help with arranging, or arranging transportation to, medical, social, recreational,
842.13 personal, or social services appointments; or

842.14 (5) provision of social or recreational services.

842.15 Arranging for services does not include making referrals or contacting a service provider
842.16 in an emergency.

842.17 Sec. 113. **REPEALER.**

842.18 (a) Minnesota Statutes 2020, sections 245.462, subdivision 4a; 245.4879, subdivision
842.19 2; 245.62, subdivisions 3 and 4; 245.69, subdivision 2; 256B.0615, subdivision 2; 256B.0616,
842.20 subdivision 2; 256B.0622, subdivisions 3 and 5a; 256B.0623, subdivisions 7, 8, 10, and 11;
842.21 256B.0625, subdivisions 5l, 35a, 35b, 61, 62, and 65; 256B.0943, subdivisions 8 and 10;
842.22 256B.0944; and 256B.0946, subdivision 5, are repealed.

842.23 (b) Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020;
842.24 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090;
842.25 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160;
842.26 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; 9520.0230; 9520.0750;
842.27 9520.0760; 9520.0770; 9520.0780; 9520.0790; 9520.0800; 9520.0810; 9520.0820;
842.28 9520.0830; 9520.0840; 9520.0850; 9520.0860; and 9520.0870, are repealed.

843.1 Sec. 114. **EFFECTIVE DATE.**

843.2 Unless otherwise stated, this article is effective July 1, 2022, or upon federal approval,
843.3 whichever is later. The commissioner of human services shall notify the revisor of statutes
843.4 when federal approval is obtained.

843.5 **ARTICLE 20**

843.6 **FORECAST ADJUSTMENTS**

843.7 Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

843.8 The dollar amounts shown in the columns marked "Appropriations" are added to or, if
843.9 shown in parentheses, are subtracted from the appropriations in Laws 2019, First Special
843.10 Session chapter 9, article 14, from the general fund, or any other fund named, to the
843.11 commissioner of human services for the purposes specified in this article, to be available
843.12 for the fiscal year indicated for each purpose. The figure "2021" used in this article means
843.13 that the appropriations listed are available for the fiscal year ending June 30, 2021.

843.14 **APPROPRIATIONS**
843.15 **Available for the Year**
843.16 **Ending June 30**
843.17 **2021**

843.18 Sec. 2. **COMMISSIONER OF HUMAN**
843.19 **SERVICES**

843.20 Subdivision 1. **Total Appropriation** **$** **(816,996,000)**

843.21 Appropriations by Fund

843.22		2021
843.23	General	(745,266,000)
843.24	Health Care Access	(36,893,000)
843.25	Federal TANF	(34,837,000)

843.26 Subd. 2. **Forecasted Programs**

843.27 (a) **Minnesota Family**
843.28 **Investment Program**
843.29 **(MFIP)/Diversionary Work**
843.30 **Program (DWP)**

843.31 Appropriations by Fund

843.32		2021
843.33	General	59,004,000
843.34	Federal TANF	(34,843,000)

843.35 (b) **MFIP Child Care Assistance** (54,158,000)

844.1 (c) **General Assistance** 3,925,000

844.2 (d) **Minnesota Supplemental Aid** 3,849,000

844.3 (e) **Housing Support** 3,022,000

844.4 (f) **Northstar Care for Children** (8,639,000)

844.5 (g) **MinnesotaCare** (36,893,000)

844.6 This appropriation is from the health care
844.7 access fund.

844.8 (h) **Medical Assistance**

844.9 Appropriations by Fund

844.10	2021
844.11 General	(694,938,000)
844.12 Health Care Access	-0-

844.13 (i) **Alternative Care** 247,000

844.14 (j) **Consolidated Chemical Dependency**
844.15 **Treatment Fund (CCDTF) Entitlement** (57,578,000)

844.16 Subd. 3. **Technical Activities** 6,000

844.17 This appropriation is from the federal TANF
844.18 fund.

844.19 Sec. 3. **EFFECTIVE DATE.**

844.20 Sections 1 and 2 are effective the day following final enactment.

844.21 **ARTICLE 21**

844.22 **APPROPRIATIONS**

844.23 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

844.24 The sums shown in the columns marked "Appropriations" are appropriated to the agencies
844.25 and for the purposes specified in this article. The appropriations are from the general fund,
844.26 or another named fund, and are available for the fiscal years indicated for each purpose.
844.27 The figures "2022" and "2023" used in this article mean that the appropriations listed under
844.28 them are available for the fiscal year ending June 30, 2022, or June 30, 2023, respectively.
844.29 "The first year" is fiscal year 2022. "The second year" is fiscal year 2023. "The biennium"
844.30 is fiscal years 2022 and 2023.

845.1 **APPROPRIATIONS**

845.2 **Available for the Year**

845.3 **Ending June 30**

845.4 **2022** **2023**

845.5 Sec. 2. **COMMISSIONER OF HUMAN**
845.6 **SERVICES**

845.7 Subdivision 1. **Total Appropriation** **$ 9,012,439,000 $ 9,579,858,000**

845.8 Appropriations by Fund

845.9	2022	2023
845.10 General	7,928,908,000	8,454,516,000
845.11 State Government 845.12 Special Revenue	4,299,000	4,299,000
845.13 Health Care Access	792,153,000	837,210,000
845.14 Federal TANF	282,623,000	278,803,000
845.15 Lottery Prize	1,896,000	1,896,000
845.16 Opiate Epidemic 845.17 Response	2,560,000	2,560,000

845.18 The amounts that may be spent for each
845.19 purpose are specified in the following
845.20 subdivisions.

845.21 Subd. 2. **TANF Maintenance of Effort**

845.22 (a) **Nonfederal Expenditures.** The
845.23 commissioner shall ensure that sufficient
845.24 qualified nonfederal expenditures are made
845.25 each year to meet the state's maintenance of
845.26 effort (MOE) requirements of the TANF block
845.27 grant specified under Code of Federal
845.28 Regulations, title 45, section 263.1. In order
845.29 to meet these basic TANF/MOE requirements,
845.30 the commissioner may report as TANF/MOE
845.31 expenditures only nonfederal money expended
845.32 for allowable activities listed in the following
845.33 clauses:

846.1 (1) MFIP cash, diversionary work program,
846.2 and food assistance benefits under Minnesota
846.3 Statutes, chapter 256J;

846.4 (2) the child care assistance programs under
846.5 Minnesota Statutes, sections 119B.03 and
846.6 119B.05, and county child care administrative
846.7 costs under Minnesota Statutes, section
846.8 119B.15;

846.9 (3) state and county MFIP administrative costs
846.10 under Minnesota Statutes, chapters 256J and
846.11 256K;

846.12 (4) state, county, and tribal MFIP employment
846.13 services under Minnesota Statutes, chapters
846.14 256J and 256K;

846.15 (5) expenditures made on behalf of legal
846.16 noncitizen MFIP recipients who qualify for
846.17 the MinnesotaCare program under Minnesota
846.18 Statutes, chapter 256L;

846.19 (6) qualifying working family credit
846.20 expenditures under Minnesota Statutes, section
846.21 290.0671;

846.22 (7) qualifying Minnesota education credit
846.23 expenditures under Minnesota Statutes, section
846.24 290.0674; and

846.25 (8) qualifying Head Start expenditures under
846.26 Minnesota Statutes, section 119A.50.

846.27 (b) **Nonfederal Expenditures; Reporting.**
846.28 For the activities listed in paragraph (a),
846.29 clauses (2) to (8), the commissioner may
846.30 report only expenditures that are excluded
846.31 from the definition of assistance under Code
846.32 of Federal Regulations, title 45, section
846.33 260.31.

847.1 (c) **Certain Expenditures Required.** The
847.2 commissioner shall ensure that the MOE used
847.3 by the commissioner of management and
847.4 budget for the February and November
847.5 forecasts required under Minnesota Statutes,
847.6 section 16A.103, contains expenditures under
847.7 paragraph (a), clause (1), equal to at least 16
847.8 percent of the total required under Code of
847.9 Federal Regulations, title 45, section 263.1.

847.10 (d) **Limitation; Exceptions.** The
847.11 commissioner must not claim an amount of
847.12 TANF/MOE in excess of the 75 percent
847.13 standard in Code of Federal Regulations, title
847.14 45, section 263.1(a)(2), except:

847.15 (1) to the extent necessary to meet the 80
847.16 percent standard under Code of Federal
847.17 Regulations, title 45, section 263.1(a)(1), if it
847.18 is determined by the commissioner that the
847.19 state will not meet the TANF work
847.20 participation target rate for the current year;

847.21 (2) to provide any additional amounts under
847.22 Code of Federal Regulations, title 45, section
847.23 264.5, that relate to replacement of TANF
847.24 funds due to the operation of TANF penalties;
847.25 and

847.26 (3) to provide any additional amounts that may
847.27 contribute to avoiding or reducing TANF work
847.28 participation penalties through the operation
847.29 of the excess MOE provisions of Code of
847.30 Federal Regulations, title 45, section
847.31 261.43(a)(2).

847.32 (e) **Supplemental Expenditures.** For the
847.33 purposes of paragraph (d), the commissioner
847.34 may supplement the MOE claim with working

848.1 family credit expenditures or other qualified
848.2 expenditures to the extent such expenditures
848.3 are otherwise available after considering the
848.4 expenditures allowed in this subdivision.

848.5 (f) **Reduction of Appropriations; Exception.**
848.6 The requirement in Minnesota Statutes, section
848.7 256.011, subdivision 3, that federal grants or
848.8 aids secured or obtained under that subdivision
848.9 be used to reduce any direct appropriations
848.10 provided by law, does not apply if the grants
848.11 or aids are federal TANF funds.

848.12 (g) **IT Appropriations Generally.** This
848.13 appropriation includes funds for information
848.14 technology projects, services, and support.
848.15 Notwithstanding Minnesota Statutes, section
848.16 16E.0466, funding for information technology
848.17 project costs shall be incorporated into the
848.18 service level agreement and paid to the Office
848.19 of MN.IT Services by the Department of
848.20 Human Services under the rates and
848.21 mechanism specified in that agreement.

848.22 (h) **Receipts for Systems Project.**
848.23 Appropriations and federal receipts for
848.24 information systems projects for MAXIS,
848.25 PRISM, MMIS, ISDS, METS, and SSIS must
848.26 be deposited in the state systems account
848.27 authorized in Minnesota Statutes, section
848.28 256.014. Money appropriated for computer
848.29 projects approved by the commissioner of the
848.30 Office of MN.IT Services, funded by the
848.31 legislature, and approved by the commissioner
848.32 of management and budget may be transferred
848.33 from one project to another and from
848.34 development to operations as the
848.35 commissioner of human services considers

849.1 necessary. Any unexpended balance in the
849.2 appropriation for these projects does not
849.3 cancel and is available for ongoing
849.4 development and operations.

849.5 (i) **Federal SNAP Education and Training**
849.6 **Grants.** Federal funds available during fiscal
849.7 years 2022 and 2023 for Supplemental
849.8 Nutrition Assistance Program Education and
849.9 Training and SNAP Quality Control
849.10 Performance Bonus grants are appropriated
849.11 to the commissioner of human services for the
849.12 purposes allowable under the terms of the
849.13 federal award. This paragraph is effective the
849.14 day following final enactment.

849.15 Subd. 3. **Central Office; Operations**

	Appropriations by Fund		
849.17	General	174,946,000	170,629,000
849.18 849.19	State Government Special Revenue	4,174,000	4,174,000
849.20	Health Care Access	16,966,000	16,966,000
849.21	Federal TANF	100,000	100,000

849.22 (a) **Administrative Recovery; Set-Aside.** The
849.23 commissioner may invoice local entities
849.24 through the SWIFT accounting system as an
849.25 alternative means to recover the actual cost of
849.26 administering the following provisions:

849.27 (1) Minnesota Statutes, section 125A.744,
849.28 subdivision 3;

849.29 (2) Minnesota Statutes, section 245.495,
849.30 paragraph (b);

849.31 (3) Minnesota Statutes, section 256B.0625,
849.32 subdivision 20, paragraph (k);

849.33 (4) Minnesota Statutes, section 256B.0924,
849.34 subdivision 6, paragraph (g);

850.1 (5) Minnesota Statutes, section 256B.0945,
850.2 subdivision 4, paragraph (d); and

850.3 (6) Minnesota Statutes, section 256F.10,
850.4 subdivision 6, paragraph (b).

850.5 (b) **Background Studies.** (1) $2,074,000 in
850.6 fiscal year 2022 is from the general fund to
850.7 provide a credit to providers who paid for
850.8 emergency background studies in NETStudy
850.9 2.0.

850.10 (2) $2,061,000 in fiscal year 2022 is from the
850.11 general fund to cover the costs of reprocessing
850.12 emergency studies conducted under
850.13 interagency agreements with other agencies.

850.14 (c) **Personal Care Assistance Compensation**
850.15 **for Services Provided by a Parent or**
850.16 **Spouse.** $349,000 in fiscal year 2022 is from
850.17 the general fund for compensation for personal
850.18 care assistance services provided by a parent
850.19 or spouse under Laws 2020, Fifth Special
850.20 Session chapter 3, article 10, section 3, as
850.21 amended.

850.22 (d) **Family Foster Setting Background**
850.23 **Studies.** $338,000 in fiscal year 2022 and
850.24 $349,000 in fiscal year 2023 are from the
850.25 general fund for costs related to implementing
850.26 and administering licensed family foster
850.27 setting background study requirements.

850.28 (e) **Cultural and Ethnic Communities**
850.29 **Leadership Council.** $18,000 in fiscal year
850.30 2022 and $62,000 in fiscal year 2023 are from
850.31 the general fund for the Cultural and Ethnic
850.32 Communities Leadership Council.

850.33 (f) **Ombudsperson for Child Care**
850.34 **Providers.** $120,000 in fiscal year 2022 and

851.1 $126,000 in fiscal year 2023 are for an
851.2 ombudsperson for child care providers under
851.3 Minnesota Statutes, section 119B.27.

851.4 (g) **Base Level Adjustment.** The general fund
851.5 base is $163,421,000 in fiscal year 2024 and
851.6 $162,260,000 in fiscal year 2025.

851.7 Subd. 4. **Central Office; Children and Families**

851.8	Appropriations by Fund		
851.9	General	18,382,000	18,407,000
851.10	Federal TANF	2,582,000	2,582,000

851.11 (a) **Financial Institution Data Match and**
851.12 **Payment of Fees.** The commissioner is
851.13 authorized to allocate up to $310,000 in fiscal
851.14 year 2022 and $310,000 in fiscal year 2023
851.15 from the systems special revenue account to
851.16 make payments to financial institutions in
851.17 exchange for performing data matches
851.18 between account information held by financial
851.19 institutions and the public authority's database
851.20 of child support obligors as authorized by
851.21 Minnesota Statutes, section 13B.06,
851.22 subdivision 7.

851.23 (b) **Base Level Adjustment.** The general fund
851.24 base is $18,677,000 in fiscal year 2024 and
851.25 $18,677,000 in fiscal year 2025.

851.26 Subd. 5. **Central Office; Health Care**

851.27	Appropriations by Fund		
851.28	General	26,282,000	24,142,000
851.29	Health Care Access	30,168,000	28,168,000

851.30 (a) **Case Management Benefit Study for**
851.31 **American Indians.** $200,000 in fiscal year
851.32 2022 is from the general fund for a contract
851.33 to conduct fiscal analysis and development of
851.34 standards for a targeted case management

852.1 benefit for American Indians. The
852.2 commissioner of human services must consult
852.3 the Minnesota Indian Affairs Council in the
852.4 development of any request for proposal and
852.5 in the evaluation of responses. This is a
852.6 onetime appropriation. Any unencumbered
852.7 balance remaining from the first year does not
852.8 cancel and is available for the second year of
852.9 the biennium.

852.10 (b) **Integrated Care for High-Risk Pregnant**
852.11 **Women Grant Program.** $106,000 in fiscal
852.12 year 2022 and $122,000 in fiscal year 2023
852.13 are from the general fund for administration
852.14 of the integrated care for high-risk pregnant
852.15 women grant program under Minnesota
852.16 Statutes, section 256B.79.

852.17 (c) **Studies on Health Care Delivery.**
852.18 $700,000 in fiscal year 2022 and $300,000 in
852.19 fiscal year 2023 are from the general fund for
852.20 the commissioner of human services to
852.21 develop a legislative proposal for a public
852.22 option program and to compare and report to
852.23 the legislature on delivery and payment system
852.24 models to deliver services to MinnesotaCare
852.25 enrollees and certain medical assistance
852.26 enrollees.

852.27 (d) **Base Level Adjustment.** The general fund
852.28 base is $24,036,000 in fiscal year 2024 and
852.29 $24,034,000 in fiscal year 2025.

852.30 Subd. 6. **Central Office; Continuing Care for**
852.31 **Older Adults**

852.32 Appropriations by Fund

852.33	General	18,873,000	18,900,000
852.34 852.35	State Government Special Revenue	125,000	125,000

853.1 (a) **Assisted Living Survey.** $2,593,000 in
853.2 fiscal year 2022 and $2,593,000 in fiscal year
853.3 2023 are from the general fund for
853.4 development and administration of a resident
853.5 experience survey and family survey for all
853.6 assisted living facilities according to
853.7 Minnesota Statutes, section 256B.439,
853.8 subdivision 3c. These appropriations are
853.9 available in either year of the biennium.

853.10 (b) **Base Level Adjustment.** The general fund
853.11 base is $18,859,000 in fiscal year 2024 and
853.12 $18,900,000 in fiscal year 2025.

853.13 Subd. 7. **Central Office; Community Supports**

853.14	Appropriations by Fund		
853.15	General	35,294,000	35,846,000
853.16	Lottery Prize	163,000	163,000
853.17 853.18	Opioid Epidemic Response	60,000	60,000

853.19 (a) **Study of Self Directed Tiered Wage**
853.20 **Structure.** $25,000 in fiscal year 2022 is from
853.21 the general fund for a study of the feasibility
853.22 of a tiered wage structure for individual
853.23 providers. This is a onetime appropriation.
853.24 This appropriation is available only if the labor
853.25 agreement between the state of Minnesota and
853.26 the Service Employees International Union
853.27 Healthcare Minnesota under Minnesota
853.28 Statutes, section 179A.54, is approved under
853.29 Minnesota Statutes, section 3.855.

853.30 (b) **Substance Use Disorder Treatment**
853.31 **Paperwork Reduction.** $234,000 in fiscal
853.32 year 2022 and $201,000 in fiscal year 2023
853.33 are from the general fund for a contract with
853.34 a vendor to develop, assess, and recommend
853.35 systems improvements to minimize regulatory

854.1 paperwork and improve systems for licensed
854.2 substance use disorder programs. This is a
854.3 onetime appropriation.

854.4 (c) **Case Management and Substance Use**
854.5 **Disorder Treatment Rate Methodology**
854.6 **Analysis.** $500,000 in fiscal year 2022 and
854.7 $200,000 in fiscal year 2023 are from the
854.8 general fund for the fiscal analysis needed to
854.9 establish federally compliant payment
854.10 methodologies for all medical
854.11 assistance-funded case management services,
854.12 including substance use disorder treatment
854.13 rates. This is a onetime appropriation.

854.14 (d) **Substance Use Disorder Community of**
854.15 **Practice.** $250,000 in fiscal year 2022 and
854.16 $250,000 in fiscal year 2023 are from the
854.17 general fund for the commissioner of human
854.18 services to establish and administer the
854.19 substance use disorder community of practice,
854.20 including providing compensation for
854.21 community of practice participants.

854.22 (e) **Sober Housing Program**
854.23 **Recommendations Development.** $90,000
854.24 in fiscal year 2022 is from the general fund
854.25 for developing recommendations related to
854.26 sober housing programs and completing and
854.27 submitting a report on the recommendations
854.28 to the legislature.

854.29 (f) **Base Level Adjustment.** The general fund
854.30 base is $34,257,000 in fiscal year 2024 and
854.31 $34,289,000 in fiscal year 2025. The opiate
854.32 epidemic response fund base is $60,000 in
854.33 fiscal year 2024 and $0 in fiscal year 2025.

854.34 Subd. 8. **Forecasted Programs; MFIP/DWP**

855.1 Appropriations by Fund

855.2 General	92,588,000	91,668,000
855.3 Federal TANF	104,285,000	104,410,000

855.4 Subd. 9. **Forecasted Programs; MFIP Child Care** 855.5 **Assistance.**	103,347,000	110,788,000
855.6 Subd. 10. **Forecasted Programs; General** 855.7 **Assistance.**	53,574,000	52,835,000

855.8 (a) **General Assistance Standard.** The 855.9 commissioner shall set the monthly standard 855.10 of assistance for general assistance units 855.11 consisting of an adult recipient who is 855.12 childless and unmarried or living apart from 855.13 parents or a legal guardian at $203. The 855.14 commissioner may reduce this amount 855.15 according to Laws 1997, chapter 85, article 3, 855.16 section 54.

855.17 (b) **Emergency General Assistance Limit.** 855.18 The amount appropriated for emergency 855.19 general assistance is limited to no more than 855.20 $6,729,812 in fiscal year 2022 and $6,729,812 855.21 in fiscal year 2023. Funds to counties shall be 855.22 allocated by the commissioner using the 855.23 allocation method under Minnesota Statutes, 855.24 section 256D.06.

855.25 Subd. 11. **Forecasted Programs; Minnesota** 855.26 **Supplemental Aid**	51,779,000	52,486,000
855.27 Subd. 12. **Forecasted Programs; Housing** 855.28 **Support**	184,005,000	191,966,000
855.29 Subd. 13. **Forecasted Programs; Northstar Care** 855.30 **for Children**	110,583,000	121,246,000
855.31 Subd. 14. **Forecasted Programs; MinnesotaCare**	113,474,000	159,610,000

855.32 **Generally.** This appropriation is from the 855.33 health care access fund.

855.34 Subd. 15. **Forecasted Programs; Medical** 855.35 **Assistance**

856.1 Appropriations by Fund

856.2 General	6,041,354,000	6,553,259,000
856.3 Health Care Access	628,080,000	629,001,000

856.4 (a) **Behavioral Health Services.** $1,000,000
856.5 in fiscal year 2022 and $1,000,000 in fiscal
856.6 year 2023 are for behavioral health services
856.7 provided by hospitals identified under
856.8 Minnesota Statutes, section 256.969,
856.9 subdivision 2b, paragraph (a), clause (4). The
856.10 increase in payments shall be made by
856.11 increasing the adjustment under Minnesota
856.12 Statutes, section 256.969, subdivision 2b,
856.13 paragraph (e), clause (2).

856.14 (b) **Base Level Adjustment.** The health care
856.15 access fund base is $604,758,000 in fiscal year
856.16 2024 and $604,758,000 in fiscal year 2025.

856.17 Subd. 16. **Forecasted Programs; Alternative** 856.18 **Care**	45,669,000	45,656,000

856.19 **Alternative Care Transfer.** Any money
856.20 allocated to the alternative care program that
856.21 is not spent for the purposes indicated does
856.22 not cancel but must be transferred to the
856.23 medical assistance account.

856.24 Subd. 17. **Forecasted Programs; Behavioral** 856.25 **Health Fund**	132,377,000	116,706,000

856.26 (a) **Grants to Tribal Governments.**
856.27 $28,873,377 in fiscal year 2022 is from the
856.28 general fund to satisfy the value of
856.29 overpayments owed by the Leech Lake Band
856.30 of Ojibwe and White Earth Band of Chippewa
856.31 to repay overpayments for medication-assisted
856.32 treatment services between fiscal year 2014
856.33 and fiscal year 2019. The grant to the Leech
856.34 Lake Band of Ojibwe shall be $14,666,122
856.35 and the grant to the White Earth Band of

857.1 Chippewa shall be $14,207,215. This is a
857.2 onetime appropriation.

857.3 (b) **Institutions for Mental Disease**
857.4 **Payments.** $8,328,000 in fiscal year 2022 is
857.5 from the general fund for the commissioner
857.6 of human services to reimburse counties for
857.7 the amount identified by the commissioner for
857.8 the statewide county share of costs for which
857.9 federal funds were claimed, but were not
857.10 eligible for federal funding for substance use
857.11 disorder services provided in institutions for
857.12 mental disease, for claims paid between
857.13 January 1, 2014, and June 30, 2019. The
857.14 commissioner of human services shall allocate
857.15 this appropriation between counties in the
857.16 amount identified by the department that is
857.17 owed by each county. Prior to a county
857.18 receiving reimbursement, the county must pay
857.19 in full any unpaid consolidated chemical
857.20 dependency treatment fund invoiced county
857.21 share. This is a onetime appropriation.

857.22 Subd. 18. **Grant Programs; Support Services**
857.23 **Grants**

857.24 Appropriations by Fund

857.25 General	8,715,000	8,715,000
857.26 Federal TANF	96,312,000	96,311,000

857.27 Subd. 19. **Grant Programs; BSF Child Care**
857.28 **Grants.** 53,350,000 53,362,000

857.29 **Base Level Adjustment.** The general fund
857.30 base is $53,366,000 in fiscal year 2024 and
857.31 $53,366,000 in fiscal year 2025.

857.32 Subd. 20. **Grant Programs; Child Care**
857.33 **Development Grants.** 2,317,000 2,257,000

857.34 (a) **TEACH Grant Program.** $500,000 in
857.35 fiscal year 2022 and $500,000 in fiscal year

858.1 2023 are for TEACH program grants under
858.2 Minnesota Statutes, section 136A.128.

858.3 (b) **Peer Mentoring Program for Licensed**
858.4 **Family Child Care Providers.** $30,000 in
858.5 fiscal year 2022 and $20,000 in fiscal year
858.6 2023 are for a grant to the Minnesota Child
858.7 Care Provider Information Network for
858.8 establishing a peer mentoring program for
858.9 licensed family child care providers in the
858.10 state. The grant money must be used to revise
858.11 and update peer mentoring program curricula,
858.12 recruit and train mentors and program
858.13 participants, and support mentors and active
858.14 mentoring. The Minnesota Child Care
858.15 Provider Information Network must submit
858.16 to the commissioner an initial report
858.17 describing the program's implementation
858.18 progress and financial accounting by
858.19 September 1, 2022, and a final report must be
858.20 submitted by June 30, 2023. Any unexpended
858.21 balance in the first year does not cancel and
858.22 is available in the second year. This is a
858.23 onetime appropriation.

858.24 (c) **Report on Foster Children Participation**
858.25 **in Early Childhood Programs.** $50,000 in
858.26 fiscal year 2022 is for interim and final reports
858.27 on foster children's participation in early
858.28 childhood programs. This is a onetime
858.29 appropriation and is available until June 30,
858.30 2023.

858.31 (d) **Child Care Center Regulation**
858.32 **Modernization.** $577,000 in fiscal year 2022
858.33 and $741,000 in fiscal year 2023 are for the
858.34 child care center regulation modernization

859.1 project. This is a onetime appropriation and
859.2 remains available until June 30, 2024.

859.3 (e) **Family Child Care Regulation**
859.4 **Modernization.** $478,000 in fiscal year 2022
859.5 and $642,000 in fiscal year 2023 are for the
859.6 family child care regulation modernization
859.7 project. This is a onetime appropriation and
859.8 remains available until June 30, 2024.

859.9 (f) **Base Level Adjustment.** The general fund
859.10 base is $2,237,000 in fiscal year 2024 and
859.11 $2,237,000 in fiscal year 2025.

859.12 Subd. 21. **Grant Programs; Child Support**
859.13 **Enforcement Grants** 50,000 50,000

859.14 Subd. 22. **Grant Programs; Children's Services**
859.15 **Grants**

859.16	Appropriations by Fund		
859.17	General	52,133,000	51,848,000
859.18	Federal TANF	140,000	140,000

859.19 (a) **Title IV-E Adoption Assistance.** The
859.20 commissioner shall allocate funds from the
859.21 Title IV-E reimbursement to the state from
859.22 the Fostering Connections to Success and
859.23 Increasing Adoptions Act for adoptive, foster,
859.24 and kinship families as required in Minnesota
859.25 Statutes, section 256N.261.

859.26 (b) **Indian Child Welfare Training.**
859.27 $1,012,000 in fiscal year 2022 and $993,000
859.28 in fiscal year 2023 are from the general fund
859.29 for the establishment and operation of the
859.30 Tribal Training and Certification Partnership
859.31 at the University of Minnesota-Duluth to
859.32 provide training, establish federal Indian Child
859.33 Welfare Act and Minnesota Family
859.34 Preservation Act training requirements for
859.35 county child welfare workers, and develop

860.1 indigenous child welfare training for American
860.2 Indian Tribes. The base for this appropriation
860.3 is $1,053,000 in fiscal year 2024 and
860.4 $1,053,000 in fiscal year 2025.

860.5 (c) **Parent Support for Better Outcomes**
860.6 **Grants.** $150,000 in fiscal year 2022 and
860.7 $150,000 in fiscal year 2023 are from the
860.8 general fund for grants to Minnesota One-Stop
860.9 for Communities to provide mentoring,
860.10 guidance, and support services to parents
860.11 navigating the child welfare system in
860.12 Minnesota, in order to promote the
860.13 development of safe, stable, and healthy
860.14 families. Grant money may be used for parent
860.15 mentoring, peer-to-peer support groups,
860.16 housing support services, training, staffing,
860.17 and administrative costs.

860.18 860.19	Subd. 23. **Grant Programs; Children and Community Service Grants**	60,251,000	60,856,000
860.20 860.21	Subd. 24. **Grant Programs; Children and Economic Support Grants**	34,040,000	34,040,000

860.22 (a) **Minnesota Food Assistance Program.**
860.23 Unexpended funds for the Minnesota food
860.24 assistance program for fiscal year 2022 do not
860.25 cancel but are available for this purpose in
860.26 fiscal year 2023.

860.27 (b) **Emergency Shelters.** $2,500,000 in fiscal
860.28 year 2022 and $2,500,000 in fiscal year 2023
860.29 are for short-term housing facilities to increase
860.30 the supply and improve the condition of
860.31 shelters for individuals and families without
860.32 a permanent residence. The commissioner
860.33 shall ensure that a portion of the funds are
860.34 expended to provide for short-term housing
860.35 facilities for tribes and shall ensure equitable

861.1 geographic distribution of funds. This
861.2 appropriation is available until June 30, 2026.

861.3 (c) **Emergency Services Grants.** $9,000,000
861.4 in fiscal year 2022 and $9,000,000 in fiscal
861.5 year 2023 are to provide emergency services
861.6 grants under Minnesota Statutes, section
861.7 256E.36.

861.8 Subd. 25. **Grant Programs; Health Care Grants**

861.9	Appropriations by Fund		
861.10	General	4,811,000	4,811,000
861.11	Health Care Access	3,465,000	3,465,000

861.12 **Integrated Care for High Risk Pregnancies**
861.13 **Initiative.** $1,100,000 in fiscal year 2022 and
861.14 $1,100,000 in fiscal year 2023 are from the
861.15 general fund for the commissioner of human
861.16 services to enter into a contract with the
861.17 Integrated Care for High Risk Pregnancies
861.18 (ICHRP) initiative to provide support to the
861.19 integrated care for high-risk pregnant women
861.20 grant program under Minnesota Statutes,
861.21 section 256B.79.

861.22 861.23	Subd. 26. **Grant Programs; Other Long-Term Care Grants**	1,925,000	1,925,000
861.24 861.25	Subd. 27. **Grant Programs; Aging and Adult Services Grants**	32,495,000	32,495,000
861.26 861.27	Subd. 28. **Grant Programs; Deaf and Hard-of-Hearing Grants**	2,886,000	2,886,000
861.28	Subd. 29. **Grant Programs; Disabilities Grants**	20,251,000	18,863,000

861.29 **Training Stipends for Direct Support**
861.30 **Services Providers.** $1,000,000 in fiscal year
861.31 2022 is from the general fund for stipends for
861.32 individual providers of direct support services
861.33 as defined in Minnesota Statutes, section
861.34 256B.0711, subdivision 1. These stipends are
861.35 available to individual providers who have

862.1 completed designated voluntary trainings
862.2 made available through the State-Provider
862.3 Cooperation Committee formed by the State
862.4 of Minnesota and the Service Employees
862.5 International Union Healthcare Minnesota.
862.6 Any unspent appropriation in fiscal year 2022
862.7 is available in fiscal year 2023. This is a
862.8 onetime appropriation. This appropriation is
862.9 available only if the labor agreement between
862.10 the state of Minnesota and the Service
862.11 Employees International Union Healthcare
862.12 Minnesota under Minnesota Statutes, section
862.13 179A.54, is approved under Minnesota
862.14 Statutes, section 3.855.

862.15 Subd. 30. **Grant Programs; Housing Support**
862.16 **Grants** 11,364,000 11,364,000

862.17 **Long-Term Homeless Supportive Services.**
862.18 $1,000,000 in fiscal year 2022 and $1,000,000
862.19 in fiscal year 2023 are for long-term homeless
862.20 supportive services under Minnesota Statutes,
862.21 section 256K.26.

862.22 Subd. 31. **Grant Programs; Adult Mental Health**
862.23 **Grants**

862.24 Appropriations by Fund

862.25 General	84,073,000	84,074,000
862.26 Opiate Epidemic 862.27 Response	2,000,000	2,000,000

862.28 (a) **Culturally and Linguistically**
862.29 **Appropriate Services Implementation**
862.30 **Grants.** $750,000 in fiscal year 2022 and
862.31 $750,000 in fiscal year 2023 are from the
862.32 general fund for grants to substance use
862.33 disorder treatment providers to implement
862.34 culturally and linguistically appropriate
862.35 services standards, according to the
862.36 implementation and transition plan developed

863.1 by the commissioner. This is a onetime
863.2 appropriation.

863.3 (b) **Base Level Adjustment.** The general fund
863.4 base is $83,324,000 in fiscal year 2024 and
863.5 $83,324,000 in fiscal year 2025. The opiate
863.6 epidemic response fund base is $2,000,000 in
863.7 fiscal year 2024 and $0 in fiscal year 2025.

863.8 Subd. 32. **Grant Programs; Child Mental Health** 863.9 **Grants**	28,703,000	28,703,000

863.10 (a) **Children's Residential Facilities.**
863.11 $3,000,000 in fiscal year 2022 and $3,000,000
863.12 in fiscal year 2023 are to reimburse counties
863.13 and Tribal governments for a portion of the
863.14 costs of treatment in children's residential
863.15 facilities. The commissioner shall distribute
863.16 the appropriation on an annual basis to
863.17 counties and Tribal governments
863.18 proportionally based on a methodology
863.19 developed by the commissioner. Of this
863.20 appropriation, $100,000 in fiscal year 2022
863.21 and $100,000 in fiscal year 2023 are available
863.22 to the commissioner for administrative
863.23 expenses and $70,000 in fiscal year 2022 is
863.24 available to the commissioner for the
863.25 children's mental health residential treatment
863.26 work group.

863.27 (b) **Base Level Adjustment.** The general fund
863.28 base is $28,726,000 in fiscal year 2024 and
863.29 $28,726,000 in fiscal year 2025.

863.30 Subd. 33. **Grant Programs; Chemical**
863.31 **Dependency Treatment Support Grants**

863.32	Appropriations by Fund	
863.33 General	2,846,000	2,845,000

864.1 Lottery Prize 1,733,000 1,733,000

864.2 Opiate Epidemic
864.3 Response 500,000 500,000

864.4 (a) **Problem Gambling.** $225,000 in fiscal
864.5 year 2022 and $225,000 in fiscal year 2023
864.6 are from the lottery prize fund for a grant to
864.7 the state affiliate recognized by the National
864.8 Council on Problem Gambling. The affiliate
864.9 must provide services to increase public
864.10 awareness of problem gambling, education,
864.11 training for individuals and organizations
864.12 providing effective treatment services to
864.13 problem gamblers and their families, and
864.14 research related to problem gambling.

864.15 (b) **Recovery Community Organization**
864.16 **Grants.** $573,000 in fiscal year 2022 and
864.17 $571,000 in fiscal year 2023 are from the
864.18 general fund for grants to recovery community
864.19 organizations, as defined in Minnesota
864.20 Statutes, section 254B.01, subdivision 8, to
864.21 provide for costs and community-based peer
864.22 recovery support services that are not
864.23 otherwise eligible for reimbursement under
864.24 Minnesota Statutes, section 254B.05, as part
864.25 of the continuum of care for substance use
864.26 disorders.

864.27 (c) **Base Level Adjustment.** The general fund
864.28 base is $2,636,000 in fiscal year 2024 and
864.29 $2,636,000 in fiscal year 2025. The opiate
864.30 epidemic response fund base is $500,000 in
864.31 fiscal year 2024 and $0 in fiscal year 2025.

864.32 Subd. 34. **Direct Care and Treatment -**
864.33 **Generally**

864.34 **Transfer Authority.** Money appropriated to
864.35 budget activities under this subdivision and

865.1 subdivisions 35 to 39 may be transferred
865.2 between budget activities and between years
865.3 of the biennium with the approval of the
865.4 commissioner of management and budget.

865.5 Subd. 35. **Direct Care and Treatment - Mental**
865.6 **Health and Substance Abuse** 139,946,000 144,103,000

865.7 (a) **Transfer Authority.** Money appropriated
865.8 to support the continued operations of the
865.9 Community Addiction Recovery Enterprise
865.10 (C.A.R.E.) program may be transferred to the
865.11 enterprise fund for C.A.R.E.

865.12 (b) **Operating Adjustment.** $2,307,000 in
865.13 fiscal year 2022 and $2,453,000 in fiscal year
865.14 2023 are for the Community Addiction
865.15 Recovery Enterprise program. The
865.16 commissioner may transfer $2,307,000 in
865.17 fiscal year 2022 and $2,453,000 in fiscal year
865.18 2023 to the enterprise fund for Community
865.19 Addiction Recovery Enterprise.

865.20 Subd. 36. **Direct Care and Treatment -**
865.21 **Community-Based Services** 18,771,000 19,752,000

865.22 (a) **Transfer Authority.** Money appropriated
865.23 to support the continued operations of the
865.24 Minnesota State Operated Community
865.25 Services (MSOCS) program may be
865.26 transferred to the enterprise fund for MSOCS.

865.27 (b) **Operating Adjustment.** $1,519,000 in
865.28 fiscal year 2022 and $2,541,000 in fiscal year
865.29 2023 are for the Minnesota State Operated
865.30 Community Services program. The
865.31 commissioner may transfer $1,519,000 in
865.32 fiscal year 2022 and $2,541,000 in fiscal year
865.33 2023 to the enterprise fund for Minnesota State
865.34 Operated Community Services.

866.1 Subd. 37. **Direct Care and Treatment - Forensic**
866.2 **Services** 119,854,000 122,206,000

866.3 Subd. 38. **Direct Care and Treatment - Sex**
866.4 **Offender Program** 97,570,000 99,917,000

866.5 **Transfer Authority.** Money appropriated for
866.6 the Minnesota sex offender program may be
866.7 transferred between fiscal years of the
866.8 biennium with the approval of the
866.9 commissioner of management and budget.

866.10 Subd. 39. **Direct Care and Treatment -**
866.11 **Operations** 63,504,000 65,910,000

866.12 Subd. 40. **Technical Activities** 79,204,000 78,260,000

866.13 (a) **Generally.** This appropriation is from the
866.14 federal TANF fund.

866.15 (b) **Base Level Adjustment.** The TANF fund
866.16 base is $71,493,000 in fiscal year 2024 and
866.17 $71,493,000 in fiscal year 2025.

866.18 Sec. 3. **COMMISSIONER OF HEALTH**

866.19 Subdivision 1. **Total Appropriation** **$** **268,895,000** **$** **261,403,000**

866.20 Appropriations by Fund

866.21		2022	2023
866.22	General	165,859,000	160,076,000
866.23 866.24	State Government Special Revenue	54,465,000	53,356,000
866.25	Health Care Access	36,858,000	36,258,000
866.26	Federal TANF	11,713,000	11,713,000

866.27 The amounts that may be spent for each
866.28 purpose are specified in the following
866.29 subdivisions.

866.30 Subd. 2. **Health Improvement**

866.31 Appropriations by Fund

866.32	General	123,219,000	122,214,000
866.33 866.34	State Government Special Revenue	9,103,000	7,777,000

Health Care Access	36,858,000	36,258,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 in fiscal year 2022 and $3,579,000 in fiscal year 2023 are from the TANF fund for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2022 and $4,978,000 in fiscal year 2023 are from the TANF fund for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding in each fiscal year must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding in each fiscal year must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 in fiscal year 2022 and $1,156,000 in fiscal year 2023 are from the TANF fund for family planning grants under Minnesota Statutes, section 145.925; and

868.1 (5) the commissioner may use up to 6.23
868.2 percent of the funds appropriated from the
868.3 TANF fund each fiscal year to conduct the
868.4 ongoing evaluations required under Minnesota
868.5 Statutes, section 145A.17, subdivision 7, and
868.6 training and technical assistance as required
868.7 under Minnesota Statutes, section 145A.17,
868.8 subdivisions 4 and 5.

868.9 (b) **TANF Carryforward.** Any unexpended
868.10 balance of the TANF appropriation in the first
868.11 year of the biennium does not cancel but is
868.12 available for the second year.

868.13 (c) **Maternal Death Studies.** $198,000 in
868.14 fiscal year 2022 and $198,000 in fiscal year
868.15 2023 are from the general fund to be used to
868.16 conduct maternal death studies under
868.17 Minnesota Statutes, section 145.901.

868.18 (d) **Comprehensive Advanced Life Support**
868.19 **Educational Program.** $100,000 in fiscal
868.20 year 2022 and $100,000 in fiscal year 2023
868.21 are from the general fund for the
868.22 comprehensive advanced life support
868.23 educational program under Minnesota Statutes,
868.24 section 144.6062. This is a onetime
868.25 appropriation.

868.26 (e) **Local Public Health Grants.** $7,500,000
868.27 in fiscal year 2022 and $7,500,000 in fiscal
868.28 year 2023 are from the general fund for local
868.29 public health grants under Minnesota Statutes,
868.30 section 145A.131.

868.31 (f) **Public Health Infrastructure and Health**
868.32 **Equity and Outreach.** $7,500,000 in fiscal
868.33 year 2022 and $7,500,000 in fiscal year 2023
868.34 are from the general fund for purposes of

869.1 Minnesota Statutes, sections 144.0661 to
869.2 144.0663, and to build public health
869.3 infrastructure at the state and local levels to
869.4 address current and future public health
869.5 emergencies, conduct outreach to underserved
869.6 communities in the state experiencing health
869.7 disparities, and build systems at the state and
869.8 local levels with the goals of reducing and
869.9 eliminating health disparities in these
869.10 communities. A community health board or
869.11 local unit of government must use any funds
869.12 provided under this paragraph to supplement
869.13 and not supplant local funds being used for
869.14 public health purposes.

869.15 (g) **Mental Health Cultural Community**
869.16 **Continuing Education.** $500,000 in fiscal
869.17 year 2022 and $500,000 in fiscal year 2023
869.18 are from the general fund for the mental health
869.19 cultural community continuing education grant
869.20 program.

869.21 (h) **Health Professional Education Loan**
869.22 **Forgiveness Program.** $3,000,000 in fiscal
869.23 year 2022 and $3,000,000 in fiscal year 2023
869.24 are from the general fund for loan forgiveness
869.25 under the health professional education loan
869.26 forgiveness program under Minnesota Statutes,
869.27 section 144.1501, for individuals who: (1) are
869.28 eligible alcohol and drug counselors or eligible
869.29 mental health professionals, as defined in
869.30 Minnesota Statutes, section 144.1501,
869.31 subdivision 1; and (2) are Black, indigenous,
869.32 or people of color, or members of an
869.33 underrepresented community as defined in
869.34 Minnesota Statutes, section 148E.010,
869.35 subdivision 20. Loan forgiveness shall be

870.1 provided according to this paragraph
870.2 notwithstanding the priorities and distribution
870.3 requirements for loan forgiveness in
870.4 Minnesota Statutes, section 144.1501.

870.5 (i) **Birth Records; Homeless Youth.** $72,000
870.6 in fiscal year 2022 and $32,000 in fiscal year
870.7 2023 are from the general fund for
870.8 administration and issuance of certified birth
870.9 records and statements of no vital record found
870.10 to homeless youth under Minnesota Statutes,
870.11 section 144.2255.

870.12 (j) **Trauma-Informed Gun Violence**
870.13 **Reduction Pilot Program.** $100,000 in fiscal
870.14 year 2022 is from the general fund for the
870.15 trauma-informed gun violence reduction pilot
870.16 program.

870.17 (k) **Home Visiting for Pregnant Women and**
870.18 **Families with Young Children.** $5,000,000
870.19 in fiscal year 2022 and $5,000,000 in fiscal
870.20 year 2023 are from the general fund for grants
870.21 for home visiting services under Minnesota
870.22 Statutes, section 145.87.

870.23 (l) **Supporting Healthy Development of**
870.24 **Babies During Pregnancy and Postpartum.**
870.25 $279,000 in fiscal year 2022 and $279,000 in
870.26 fiscal year 2023 are from the general fund for
870.27 a grant to the Amherst H. Wilder Foundation
870.28 for the African American Babies Coalition
870.29 initiative for community-driven training and
870.30 education on best practices to support healthy
870.31 development of babies during pregnancy and
870.32 postpartum. Grant funds must be used to build
870.33 capacity in, train, educate, or improve
870.34 practices among individuals, from youth to
870.35 elders, serving families with members who

871.1 are Black, indigenous, or people of color,
871.2 during pregnancy and postpartum. Of this
871.3 appropriation, $19,000 in fiscal year 2022 and
871.4 $19,000 in fiscal year 2023 are for the
871.5 commissioner to use for administration. This
871.6 is a onetime appropriation. Any unexpended
871.7 balance in the first year of the biennium does
871.8 not cancel and is available in the second year
871.9 of the biennium.

871.10 (m) **Dignity in Pregnancy and Childbirth.**
871.11 $1,695,000 in fiscal year 2022 and $908,000
871.12 in fiscal year 2023 are from the general fund
871.13 for purposes of Minnesota Statutes, section
871.14 144.1461. Of this appropriation, $845,000 in
871.15 fiscal year 2022 is for a grant to the University
871.16 of Minnesota School of Public Health's Center
871.17 for Antiracism Research for Health Equity, to
871.18 develop a model curriculum on anti-racism
871.19 and implicit bias for use by hospitals with
871.20 obstetric care and birth centers to provide
871.21 continuing education to staff caring for
871.22 pregnant or postpartum women. The model
871.23 curriculum must be evidence-based and must
871.24 meet the criteria in Minnesota Statutes, section
871.25 144.1461, subdivision 2, paragraph (a). The
871.26 base for this appropriation is $907,000 in fiscal
871.27 year 2024 and $860,000 in fiscal year 2025.

871.28 (n) **Recommendations to Expand Access to**
871.29 **Data from the All-Payer Claims Database.**
871.30 $55,000 in fiscal year 2022 is from the general
871.31 fund for the commissioner to develop
871.32 recommendations to expand access to data
871.33 from the all-payer claims database under
871.34 Minnesota Statutes, section 62U.04, to

872.1 additional outside entities for public health or
872.2 research purposes.

872.3 (o) **Base Level Adjustments.** The general
872.4 fund base is $120,834,000 in fiscal year 2024
872.5 and $120,787,000 in fiscal year 2025. The
872.6 state government special revenue fund base is
872.7 $7,777,000 in fiscal year 2024 and $7,777,000
872.8 in fiscal year 2025. The health care access
872.9 fund base is $36,858,000 in fiscal year 2024
872.10 and $36,258,000 in fiscal year 2025.

872.11 Subd. 3. **Health Protection**

872.12 Appropriations by Fund

872.13 General	31,070,000	26,283,000
872.14 State Government 872.15 Special Revenue	45,362,000	45,579,000

872.16 (a) **Lead Risk Assessments and Lead**
872.17 **Orders.** $1,530,000 in fiscal year 2022 and
872.18 $1,314,000 in fiscal year 2023 are from the
872.19 general fund for implementation of the
872.20 requirements for conducting lead risk
872.21 assessments under Minnesota Statutes, section
872.22 144.9504, subdivision 2, and for issuance of
872.23 lead orders under Minnesota Statutes, section
872.24 144.9504, subdivision 5.

872.25 (b) **Hospital Closure or Curtailment of**
872.26 **Operations.** $10,000 in fiscal year 2022 and
872.27 $1,000 in fiscal year 2023 are from the general
872.28 fund for purposes of Minnesota Statutes,
872.29 section 144.555, subdivisions 1a, 1b, and 2.

872.30 (c) **Transfer; Public Health Response**
872.31 **Contingency Account.** The commissioner
872.32 shall transfer $4,343,000 in fiscal year 2022
872.33 from the general fund to the public health
872.34 response contingency account established in

873.1 Minnesota Statutes, section 144.4199. This is
873.2 a onetime transfer.

873.3 (d) **Skin Lightening Products Public**
873.4 **Awareness and Education Grant Program.**
873.5 $100,000 in fiscal year 2022 and $100,000 in
873.6 fiscal year 2023 are from the general fund for
873.7 a skin lightening products public awareness
873.8 and education grant program. This is a onetime
873.9 appropriation.

873.10 (e) **Base Level Adjustments.** The general
873.11 fund base is $26,183,000 in fiscal year 2024
873.12 and $26,183,000 in fiscal year 2025. The state
873.13 government special revenue fund base is
873.14 $45,579,000 in fiscal year 2024 and
873.15 $45,579,000 in fiscal year 2025.

873.16 Subd. 4. **Health Operations** 11,570,000 11,579,000

873.17 Sec. 4. **HEALTH-RELATED BOARDS**

873.18 Subdivision 1. **Total Appropriation** **$ 27,535,000 $ 26,960,000**

873.19 Appropriations by Fund

873.20 State Government 873.21 Special Revenue	27,459,000	26,884,000
873.22 Health Care Access	76,000	76,000

873.23 This appropriation is from the state
873.24 government special revenue fund unless
873.25 specified otherwise. The amounts that may be
873.26 spent for each purpose are specified in the
873.27 following subdivisions.

873.28 Subd. 2. **Board of Behavioral Health and**
873.29 **Therapy** 877,000 875,000

873.30 Subd. 3. **Board of Chiropractic Examiners** 666,000 666,000

873.31 Subd. 4. **Board of Dentistry** 4,228,000 3,753,000

873.32 (a) **Administrative Services Unit - Operating**
873.33 **Costs.** Of this appropriation, $2,738,000 in
873.34 fiscal year 2022 and $2,263,000 in fiscal year

874.1 2023 are for operating costs of the
874.2 administrative services unit. The
874.3 administrative services unit may receive and
874.4 expend reimbursements for services it
874.5 performs for other agencies.

874.6 (b) **Administrative Services Unit - Volunteer**
874.7 **Health Care Provider Program.** Of this
874.8 appropriation, $150,000 in fiscal year 2022
874.9 and $150,000 in fiscal year 2023 are to pay
874.10 for medical professional liability coverage
874.11 required under Minnesota Statutes, section
874.12 214.40.

874.13 (c) **Administrative Services Unit -**
874.14 **Retirement Costs.** Of this appropriation,
874.15 $475,000 in fiscal year 2022 is a onetime
874.16 appropriation to the administrative services
874.17 unit to pay for the retirement costs of
874.18 health-related board employees. This funding
874.19 may be transferred to the health board
874.20 incurring retirement costs. Any board that has
874.21 an unexpended balance for an amount
874.22 transferred under this paragraph shall transfer
874.23 the unexpended amount to the administrative
874.24 services unit. These funds are available either
874.25 year of the biennium.

874.26 (d) **Administrative Services Unit - Contested**
874.27 **Cases and Other Legal Proceedings.** Of this
874.28 appropriation, $200,000 in fiscal year 2022
874.29 and $200,000 in fiscal year 2023 are for costs
874.30 of contested case hearings and other
874.31 unanticipated costs of legal proceedings
874.32 involving health-related boards funded under
874.33 this section. Upon certification by a
874.34 health-related board to the administrative
874.35 services unit that costs will be incurred and

875.1 that there is insufficient money available to
875.2 pay for the costs out of money currently
875.3 available to that board, the administrative
875.4 services unit is authorized to transfer money
875.5 from this appropriation to the board for
875.6 payment of those costs with the approval of
875.7 the commissioner of management and budget.
875.8 The commissioner of management and budget
875.9 must require any board that has an unexpended
875.10 balance for an amount transferred under this
875.11 paragraph to transfer the unexpended amount
875.12 to the administrative services unit to be
875.13 deposited in the state government special
875.14 revenue fund.

875.15 Subd. 5. **Board of Dietetics and Nutrition** 875.16 **Practice**	164,000	164,000
875.17 Subd. 6. **Board of Executives for Long Term** 875.18 **Services and Supports**	693,000	635,000
875.19 Subd. 7. **Board of Marriage and Family Therapy**	413,000	410,000
875.20 Subd. 8. **Board of Medical Practice**	5,912,000	5,868,000

875.21 **Health Professional Services Program.** This
875.22 appropriation includes $1,002,000 in fiscal
875.23 year 2022 and $1,002,000 in fiscal year 2023
875.24 for the health professional services program.

875.25 Subd. 9. **Board of Nursing**	5,345,000	5,355,000
875.26 Subd. 10. **Board of Occupational Therapy** 875.27 **Practice**	456,000	456,000
875.28 Subd. 11. **Board of Optometry**	238,000	238,000
875.29 Subd. 12. **Board of Pharmacy**	4,479,000	4,479,000

875.30 Appropriations by Fund

875.31 State Government 875.32 Special Revenue	4,403,000	4,403,000
875.33 Health Care Access	76,000	76,000

876.1 **Base Level Adjustment.** The health care
876.2 access fund base is $76,000 in fiscal year
876.3 2024, $38,000 in fiscal year 2025, and $0 in
876.4 fiscal year 2026.

876.5 Subd. 13. **Board of Physical Therapy**	564,000	564,000
876.6 Subd. 14. **Board of Podiatric Medicine**	214,000	214,000
876.7 Subd. 15. **Board of Psychology**	1,362,000	1,360,000
876.8 Subd. 16. **Board of Social Work**	1,561,000	1,560,000
876.9 Subd. 17. **Board of Veterinary Medicine**	363,000	363,000
876.10 Sec. 5. **EMERGENCY MEDICAL SERVICES** 876.11 **REGULATORY BOARD**	**$ 4,453,000**	**$ 3,829,000**

876.12 (a) **Cooper/Sams Volunteer Ambulance**
876.13 **Program.** $950,000 in fiscal year 2022 and
876.14 $950,000 in fiscal year 2023 are for the
876.15 Cooper/Sams volunteer ambulance program
876.16 under Minnesota Statutes, section 144E.40.

876.17 (1) Of this amount, $861,000 in fiscal year
876.18 2022 and $861,000 in fiscal year 2023 are for
876.19 the ambulance service personnel longevity
876.20 award and incentive program under Minnesota
876.21 Statutes, section 144E.40.

876.22 (2) Of this amount, $89,000 in fiscal year 2022
876.23 and $89,000 in fiscal year 2023 are for the
876.24 operations of the ambulance service personnel
876.25 longevity award and incentive program under
876.26 Minnesota Statutes, section 144E.40.

876.27 (b) **EMSRB Operations.** $1,880,000 in fiscal
876.28 year 2022 and $1,880,000 in fiscal year 2023
876.29 are for board operations.

876.30 (c) **Regional Grants.** $1,235,000 in fiscal year
876.31 2022 and $585,000 in fiscal year 2023 are for
876.32 regional emergency medical services
876.33 programs, to be distributed equally to the eight

emergency medical service regions under Minnesota Statutes, section 144E.52.

(d) **Ambulance Training Grants.** $361,000 in fiscal year 2022 and $361,000 in fiscal year 2023 are for training grants under Minnesota Statutes, section 144E.35.

Sec. 6. **COUNCIL ON DISABILITY**	**$**	**1,022,000**	**$**	**1,038,000**
Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES**	**$**	**2,487,000**	**$**	**2,536,000**

Department of Psychiatry Monitoring. $100,000 in fiscal year 2022 and $100,000 in fiscal year 2023 are for monitoring the Department of Psychiatry at the University of Minnesota.

Sec. 8. **OMBUDSPERSONS FOR FAMILIES**	**$**	**968,000**	**$**	**992,000**
Sec. 9. **ATTORNEY GENERAL**	**$**	**200,000**	**$**	**200,000**

Excessive Drug Price Increases. This appropriation is for costs of expert witnesses and investigations under Minnesota Statutes, section 62J.844. This is a onetime appropriation.

Sec. 10. Laws 2019, First Special Session chapter 9, article 14, section 3, as amended by Laws 2019, First Special Session chapter 12, section 6, is amended to read:

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation**	**$**	**231,829,000**	**$**	~~**236,188,000**~~ **233,584,000**

Appropriations by Fund

	2020	2021
General	124,381,000	~~126,276,000~~ 125,881,000
State Government Special Revenue	58,450,000	~~61,367,000~~ 59,158,000

Health Care Access	37,285,000	36,832,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund

General	94,980,000	~~96,117,000~~ 95,722,000
State Government Special Revenue	7,614,000	~~7,558,000~~ 6,924,000
Health Care Access	37,285,000	36,832,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 in fiscal year 2020 and $3,579,000 in fiscal year 2021 are from the TANF fund for home visiting and nutritional services under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2020 and $2,000,000 in fiscal year 2021 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2020 and $4,978,000 in fiscal year 2021 are from the TANF fund for the family home visiting grant program under Minnesota Statutes, section 145A.17. $4,000,000 of the funding in each fiscal year must be distributed to community health boards according to Minnesota Statutes,

879.1 section 145A.131, subdivision 1. $978,000 of
879.2 the funding in each fiscal year must be
879.3 distributed to tribal governments according to
879.4 Minnesota Statutes, section 145A.14,
879.5 subdivision 2a;

879.6 (4) $1,156,000 in fiscal year 2020 and
879.7 $1,156,000 in fiscal year 2021 are from the
879.8 TANF fund for family planning grants under
879.9 Minnesota Statutes, section 145.925; and

879.10 (5) The commissioner may use up to 6.23
879.11 percent of the amounts appropriated from the
879.12 TANF fund each year to conduct the ongoing
879.13 evaluations required under Minnesota Statutes,
879.14 section 145A.17, subdivision 7, and training
879.15 and technical assistance as required under
879.16 Minnesota Statutes, section 145A.17,
879.17 subdivisions 4 and 5.

879.18 (b) **TANF Carryforward.** Any unexpended
879.19 balance of the TANF appropriation in the first
879.20 year of the biennium does not cancel but is
879.21 available for the second year.

879.22 (c) **Comprehensive Suicide Prevention.**
879.23 $2,730,000 in fiscal year 2020 and $2,730,000
879.24 in fiscal year 2021 are from the general fund
879.25 for a comprehensive, community-based suicide
879.26 prevention strategy. The funds are allocated
879.27 as follows:

879.28 (1) $955,000 in fiscal year 2020 and $955,000
879.29 in fiscal year 2021 are for community-based
879.30 suicide prevention grants authorized in
879.31 Minnesota Statutes, section 145.56,
879.32 subdivision 2. Specific emphasis must be
879.33 placed on those communities with the greatest
879.34 disparities. The base for this appropriation is

880.1 $1,291,000 in fiscal year 2022 and $1,291,000
880.2 in fiscal year 2023;

880.3 (2) $683,000 in fiscal year 2020 and $683,000
880.4 in fiscal year 2021 are to support
880.5 evidence-based training for educators and
880.6 school staff and purchase suicide prevention
880.7 curriculum for student use statewide, as
880.8 authorized in Minnesota Statutes, section
880.9 145.56, subdivision 2. The base for this
880.10 appropriation is $913,000 in fiscal year 2022
880.11 and $913,000 in fiscal year 2023;

880.12 (3) $137,000 in fiscal year 2020 and $137,000
880.13 in fiscal year 2021 are to implement the Zero
880.14 Suicide framework with up to 20 behavioral
880.15 and health care organizations each year to treat
880.16 individuals at risk for suicide and support
880.17 those individuals across systems of care upon
880.18 discharge. The base for this appropriation is
880.19 $205,000 in fiscal year 2022 and $205,000 in
880.20 fiscal year 2023;

880.21 (4) $955,000 in fiscal year 2020 and $955,000
880.22 in fiscal year 2021 are to develop and fund a
880.23 Minnesota-based network of National Suicide
880.24 Prevention Lifeline, providing statewide
880.25 coverage. The base for this appropriation is
880.26 $1,321,000 in fiscal year 2022 and $1,321,000
880.27 in fiscal year 2023; and

880.28 (5) the commissioner may retain up to 18.23
880.29 percent of the appropriation under this
880.30 paragraph to administer the comprehensive
880.31 suicide prevention strategy.

880.32 (d) **Statewide Tobacco Cessation.** $1,598,000
880.33 in fiscal year 2020 and $2,748,000 in fiscal
880.34 year 2021 are from the general fund for

881.1 statewide tobacco cessation services under
881.2 Minnesota Statutes, section 144.397. The base
881.3 for this appropriation is $2,878,000 in fiscal
881.4 year 2022 and $2,878,000 in fiscal year 2023.

881.5 (e) **Health Care Access Survey.** $225,000 in
881.6 fiscal year 2020 and $225,000 in fiscal year
881.7 2021 are from the health care access fund to
881.8 continue and improve the Minnesota Health
881.9 Care Access Survey. These appropriations
881.10 may be used in either year of the biennium.

881.11 (f) **Community Solutions for Healthy Child**
881.12 **Development Grant Program.** $1,000,000
881.13 in fiscal year 2020 and $1,000,000 in fiscal
881.14 year 2021 are for the community solutions for
881.15 healthy child development grant program to
881.16 promote health and racial equity for young
881.17 children and their families under article 11,
881.18 section 107. The commissioner may use up to
881.19 23.5 percent of the total appropriation for
881.20 administration. The base for this appropriation
881.21 is $1,000,000 in fiscal year 2022, $1,000,000
881.22 in fiscal year 2023, and $0 in fiscal year 2024.

881.23 (g) **Domestic Violence and Sexual Assault**
881.24 **Prevention Program.** $375,000 in fiscal year
881.25 2020 and $375,000 in fiscal year 2021 are
881.26 from the general fund for the domestic
881.27 violence and sexual assault prevention
881.28 program under article 11, section 108. This is
881.29 a onetime appropriation.

881.30 (h) **Skin Lightening Products Public**
881.31 **Awareness Grant Program.** $100,000 in
881.32 fiscal year 2020 and $100,000 in fiscal year
881.33 2021 are from the general fund for a skin
881.34 lightening products public awareness and

882.1 education grant program. This is a onetime
882.2 appropriation.

882.3 (i) **Cannabinoid Products Workgroup.**
882.4 $8,000 in fiscal year 2020 is from the state
882.5 government special revenue fund for the
882.6 cannabinoid products workgroup. This is a
882.7 onetime appropriation.

882.8 (j) **Base Level Adjustments.** The general fund
882.9 base is $96,742,000 in fiscal year 2022 and
882.10 $96,742,000 in fiscal year 2023. The health
882.11 care access fund base is $37,432,000 in fiscal
882.12 year 2022 and $36,832,000 in fiscal year 2023.

882.13 Subd. 3. **Health Protection**

882.14 Appropriations by Fund

882.15 General	18,803,000	19,774,000
882.16 State Government 882.17 Special Revenue	50,836,000	~~53,809,000~~ 52,234,000

882.18 (a) **Public Health Laboratory Equipment.**
882.19 $840,000 in fiscal year 2020 and $655,000 in
882.20 fiscal year 2021 are from the general fund for
882.21 equipment for the public health laboratory.
882.22 This is a onetime appropriation and is
882.23 available until June 30, 2023.

882.24 (b) **Base Level Adjustment.** The general fund
882.25 base is $19,119,000 in fiscal year 2022 and
882.26 $19,119,000 in fiscal year 2023. The state
882.27 government special revenue fund base is
882.28 $53,782,000 in fiscal year 2022 and
882.29 $53,782,000 in fiscal year 2023.

882.30 Subd. 4. **Health Operations** 10,598,000 10,385,000

882.31 **Base Level Adjustment.** The general fund
882.32 base is $10,912,000 in fiscal year 2022 and
882.33 $10,912,000 in fiscal year 2023.

883.1 **EFFECTIVE DATE.** This section is effective the day following final enactment and
883.2 the reductions in subdivisions 1 to 3 are onetime reductions.

883.3 Sec. 11. **APPROPRIATION; MINNESOTA FAMILY INVESTMENT PROGRAM**
883.4 **SUPPLEMENTAL PAYMENT.**

883.5 $24,235,000 in fiscal year 2021 is appropriated from the TANF fund to the commissioner
883.6 of human services to provide a onetime cash benefit of up to $750 for each household
883.7 enrolled in the Minnesota family investment program or diversionary work program under
883.8 Minnesota Statutes, chapter 256J, at the time that the cash benefit is distributed. The
883.9 commissioner shall distribute these funds through existing systems and in a manner that
883.10 minimizes the burden to families. This is a onetime appropriation.

883.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

883.12 Sec. 12. **APPROPRIATION; MINNESOTACARE PREMIUMS.**

883.13 $108,000 in fiscal year 2021 is appropriated from the general fund and $44,000 in fiscal
883.14 year 2021 is appropriated from the health care access fund to the commissioner of human
883.15 services to implement changes to MinnesotaCare premiums.

883.16 **EFFECTIVE DATE.** This section is effective the day following final enactment.

883.17 Sec. 13. **APPROPRIATION; REFINANCING OF EMERGENCY CHILD CARE**
883.18 **GRANTS; CANCELLATION.**

883.19 $26,622,626 in fiscal year 2021 is appropriated from the coronavirus relief federal fund
883.20 to the commissioner of human services for fiscal year 2020 to replace a portion of the general
883.21 fund appropriation in Laws 2020, chapter 71, article 1, section 2, subdivision 9. The general
883.22 fund appropriation that is replaced by coronavirus relief funds under this section is canceled
883.23 to the general fund. This is a onetime appropriation.

883.24 **EFFECTIVE DATE.** This section is effective the day following final enactment.

883.25 Sec. 14. **CANCELLATION; TRANSFER FROM STATE GOVERNMENT SPECIAL**
883.26 **REVENUE FUND TO GENERAL FUND.**

883.27 The $77,000 transfer each year from the state government special revenue fund to the
883.28 general fund under Laws 2008, chapter 364, section 17, paragraph (b), is canceled. This
883.29 section does not expire.

883.30 **EFFECTIVE DATE.** This section is effective June 30, 2021.

884.1 Sec. 15. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; CHILD**
884.2 **CARE AND DEVELOPMENT BLOCK GRANT ALLOCATION.**

884.3 (a) The commissioner of human services shall allocate $212,400,000 from the child care
884.4 and development block grant amount in the federal fund as follows:

884.5 (1) $1,435,000 for the quality rating and improvement system's evaluation and equity
884.6 report under Minnesota Statutes, section 124D.142, subdivisions 3 and 4; and

884.7 (2) the remaining amount to reprioritize the basic sliding fee program waiting list under
884.8 Minnesota Statutes, section 119B.03, to increase child care assistance rates for legal,
884.9 nonlicensed family child care providers under Minnesota Statutes, section 119B.13,
884.10 subdivision 1a, and to increase child care assistance rates under Minnesota Statutes, section
884.11 119B.13, subdivision 1, paragraph (a), to the 50th percentile of the most recent market rate
884.12 survey. The commissioner may not increase the rate differential percentage established
884.13 under Minnesota Statutes, section 119B.13, subdivision 3a or 3b.

884.14 (b) Each year, an amount equal to at least 88 percent of the federal discretionary funding
884.15 in the Child Care and Development Block Grant of 2014, Public Law 113-186, in federal
884.16 fiscal year 2018 above the amounts authorized in federal fiscal year 2017, not to exceed the
884.17 cost of rate adjustments, shall be allocated to pay the cost of rate adjustments based on the
884.18 most recent market survey.

884.19 (c) When increased federal discretionary child care and development block grant funding
884.20 is used to pay for the rate increase under paragraph (a), the commissioner, in consultation
884.21 with the commissioner of management and budget, may adjust the amount of working family
884.22 credit expenditures as needed to meet the state's maintenance of effort requirements for the
884.23 TANF block grant.

884.24 Sec. 16. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; CHILD**
884.25 **CARE STABILIZATION.**

884.26 The commissioner shall allocate $325,000,000 from the child care and development
884.27 block grant amount in the federal fund for the following purposes:

884.28 (1) $1,500,000 for the Children's Cabinet to conduct an evaluation of the use of federal
884.29 money on early care and learning programs;

884.30 (2) $500,000 to award grants to community-based organizations working with family,
884.31 friend, and neighbor caregivers, with a particular emphasis on such caregivers serving
884.32 children from low-income families, families of color, Tribal communities, or families with

885.1 limited English language proficiency, to promote healthy development, social-emotional
885.2 learning, early literacy, and school readiness;

885.3 (3) $100,000 for a grant program to test strategies by which family child care providers
885.4 could share services;

885.5 (4) $500,000 for competitive grants to expand access to child care for children with
885.6 disabilities;

885.7 (5) $5,000,000 for child care improvement grants under Minnesota Statutes, section
885.8 119B.25;

885.9 (6) $5,000,000 for administering the monthly grants under clause (7); and

885.10 (7) the remaining amount to award monthly grants, between July 1, 2021, and June 30,
885.11 2023, to providers of early care and education to support the stability of the sector with
885.12 providers required to direct 75 percent of such grants to employees or other individuals
885.13 providing early care and education services.

885.14 Sec. 17. **FEDERAL FUNDS FOR VACCINE ACTIVITIES; APPROPRIATION.**

885.15 Federal funds made available to the commissioner of health for vaccine activities are
885.16 appropriated to the commissioner for that purpose and shall be used to support work under
885.17 Minnesota Statutes, sections 144.067 to 144.069.

885.18 Sec. 18. **FEDERAL FUNDS REPLACEMENT; APPROPRIATION.**

885.19 Notwithstanding any law to the contrary, the commissioner of management and budget
885.20 must determine whether the expenditures authorized under this act are eligible uses of federal
885.21 funding received under the Coronavirus State Fiscal Recovery Fund or any other federal
885.22 funds received by the state under the American Rescue Plan Act, Public Law 117-2. If the
885.23 commissioner of management and budget determines an expenditure is eligible for funding
885.24 under Public Law 117-2, the amount of the eligible expenditure is appropriated from the
885.25 account where those amounts have been deposited and the corresponding general fund
885.26 amounts appropriated under this act are canceled to the general fund.

885.27 **EFFECTIVE DATE.** This section is effective the day following final enactment.

885.28 Sec. 19. **TRANSFERS; HUMAN SERVICES.**

885.29 Subdivision 1. **Grants.** The commissioner of human services, with the approval of the
885.30 commissioner of management and budget, may transfer unencumbered appropriation balances
885.31 for the biennium ending June 30, 2023, within fiscal years among the MFIP, general

886.1 assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota
886.2 Statutes, section 119B.05, Minnesota supplemental aid program, group residential housing
886.3 program, the entitlement portion of Northstar Care for Children under Minnesota Statutes,
886.4 chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment
886.5 fund, and between fiscal years of the biennium. The commissioner shall inform the chairs
886.6 and ranking minority members of the senate Health and Human Services Finance Division
886.7 and the house of representatives Health Finance and Policy Committee and Human Services
886.8 Finance and Policy Committee quarterly about transfers made under this subdivision.

886.9 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money
886.10 may be transferred within the Department of Human Services as the commissioners consider
886.11 necessary, with the advance approval of the commissioner of management and budget. The
886.12 commissioner shall inform the chairs and ranking minority members of the senate Health
886.13 and Human Services Finance Division and the house of representatives Health Finance and
886.14 Policy Committee and Human Services Finance and Policy Committee quarterly about
886.15 transfers made under this subdivision.

886.16 Sec. 20. **TRANSFERS; HEALTH.**

886.17 Positions, salary money, and nonsalary administrative money may be transferred within
886.18 the Department of Health as the commissioner considers necessary, with the advance
886.19 approval of the commissioner of management and budget. The commissioner shall inform
886.20 the chairs and ranking minority members of the legislative committees with jurisdiction
886.21 over health and human services finance quarterly about transfers made under this section.

886.22 Sec. 21. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

886.23 The commissioners of health and human services shall not use indirect cost allocations
886.24 to pay for the operational costs of any program for which they are responsible.

886.25 Sec. 22. **APPROPRIATION ENACTED MORE THAN ONCE.**

886.26 If an appropriation in this act is enacted more than once in the 2021 legislative session,
886.27 the appropriation must be given effect only once.

886.28 **EFFECTIVE DATE.** This section is effective the day following final enactment.

886.29 Sec. 23. **EXPIRATION OF UNCODIFIED LANGUAGE.**

886.30 All uncodified language contained in this article expires on June 30, 2023, unless a
886.31 different expiration date is explicit.

887.1 Sec. 24. **REPEALER.**

887.2 Minnesota Statutes 2020, section 16A.724, subdivision 2, is repealed effective June 30,
887.3 2025.

887.4 Sec. 25. **EFFECTIVE DATE.**

887.5 This article is effective July 1, 2021, unless a different effective date is specified.

16A.724 HEALTH CARE ACCESS FUND.

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in fiscal year 2016 shall not exceed $48,000,000, the amount in fiscal year 2017 shall not exceed $122,000,000, and the amount in any fiscal biennium thereafter shall not exceed $244,000,000. The purpose of this transfer is to meet the rate increase required under section 256B.04, subdivision 25.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

62A.67 SHORT TITLE.

Sections 62A.67 to 62A.672 may be cited as the "Minnesota Telemedicine Act."

62A.671 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 62A.67 to 62A.672, the terms defined in this section have the meanings given.

Subd. 2. **Distant site.** "Distant site" means a site at which a licensed health care provider is located while providing health care services or consultations by means of telemedicine.

Subd. 3. **Health care provider.** "Health care provider" has the meaning provided in section 62A.63, subdivision 2.

Subd. 4. **Health carrier.** "Health carrier" has the meaning provided in section 62A.011, subdivision 2.

Subd. 5. **Health plan.** "Health plan" means a health plan as defined in section 62A.011, subdivision 3, and includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred and are designed to pay benefits directly to the policyholder.

Subd. 6. **Licensed health care provider.** "Licensed health care provider" means a health care provider who is:

(1) licensed under chapter 147, 147A, 148, 148B, 148E, 148F, 150A, or 153; a mental health professional as defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; or vendor of medical care defined in section 256B.02, subdivision 7; and

(2) authorized within their respective scope of practice to provide the particular service with no supervision or under general supervision.

Subd. 7. **Originating site.** "Originating site" means a site including, but not limited to, a health care facility at which a patient is located at the time health care services are provided to the patient by means of telemedicine.

Subd. 8. **Store-and-forward technology.** "Store-and-forward technology" means the transmission of a patient's medical information from an originating site to a health care provider at a distant site without the patient being present, or the delivery of telemedicine that does not occur in real time via synchronous transmissions.

Subd. 9. **Telemedicine.** "Telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

62A.672 COVERAGE OF TELEMEDICINE SERVICES.

Subdivision 1. **Coverage of telemedicine.** (a) A health plan sold, issued, or renewed by a health carrier for which coverage of benefits begins on or after January 1, 2017, shall include coverage for telemedicine benefits in the same manner as any other benefits covered under the policy, plan, or contract, and shall comply with the regulations of this section.

(b) Nothing in this section shall be construed to:

(1) require a health carrier to provide coverage for services that are not medically necessary;

(2) prohibit a health carrier from establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service via telemedicine for which the health carrier does not already reimburse other health care providers for delivering via telemedicine, so long as the criteria are not unduly burdensome or unreasonable for the particular service; or

(3) prevent a health carrier from requiring a health care provider to agree to certain documentation or billing practices designed to protect the health carrier or patients from fraudulent claims so long as the practices are not unduly burdensome or unreasonable for the particular service.

Subd. 2. **Parity between telemedicine and in-person services.** A health carrier shall not exclude a service for coverage solely because the service is provided via telemedicine and is not provided through in-person consultation or contact between a licensed health care provider and a patient.

Subd. 3. **Reimbursement for telemedicine services.** (a) A health carrier shall reimburse the distant site licensed health care provider for covered services delivered via telemedicine on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered in person by the distant site licensed health care provider.

(b) It is not a violation of this subdivision for a health carrier to include a deductible, co-payment, or coinsurance requirement for a health care service provided via telemedicine, provided that the deductible, co-payment, or coinsurance is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable if the same services were provided through in-person contact.

62J.63 CENTER FOR HEALTH CARE PURCHASING IMPROVEMENT.

Subd. 3. **Report.** The commissioner of health must report annually to the legislature and the governor on the operations, activities, and impacts of the center. The report must be posted on the Department of Health website and must be available to the public. The report must include a description of the state's efforts to develop and use more common strategies for health care performance measurement and health care purchasing. The report must also include an assessment of the impacts of these efforts, especially in promoting greater transparency of health care costs and quality, and greater accountability for health care results and improvement.

119B.125 PROVIDER REQUIREMENTS.

Subd. 5. **Provisional payment.** After a county receives a completed application from a provider, the county may issue provisional authorization and payment to the provider during the time needed to determine whether to give final authorization to the provider.

144.0721 ASSESSMENTS OF CARE AND SERVICES TO NURSING HOME RESIDENTS.

Subdivision 1. **Appropriateness and quality.** Until the date of implementation of the revised case mix system based on the minimum data set, the commissioner of health shall assess the appropriateness and quality of care and services furnished to private paying residents in nursing homes and boarding care homes that are certified for participation in the medical assistance program under United States Code, title 42, sections 1396-1396p. These assessments shall be conducted until the date of implementation of the revised case mix system with the exception of provisions requiring recommendations for changes in the level of care provided to the private paying residents.

144.0722 RESIDENT REIMBURSEMENT CLASSIFICATIONS.

Subdivision 1. **Resident reimbursement classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under section 144.0721, or under rules established by the commissioner of human services under chapter 256R. The reimbursement classifications established by the commissioner must conform to the rules established by the commissioner of human services.

Subd. 2. **Notice of resident reimbursement classification.** The commissioner of health shall notify each resident, and the nursing home or boarding care home in which the resident resides, of the reimbursement classification established under subdivision 1. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification. The notice of resident classification must be sent by first-class mail. The individual resident notices may be sent to the resident's nursing home or boarding care home for distribution to the resident. The nursing home or boarding care home is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the notices from the department.

Subd. 2a. **Semiannual assessment by nursing facilities.** Notwithstanding Minnesota Rules, part 9549.0059, subpart 2, item B, the individual dependencies items 21 to 24 and 28 are required to be completed in accordance with the Facility Manual for Completing Case Mix Requests for Classification, July 1987, issued by the Minnesota Department of Health.

Subd. 3. **Request for reconsideration.** The resident or the nursing home or boarding care home may request that the commissioner reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the receipt of the notice of resident classification. For reconsideration requests submitted by or on behalf of the resident, the time period for submission of the request begins as of the date the resident or the resident's representative receives the classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation establishing that the needs of the resident at the time of the assessment resulting in the disputed classification justify a change of classification.

Subd. 3a. **Access to information.** Upon written request, the nursing home or boarding care home must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the department to support the assessment findings. The nursing home or boarding care home shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues. For the purposes of this section, "representative" includes the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the nursing home ombudsman's office whose assistance has been requested, or any other individual designated by the resident.

Subd. 3b. **Facility's request for reconsideration.** In addition to the information required in subdivision 3, a reconsideration request from a nursing home or boarding care home must contain the following information: the date the resident reimbursement classification notices were received by the facility; the date the classification notices were distributed to the resident or the resident's representative; and a copy of a notice sent to the resident or to the resident's representative. This notice must tell the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the department and the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide this information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

Subd. 4. **Reconsideration.** The commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under subdivision 3. If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. In its discretion, the commissioner may review the

reimbursement classifications assigned to all residents in the facility. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the needs of the resident at the time of the assessment. The resident and the nursing home or boarding care home shall be notified within five working days after the decision is made. The commissioner's decision under this subdivision is the final administrative decision of the agency.

Subd. 5. **Audit authority.** The Department of Health may audit assessments of nursing home and boarding care home residents. These audits may be in addition to the assessments completed by the department under section 144.0721. The audits may be conducted at the facility, and the department may conduct the audits on an unannounced basis.

144.0724 RESIDENT REIMBURSEMENT CLASSIFICATION.

Subd. 10. **Transition.** After implementation of this section, reconsiderations requested for classifications made under section 144.0722, subdivision 1, shall be determined under section 144.0722, subdivision 3.

144.693 MEDICAL MALPRACTICE CLAIMS; REPORTS.

Subdivision 1. **Insurers' reports to commissioner.** On or before September 1, 1976, and on or before March 1 and September 1 of each year thereafter, each insurer providing professional liability insurance to one or more hospitals, outpatient surgery centers, or health maintenance organizations, shall submit to the state commissioner of health a report listing by facility or organization all claims which have been closed by or filed with the insurer during the period ending December 31 of the previous year or June 30 of the current year. The report shall contain, but not be limited to, the following information:

(1) the total number of claims made against each facility or organization which were filed or closed during the reporting period;

(2) the date each new claim was filed with the insurer;

(3) the allegations contained in each claim filed during the reporting period;

(4) the disposition and closing date of each claim closed during the reporting period;

(5) the dollar amount of the award or settlement for each claim closed during the reporting period; and

(6) any other information the commissioner of health may, by rule, require.

Any hospital, outpatient surgery center, or health maintenance organization which is self insured shall be considered to be an insurer for the purposes of this section and shall comply with the reporting provisions of this section.

A report from an insurer submitted pursuant to this section is private data, as defined in section 13.02, subdivision 12, accessible to the facility or organization which is the subject of the data, and to its authorized agents. Any data relating to patient records which is reported to the state commissioner of health pursuant to this section shall be reported in the form of summary data, as defined in section 13.02, subdivision 19.

Subd. 2. **Report to legislature.** The state commissioner of health shall collect and review the data reported pursuant to subdivision 1. On December 1, 1976, and on January 2 of each year thereafter, the state commissioner of health shall report to the legislature the findings related to the incidence and size of malpractice claims against hospitals, outpatient surgery centers, and health maintenance organizations, and shall make any appropriate recommendations to reduce the incidence and size of the claims. Data published by the state commissioner of health pursuant to this subdivision with respect to malpractice claims information shall be summary data within the meaning of section 13.02, subdivision 19.

Subd. 3. **Access to insurers' records.** The state commissioner of health shall have access to the records of any insurer relating to malpractice claims made against hospitals, outpatient surgery centers, and health maintenance organizations in years prior to 1976 if the commissioner determines the records are necessary to fulfill the duties of the commissioner under Laws 1976, chapter 325.

245.462 DEFINITIONS.

Subd. 4a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional cosigning individual treatment plans and by entries in the client's record regarding supervisory activities.

245.4871 DEFINITIONS.

Subd. 32a. **Responsible social services agency.** "Responsible social services agency" is defined in section 260C.007, subdivision 27a.

245.4879 EMERGENCY SERVICES.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to the child with an emotional disturbance provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) When emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

245.62 COMMUNITY MENTAL HEALTH CENTER.

Subd. 3. **Clinical supervisor.** All community mental health center services shall be provided under the clinical supervision of a licensed psychologist licensed under sections 148.88 to 148.98, or a physician who is board certified or eligible for board certification in psychiatry, and who is licensed under section 147.02.

Subd. 4. **Rules.** The commissioner shall promulgate rules to establish standards for the designation of an agency as a community mental health center. These standards shall include, but are not limited to:

(1) provision of mental health services in the prevention, identification, treatment and aftercare of emotional disorders, chronic and acute mental illness, developmental disabilities, and alcohol and drug abuse and dependency, including the services listed in section 245.61 except detoxification services;

(2) establishment of a community mental health center board pursuant to section 245.66; and

(3) approval pursuant to section 245.69, subdivision 2.

245.69 ADDITIONAL DUTIES OF COMMISSIONER.

Subd. 2. **Approval of centers and clinics.** The commissioner of human services has the authority to approve or disapprove public and private mental health centers and public and private mental health clinics for the purposes of section 62A.152, subdivision 2. For the purposes of this subdivision the commissioner shall promulgate rules in accordance with sections 14.001 to 14.69. The rules shall require each applicant to pay a fee to cover costs of processing applications and determining compliance with the rules and this subdivision. The commissioner may contract with any state agency, individual, corporation or association to which the commissioner shall delegate all but final approval and disapproval authority to determine compliance or noncompliance.

(a) Each approved mental health center and each approved mental health clinic shall have a multidisciplinary team of professional staff persons as required by rule. A mental health center or mental health clinic may provide the staffing required by rule by means of written contracts with professional persons or with other health care providers. Any personnel qualifications developed by rule shall be consistent with any personnel standards developed pursuant to chapter 214.

(b) Each approved mental health clinic and each approved mental health center shall establish a written treatment plan for each outpatient for whom services are reimbursable through insurance or public assistance. The treatment plan shall be developed in accordance with the rules and shall include a patient history, treatment goals, a statement of diagnosis and a treatment strategy. The clinic or center shall provide access to hospital admission as a bed patient as needed by any outpatient. The clinic or center shall ensure ongoing consultation among and availability of all members of the multidisciplinary team.

(c) As part of the required consultation, members of the multidisciplinary team shall meet at least twice monthly to conduct case reviews, peer consultations, treatment plan development and in-depth case discussion. Written minutes of these meetings shall be kept at the clinic or center for three years.

(d) Each approved center or clinic shall establish mechanisms for quality assurance and submit documentation concerning the mechanisms to the commissioner as required by rule, including:

(1) continuing education of each professional staff person;

(2) an ongoing internal utilization and peer review plan and procedures;

(3) mechanisms of staff supervision; and

(4) procedures for review by the commissioner or a delegate.

(e) The commissioner shall disapprove an applicant, or withdraw approval of a clinic or center, which the commissioner finds does not comply with the requirements of the rules or this subdivision. A clinic or center which is disapproved or whose approval is withdrawn is entitled to a contested case hearing and judicial review pursuant to sections 14.01 to 14.69.

(f) Data on individuals collected by approved clinics and centers, including written minutes of team meetings, is private data on individuals within the welfare system as provided in chapter 13.

(g) Each center or clinic that is approved and in compliance with the commissioner's existing rule on July 1, 1980, is approved for purposes of section 62A.152, subdivision 2, until rules are promulgated to implement this section.

245.735 EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.

Subdivision 1. **Excellence in Mental Health demonstration project.** The commissioner shall develop and execute projects to reform the mental health system by participating in the Excellence in Mental Health demonstration project.

Subd. 2. **Federal proposal.** The commissioner shall develop and submit to the United States Department of Health and Human Services a proposal for the Excellence in Mental Health demonstration project. The proposal shall include any necessary state plan amendments, waivers, requests for new funding, realignment of existing funding, and other authority necessary to implement the projects specified in subdivision 3.

Subd. 4. **Public participation.** In developing and implementing CCBHCs under subdivision 3, the commissioner shall consult, collaborate, and partner with stakeholders, including but not limited to mental health providers, substance use disorder treatment providers, advocacy organizations, licensed mental health professionals, counties, tribes, hospitals, other health care providers, and Minnesota public health care program enrollees who receive mental health services and their families.

245C.10 BACKGROUND STUDY; FEES.

Subd. 2. **Supplemental nursing services agencies.** The commissioner shall recover the cost of the background studies initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1, through a fee of no more than $20 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 2a. **Occupations regulated by commissioner of health.** The commissioner shall set fees to recover the cost of combined background studies and criminal background checks initiated by applicants, licensees, and certified practitioners regulated under sections 148.511 to 148.5198 and chapter 153A. The fees collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks.

Subd. 3. **Personal care provider organizations.** The commissioner shall recover the cost of background studies initiated by a personal care provider organization under sections 256B.0651 to 256B.0654 and 256B.0659 through a fee of no more than $20 per study charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 4. **Temporary personnel agencies, educational programs, and professional services agencies.** The commissioner shall recover the cost of the background studies initiated by temporary personnel agencies, educational programs, and professional services agencies that initiate background studies under section 245C.03, subdivision 4, through a fee of no more than $20 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 5. **Adult foster care and family adult day services.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for the purposes of adult foster care and family adult day services licensing, through a fee of no more than $20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** The commissioner shall recover the cost of background studies initiated by unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities under section 256B.4912 through a fee of no more than $20 per study.

Subd. 7. **Private agencies.** The commissioner shall recover the cost of conducting background studies under section 245C.33 for studies initiated by private agencies for the purpose of adoption through a fee of no more than $70 per study charged to the private agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 8. **Children's therapeutic services and supports providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 7, for the purposes of children's therapeutic services and supports under section 256B.0943, through a fee of no more than $20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for all programs that are licensed by the commissioner, except child foster care when the applicant or license holder resides in the home where child foster care services are provided, family child care, child care centers, certified

license-exempt child care centers, and legal nonlicensed child care authorized under chapter 119B, through a fee of no more than $20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 9a. **Child care programs.** The commissioner shall recover the cost of a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care providers authorized under chapter 119B through a fee of no more than $40 per study charged to the license holder. A fee of no more than $20 per study shall be charged for studies conducted under section 245C.05, subdivision 5a, paragraph (a). The fees collected under this subdivision are appropriated to the commissioner to conduct background studies.

Subd. 10. **Community first services and supports organizations.** The commissioner shall recover the cost of background studies initiated by an agency-provider delivering services under section 256B.85, subdivision 11, or a financial management services provider providing service functions under section 256B.85, subdivision 13, through a fee of no more than $20 per study, charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 11. **Providers of housing support.** The commissioner shall recover the cost of background studies initiated by providers of housing support under section 256I.04 through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 12. **Child protection workers or social services staff having responsibility for child protective duties.** The commissioner shall recover the cost of background studies initiated by county social services agencies and local welfare agencies for individuals who are required to have a background study under section 626.559, subdivision 1b, through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 13. **Providers of special transportation service.** The commissioner shall recover the cost of background studies initiated by providers of special transportation service under section 174.30 through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 14. **Children's residential facilities.** The commissioner shall recover the cost of background studies initiated by a licensed children's residential facility through a fee of no more than $51 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Subd. 16. **Providers of housing support services.** The commissioner shall recover the cost of background studies initiated by providers of housing support services under section 256B.051 through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

256B.0596 MENTAL HEALTH CASE MANAGEMENT.

256B.0596 MENTAL HEALTH CASE MANAGEMENT.

Counties shall contract with eligible providers willing to provide mental health case management services under section 256B.0625, subdivision 20. In order to be eligible, in addition to general provider requirements under this chapter, the provider must:

(1) be willing to provide the mental health case management services; and

(2) have a minimum of at least one contact with the client per week. This section is not intended to limit the ability of a county to provide its own mental health case management services.

256B.0596 MENTAL HEALTH CASE MANAGEMENT.

Counties shall contract with eligible providers willing to provide mental health case management services under section 256B.0625, subdivision 20. In order to be eligible, in addition to general provider requirements under this chapter, the provider must:

(1) be willing to provide the mental health case management services; and

(2) have a minimum of at least one contact with the client per week. This section is not intended to limit the ability of a county to provide its own mental health case management services.

256B.0615 MENTAL HEALTH CERTIFIED PEER SPECIALIST.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified peer specialist program model, which:

(1) provides nonclinical peer support counseling by certified peer specialists;

(2) provides a part of a wraparound continuum of services in conjunction with other community mental health services;

(3) is individualized to the consumer; and

(4) promotes socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

256B.0616 MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified family peer specialists program model which:

(1) provides nonclinical family peer support counseling, building on the strengths of families and helping them achieve desired outcomes;

(2) collaborates with others providing care or support to the family;

(3) provides nonadversarial advocacy;

(4) promotes the individual family culture in the treatment milieu;

(5) links parents to other parents in the community;

(6) offers support and encouragement;

(7) assists parents in developing coping mechanisms and problem-solving skills;

(8) promotes resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services;

(9) establishes and provides peer-led parent support groups; and

(10) increases the child's ability to function better within the child's home, school, and community by educating parents on community resources, assisting with problem solving, and educating parents on mental illnesses.

256B.0622 ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL TREATMENT SERVICES.

Subd. 3. **Eligibility for intensive residential treatment services.** An eligible client for intensive residential treatment services is an individual who:

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

(4) because of a mental illness, has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced;

(5) has one or more of the following: a history of recurring or prolonged inpatient hospitalizations in the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services yielding poor outcomes; and

(6) in the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided.

Subd. 5a. **Standards for intensive residential rehabilitative mental health services.** (a) The standards in this subdivision apply to intensive residential mental health services.

(b) The provider of intensive residential treatment services must have sufficient staff to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the treatment plan and

to safely supervise and direct the activities of clients, given the client's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education, when appropriate.

(c) At a minimum:

(1) staff must provide direction and supervision whenever clients are present in the facility;

(2) staff must remain awake during all work hours;

(3) there must be a staffing ratio of at least one to nine clients for each day and evening shift. If more than nine clients are present at the residential site, there must be a minimum of two staff during day and evening shifts, one of whom must be a mental health practitioner or mental health professional;

(4) if services are provided to clients who need the services of a medical professional, the provider shall ensure that these services are provided either by the provider's own medical staff or through referral to a medical professional; and

(5) the provider must ensure the timely availability of a licensed registered nurse, either directly employed or under contract, who is responsible for ensuring the effectiveness and safety of medication administration in the facility and assessing clients for medication side effects and drug interactions.

(d) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5, who are trained and supervised according to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, paragraph (a), clause (4), item (iv).

(e) The clinical supervisor must be an active member of the intensive residential services treatment team. The team must meet with the clinical supervisor at least weekly to discuss clients' progress and make rapid adjustments to meet clients' needs. The team meeting shall include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the client's treatment record.

(f) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(g) The initial functional assessment must be completed within ten days of intake and updated at least every 30 days, or prior to discharge from the service, whichever comes first.

(h) The initial individual treatment plan must be completed within 24 hours of admission. Within ten days of admission, the initial treatment plan must be refined and further developed, except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the client and updated at least monthly.

256B.0623 ADULT REHABILITATIVE MENTAL HEALTH SERVICES COVERED.

Subd. 7. **Personnel file.** The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff. Each file must contain:

(1) an annual performance review;

(2) a summary of on-site service observations and charting review;

(3) a criminal background check of all direct service staff;

(4) evidence of academic degree and qualifications;

(5) a copy of professional license;

(6) any job performance recognition and disciplinary actions;

(7) any individual staff written input into own personnel file;

(8) all clinical supervision provided; and

(9) documentation of compliance with continuing education requirements.

Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within three years preceding admission, an adult diagnostic assessment update must be completed. An update shall include a face-to-face interview with the recipient and a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required.

Subd. 10. **Individual treatment plan.** All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient. The provisions in clauses (1) and (2) apply:

(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake. The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

(2) The individual treatment plan must include:

(i) a list of problems identified in the assessment;

(ii) the recipient's strengths and resources;

(iii) concrete, measurable goals to be achieved, including time frames for achievement;

(iv) specific objectives directed toward the achievement of each one of the goals;

(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;

(vi) cultural considerations, resources, and needs of the recipient must be included;

(vii) planned frequency and type of services must be initiated; and

(viii) clear progress notes on outcome of goals.

(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).

Subd. 11. **Recipient file.** Providers of adult rehabilitative mental health services must maintain a file for each recipient that contains the following information:

(1) diagnostic assessment or verification of its location that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;

(2) functional assessments;

(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(4) recipient history;

(5) signed release forms;

(6) recipient health information and current medications;

(7) emergency contacts for the recipient;

(8) case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;

(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;

(10) summary of recipient case reviews by staff; and

(11) written information by the recipient that the recipient requests be included in the file.

256B.0625 COVERED SERVICES.

Subd. 5l. **Intensive mental health outpatient treatment.** Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy. The commissioner shall establish:

(1) certification procedures to ensure that providers of these services are qualified; and

(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

Subd. 18c. **Nonemergency Medical Transportation Advisory Committee.** (a) The Nonemergency Medical Transportation Advisory Committee shall advise the commissioner on the administration of nonemergency medical transportation covered under medical assistance. The advisory committee shall meet at least quarterly the first year following January 1, 2015, and at least biannually thereafter and may meet more frequently as required by the commissioner. The advisory committee shall annually elect a chair from among its members, who shall work with the commissioner or the commissioner's designee to establish the agenda for each meeting. The commissioner, or the commissioner's designee, shall attend all advisory committee meetings.

(b) The Nonemergency Medical Transportation Advisory Committee shall advise and make recommendations to the commissioner on:

(1) updates to the nonemergency medical transportation policy manual;

(2) other aspects of the nonemergency medical transportation system, as requested by the commissioner; and

(3) other aspects of the nonemergency medical transportation system, as requested by:

(i) a committee member, who may request an item to be placed on the agenda for a future meeting. The request may be considered by the committee and voted upon. If the motion carries, the meeting agenda item may be developed for presentation to the committee; and

(ii) a member of the public, who may approach the committee by letter or e-mail requesting that an item be placed on a future meeting agenda. The request may be considered by the committee and voted upon. If the motion carries, the agenda item may be developed for presentation to the committee.

(c) The Nonemergency Medical Transportation Advisory Committee shall coordinate its activities with the Minnesota Council on Transportation Access established under section 174.285. The chair of the advisory committee, or the chair's designee, shall attend all meetings of the Minnesota Council on Transportation Access.

(d) The Nonemergency Medical Transportation Advisory Committee shall expire December 1, 2019.

Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical Transportation Advisory Committee consists of:

(1) four voting members who represent counties, utilizing the rural urban commuting area classification system. As defined in subdivision 17, these members shall be designated as follows:

(i) two counties within the 11-county metropolitan area;

(ii) one county representing the rural area of the state; and

(iii) one county representing the super rural area of the state.

The Association of Minnesota Counties shall appoint one county within the 11-county metropolitan area and one county representing the super rural area of the state. The Minnesota Inter-County

Association shall appoint one county within the 11-county metropolitan area and one county representing the rural area of the state;

(2) three voting members who represent medical assistance recipients, including persons with physical and developmental disabilities, persons with mental illness, seniors, children, and low-income individuals;

(3) five voting members who represent providers that deliver nonemergency medical transportation services to medical assistance enrollees, one of whom is a taxicab owner or operator;

(4) two voting members of the house of representatives, one from the majority party and one from the minority party, appointed by the speaker of the house, and two voting members from the senate, one from the majority party and one from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(5) one voting member who represents demonstration providers as defined in section 256B.69, subdivision 2;

(6) one voting member who represents an organization that contracts with state or local governments to coordinate transportation services for medical assistance enrollees;

(7) one voting member who represents the Minnesota State Council on Disability;

(8) the commissioner of transportation or the commissioner's designee, who shall serve as a voting member;

(9) one voting member appointed by the Minnesota Ambulance Association; and

(10) one voting member appointed by the Minnesota Hospital Association.

(b) Members of the advisory committee shall not be employed by the Department of Human Services. Members of the advisory committee shall receive no compensation.

Subd. 18e. **Single administrative structure and delivery system.** The commissioner, in coordination with the commissioner of transportation, shall implement a single administrative structure and delivery system for nonemergency medical transportation, beginning the latter of the date the single administrative assessment tool required in this subdivision is available for use, as determined by the commissioner or by July 1, 2016.

In coordination with the Department of Transportation, the commissioner shall develop and authorize a web-based single administrative structure and assessment tool, which must operate 24 hours a day, seven days a week, to facilitate the enrollee assessment process for nonemergency medical transportation services. The web-based tool shall facilitate the transportation eligibility determination process initiated by clients and client advocates; shall include an accessible automated intake and assessment process and real-time identification of level of service eligibility; and shall authorize an appropriate and auditable mode of transportation authorization. The tool shall provide a single framework for reconciling trip information with claiming and collecting complaints regarding inappropriate level of need determinations, inappropriate transportation modes utilized, and interference with accessing nonemergency medical transportation. The web-based single administrative structure shall operate on a trial basis for one year from implementation and, if approved by the commissioner, shall be permanent thereafter. The commissioner shall seek input from the Nonemergency Medical Transportation Advisory Committee to ensure the software is effective and user-friendly and make recommendations regarding funding of the single administrative system.

Subd. 18h. **Managed care.** (a) The following subdivisions apply to managed care plans and county-based purchasing plans:

(1) subdivision 17, paragraphs (a), (b), (i), and (n);

(2) subdivision 18; and

(3) subdivision 18a.

(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service specified in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

Subd. 35a. **Children's mental health crisis response services.** Medical assistance covers children's mental health crisis response services according to section 256B.0944.

Subd. 35b. **Children's therapeutic services and supports.** Medical assistance covers children's therapeutic services and supports according to section 256B.0943.

Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who has determined it medically necessary to involve family members in the child's care. For the purposes of this subdivision, "family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

Subd. 65. **Outpatient mental health services.** Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy according to Minnesota Rules, part 9505.0372, when the mental health services are performed by a mental health practitioner working as a clinical trainee according to section 245.462, subdivision 17, paragraph (g).

256B.0916 EXPANSION OF HOME AND COMMUNITY-BASED SERVICES.

Subd. 2. **Distribution of funds; partnerships.** (a) Beginning with fiscal year 2000, the commissioner shall distribute all funding available for home and community-based waiver services for persons with developmental disabilities to individual counties or to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals. The commissioner shall encourage counties to form partnerships that have a sufficient number of recipients and funding to adequately manage the risk and maximize use of available resources.

(b) Counties must submit a request for funds and a plan for administering the program as required by the commissioner. The plan must identify the number of clients to be served, their ages, and their priority listing based on:

(1) requirements in Minnesota Rules, part 9525.1880; and

(2) statewide priorities identified in section 256B.092, subdivision 12.

The plan must also identify changes made to improve services to eligible persons and to improve program management.

(c) In allocating resources to counties, priority must be given to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals and to counties determined by the commissioner to have sufficient waiver capacity to maximize resource use.

(d) Within 30 days after receiving the county request for funds and plans, the commissioner shall provide a written response to the plan that includes the level of resources available to serve additional persons.

(e) Counties are eligible to receive medical assistance administrative reimbursement for administrative costs under criteria established by the commissioner.

(f) The commissioner shall manage waiver allocations in such a manner as to fully use available state and federal waiver appropriations.

Subd. 3. **Failure to develop partnerships or submit a plan.** (a) By October 1 of each year the commissioner shall notify the county board if any county determined by the commissioner to have insufficient capacity to maximize use of available resources fails to develop a partnership with other counties or fails to submit a plan as required in subdivision 2. The commissioner shall provide needed technical assistance to a county or group of counties that fails to form a partnership or submit a plan. If a county has not joined a county partnership or submitted a plan within 30 days following the notice by the commissioner of its failure, the commissioner shall require and assist that county to develop a plan or contract with another county or group of counties to plan and administer the waiver services program in that county.

(b) Counties may request technical assistance, management information, and administrative support from the commissioner at any time. The commissioner shall respond to county requests within 30 days. Priority shall be given to activities that support the administrative needs of newly formed county partnerships.

Subd. 4. **Allowed reserve.** Counties or groups of counties participating in partnerships that have submitted a plan under this section may develop an allowed reserve amount to meet crises and other unmet needs of current home and community-based waiver recipients. The amount of the allowed reserve shall be a county specific amount based upon documented past experience and projected need for the coming year described in an allowed reserve plan submitted for approval to the commissioner with the allocation request for the fiscal year.

Subd. 5. **Allocation of new diversions and priorities for reassignment of resources for developmental disabilities.** (a) The commissioner shall monitor county utilization of allocated resources and, as appropriate, reassign resources not utilized.

(b) Effective July 1, 2002, the commissioner shall authorize the spending of new diversion resources beginning January 1 of each year.

(c) Effective July 1, 2002, the commissioner shall manage the reassignment of waiver resources that occur from persons who have left the waiver in a manner that results in the cost reduction equivalent to delaying the reuse of those waiver resources by 180 days.

(d) Priority consideration for reassignment of resources shall be given to counties that form partnerships. In addition to the priorities listed in Minnesota Rules, part 9525.1880, the commissioner shall also give priority consideration to persons whose living situations are unstable due to the age or incapacity of the primary caregiver and to children to avoid out-of-home placement.

Subd. 8. **Financial and wait-list data reporting.** (a) The commissioner shall make available financial and waiting list information on the department's website.

(b) The financial information must include:

(1) the most recent end of session forecast available for the disability home and community-based waiver programs authorized under sections 256B.092 and 256B.49; and

(2) the most current financial information, updated at least monthly for the disability home and community-based waiver program authorized under section 256B.092 and three disability home and community-based waiver programs authorized under section 256B.49 for each county and tribal agency, including:

(i) the amount of resources allocated;

(ii) the amount of resources authorized for participants; and

(iii) the amount of allocated resources not authorized and the amount not used as provided in subdivision 12, and section 256B.49, subdivision 27.

(c) The waiting list information must be provided quarterly beginning August 1, 2016, and must include at least:

(1) the number of persons screened and waiting for services listed by urgency category, the number of months on the wait list, age group, and the type of services requested by those waiting;

(2) the number of persons beginning waiver services who were on the waiting list, and the number of persons beginning waiver services who were not on the waiting list;

(3) the number of persons who left the waiting list but did not begin waiver services; and

(4) the number of persons on the waiting list with approved funding but without a waiver service agreement and the number of days from funding approval until a service agreement is effective for each person.

(d) By December 1 of each year, the commissioner shall compile a report posted on the department's website that includes:

(1) the financial information listed in paragraph (b) for the most recently completed allocation period;

(2) for the previous four quarters, the waiting list information listed in paragraph (c);

(3) for a 12-month period ending October 31, a list of county and tribal agencies required to submit a corrective action plan under subdivisions 11 and 12, and section 256B.49, subdivisions 26 and 27; and

(4) for a 12-month period ending October 31, a list of the county and tribal agencies from which resources were moved as authorized in section 256B.092, subdivision 12, and section 256B.49, subdivision 11a, the amount of resources taken from each agency, the counties that were given increased resources as a result, and the amounts provided.

Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending in excess of the allocation made by the commissioner. In the event a county or tribal agency spends in excess of the allocation made by the commissioner for a given allocation period, they must submit a corrective action plan to the commissioner for approval. The plan must state the actions the agency will take to correct their overspending for the two years following the period when the overspending occurred. The commissioner shall recoup spending in excess of the allocation only in cases where statewide spending exceeds the appropriation designated for the home and community-based services waivers. Nothing in this subdivision shall be construed as reducing the county's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to them for that purpose.

Subd. 12. **Use of waiver allocations.** County and tribal agencies are responsible for spending the annual allocation made by the commissioner. In the event a county or tribal agency spends less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services. If a county or tribe does not submit a plan when required or implement the changes required, the commissioner shall assure access to waiver services within the county's or tribe's available allocation and take other actions needed to assure that all waiver participants in that county or tribe are receiving appropriate waiver services to meet their needs.

256B.0924 TARGETED CASE MANAGEMENT SERVICES.

Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment under subdivision 6 if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contact.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;

(3) established protocols addressing how and when to discontinue interactive video services; and

(4) established a quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video:

(1) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the person receiving case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized;

(4) the location of the originating site and the distant site; and

(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).

256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.

Subd. 8. **Required preservice and continuing education.** (a) A provider entity shall establish a plan to provide preservice and continuing education for staff. The plan must clearly describe the type of training necessary to maintain current skills and obtain new skills and that relates to the provider entity's goals and objectives for services offered.

(b) A provider that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of preservice training. The preservice training must include parent team training. The preservice training must include 15 hours of in-person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Curricula for parent team training must be approved in advance by the commissioner. Components of parent team training include:

(1) partnering with parents;

(2) fundamentals of family support;

(3) fundamentals of policy and decision making;

(4) defining equal partnership;

(5) complexities of the parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses;

(6) sibling impacts;

(7) support networks; and

(8) community resources.

(c) A provider entity that employs a mental health practitioner and a mental health behavioral aide to provide children's therapeutic services and supports under this section must require the mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. The continuing education must be related to serving the needs of a child with emotional disturbance in the child's home environment and the child's family.

(d) The provider entity must document the mental health practitioner's or mental health behavioral aide's annual completion of the required continuing education. The documentation must include the date, subject, and number of hours of the continuing education, and attendance records, as verified by the staff member's signature, job title, and the instructor's name. The provider entity must keep documentation for each employee, including records of attendance at professional workshops and conferences, at a central location and in the employee's personnel file.

Subd. 10. **Service authorization.** Children's therapeutic services and supports are subject to authorization criteria and standards published by the commissioner according to section 256B.0625, subdivision 25.

256B.0944 CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation that, but for the provision of crisis response services to the child, would likely result in significantly reduced levels of functioning in primary activities of daily living, an emergency situation, or the child's placement in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or crisis mental health practitioner determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests the child may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency. Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Mental health mobile services must be provided on site by a mobile crisis intervention team outside of an inpatient hospital setting.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

Subd. 2. **Medical assistance coverage.** Medical assistance covers medically necessary children's mental health crisis response services, subject to federal approval, if provided to an eligible recipient under subdivision 3, by a qualified provider entity under subdivision 4 or a qualified individual provider working within the provider's scope of practice, and identified in the recipient's individual crisis treatment plan under subdivision 8.

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is eligible for medical assistance;

(2) is under age 18 or between the ages of 18 and 21;

(3) is screened as possibly experiencing a mental health crisis or mental health emergency where a mental health crisis assessment is needed;

(4) is assessed as experiencing a mental health crisis or mental health emergency, and mental health mobile crisis intervention or mental health crisis stabilization services are determined to be medically necessary; and

(5) meets the criteria for emotional disturbance or mental illness.

Subd. 4. **Provider entity standards.** (a) A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:

(1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility;

(2) a county board-operated entity; or

(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.

(b) The children's mental health crisis response services provider entity must:

(1) ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(2) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;

(3) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4889; and

(4) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high-risk situations.

Subd. 4a. **Alternative provider standards.** If a provider entity demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services 24 hours a day, seven days a week, according to the standards in subdivision 4, paragraph (b), clause (1), the commissioner may approve a crisis response provider based on an alternative plan proposed by a provider entity. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of crisis services; and

(2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays.

Subd. 5. **Mobile crisis intervention staff qualifications.** (a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:

(1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph (o); or

(2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.

(b) The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including the county social services agency, mental health service providers, and local law enforcement, if necessary.

Subd. 6. **Initial screening and crisis assessment planning.** (a) Before initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify the parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment must evaluate any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As the opportunity presents itself during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of

the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required under subdivision 9.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The crisis treatment plan must be updated as needed to reflect current goals and services. The team must involve the client and the client's family in developing and implementing the plan.

(e) The team must document in progress notes which short-term goals have been met and when no further crisis intervention services are required.

(f) If the client's crisis is stabilized, but the client needs a referral for mental health crisis stabilization services or to other services, the team must provide a referral to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Subd. 7. **Crisis stabilization services.** Crisis stabilization services must be provided by a mental health professional or a mental health practitioner, as defined in section 245.462, subdivision 17, who works under the clinical supervision of a mental health professional and for a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 8;

(2) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community; and

(3) mental health practitioners must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 8. **Treatment plan.** (a) The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;

(4) specific objectives directed toward the achievement of each goal;

(5) documentation of the participants involved in the service planning;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur; and

(8) clear progress notes on the outcome of goals.

(b) The client, if clinically appropriate, must be a participant in the development of the crisis stabilization treatment plan. The client or the client's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the client and the client's legal guardian. The plan should include services arranged, including specific providers where applicable.

(c) A treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. A written plan must be completed within 24 hours of beginning services with the client.

Subd. 9. **Supervision.** (a) A mental health practitioner may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by telephone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by telephone, during the first three hours when a mental health practitioner provides on-site service; and

(4) the mental health professional must review and approve the tentative crisis assessment and crisis treatment plan, document the consultation, and sign the crisis assessment and treatment plan within the next business day.

(b) If the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan. The on-site observation must be documented in the client's record and signed by the mental health professional.

Subd. 10. **Client record.** The provider must maintain a file for each client that complies with the requirements under section 256B.0943, subdivision 11, and contains the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient for not signing the plan;

(2) signed release of information forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records that document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

Subd. 11. **Excluded services.** The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) transportation services under children's mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide children's mental health crisis response services;

(5) crisis response services provided by a residential treatment center to clients in their facility;

(6) services performed by volunteers;

(7) direct billing of time spent "on call" when not delivering services to a recipient;

(8) provider service time included in case management reimbursement;

(9) outreach services to potential recipients; and

(10) a mental health service that is not medically necessary.

256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.

Subd. 5. **Service authorization.** The commissioner will administer authorizations for services under this section in compliance with section 256B.0625, subdivision 25.

256B.097 STATE QUALITY ASSURANCE, QUALITY IMPROVEMENT, AND LICENSING SYSTEM.

Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a State Quality Assurance, Quality

Improvement, and Licensing System for Minnesotans receiving disability services is enacted. This system is a partnership between the Department of Human Services and the State Quality Council established under subdivision 3.

(b) This system is a result of the recommendations from the Department of Human Services' licensing and alternative quality assurance study mandated under Laws 2005, First Special Session chapter 4, article 7, section 57, and presented to the legislature in February 2007.

(c) The disability services eligible under this section include:

(1) the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, or section 256B.49, including brain injuries and services for those who qualify for nursing facility level of care or hospital facility level of care and any other services licensed under chapter 245D;

(2) home care services under section 256B.0651;

(3) family support grants under section 252.32;

(4) consumer support grants under section 256.476;

(5) semi-independent living services under section 252.275; and

(6) services provided through an intermediate care facility for the developmentally disabled.

(d) For purposes of this section, the following definitions apply:

(1) "commissioner" means the commissioner of human services;

(2) "council" means the State Quality Council under subdivision 3;

(3) "Quality Assurance Commission" means the commission under section 256B.0951; and

(4) "system" means the State Quality Assurance, Quality Improvement and Licensing System under this section.

Subd. 2. **Duties of commissioner of human services.** (a) The commissioner of human services shall establish the State Quality Council under subdivision 3.

(b) The commissioner shall initially delegate authority to perform licensing functions and activities according to section 245A.16 to a host county in Region 10. The commissioner must not license or reimburse a participating facility, program, or service located in Region 10 if the commissioner has received notification from the host county that the facility, program, or service has failed to qualify for licensure.

(c) The commissioner may conduct random licensing inspections based on outcomes adopted under section 256B.0951, subdivision 3, at facilities or programs, and of services eligible under this section. The role of the random inspections is to verify that the system protects the safety and well-being of persons served and maintains the availability of high-quality services for persons with disabilities.

(d) The commissioner shall ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety and health or violated services-related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

(e) The commissioner shall seek a federal waiver by July 1, 2012, to allow intermediate care facilities for persons with developmental disabilities to participate in this system.

Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality Council which must define regional quality councils, and carry out a community-based, person-directed quality review component, and a comprehensive system for effective incident reporting, investigation, analysis, and follow-up.

(b) By August 1, 2011, the commissioner of human services shall appoint the members of the initial State Quality Council. Members shall include representatives from the following groups:

(1) disability service recipients and their family members;

(2) during the first four years of the State Quality Council, there must be at least three members from the Region 10 stakeholders. As regional quality councils are formed under subdivision 4, each regional quality council shall appoint one member;

(3) disability service providers;

(4) disability advocacy groups; and

(5) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(c) Members of the council who do not receive a salary or wages from an employer for time spent on council duties may receive a per diem payment when performing council duties and functions.

(d) The State Quality Council shall:

(1) assist the Department of Human Services in fulfilling federally mandated obligations by monitoring disability service quality and quality assurance and improvement practices in Minnesota;

(2) establish state quality improvement priorities with methods for achieving results and provide an annual report to the legislative committees with jurisdiction over policy and funding of disability services on the outcomes, improvement priorities, and activities undertaken by the commission during the previous state fiscal year;

(3) identify issues pertaining to financial and personal risk that impede Minnesotans with disabilities from optimizing choice of community-based services; and

(4) recommend to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and civil law by January 15, 2014, statutory and rule changes related to the findings under clause (3) that promote individualized service and housing choices balanced with appropriate individualized protection.

(e) The State Quality Council, in partnership with the commissioner, shall:

(1) approve and direct implementation of the community-based, person-directed system established in this section;

(2) recommend an appropriate method of funding this system, and determine the feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

(3) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems;

(4) establish variable licensure periods not to exceed three years based on outcomes achieved; and

(5) in cooperation with the Quality Assurance Commission, design a transition plan for licensed providers from Region 10 into the alternative licensing system.

(f) The State Quality Council shall notify the commissioner of human services that a facility, program, or service has been reviewed by quality assurance team members under subdivision 4, paragraph (b), clause (13), and qualifies for a license.

(g) The State Quality Council, in partnership with the commissioner, shall establish an ongoing review process for the system. The review shall take into account the comprehensive nature of the system which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to persons with disabilities. The review shall address efficiencies and effectiveness of the system.

(h) The State Quality Council may recommend to the commissioner certain variances from the standards governing licensure of programs for persons with disabilities in order to improve the quality of services so long as the recommended variances do not adversely affect the health or safety of persons being served or compromise the qualifications of staff to provide services.

(i) The safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make recommendations to the commissioner or to the legislature in the report required under paragraph (c) regarding alternatives or modifications to the safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c).

(j) The State Quality Council may hire staff to perform the duties assigned in this subdivision.

Subd. 4. **Regional quality councils.** (a) The commissioner shall establish, as selected by the State Quality Council, regional quality councils of key stakeholders, including regional representatives of:

(1) disability service recipients and their family members;

(2) disability service providers;

(3) disability advocacy groups; and

(4) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(b) Each regional quality council shall:

(1) direct and monitor the community-based, person-directed quality assurance system in this section;

(2) approve a training program for quality assurance team members under clause (13);

(3) review summary reports from quality assurance team reviews and make recommendations to the State Quality Council regarding program licensure;

(4) make recommendations to the State Quality Council regarding the system;

(5) resolve complaints between the quality assurance teams, counties, providers, persons receiving services, their families, and legal representatives;

(6) analyze and review quality outcomes and critical incident data reporting incidents of life safety concerns immediately to the Department of Human Services licensing division;

(7) provide information and training programs for persons with disabilities and their families and legal representatives on service options and quality expectations;

(8) disseminate information and resources developed to other regional quality councils;

(9) respond to state-level priorities;

(10) establish regional priorities for quality improvement;

(11) submit an annual report to the State Quality Council on the status, outcomes, improvement priorities, and activities in the region;

(12) choose a representative to participate on the State Quality Council and assume other responsibilities consistent with the priorities of the State Quality Council; and

(13) recruit, train, and assign duties to members of quality assurance teams, taking into account the size of the service provider, the number of services to be reviewed, the skills necessary for the team members to complete the process, and ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with anyone served at the facility, program, or service. Quality assurance teams must be comprised of county staff, persons receiving services or the person's families, legal representatives, members of advocacy organizations, providers, and other involved community members. Team members must complete the training program approved by the regional quality council and must demonstrate performance-based competency. Team members may be paid a per diem and reimbursed for expenses related to their participation in the quality assurance process.

(c) The commissioner shall monitor the safety standards, rights, and procedural protections for the monitoring of psychotropic medications and those identified under sections 245.825; 245.91 to 245.97; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivision 1b, clause (7); and 626.557; and chapter 260E.

(d) The regional quality councils may hire staff to perform the duties assigned in this subdivision.

(e) The regional quality councils may charge fees for their services.

(f) The quality assurance process undertaken by a regional quality council consists of an evaluation by a quality assurance team of the facility, program, or service. The process must include an evaluation of a random sample of persons served. The sample must be representative of each service provided. The sample size must be at least five percent but not less than two persons served. All persons must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.

(g) A facility, program, or service may contest a licensing decision of the regional quality council as permitted under chapter 245A.

Subd. 5. **Annual survey of service recipients.** The commissioner, in consultation with the State Quality Council, shall conduct an annual independent statewide survey of service recipients, randomly selected, to determine the effectiveness and quality of disability services. The survey must be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services (CMS) Quality Framework. The survey must analyze whether desired outcomes for persons with different demographic, diagnostic, health, and functional needs, who are receiving different types of services in different settings and with different costs, have been achieved. Annual statewide and regional reports of the results must be published and used to assist regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 6. **Mandated reporters.** Members of the State Quality Council under subdivision 3, the regional quality councils under subdivision 4, and quality assurance team members under subdivision 4, paragraph (b), clause (13), are mandated reporters as defined in sections 260E.06, subdivision 1, and 626.5572, subdivision 16.

256B.49 HOME AND COMMUNITY-BASED SERVICE WAIVERS FOR PERSONS WITH DISABILITIES.

Subd. 26. **Excess allocations.** Effective July 1, 2018, county and tribal agencies will be responsible for spending in excess of the annual allocation made by the commissioner. In the event a county or tribal agency spends in excess of the allocation made by the commissioner for a given allocation period, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The plan must state the actions the agency will take to correct its overspending for the two years following the period when the overspending occurred. The commissioner shall recoup funds spent in excess of the allocation only in cases when statewide spending exceeds the appropriation designated for the home and community-based services waivers. Nothing in this subdivision shall be construed as reducing the county or tribe's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to it for that purpose.

Subd. 27. **Use of waiver allocations.** (a) Effective until June 30, 2018, county and tribal agencies are responsible for authorizing the annual allocation made by the commissioner. In the event a county or tribal agency authorizes less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services.

(b) Effective July 1, 2018, county and tribal agencies are responsible for spending the annual allocation made by the commissioner. In the event a county or tribal agency spends less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services.

(c) If a county or tribe does not submit a plan when required or implement the changes required, the commissioner shall assure access to waiver services within the county or tribe's available allocation, and take other actions needed to assure that all waiver participants in that county or tribe are receiving appropriate waiver services to meet their needs.

256D.051 SNAP EMPLOYMENT AND TRAINING PROGRAM.

Subdivision 1. **SNAP employment and training program.** The commissioner shall implement a SNAP employment and training program in order to meet the SNAP employment and training participation requirements of the United States Department of Agriculture. Unless exempt under subdivision 3a, each adult recipient in the unit must participate in the SNAP employment and training program each month that the person is eligible for SNAP benefits. The person's participation in SNAP employment and training services must begin no later than the first day of the calendar month following the determination of eligibility for SNAP benefits. With the county agency's consent, and to the extent of available resources, the person may voluntarily continue to participate in SNAP employment and training services for up to three additional consecutive months immediately

following termination of SNAP benefits in order to complete the provisions of the person's employability development plan.

Subd. 1a. **Notices and sanctions.** (a) At the time the county agency notifies the household that it is eligible for SNAP benefits, the county agency must inform all mandatory employment and training services participants as identified in subdivision 1 in the household that they must comply with all SNAP employment and training program requirements each month, including the requirement to attend an initial orientation to the SNAP employment and training program and that SNAP eligibility will end unless the participants comply with the requirements specified in the notice.

(b) A participant who fails without good cause to comply with SNAP employment and training program requirements of this section, including attendance at orientation, will lose SNAP eligibility for the following periods:

(1) for the first occurrence, for one month or until the person complies with the requirements not previously complied with, whichever is longer;

(2) for the second occurrence, for three months or until the person complies with the requirements not previously complied with, whichever is longer; or

(3) for the third and any subsequent occurrence, for six months or until the person complies with the requirements not previously complied with, whichever is longer.

If the participant is not the SNAP head of household, the person shall be considered an ineligible household member for SNAP purposes. If the participant is the SNAP head of household, the entire household is ineligible for SNAP as provided in Code of Federal Regulations, title 7, section 273.7(g). "Good cause" means circumstances beyond the control of the participant, such as illness or injury, illness or injury of another household member requiring the participant's presence, a household emergency, or the inability to obtain child care for children between the ages of six and 12 or to obtain transportation needed in order for the participant to meet the SNAP employment and training program participation requirements.

(c) The county agency shall mail or hand deliver a notice to the participant not later than five days after determining that the participant has failed without good cause to comply with SNAP employment and training program requirements which specifies the requirements that were not complied with, the factual basis for the determination of noncompliance, and the right to reinstate eligibility upon a showing of good cause for failure to meet the requirements. The notice must ask the reason for the noncompliance and identify the participant's appeal rights. The notice must request that the participant inform the county agency if the participant believes that good cause existed for the failure to comply and must state that the county agency intends to terminate eligibility for SNAP benefits due to failure to comply with SNAP employment and training program requirements.

(d) If the county agency determines that the participant did not comply during the month with all SNAP employment and training program requirements that were in effect, and if the county agency determines that good cause was not present, the county must provide a ten-day notice of termination of SNAP benefits. The amount of SNAP benefits that are withheld from the household and determination of the impact of the sanction on other household members is governed by Code of Federal Regulations, title 7, section 273.7.

(e) The participant may appeal the termination of SNAP benefits under the provisions of section 256.045.

Subd. 2. **County agency duties.** (a) The county agency shall provide to SNAP benefit recipients a SNAP employment and training program. The program must include:

(1) orientation to the SNAP employment and training program;

(2) an individualized employability assessment and an individualized employability development plan that includes assessment of literacy, ability to communicate in the English language, educational and employment history, and that estimates the length of time it will take the participant to obtain employment. The employability assessment and development plan must be completed in consultation with the participant, must assess the participant's assets, barriers, and strengths, and must identify steps necessary to overcome barriers to employment. A copy of the employability development plan must be provided to the registrant;

(3) referral to available accredited remedial or skills training programs designed to address participant's barriers to employment;

(4) referral to available programs that provide subsidized or unsubsidized employment as necessary;

(5) a job search program, including job seeking skills training; and

(6) other activities, to the extent of available resources designed by the county agency to prepare the participant for permanent employment.

In order to allow time for job search, the county agency may not require an individual to participate in the SNAP employment and training program for more than 32 hours a week. The county agency shall require an individual to spend at least eight hours a week in job search or other SNAP employment and training program activities.

(b) The county agency shall prepare an annual plan for the operation of its SNAP employment and training program. The plan must be submitted to and approved by the commissioner of employment and economic development. The plan must include:

(1) a description of the services to be offered by the county agency;

(2) a plan to coordinate the activities of all public entities providing employment-related services in order to avoid duplication of effort and to provide services more efficiently;

(3) a description of the factors that will be taken into account when determining a client's employability development plan; and

(4) provisions to ensure that the county agency's employment and training service provider provides each recipient with an orientation, employability assessment, and employability development plan as specified in paragraph (a), clauses (1) and (2), within 30 days of the recipient's eligibility for assistance.

Subd. 2a. **Duties of commissioner.** In addition to any other duties imposed by law, the commissioner shall:

(1) based on this section and section 256D.052 and Code of Federal Regulations, title 7, section 273.7, supervise the administration of SNAP employment and training services to county agencies;

(2) disburse money appropriated for SNAP employment and training services to county agencies based upon the county's costs as specified in section 256D.051, subdivision 6c;

(3) accept and supervise the disbursement of any funds that may be provided by the federal government or from other sources for use in this state for SNAP employment and training services;

(4) cooperate with other agencies including any agency of the United States or of another state in all matters concerning the powers and duties of the commissioner under this section and section 256D.052; and

(5) in cooperation with the commissioner of employment and economic development, ensure that each component of an employment and training program carried out under this section is delivered through a statewide workforce development system, unless the component is not available locally through such a system.

Subd. 3. **Participant duties.** In order to receive SNAP assistance, a registrant shall: (1) cooperate with the county agency in all aspects of the SNAP employment and training program; (2) accept any suitable employment, including employment offered through the Job Training Partnership Act, and other employment and training options; and (3) participate in SNAP employment and training activities assigned by the county agency. The county agency may terminate assistance to a registrant who fails to cooperate in the SNAP employment and training program, as provided in subdivision 1a.

Subd. 3a. **Requirement to register work.** (a) To the extent required under Code of Federal Regulations, title 7, section 273.7(a), each applicant for and recipient of SNAP benefits is required to register for work as a condition of eligibility for SNAP benefits. Applicants and recipients are registered by signing an application or annual reapplication for SNAP benefits, and must be informed that they are registering for work by signing the form.

(b) The commissioner shall determine, within federal requirements, persons required to participate in the SNAP employment and training program.

(c) The following SNAP benefit recipients are exempt from mandatory participation in SNAP employment and training services:

(1) recipients of benefits under the Minnesota family investment program, Minnesota supplemental aid program, or the general assistance program;

(2) a child;

(3) a recipient over age 55;

(4) a recipient who has a mental or physical illness, injury, or incapacity which is expected to continue for at least 30 days and which impairs the recipient's ability to obtain or retain employment as evidenced by professional certification or the receipt of temporary or permanent disability benefits issued by a private or government source;

(5) a parent or other household member responsible for the care of either a dependent child in the household who is under age six or a person in the household who is professionally certified as having a physical or mental illness, injury, or incapacity. Only one parent or other household member may claim exemption under this provision;

(6) a recipient receiving unemployment insurance or who has applied for unemployment insurance and has been required to register for work with the Department of Employment and Economic Development as part of the unemployment insurance application process;

(7) a recipient participating each week in a drug addiction or alcohol abuse treatment and rehabilitation program, provided the operators of the treatment and rehabilitation program, in consultation with the county agency, recommend that the recipient not participate in the SNAP employment and training program;

(8) a recipient employed or self-employed for 30 or more hours per week at employment paying at least minimum wage, or who earns wages from employment equal to or exceeding 30 hours multiplied by the federal minimum wage; or

(9) a student enrolled at least half time in any school, training program, or institution of higher education. When determining if a student meets this criteria, the school's, program's or institution's criteria for being enrolled half time shall be used.

Subd. 3b. **Orientation.** The county agency or its employment and training service provider must provide an orientation to SNAP employment and training services to each nonexempt SNAP benefit recipient within 30 days of the date that SNAP eligibility is determined. The orientation must inform the participant of the requirement to participate in services, the date, time, and address to report to for services, the name and telephone number of the SNAP employment and training service provider, the consequences for failure without good cause to comply, the services and support services available through SNAP employment and training services and other providers of similar services, and must encourage the participant to view the SNAP benefits program as a temporary means of supplementing the family's food needs until the family achieves self-sufficiency through employment. The orientation may be provided through audio-visual methods, but the participant must have the opportunity for face-to-face interaction with county agency staff.

Subd. 6b. **Federal reimbursement.** (a) Federal financial participation from the United States Department of Agriculture for SNAP employment and training expenditures that are eligible for reimbursement through the SNAP employment and training program are dedicated funds and are annually appropriated to the commissioner of human services for the operation of the SNAP employment and training program.

(b) The appropriation must be used for skill attainment through employment, training, and support services for SNAP participants.

(c) Federal financial participation for the nonstate portion of SNAP employment and training costs must be paid to the county agency or service provider that incurred the costs.

Subd. 6c. **Program funding.** Within the limits of available resources, the commissioner shall reimburse the actual costs of county agencies and their employment and training service providers for the provision of SNAP employment and training services, including participant support services, direct program services, and program administrative activities. The cost of services for each county's SNAP employment and training program shall not exceed the annual allocated amount. No more than 15 percent of program funds may be used for administrative activities. The county agency may expend county funds in excess of the limits of this subdivision without state reimbursement.

Program funds shall be allocated based on the county's average number of SNAP eligible cases as compared to the statewide total number of such cases. The average number of cases shall be based on counts of cases as of March 31, June 30, September 30, and December 31 of the previous

calendar year. The commissioner may reallocate unexpended money appropriated under this section to those county agencies that demonstrate a need for additional funds.

Subd. 7. **Registrant status.** A registrant under this section is not an employee for the purposes of workers' compensation, unemployment benefits, retirement, or civil service laws, and shall not perform work ordinarily performed by a regular public employee.

Subd. 8. **Voluntary quit.** A person who is required to participate in SNAP employment and training services is not eligible for SNAP benefits if, without good cause, the person refuses a legitimate offer of, or quits, suitable employment within 60 days before the date of application. A person who is required to participate in SNAP employment and training services and, without good cause, voluntarily quits suitable employment or refuses a legitimate offer of suitable employment while receiving SNAP benefits shall be terminated from the SNAP program as specified in subdivision 1a.

Subd. 9. **Subcontractors.** A county agency may, at its option, subcontract any or all of the duties under this section to a public or private entity approved by the commissioner of employment and economic development.

Subd. 18. **Work experience placements.** (a) To the extent of available resources, each county agency must establish and operate a work experience component in the SNAP employment and training program for recipients who are subject to a federal limit of three months of SNAP eligibility in any 36-month period. The purpose of the work experience component is to enhance the participant's employability, self-sufficiency, and to provide meaningful, productive work activities.

(b) The commissioner shall assist counties in the design and implementation of these components. The commissioner must ensure that job placements under a work experience component comply with section 256J.72. Written or oral concurrence with job duties of persons placed under the community work experience program shall be obtained from the appropriate exclusive bargaining representative.

(c) Worksites developed under this section are limited to projects that serve a useful public service such as health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, community service, services to aged citizens or citizens with a disability, and child care. To the extent possible, the prior training, skills, and experience of a recipient must be used in making appropriate work experience assignments.

(d) Structured, supervised volunteer work with an agency or organization that is monitored by the county service provider may, with the approval of the county agency, be used as a work experience placement.

(e) As a condition of placing a person receiving SNAP benefits in a program under this subdivision, the county agency shall first provide the recipient the opportunity:

(1) for placement in suitable subsidized or unsubsidized employment through participation in job search under section 256D.051; or

(2) for placement in suitable employment through participation in on-the-job training, if such employment is available.

(f) The county agency shall limit the maximum monthly number of hours that any participant may work in a work experience placement to a number equal to the amount of the family's monthly SNAP benefit allotment divided by the greater of the federal minimum wage or the applicable state minimum wage.

After a participant has been assigned to a position for nine months, the participant may not continue in that assignment unless the maximum number of hours a participant works is no greater than the amount of the SNAP benefit divided by the rate of pay for individuals employed in the same or similar occupations by the same employer at the same site.

(g) The participant's employability development plan must include the length of time needed in the work experience program, the need to continue job seeking activities while participating in work experience, and the participant's employment goals.

(h) After each six months of a recipient's participation in a work experience job placement, and at the conclusion of each work experience assignment under this section, the county agency shall reassess and revise, as appropriate, the participant's employability development plan.

(i) A participant has good cause for failure to cooperate with a work experience job placement if, in the judgment of the employment and training service provider, the reason for failure is reasonable and justified. Good cause for purposes of this section is defined in subdivision 1a, paragraph (b).

(j) A recipient who has failed without good cause to participate in or comply with the work experience job placement shall be terminated from participation in work experience job activities. If the recipient is not exempt from mandatory SNAP employment and training program participation under subdivision 3a, the recipient will be assigned to other mandatory program activities. If the recipient is exempt from mandatory participation but is participating as a volunteer, the person shall be terminated from the SNAP employment and training program.

256D.052 LITERACY TRAINING FOR RECIPIENTS.

Subd. 3. **Participant literacy transportation costs.** Within the limits of the state appropriation the county agency must provide transportation to enable Supplemental Nutrition Assistance Program (SNAP) employment and training participants to participate in literacy training under this section. The state shall reimburse county agencies for the costs of providing transportation under this section up to the amount of the state appropriation. Counties must make every effort to ensure that child care is available as needed by recipients who are pursuing literacy training.

256J.08 DEFINITIONS.

Subd. 10. **Budget month.** "Budget month" means the calendar month which the county agency uses to determine the income or circumstances of an assistance unit to calculate the amount of the assistance payment in the payment month.

Subd. 53. **Lump sum.** "Lump sum" means nonrecurring income that is not excluded in section 256J.21.

Subd. 61. **Monthly income test.** "Monthly income test" means the test used to determine ongoing eligibility and the assistance payment amount according to section 256J.21.

Subd. 62. **Nonrecurring income.** "Nonrecurring income" means a form of income which is received:

(1) only one time or is not of a continuous nature; or

(2) in a prospective payment month but is no longer received in the corresponding retrospective payment month.

Subd. 81. **Retrospective budgeting.** "Retrospective budgeting" means a method of determining the amount of the assistance payment in which the payment month is the second month after the budget month.

Subd. 83. **Significant change.** "Significant change" means a decline in gross income of the amount of the disregard as defined in section 256P.03 or more from the income used to determine the grant for the current month.

256J.21 INCOME LIMITATIONS.

Subdivision 1. **Income inclusions.** To determine MFIP eligibility, the county agency must evaluate income received by members of an assistance unit, or by other persons whose income is considered available to the assistance unit, and only count income that is available to the member of the assistance unit. Income is available if the individual has legal access to the income. All payments, unless specifically excluded in subdivision 2, must be counted as income. The county agency shall verify the income of all MFIP recipients and applicants.

Subd. 2. **Income exclusions.** The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9555.5050 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0654, payments for family foster care for children under section 260C.4411 or chapter 256N, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

(2) reimbursements for employment training received through the Workforce Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

(3) reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, employment, or informal carpooling arrangements directly related to employment;

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

(5) loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

(6) loans from private individuals, regardless of purpose, provided an applicant or participant documents that the lender expects repayment;

(7)(i) state income tax refunds; and

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

(iii) state homeowners and renters credits under chapter 290A; and

(iv) federal or state tax rebates;

(9) funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency, state or local government, or disaster assistance organizations, subsequent to a presidential declaration of disaster;

(10) the portion of an insurance settlement that is used to pay medical, funeral, and burial expenses, or to repair or replace insured property;

(11) reimbursements for medical expenses that cannot be paid by medical assistance;

(12) payments by a vocational rehabilitation program administered by the state under chapter 268A, except those payments that are for current living expenses;

(13) in-kind income, including any payments directly made by a third party to a provider of goods and services;

(14) assistance payments to correct underpayments, but only for the month in which the payment is received;

(15) payments for short-term emergency needs under section 256J.626, subdivision 2;

(16) funeral and cemetery payments as provided by section 256.935;

(17) nonrecurring cash gifts of $30 or less, not exceeding $30 per participant in a calendar month;

(18) any form of energy assistance payment made through Public Law 97-35, Low-Income Home Energy Assistance Act of 1981, payments made directly to energy providers by other public and private agencies, and any form of credit or rebate payment issued by energy providers;

(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient;

(20) Minnesota supplemental aid, including retroactive payments;

(21) proceeds from the sale of real or personal property;

(22) adoption or kinship assistance payments under chapter 256N or 259A and Minnesota permanency demonstration title IV-E waiver payments;

(23) state-funded family subsidy program payments made under section 252.32 to help families care for children with developmental disabilities, consumer support grant funds under section 256.476, and resources and services for a disabled household member under one of the home and community-based waiver services programs under chapter 256B;

(24) interest payments and dividends from property that is not excluded from and that does not exceed the asset limit;

(25) rent rebates;

(26) income earned by a minor caregiver, minor child through age 6, or a minor child who is at least a half-time student in an approved elementary or secondary education program;

(27) income earned by a caregiver under age 20 who is at least a half-time student in an approved elementary or secondary education program;

(28) MFIP child care payments under section 119B.05;

(29) all other payments made through MFIP to support a caregiver's pursuit of greater economic stability;

(30) income a participant receives related to shared living expenses;

(31) reverse mortgages;

(32) benefits provided by the Child Nutrition Act of 1966, United States Code, title 42, chapter 13A, sections 1771 to 1790;

(33) benefits provided by the women, infants, and children (WIC) nutrition program, United States Code, title 42, chapter 13A, section 1786;

(34) benefits from the National School Lunch Act, United States Code, title 42, chapter 13, sections 1751 to 1769e;

(35) relocation assistance for displaced persons under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12, chapter 13, sections 1701 to 1750jj;

(36) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part 2, sections 2271 to 2322;

(37) war reparations payments to Japanese Americans and Aleuts under United States Code, title 50, sections 1989 to 1989d;

(38) payments to veterans or their dependents as a result of legal settlements regarding Agent Orange or other chemical exposure under Public Law 101-239, section 10405, paragraph (a)(2)(E);

(39) income that is otherwise specifically excluded from MFIP consideration in federal law, state law, or federal regulation;

(40) security and utility deposit refunds;

(41) American Indian tribal land settlements excluded under Public Laws 98-123, 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and Mille Lacs reservations and payments to members of the White Earth Band, under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

(42) all income of the minor parent's parents and stepparents when determining the grant for the minor parent in households that include a minor parent living with parents or stepparents on MFIP with other children;

(43) income of the minor parent's parents and stepparents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor parent's child in households that include a minor parent living with parents or stepparents not on MFIP when determining the grant for the minor parent. The remainder of income is deemed as specified in section 256J.37, subdivision 1b;

(44) payments made to children eligible for relative custody assistance under section 257.85;

(45) vendor payments for goods and services made on behalf of a client unless the client has the option of receiving the payment in cash;

(46) the principal portion of a contract for deed payment;

(47) cash payments to individuals enrolled for full-time service as a volunteer under AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps National, and AmeriCorps NCCC;

(48) housing assistance grants under section 256J.35, paragraph (a); and

(49) child support payments of up to $100 for an assistance unit with one child and up to $200 for an assistance unit with two or more children.

256J.30 APPLICANT AND PARTICIPANT REQUIREMENTS AND RESPONSIBILITIES.

Subd. 5. **Monthly MFIP household reports.** Each assistance unit with a member who has earned income or a recent work history, and each assistance unit that has income deemed to it from a financially responsible person must complete a monthly MFIP household report form. "Recent work history" means the individual received earned income in the report month or any of the previous three calendar months even if the earnings are excluded. To be complete, the MFIP household report form must be signed and dated by the caregivers no earlier than the last day of the reporting period. All questions required to determine assistance payment eligibility must be answered, and documentation of earned income must be included.

Subd. 7. **Due date of MFIP household report form.** An MFIP household report form must be received by the county agency by the eighth calendar day of the month following the reporting period covered by the form. When the eighth calendar day of the month falls on a weekend or holiday, the MFIP household report form must be received by the county agency the first working day that follows the eighth calendar day.

Subd. 8. **Late MFIP household report forms.** (a) Paragraphs (b) to (e) apply to the reporting requirements in subdivision 7.

(b) When the county agency receives an incomplete MFIP household report form, the county agency must immediately return the incomplete form and clearly state what the caregiver must do for the form to be complete.

(c) The automated eligibility system must send a notice of proposed termination of assistance to the assistance unit if a complete MFIP household report form is not received by a county agency. The automated notice must be mailed to the caregiver by approximately the 16th of the month. When a caregiver submits an incomplete form on or after the date a notice of proposed termination has been sent, the termination is valid unless the caregiver submits a complete form before the end of the month.

(d) An assistance unit required to submit an MFIP household report form is considered to have continued its application for assistance if a complete MFIP household report form is received within a calendar month after the month in which the form was due and assistance shall be paid for the period beginning with the first day of that calendar month.

(e) A county agency must allow good cause exemptions from the reporting requirements under subdivision 5 when any of the following factors cause a caregiver to fail to provide the county agency with a completed MFIP household report form before the end of the month in which the form is due:

(1) an employer delays completion of employment verification;

(2) a county agency does not help a caregiver complete the MFIP household report form when the caregiver asks for help;

(3) a caregiver does not receive an MFIP household report form due to mistake on the part of the department or the county agency or due to a reported change in address;

(4) a caregiver is ill, or physically or mentally incapacitated; or

(5) some other circumstance occurs that a caregiver could not avoid with reasonable care which prevents the caregiver from providing a completed MFIP household report form before the end of the month in which the form is due.

256J.33 PROSPECTIVE AND RETROSPECTIVE MFIP ELIGIBILITY.

Subd. 3. **Retrospective eligibility.** After the first two months of MFIP eligibility, a county agency must continue to determine whether an assistance unit is prospectively eligible for the payment month by looking at all factors other than income and then determine whether the assistance unit is retrospectively income eligible by applying the monthly income test to the income from the budget month. When the monthly income test is not satisfied, the assistance payment must be suspended when ineligibility exists for one month or ended when ineligibility exists for more than one month.

Subd. 4. **Monthly income test.** A county agency must apply the monthly income test retrospectively for each month of MFIP eligibility. An assistance unit is not eligible when the countable income equals or exceeds the MFIP standard of need or the family wage level for the assistance unit. The income applied against the monthly income test must include:

(1) gross earned income from employment, prior to mandatory payroll deductions, voluntary payroll deductions, wage authorizations, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36, unless the employment income is specifically excluded under section 256J.21, subdivision 2;

(2) gross earned income from self-employment less deductions for self-employment expenses in section 256J.37, subdivision 5, but prior to any reductions for personal or business state and federal income taxes, personal FICA, personal health and life insurance, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36;

(3) unearned income after deductions for allowable expenses in section 256J.37, subdivision 9, and allocations in section 256J.36, unless the income has been specifically excluded in section 256J.21, subdivision 2;

(4) gross earned income from employment as determined under clause (1) which is received by a member of an assistance unit who is a minor child or minor caregiver and less than a half-time student;

(5) child support received by an assistance unit, excluded under section 256J.21, subdivision 2, clause (49), or section 256P.06, subdivision 3, clause (2), item (xvi);

(6) spousal support received by an assistance unit;

(7) the income of a parent when that parent is not included in the assistance unit;

(8) the income of an eligible relative and spouse who seek to be included in the assistance unit; and

(9) the unearned income of a minor child included in the assistance unit.

Subd. 5. **When to terminate assistance.** When an assistance unit is ineligible for MFIP assistance for two consecutive months, the county agency must terminate MFIP assistance.

256J.34 CALCULATING ASSISTANCE PAYMENTS.

Subdivision 1. **Prospective budgeting.** A county agency must use prospective budgeting to calculate the assistance payment amount for the first two months for an applicant who has not received assistance in this state for at least one payment month preceding the first month of payment under a current application. Notwithstanding subdivision 3, paragraph (a), clause (2), a county agency must use prospective budgeting for the first two months for a person who applies to be added to an assistance unit. Prospective budgeting is not subject to overpayments or underpayments unless fraud is determined under section 256.98.

(a) The county agency must apply the income received or anticipated in the first month of MFIP eligibility against the need of the first month. The county agency must apply the income received or anticipated in the second month against the need of the second month.

(b) When the assistance payment for any part of the first two months is based on anticipated income, the county agency must base the initial assistance payment amount on the information available at the time the initial assistance payment is made.

(c) The county agency must determine the assistance payment amount for the first two months of MFIP eligibility by budgeting both recurring and nonrecurring income for those two months.

Subd. 2. **Retrospective budgeting.** The county agency must use retrospective budgeting to calculate the monthly assistance payment amount after the payment for the first two months has been made under subdivision 1.

Subd. 3. **Additional uses of retrospective budgeting.** Notwithstanding subdivision 1, the county agency must use retrospective budgeting to calculate the monthly assistance payment amount for the first two months under paragraphs (a) and (b).

(a) The county agency must use retrospective budgeting to determine the amount of the assistance payment in the first two months of MFIP eligibility:

(1) when an assistance unit applies for assistance for the same month for which assistance has been interrupted, the interruption in eligibility is less than one payment month, the assistance payment for the preceding month was issued in this state, and the assistance payment for the immediately preceding month was determined retrospectively; or

(2) when a person applies in order to be added to an assistance unit, that assistance unit has received assistance in this state for at least the two preceding months, and that person has been living with and has been financially responsible for one or more members of that assistance unit for at least the two preceding months.

(b) Except as provided in clauses (1) to (4), the county agency must use retrospective budgeting and apply income received in the budget month by an assistance unit and by a financially responsible household member who is not included in the assistance unit against the MFIP standard of need or family wage level to determine the assistance payment to be issued for the payment month.

(1) When a source of income ends prior to the third payment month, that income is not considered in calculating the assistance payment for that month. When a source of income ends prior to the fourth payment month, that income is not considered when determining the assistance payment for that month.

(2) When a member of an assistance unit or a financially responsible household member leaves the household of the assistance unit, the income of that departed household member is not budgeted retrospectively for any full payment month in which that household member does not live with that household and is not included in the assistance unit.

(3) When an individual is removed from an assistance unit because the individual is no longer a minor child, the income of that individual is not budgeted retrospectively for payment months in which that individual is not a member of the assistance unit, except that income of an ineligible child in the household must continue to be budgeted retrospectively against the child's needs when the parent or parents of that child request allocation of their income against any unmet needs of that ineligible child.

(4) When a person ceases to have financial responsibility for one or more members of an assistance unit, the income of that person is not budgeted retrospectively for the payment months which follow the month in which financial responsibility ends.

Subd. 4. **Significant change in gross income.** The county agency must recalculate the assistance payment when an assistance unit experiences a significant change, as defined in section 256J.08, resulting in a reduction in the gross income received in the payment month from the gross income received in the budget month. The county agency must issue a supplemental assistance payment based on the county agency's best estimate of the assistance unit's income and circumstances for the payment month. Supplemental assistance payments that result from significant changes are limited to two in a 12-month period regardless of the reason for the change. Notwithstanding any other statute or rule of law, supplementary assistance payments shall not be made when the significant change in income is the result of receipt of a lump sum, receipt of an extra paycheck, business fluctuation in self-employment income, or an assistance unit member's participation in a strike or other labor action.

256J.37 TREATMENT OF INCOME AND LUMP SUMS.

Subd. 10. **Treatment of lump sums.** (a) The agency must treat lump-sum payments as earned or unearned income. If the lump-sum payment is included in the category of income identified in subdivision 9, it must be treated as unearned income. A lump sum is counted as income in the month received and budgeted either prospectively or retrospectively depending on the budget cycle at the time of receipt. When an individual receives a lump-sum payment, that lump sum must be combined with all other earned and unearned income received in the same budget month, and it must be applied according to paragraphs (a) to (c). A lump sum may not be carried over into subsequent months. Any funds that remain in the third month after the month of receipt are counted in the asset limit.

(b) For a lump sum received by an applicant during the first two months, prospective budgeting is used to determine the payment and the lump sum must be combined with other earned or unearned income received and budgeted in that prospective month.

(c) For a lump sum received by a participant after the first two months of MFIP eligibility, the lump sum must be combined with other income received in that budget month, and the combined amount must be applied retrospectively against the applicable payment month.

(d) When a lump sum, combined with other income under paragraphs (b) and (c), is less than the MFIP transitional standard for the appropriate payment month, the assistance payment must be reduced according to the amount of the countable income. When the countable income is greater than the MFIP standard or family wage level, the assistance payment must be suspended for the payment month.

256S.20 CUSTOMIZED LIVING SERVICES; POLICY.

Subd. 2. **Customized living services requirements.** Customized living services and 24-hour customized living services may only be provided in a building that is registered as a housing with services establishment under chapter 144D.

9505.0275 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT.

Subpart 1. **Definition.** "Early and periodic screening, diagnosis, and treatment service" means a service provided to a recipient under age 21 to identify a potentially disabling condition and to provide diagnosis and treatment for a condition identified according to the requirements of the Code of Federal Regulations, title 42, section 441.55 and parts 9505.1693 to 9505.1748.

Subp. 2. **Duties of provider.** The provider shall sign a provider agreement stating that the provider will provide screening services according to standards in parts 9505.1693 to 9505.1748 and Code of Federal Regulations, title 42, sections 441.50 to 441.62.

9505.0370 DEFINITIONS.

Subpart 1. **Scope.** For parts 9505.0370 to 9505.0372, the following terms have the meanings given them.

Subp. 2. **Adult day treatment.** "Adult day treatment" or "adult day treatment program" means a structured program of treatment and care.

Subp. 3. **Child.** "Child" means a person under 18 years of age.

Subp. 4. **Client.** "Client" means an eligible recipient who is determined to have or who is being assessed for a mental illness as specified in part 9505.0371.

Subp. 5. **Clinical summary.** "Clinical summary" means a written description of a clinician's formulation of the cause of the client's mental health symptoms, the client's prognosis, and the likely consequences of the symptoms; how the client meets the criteria for the diagnosis by describing the client's symptoms, the duration of symptoms, and functional impairment; an analysis of the client's other symptoms, strengths, relationships, life situations, cultural influences, and health concerns and their potential interaction with the diagnosis and formulation of the client's mental health condition; and alternative diagnoses that were considered and ruled out.

Subp. 6. **Clinical supervision.** "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

Subp. 7. **Clinical supervisor.** "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

Subp. 8. **Cultural competence or culturally competent.** "Cultural competence" or "culturally competent" means the mental health provider's:

A. awareness of the provider's own cultural background, and the related assumptions, values, biases, and preferences that influence assessment and intervention processes;

B. ability and will to respond to the unique needs of an individual client that arise from the client's culture;

C. ability to utilize the client's culture as a resource and as a means to optimize mental health care; and

D. willingness to seek educational, consultative, and learning experiences to expand knowledge of and increase effectiveness with culturally diverse populations.

Subp. 9. **Cultural influences.** "Cultural influences" means historical, geographical, and familial factors that affect assessment and intervention processes. Cultural influences that are relevant to the client may include the client's:

A. racial or ethnic self-identification;

B. experience of cultural bias as a stressor;

C. immigration history and status;

D. level of acculturation;

E. time orientation;

F. social orientation;

G. verbal communication style;

H. locus of control;

I. spiritual beliefs; and

J. health beliefs and the endorsement of or engagement in culturally specific healing practices.

Subp. 10. **Culture.** "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

Subp. 11. **Diagnostic assessment.** "Diagnostic assessment" means a written assessment that documents a clinical and functional face-to-face evaluation of the client's mental health, including the nature, severity and impact of behavioral difficulties, functional impairment, and subjective distress of the client, and identifies the client's strengths and resources.

Subp. 12. **Dialectical behavior therapy.** "Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program is certified by the commissioner and involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

Subp. 13. **Explanation of findings.** "Explanation of findings" means the explanation of a client's diagnostic assessment, psychological testing, treatment program, and consultation with culturally informed mental health consultants as required under parts 9520.0900 to 9520.0926, or other accumulated data and recommendations to the client, client's family, primary caregiver, or other responsible persons.

Subp. 14. **Family.** "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, or persons who are presently residing together as a family unit.

Subp. 15. **Individual treatment plan.** "Individual treatment plan" means a written plan that outlines and defines the course of treatment. It delineates the goals, measurable objectives, target dates for achieving specific goals, main participants in treatment process, and recommended services that are based on the client's diagnostic assessment and other meaningful data that are needed to aid the client's recovery and enhance resiliency.

Subp. 16. **Medication management.** "Medication management" means a service that determines the need for or effectiveness of the medication prescribed for the treatment of a client's symptoms of a mental illness.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a person who is qualified according to part 9505.0371, subpart 5, items B and C, and provides mental health services to a client with a mental illness under the clinical supervision of a mental health professional.

Subp. 18. **Mental health professional.** "Mental health professional" means a person who is enrolled to provide medical assistance services and is qualified according to part 9505.0371, subpart 5, item A.

Subp. 19. **Mental health telemedicine.** "Mental health telemedicine" has the meaning given in Minnesota Statutes, section 256B.0625, subdivision 46.

Subp. 20. **Mental illness.** "Mental illness" has the meaning given in Minnesota Statutes, section 245.462, subdivision 20. "Mental illness" includes "emotional disturbance" as defined in Minnesota Statutes, section 245.4871, subdivision 15.

Subp. 21. **Multidisciplinary staff.** "Multidisciplinary staff" means a group of individuals from diverse disciplines who come together to provide services to clients under part 9505.0372, subparts 8, 9, and 10.

Subp. 22. **Neuropsychological assessment.** "Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist.

Subp. 23. **Neuropsychological testing.** "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn and recall information; and use problem-solving and judgment.

Subp. 24. **Partial hospitalization program.** "Partial hospitalization program" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x, (ff), that is provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services.

Subp. 25. **Primary caregiver.** "Primary caregiver" means a person, other than the facility staff, who has primary legal responsibility for providing the client with food, clothing, shelter, direction, guidance, and nurturance.

Subp. 26. **Psychological testing.** "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the recipient's mental, intellectual, and emotional functioning.

Subp. 27. **Psychotherapy.** "Psychotherapy" means treatment of a client with mental illness that applies the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client.

Subp. 28. **Supervisee.** "Supervisee" means an individual who requires clinical supervision because the individual does not meet mental health professional standards in part 9505.0371, subpart 5, item A.

9505.0371 MEDICAL ASSISTANCE COVERAGE REQUIREMENTS FOR OUTPATIENT MENTAL HEALTH SERVICES.

Subpart 1. **Purpose.** This part describes the requirements that outpatient mental health services must meet to receive medical assistance reimbursement.

Subp. 2. **Client eligibility for mental health services.** The following requirements apply to mental health services:

A. The provider must use a diagnostic assessment as specified in part 9505.0372 to determine a client's eligibility for mental health services under this part, except:

(1) prior to completion of a client's initial diagnostic assessment, a client is eligible for:

(a) one explanation of findings;

(b) one psychological testing; and

(c) either one individual psychotherapy session, one family psychotherapy session, or one group psychotherapy session; and

(2) for a client who is not currently receiving mental health services covered by medical assistance, a crisis assessment as specified in Minnesota Statutes, section 256B.0624 or 256B.0944, conducted in the past 60 days may be used to allow up to ten sessions of mental health services within a 12-month period.

B. A brief diagnostic assessment must meet the requirements of part 9505.0372, subpart 1, item D, and:

(1) may be used to allow up to ten sessions of mental health services as specified in part 9505.0372 within a 12-month period before a standard or extended diagnostic assessment is required when the client is:

(a) a new client; or

(b) an existing client who has had fewer than ten sessions of psychotherapy in the previous 12 months and is projected to need fewer than ten sessions of psychotherapy in the next 12 months, or who only needs medication management; and

(2) may be used for a subsequent annual assessment, if based upon the client's treatment history and the provider's clinical judgment, the client will need ten or fewer sessions of mental health services in the upcoming 12-month period; and

(3) must not be used for:

(a) a client or client's family who requires a language interpreter to participate in the assessment unless the client meets the requirements of subitem (1), unit (b), or (2); or

(b) more than ten sessions of mental health services in a 12-month period. If, after completion of ten sessions of mental health services, the mental health professional determines the need for additional sessions, a standard assessment or extended assessment must be completed.

C. For a child, a new standard or extended diagnostic assessment must be completed:

(1) when the child does not meet the criteria for a brief diagnostic assessment;

(2) at least annually following the initial diagnostic assessment, if:

(a) additional services are needed; and

(b) the child does not meet criteria for brief assessment;

(3) when the child's mental health condition has changed markedly since the child's most recent diagnostic assessment; or

(4) when the child's current mental health condition does not meet criteria of the child's current diagnosis.

D. For an adult, a new standard diagnostic assessment or extended diagnostic assessment must be completed:

(1) when the adult does not meet the criteria for a brief diagnostic assessment or an adult diagnostic assessment update;

(2) at least every three years following the initial diagnostic assessment for an adult who receives mental health services;

(3) when the adult's mental health condition has changed markedly since the adult's most recent diagnostic assessment; or

(4) when the adult's current mental health condition does not meet criteria of the current diagnosis.

E. An adult diagnostic assessment update must be completed at least annually unless a new standard or extended diagnostic assessment is performed. An adult diagnostic assessment update must include an update of the most recent standard or extended diagnostic assessment and any recent adult diagnostic assessment updates that have occurred since the last standard or extended diagnostic assessment.

Subp. 3. **Authorization for mental health services.** Mental health services under this part are subject to authorization criteria and standards published by the commissioner according to Minnesota Statutes, section 256B.0625, subdivision 25.

Subp. 4. **Clinical supervision.**

A. Clinical supervision must be based on each supervisee's written supervision plan and must:

(1) promote professional knowledge, skills, and values development;

(2) model ethical standards of practice;

(3) promote cultural competency by:

(a) developing the supervisee's knowledge of cultural norms of behavior for individual clients and generally for the clients served by the supervisee regarding the client's cultural influences, age, class, gender, sexual orientation, literacy, and mental or physical disability;

(b) addressing how the supervisor's and supervisee's own cultures and privileges affect service delivery;

(c) developing the supervisee's ability to assess their own cultural competence and to identify when consultation or referral of the client to another provider is needed; and

(d) emphasizing the supervisee's commitment to maintaining cultural competence as an ongoing process;

(4) recognize that the client's family has knowledge about the client and will continue to play a role in the client's life and encourage participation among the client, client's family, and providers as treatment is planned and implemented; and

(5) monitor, evaluate, and document the supervisee's performance of assessment, treatment planning, and service delivery.

B. Clinical supervision must be conducted by a qualified supervisor using individual or group supervision. Individual or group face-to-face supervision may be conducted via electronic communications that utilize interactive telecommunications equipment that includes at a minimum audio and video equipment for two-way, real-time, interactive communication between the supervisor and supervisee, and meet the equipment and connection standards of part 9505.0370, subpart 19.

(1) Individual supervision means one or more designated clinical supervisors and one supervisee.

(2) Group supervision means one clinical supervisor and two to six supervisees in face-to-face supervision.

C. The supervision plan must be developed by the supervisor and the supervisee. The plan must be reviewed and updated at least annually. For new staff the plan must be completed and implemented within 30 days of the new staff person's employment. The supervision plan must include:

(1) the name and qualifications of the supervisee and the name of the agency in which the supervisee is being supervised;

(2) the name, licensure, and qualifications of the supervisor;

(3) the number of hours of individual and group supervision to be completed by the supervisee including whether supervision will be in person or by some other method approved by the commissioner;

(4) the policy and method that the supervisee must use to contact the clinical supervisor during service provision to a supervisee;

(5) procedures that the supervisee must use to respond to client emergencies; and

(6) authorized scope of practices, including:

(a) description of the supervisee's service responsibilities;

(b) description of client population; and

(c) treatment methods and modalities.

D. Clinical supervision must be recorded in the supervisee's supervision record. The documentation must include:

(1) date and duration of supervision;

(2) identification of supervision type as individual or group supervision;

(3) name of the clinical supervisor;

(4) subsequent actions that the supervisee must take; and

(5) date and signature of the clinical supervisor.

E. Clinical supervision pertinent to client treatment changes must be recorded by a case notation in the client record after supervision occurs.

Subp. 5. **Qualified providers.** Medical assistance covers mental health services according to part 9505.0372 when the services are provided by mental health professionals or mental health practitioners qualified under this subpart.

A. A mental health professional must be qualified in one of the following ways:

(1) in clinical social work, a person must be licensed as an independent clinical social worker by the Minnesota Board of Social Work under Minnesota Statutes, chapter 148D until August 1, 2011, and thereafter under Minnesota Statutes, chapter 148E;

(2) in psychology, a person licensed by the Minnesota Board of Psychology under Minnesota Statutes, sections 148.88 to 148.98, who has stated to the board competencies in the diagnosis and treatment of mental illness;

(3) in psychiatry, a physician licensed under Minnesota Statutes, chapter 147, who is certified by the American Board of Psychiatry and Neurology or is eligible for board certification;

(4) in marriage and family therapy, a person licensed as a marriage and family therapist by the Minnesota Board of Marriage and Family Therapy under Minnesota Statutes, sections 148B.29 to 148B.39, and defined in parts 5300.0100 to 5300.0350;

(5) in professional counseling, a person licensed as a professional clinical counselor by the Minnesota Board of Behavioral Health and Therapy under Minnesota Statutes, section 148B.5301;

(6) a tribally approved mental health care professional, who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), and who is serving a federally recognized Indian tribe; or

(7) in psychiatric nursing, a registered nurse who is licensed under Minnesota Statutes, sections 148.171 to 148.285, and meets one of the following criteria:

(a) is certified as a clinical nurse specialist;

(b) for children, is certified as a nurse practitioner in child or adolescent or family psychiatric and mental health nursing by a national nurse certification organization; or

(c) for adults, is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization.

B. A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults. A mental health practitioner must be qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university; and

(a) has at least 2,000 hours of supervised experience in the delivery of mental health services to clients with mental illness; or

(b) is fluent in the non-English language of the cultural group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once a week until the requirements of 2,000 hours of supervised experience are met;

(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to clients with mental illness. Hours worked as a mental health behavioral aide I or II under Minnesota Statutes, section 256B.0943, subdivision 7, may be included in the 6,000 hours of experience for child clients;

(3) is a graduate student in one of the mental health professional disciplines defined in item A and is formally assigned by an accredited college or university to an agency or facility for clinical training;

(4) holds a master's or other graduate degree in one of the mental health professional disciplines defined in item A from an accredited college or university; or

(5) is an individual who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), who is serving a federally recognized Indian tribe.

C. Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy performed by a mental health practitioner working as a clinical trainee when:

(1) the mental health practitioner is:

(a) complying with requirements for licensure or board certification as a mental health professional, as defined in item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or

(b) a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional defined in item A; and

(2) the mental health practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of:

(a) direct practice;

(b) treatment team collaboration;

(c) continued professional learning; and

(d) job management.

D. A clinical supervisor must:

(1) be a mental health professional licensed as specified in item A;

(2) hold a license without restrictions that has been in good standing for at least one year while having performed at least 1,000 hours of clinical practice;

(3) be approved, certified, or in some other manner recognized as a qualified clinical supervisor by the person's professional licensing board, when this is a board requirement;

(4) be competent as demonstrated by experience and graduate-level training in the area of practice and the activities being supervised;

(5) not be the supervisee's blood or legal relative or cohabitant, or someone who has acted as the supervisee's therapist within the past two years;

(6) have experience and skills that are informed by advanced training, years of experience, and mastery of a range of competencies that demonstrate the following:

(a) capacity to provide services that incorporate best practice;

(b) ability to recognize and evaluate competencies in supervisees;

(c) ability to review assessments and treatment plans for accuracy and appropriateness;

(d) ability to give clear direction to mental health staff related to alternative strategies when a client is struggling with moving towards recovery; and

(e) ability to coach, teach, and practice skills with supervisees;

(7) accept full professional liability for a supervisee's direction of a client's mental health services;

(8) instruct a supervisee in the supervisee's work, and oversee the quality and outcome of the supervisee's work with clients;

(9) review, approve, and sign the diagnostic assessment, individual treatment plans, and treatment plan reviews of clients treated by a supervisee;

(10) review and approve the progress notes of clients treated by the supervisee according to the supervisee's supervision plan;

(11) apply evidence-based practices and research-informed models to treat clients;

(12) be employed by or under contract with the same agency as the supervisee;

(13) develop a clinical supervision plan for each supervisee;

(14) ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices;

(15) establish an evaluation process that identifies the performance and competence of each supervisee; and

(16) document clinical supervision of each supervisee and securely maintain the documentation record.

Subp. 6. **Release of information.** Providers who receive a request for client information and providers who request client information must:

A. comply with data practices and medical records standards in Minnesota Statutes, chapter 13, and Code of Federal Regulations, title 45, part 164; and

B. subject to the limitations in item A, promptly provide client information, including a written diagnostic assessment, to other providers who are treating the client to ensure that the client will get services without undue delay.

Subp. 7. **Individual treatment plan.** Except as provided in subpart 2, item A, subitem (1), a medical assistance payment is available only for services provided in accordance with the client's written individual treatment plan (ITP). The client must be involved in the development, review, and revision of the client's ITP. For all mental health services, except as provided in subpart 2, item A, subitem (1), and medication management, the ITP and subsequent revisions of the ITP must be signed by the client before treatment begins. The mental health professional or practitioner shall request the client, or other person authorized by statute to consent to mental health services for the client, to sign the client's ITP or revision of the ITP. In the case of a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child shall be asked to sign the child's ITP and revisions of the ITP. If the client or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the refusal to sign the plan and the reason or reasons for the refusal. A client's individual treatment plan must be:

A. based on the client's current diagnostic assessment;

B. developed by identifying the client's service needs and considering relevant cultural influences to identify planned interventions that contain specific treatment goals and measurable objectives for the client; and

C. reviewed at least once every 90 days, and revised as necessary. Revisions to the initial individual treatment plan do not require a new diagnostic assessment unless the client's mental health status has changed markedly as provided in subpart 2.

Subp. 8. **Documentation.** To obtain medical assistance payment for an outpatient mental health service, a mental health professional or a mental health practitioner must promptly document:

A. in the client's mental health record:

(1) each occurrence of service to the client including the date, type of service, start and stop time, scope of the mental health service, name and title of the person who gave the service, and date of documentation; and

(2) all diagnostic assessments and other assessments, psychological test results, treatment plans, and treatment plan reviews;

B. the provider's contact with persons interested in the client such as representatives of the courts, corrections systems, or schools, or the client's other mental health providers, case manager, family, primary caregiver, legal representative, including the name and date of the contact or, if applicable, the reason the client's family, primary caregiver, or legal representative was not contacted; and

C. dates that treatment begins and ends and reason for the discontinuation of the mental health service.

Subp. 9. **Service coordination.** The provider must coordinate client services as authorized by the client as follows:

A. When a recipient receives mental health services from more than one mental health provider, each provider must coordinate mental health services they provide to the client with other mental health service providers to ensure services are provided in the most efficient manner to achieve maximum benefit for the client.

B. The mental health provider must coordinate mental health care with the client's physical health provider.

Subp. 10. **Telemedicine services.** Mental health services in part 9505.0372 covered as direct face-to-face services may be provided via two-way interactive video if it is medically appropriate to the client's condition and needs. The interactive video equipment and connection must comply with Medicare standards that are in effect at the time of service. The commissioner may specify parameters within which mental health services can be provided via telemedicine.

9505.0372 COVERED SERVICES.

Subpart 1. **Diagnostic assessment.** Medical assistance covers four types of diagnostic assessments when they are provided in accordance with the requirements in this subpart.

A. To be eligible for medical assistance payment, a diagnostic assessment must:

(1) identify a mental health diagnosis and recommended mental health services, which are the factual basis to develop the recipient's mental health services and treatment plan; or

(2) include a finding that the client does not meet the criteria for a mental health disorder.

B. A standard diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The standard diagnostic assessment must be done within the cultural context of the client and must include relevant information about:

(1) the client's current life situation, including the client's:

(a) age;

(b) current living situation, including household membership and housing status;

(c) basic needs status including economic status;

(d) education level and employment status;

(e) significant personal relationships, including the client's evaluation of relationship quality;

(f) strengths and resources, including the extent and quality of social networks;

(g) belief systems;

(h) contextual nonpersonal factors contributing to the client's presenting concerns;

(i) general physical health and relationship to client's culture; and

(j) current medications;

(2) the reason for the assessment, including the client's:

(a) perceptions of the client's condition;

(b) description of symptoms, including reason for referral;

(c) history of mental health treatment, including review of the client's records;

(d) important developmental incidents;

(e) maltreatment, trauma, or abuse issues;

(f) history of alcohol and drug usage and treatment;

(g) health history and family health history, including physical, chemical, and mental health history; and

(h) cultural influences and their impact on the client;

(3) the client's mental status examination;

(4) the assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(5) the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

(6) assessment methods and use of standardized assessment tools by the provider as determined and periodically updated by the commissioner;

(7) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(8) the client data that is adequate to support the findings on all axes of the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and any differential diagnosis.

C. An extended diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The face-to-face interview is conducted over three or more assessment appointments because the client's complex needs necessitate significant additional assessment time. Complex needs are those caused by acuity of psychotic disorder; cognitive or neurocognitive impairment; need to consider past diagnoses and determine their current applicability; co-occurring substance abuse use disorder; or disruptive or changing environments, communication barriers, or cultural considerations as documented in the assessment. For child clients, the appointments may be conducted outside the diagnostician's office for face-to-face consultation and information gathering with family members, doctors, caregivers, teachers, and other providers, with or without the child present, and may involve directly observing the child in various settings that the child frequents such as home, school, or care settings. To complete the diagnostic assessment with adult clients, the appointments may be conducted outside of the diagnostician's office for face-to-face assessment with the adult client. The appointment may involve directly observing the adult client in various settings that the adult frequents, such as home, school, job, service settings, or community settings. The appointments may include face-to-face meetings with the adult client and the client's family members, doctors, caregivers, teachers, social support network members, recovery support resource representatives, and other providers for consultation and information gathering for the diagnostic assessment. The components of an extended diagnostic assessment include the following relevant information:

(1) for children under age 5:

(a) utilization of the DC:0-3R diagnostic system for young children;

(b) an early childhood mental status exam that assesses the client's developmental, social, and emotional functioning and style both within the family and with the examiner and includes:

i. physical appearance including dysmorphic features;

ii. reaction to new setting and people and adaptation during evaluation;

iii. self-regulation, including sensory regulation, unusual behaviors, activity level, attention span, and frustration tolerance;

iv. physical aspects, including motor function, muscle tone, coordination, tics, abnormal movements, and seizure activity;

v. vocalization and speech production, including expressive and receptive language;

vi. thought, including fears, nightmares, dissociative states, and hallucinations;

vii. affect and mood, including modes of expression, range, responsiveness, duration, and intensity;

viii. play, including structure, content, symbolic functioning, and modulation of aggression;

ix. cognitive functioning; and

x. relatedness to parents, other caregivers, and examiner; and

(c) other assessment tools as determined and periodically revised by the commissioner;

(2) for children ages 5 to 18, completion of other assessment standards for children as determined and periodically revised by the commissioner; and

(3) for adults, completion of other assessment standards for adults as determined and periodically revised by the commissioner.

D. A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The professional or practitioner must gather initial background information using the components of a standard diagnostic assessment in item B, subitems (1), (2), unit (b), (3), and (5), and draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem. Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.

E. Adult diagnostic assessment update includes a face-to-face interview with the client, and contains a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C, who reviews a standard or extended diagnostic assessment. The adult diagnostic assessment update must update the most recent assessment document in writing in the following areas:

(1) review of the client's life situation, including an interview with the client about the client's current life situation, and a written update of those parts where significant new or changed information exists, and documentation where there has not been significant change;

(2) review of the client's presenting problems, including an interview with the client about current presenting problems and a written update of those parts where there is significant new or changed information, and note parts where there has not been significant change;

(3) screenings for substance use, abuse, or dependency and other screenings as determined by the commissioner;

(4) the client's mental health status examination;

(5) assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(6) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary, or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(7) the client's diagnosis on all axes of the current edition of the Diagnostic and Statistical Manual and any differential diagnosis.

Subp. 2. **Neuropsychological assessment.** A neuropsychological assessment must include a face-to-face interview with the client, the interpretation of the test results, and preparation and completion of a report. A client is eligible for a neuropsychological assessment if at least one of the following criteria is met:

A. There is a known or strongly suspected brain disorder based on medical history or neurological evaluation such as a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorders, significant exposure to neurotoxins, central nervous system infections, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformations of the brain; or

B. In the absence of a medically verified brain disorder based on medical history or neurological evaluation, there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology, or suspected neuropsychological impairment in addition to functional psychopathology. Examples include:

(1) poor memory or impaired problem solving;

(2) change in mental status evidenced by lethargy, confusion, or disorientation;

(3) deterioration in level of functioning;

(4) marked behavioral or personality change;

(5) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;

(6) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers; and

(7) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

C. If neither criterion in item A nor B is fulfilled, neuropsychological evaluation is not indicated.

D. The neuropsychological assessment must be conducted by a neuropsychologist with competence in the area of neuropsychological assessment as stated to the Minnesota Board of Psychology who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program:

(a) completed an internship, or its equivalent, in a clinically relevant area of professional psychology;

(b) completed the equivalent of two full-time years of experience and specialized training, at least one which is at the postdoctoral level, in the study and practices of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist; and

(c) holds a current license to practice psychology independently in accordance with Minnesota Statutes, sections 148.88 to 148.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in subitem (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010.

Subp. 3. **Neuropsychological testing.**

A. Medical assistance covers neuropsychological testing when the client has either:

(1) a significant mental status change that is not a result of a metabolic disorder that has failed to respond to treatment;

(2) in children or adolescents, a significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers;

(3) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities, as required to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(a) traumatic brain injury;

(b) stroke;

(c) brain tumor;

(d) substance abuse or dependence;

(e) cerebral anoxic or hypoxic episode;

(f) central nervous system infection or other infectious disease;

(g) neoplasms or vascular injury of the central nervous system;

(h) neurodegenerative disorders;

(i) demyelinating disease;

(j) extrapyramidal disease;

(k) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(l) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders such as lupus, erythematosis, or celiac disease;

(m) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, such as phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(n) severe or prolonged nutrition or malabsorption syndromes; or

(o) a condition presenting in a manner making it difficult for a clinician to distinguish between:

i. the neurocognitive effects of a neurogenic syndrome such as dementia or encephalopathy; and

ii. a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function, or another disorder such as autism, selective mutism, anxiety disorder, or reactive attachment disorder.

B. Neuropsychological testing must be administered or clinically supervised by a neuropsychologist qualified as defined in subpart 2, item D.

C. Neuropsychological testing is not covered when performed:

(1) primarily for educational purposes;

(2) primarily for vocational counseling or training;

(3) for personnel or employment testing;

(4) as a routine battery of psychological tests given at inpatient admission or continued stay; or

(5) for legal or forensic purposes.

Subp. 4. **Psychological testing.** Psychological testing must meet the following requirements:

A. The psychological testing must:

(1) be administered or clinically supervised by a licensed psychologist with competence in the area of psychological testing as stated to the Minnesota Board of Psychology; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a mental health practitioner working as a clinical psychology trainee as required by part 9505.0371, subpart 5, item C, under the clinical supervision of a licensed psychologist according to part 9505.0371, subpart 5, item A, subitem (2).

B. The administration, scoring, and interpretation of the psychological tests must be done under the clinical supervision of a licensed psychologist when performed by a technician, psychometrist, or psychological assistant or as part of a computer-assisted psychological testing program.

C. The report resulting from the psychological testing must be:

(1) signed by the psychologist conducting the face-to-face interview;

(2) placed in the client's record; and

(3) released to each person authorized by the client.

Subp. 5. **Explanations of findings.** To be eligible for medical assistance payment, the mental health professional providing the explanation of findings must obtain the authorization of the client or the client's representative to release the information as required in part 9505.0371, subpart 6. Explanation of findings is provided to the client, client's family, and caregivers, or to other providers to help them understand the results of the testing or diagnostic assessment, better understand the client's illness, and provide professional insight needed to carry out a plan of treatment. An explanation of findings is not paid separately when the results of psychological testing or a diagnostic assessment are explained to the client or the client's representative as part of the psychological testing or a diagnostic assessment.

Subp. 6. **Psychotherapy.** Medical assistance covers psychotherapy as conducted by a mental health professional or a mental health practitioner as defined in part 9505.0371, subpart 5, item C, as provided in this subpart.

A. Individual psychotherapy is psychotherapy designed for one client.

B. Family psychotherapy is designed for the client and one or more family members or the client's primary caregiver whose participation is necessary to accomplish the client's

treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance. For purposes of this subpart, the phrase "whose participation is necessary to accomplish the client's treatment goals" does not include shift or facility staff members at the client's residence. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of time of the exclusion. The mental health professional must also document the reason or reasons why a member of the client's family is excluded.

C. Group psychotherapy is appropriate for individuals who because of the nature of their emotional, behavioral, or social dysfunctions can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or practitioner is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two mental health practitioners or one mental health professional and one mental health practitioner is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 persons.

D. A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in client's treatment plan. If the client is excluded, the mental health professional or practitioner must document the reason for and the length of the time of the exclusion. The mental health professional or practitioner must document the reasons why a member of the client's family is excluded.

Subp. 7. **Medication management.** The determination or evaluation of the effectiveness of a client's prescribed drug must be carried out by a physician or by an advanced practice registered nurse, as defined in Minnesota Statutes, sections 148.171 to 148.285, who is qualified in psychiatric nursing.

Subp. 8. **Adult day treatment.** Adult day treatment payment limitations include the following conditions.

A. Adult day treatment must consist of at least one hour of group psychotherapy, and must include group time focused on rehabilitative interventions, or other therapeutic services that are provided by a multidisciplinary staff. Adult day treatment is an intensive psychotherapeutic treatment. The services must stabilize the client's mental health status, and develop and improve the client's independent living and socialization skills. The goal of adult day treatment is to reduce or relieve the effects of mental illness so that an individual is able to benefit from a lower level of care and to enable the client to live and function more independently in the community. Day treatment services are not a part of inpatient or residential treatment services.

B. To be eligible for medical assistance payment, a day treatment program must:

(1) be reviewed by and approved by the commissioner;

(2) be provided to a group of clients by a multidisciplinary staff under the clinical supervision of a mental health professional;

(3) be available to the client at least two days a week for at least three consecutive hours per day. The day treatment may be longer than three hours per day, but medical assistance must not reimburse a provider for more than 15 hours per week;

(4) include group psychotherapy done by a mental health professional, or mental health practitioner qualified according to part 9505.0371, subpart 5, item C, and rehabilitative interventions done by a mental health professional or mental health practitioner daily;

(5) be included in the client's individual treatment plan as necessary and appropriate. The individual treatment plan must include attainable, measurable goals as they relate to services and must be completed before the first day treatment session. The vendor must review the recipient's progress and update the treatment plan at least every 30 days until the client is discharged and include an available discharge plan for the client in the treatment plan; and

(6) document the interventions provided and the client's response daily.

C. To be eligible for adult day treatment, a recipient must:

(1) be 18 years of age or older;

(2) not be residing in a nursing facility, hospital, institute of mental disease, or regional treatment center, unless the recipient has an active discharge plan that indicates a move to an independent living arrangement within 180 days;

(3) have a diagnosis of mental illness as determined by a diagnostic assessment;

(4) have the capacity to engage in the rehabilitative nature, the structured setting, and the therapeutic parts of psychotherapy and skills activities of a day treatment program and demonstrate measurable improvements in the recipient's functioning related to the recipient's mental illness that would result from participating in the day treatment program;

(5) have at least three areas of functional impairment as determined by a functional assessment with the domains prescribed by Minnesota Statutes, section 245.462, subdivision 11a;

(6) have a level of care determination that supports the need for the level of intensity and duration of a day treatment program; and

(7) be determined to need day treatment by a mental health professional who must deem the day treatment services medically necessary.

D. The following services are not covered by medical assistance if they are provided by a day treatment program:

(1) a service that is primarily recreation-oriented or that is provided in a setting that is not medically supervised. This includes: sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultation with other providers or service agency staff about the care or progress of a client;

(4) prevention or education programs provided to the community;

(5) day treatment for recipients with primary diagnoses of alcohol or other drug abuse;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours daily; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Subp. 9. **Partial hospitalization.** Partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission as specified in part 9505.0520, subpart 1, and who has the family and community resources

necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services provided by a multidisciplinary staff to treat the client's mental illness.

Subp. 10. **Dialectical behavior therapy (DBT).** Dialectical behavior therapy (DBT) treatment services must meet the following criteria:

A. DBT must be provided according to this subpart and Minnesota Statutes, section 256B.0625, subdivision 5l.

B. DBT is an outpatient service that is determined to be medically necessary by either: (1) a mental health professional qualified according to part 9505.0371, subpart 5, or (2) a mental health practitioner working as a clinical trainee according to part 9505.0371, subpart 5, item C, who is under the clinical supervision of a mental health professional according to part 9505.0371, subpart 5, item D, with specialized skill in dialectical behavior therapy. The treatment recommendation must be based upon a comprehensive evaluation that includes a diagnostic assessment and functional assessment of the client, and review of the client's prior treatment history. Treatment services must be provided pursuant to the client's individual treatment plan and provided to a client who satisfies the criteria in item C.

C. To be eligible for DBT, a client must:

(1) be 18 years of age or older;

(2) have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services;

(3) meet one of the following criteria:

(a) have a diagnosis of borderline personality disorder; or

(b) have multiple mental health diagnoses and exhibit behaviors characterized by impulsivity, intentional self-harm behavior, and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas;

(4) understand and be cognitively capable of participating in DBT as an intensive therapy program and be able and willing to follow program policies and rules assuring safety of self and others; and

(5) be at significant risk of one or more of the following if DBT is not provided:

(a) mental health crisis;

(b) requiring a more restrictive setting such as hospitalization;

(c) decompensation; or

(d) engaging in intentional self-harm behavior.

D. The treatment components of DBT are individual therapy and group skills as follows:

(1) Individual DBT combines individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and reinforce the use of adaptive skillful behaviors. The therapist must:

(a) identify, prioritize, and sequence behavioral targets;

(b) treat behavioral targets;

(c) generalize DBT skills to the client's natural environment through telephone coaching outside of the treatment session;

(d) measure the client's progress toward DBT targets;

(e) help the client manage crisis and life-threatening behaviors; and

(f) help the client learn and apply effective behaviors when working with other treatment providers.

(2) Individual DBT therapy is provided by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

(3) Group DBT skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce the client's suicidal and other dysfunctional coping behaviors and restore function by teaching the client adaptive skills in the following areas:

(a) mindfulness;

(b) interpersonal effectiveness;

(c) emotional regulation; and

(d) distress tolerance.

(4) Group DBT skills training is provided by two mental health professionals, or by a mental health professional cofacilitating with a mental health practitioner.

(5) The need for individual DBT skills training must be determined by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

E. A program must be certified by the commissioner as a DBT provider. To qualify for certification, a provider must:

(1) hold current accreditation as a DBT program from a nationally recognized certification body approved by the commissioner or submit to the commissioner's inspection and provide evidence that the DBT program's policies, procedures, and practices will continuously meet the requirements of this subpart;

(2) be enrolled as a MHCP provider;

(3) collect and report client outcomes as specified by the commissioner; and

(4) have a manual that outlines the DBT program's policies, procedures, and practices which meet the requirements of this subpart.

F. The DBT treatment team must consist of persons who are trained in DBT treatment. The DBT treatment team may include persons from more than one agency. Professional and clinical affiliations with the DBT team must be delineated:

(1) A DBT team leader must:

(a) be a mental health professional employed by, affiliated with, or contracted by a DBT program certified by the commissioner;

(b) have appropriate competencies and working knowledge of the DBT principles and practices; and

(c) have knowledge of and ability to apply the principles and DBT practices that are consistent with evidence-based practices.

(2) DBT team members who provide individual DBT or group skills training must:

(a) be a mental health professional or be a mental health practitioner, who is employed by, affiliated with, or contracted with a DBT program certified by the commissioner;

(b) have or obtain appropriate competencies and working knowledge of DBT principles and practices within the first six months of becoming a part of the DBT program;

(c) have or obtain knowledge of and ability to apply the principles and practices of DBT consistently with evidence-based practices within the first six months of working at the DBT program;

(d) participate in DBT consultation team meetings; and

(e) require mental health practitioners to have ongoing clinical supervision by a mental health professional who has appropriate competencies and working knowledge of DBT principles and practices.

Subp. 11. **Noncovered services.** The mental health services in items A to J are not eligible for medical assistance payment under this part:

A. a mental health service that is not medically necessary;

B. a neuropsychological assessment carried out by a person other than a neuropsychologist who is qualified according to part 9505.0372, subpart 2, item D;

C. a service ordered by a court that is solely for legal purposes and not related to the recipient's diagnosis or treatment for mental illness;

D. services dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health;

E. a service that is only for a vocational purpose or an educational purpose that is not mental health related;

F. staff training that is not related to a client's individual treatment plan or plan of care;

G. child and adult protection services;

H. fund-raising activities;

I. community planning; and

J. client transportation.

9505.1693 SCOPE AND PURPOSE.

Parts 9505.1693 to 9505.1748 govern the early and periodic screening, diagnosis, and treatment (EPSDT) program.

Parts 9505.1693 to 9505.1748 must be read in conjunction with section 1905(a)(4)(B) of the Social Security Act, as amended through December 31, 1981, and the Code of Federal Regulations, title 42, part 441, subpart B, as amended through October 1, 1987, and section 6403 of the Omnibus Budget Reconciliation Act of 1989. The purpose of the EPSDT program is to identify potentially disabling conditions in children eligible for medical assistance, to provide diagnosis and treatment for conditions identified, and to encourage parents and their children to use health care services when necessary.

9505.1696 DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 9505.1693 to 9505.1748, the following terms have the meanings given them.

Subp. 2. **Child.** "Child" means a person who is eligible for early and periodic screening, diagnosis, and treatment under part 9505.1699.

Subp. 3. **Community health clinic.** "Community health clinic" means a clinic that provides services by or under the supervision of a physician and that:

A. is incorporated as a nonprofit corporation under Minnesota Statutes, chapter 317A;

B. is exempt from federal income tax under Internal Revenue Code of 1986, section 501(c)(3), as amended through December 31, 1987;

C. is established to provide health services to low-income population groups; and

D. has written clinic policies describing the services provided by the clinic and concerning (1) the medical management of health problems, including problems that require referral to physicians, (2) emergency health services, and (3) the maintenance and review of health records by the physician.

Subp. 4. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 5. **Diagnosis.** "Diagnosis" means the identification and determination of the nature or cause of a disease or abnormality through the use of a health history; physical, developmental, and psychological examination; and laboratory tests.

Subp. 6. **Early and periodic screening clinic or EPS clinic.** "Early and periodic screening clinic" or "EPS clinic" means an individual or facility that is approved by the Minnesota Department of Health under parts 4615.0900 to 4615.2000.

Subp. 7. **Early and periodic screening, diagnosis, and treatment program or EPSDT program.** "Early and periodic screening, diagnosis, and treatment program" or "EPSDT program" means the program that provides screening, diagnosis, and treatment under parts 9505.1693 to 9505.1748; Code of Federal Regulations, title 42, section 441.55, as amended through October 1, 1986; and Minnesota Statutes, section 256B.02, subdivision 8, paragraph (12).

Subp. 8. **EPSDT clinic.** "EPSDT clinic" means a facility supervised by a physician that provides screening according to parts 9505.1693 to 9505.1748 or an EPS clinic.

Subp. 9. **EPSDT provider agreement.** "EPSDT provider agreement" means the agreement required by part 9505.1703, subpart 2.

Subp. 11. **Follow-up.** "Follow-up" means efforts by a local agency to ensure that a screening requested for a child is provided to that child and that diagnosis and treatment indicated as necessary by a screening are also provided to that child.

Subp. 12. **Head Start agency.** "Head Start agency" refers to the child development program administered by the United States Department of Health and Human Services, Office of Administration for Children, Youth and Families.

Subp. 13. **Local agency.** "Local agency" means the county welfare board, multicounty welfare board, or human service agency established in Minnesota Statutes, section 256B.02, subdivision 6, and Minnesota Statutes, chapter 393.

Subp. 14. **Medical assistance.** "Medical assistance" means the program authorized by title XIX of the Social Security Act and Minnesota Statutes, chapters 256 and 256B.

Subp. 15. **Outreach.** "Outreach" means efforts by the department or a local agency to inform eligible persons about early and periodic screening, diagnosis, and treatment or to encourage persons to use the EPSDT program.

Subp. 16. **Parent.** "Parent" refers to the genetic or adoptive parent of a child.

Subp. 17. **Physician.** "Physician" means a person who is licensed to provide health services within the scope of the person's profession under Minnesota Statutes, chapter 147.

Subp. 18. **Prepaid health plan.** "Prepaid health plan" means a health insurer licensed and operating under Minnesota Statutes, chapters 60A, 62A, and 62C, and a health maintenance organization licensed and operating under Minnesota Statutes, chapter 62D to provide health services to recipients of medical assistance entitlements.

Subp. 19. **Public health nursing service.** "Public health nursing service" means the nursing program provided by a community health board under Minnesota Statutes, section 145A.04, subdivisions 1 and 1a.

Subp. 20. **Screening.** "Screening" means the use of quick, simple procedures to separate apparently well children from those who need further examination for possible physical, developmental, or psychological problems.

Subp. 21. **Skilled professional medical personnel and supporting staff.** "Skilled professional medical personnel" and "supporting staff" means persons as defined by Code of Federal Regulations, title 42, section 432.2, as amended through October 1, 1987.

Subp. 22. **Treatment.** "Treatment" means the prevention, correction, or amelioration of a disease or abnormality identified by screening or diagnosis.

9505.1699 ELIGIBILITY TO BE SCREENED.

A person under age 21 who is eligible for medical assistance is eligible for the EPSDT program.

9505.1701 CHOICE OF PROVIDER.

Subpart 1. **Choice of screening provider.** Except as provided by subpart 3, a child or parent of a child who requests screening may choose any screening provider who has signed an EPSDT provider agreement and a medical assistance provider agreement.

Subp. 2. **Choice of diagnosis and treatment provider.** Except as provided by subpart 3, a child or parent of a child may choose any diagnosis and treatment provider as provided by part 9505.0190.

Subp. 3. **Exception to subparts 1 and 2.** A child who is enrolled in a prepaid health plan must receive screening, diagnosis, and treatment from that plan.

9505.1703 ELIGIBILITY TO PROVIDE SCREENING.

Subpart 1. **Providers.** An EPSDT clinic or a community health clinic shall be approved for medical assistance reimbursement for EPSDT services if it complies with the requirements of parts 9505.1693 to 9505.1748. A Head Start agency shall be approved as provided by subpart 2.

Subp. 2. **EPSDT provider agreement.** To be eligible to provide screening and receive reimbursement under the EPSDT program, an individual or facility must sign an EPSDT provider agreement provided by the department and a medical assistance provider agreement under part 9505.0195 or be a prepaid health plan.

Subp. 3. **Terms of EPSDT provider agreement.** The EPSDT provider agreement required by subpart 2 must state that the provider must:

A. screen children according to parts 9505.1693 to 9505.1748;

B. report all findings of the screenings on EPSDT screening forms; and

C. refer children for diagnosis and treatment if a referral is indicated by the screening.

The EPSDT provider agreement also must state that the department will provide training according to part 9505.1712 and will train and consult with the provider on billing and reporting procedures.

9505.1706 REIMBURSEMENT.

Subpart 1. **Maximum payment rates.** Payment rates shall be as provided by part 9505.0445, item M.

Subp. 2. **Eligibility for reimbursement; Head Start agency.** A Head Start agency may complete all the screening components under part 9505.1718, subparts 2 to 14 or those components that have not been completed by another provider within the six months before completion of the screening components by the Head Start agency. A Head Start agency that completes the previously incomplete screening components must document on the EPSDT screening form that the other screening components of part 9505.1718, subparts 2 to 14, have been completed by another provider.

The department shall reimburse a Head Start agency for those screening components of part 9505.1718, subparts 2 to 14, that the Head Start agency has provided. The amount of reimbursement must be the same as a Head Start agency's usual and customary cost for each screening component or the maximum fee determined under subpart 1, whichever is lower.

Subp. 3. **Prepaid health plan.** A prepaid health plan is not eligible for a separate payment for screening. The early and periodic screening, diagnosis, and treatment screening must be a service included within the prepaid capitation rate specified in its contract with the department.

9505.1712 TRAINING.

The department must train the staff of an EPSDT clinic that is supervised by a physician on how to comply with the procedures required by part 9505.1718 if the EPSDT clinic requests the training.

9505.1715 COMPLIANCE WITH SURVEILLANCE AND UTILIZATION REVIEW.

A screening provider must comply with the surveillance and utilization review requirements of parts 9505.2160 to 9505.2245.

9505.1718 SCREENING STANDARDS FOR AN EPSDT CLINIC.

Subpart 1. **Requirement.** An early and periodic screening, diagnosis, and treatment screening must meet the requirements of subparts 2 to 15 except as provided by part 9505.1706, subpart 2.

Subp. 2. **Health and developmental history.** A history of a child's health and development must be obtained from the child, parent of the child, or an adult who is familiar with the child's health history. The history must include information on sexual development, lead and tuberculosis exposure, nutrition intake, chemical abuse, and social, emotional, and mental health status.

Subp. 3. **Assessment of physical growth.** The child's height or length and the child's weight must be measured and the results plotted on a growth grid based on data from the National Center for Health Statistics (NCHS). The head circumference of a child up to 36 months of age or a child whose growth in head circumference appears to deviate from the expected circumference for that child must be measured and plotted on an NCHS-based growth grid.

Subp. 4. **Physical examination.** The following must be checked according to accepted medical procedures: pulse; respiration; blood pressure; head; eyes; ears; nose; mouth; pharynx; neck; chest; heart; lungs; abdomen; spine; genitals; extremities; joints; muscle tone; skin; and neurological condition.

Subp. 5. **Vision.** A child must be checked for a family history of maternal and neonatal infection and ocular abnormalities. A child must be observed for pupillary reflex; the presence of nystagmus; and muscle balance, which includes an examination for esotropia, exotropia, phorias, and extraocular movements. The external parts of a child's eyes must be examined including the lids, conjunctiva, cornea, iris, and pupils. A child or parent of the child must be asked whether he or she has concerns about the child's vision.

Subp. 6. **Vision of a child age three or older.** In addition to the requirements of subpart 5, the visual acuity of a child age three years or older must be checked by use of the Screening Test for Young Children and Retardates (STYCAR) or the Snellen Alphabet Chart.

Subp. 7. **Hearing.** A child must be checked for a family history of hearing disability or loss, delay of language acquisition or history of such delay, the ability to determine the direction of a sound, and a history of repeated otitis media during early life. A child or parent of the child must be asked whether he or she has any concerns regarding the child's hearing.

Subp. 8. **Hearing of a child age three or older.** In addition to the requirements of subpart 7, a child age three or older must receive a pure tone audiometric test or referral for the test if the examination under subpart 7 indicates the test is needed.

Subp. 9. **Development.** A child must be screened for the following according to the screening provider's standard procedures: fine and gross motor development, speech and language development, social development, cognitive development, and self-help skills. Standardized tests that are used in screening must be culturally sensitive and have norms for the age range tested, written procedures for administration and for scoring and interpretation that are statistically reliable and valid. The provider must use a combination of the child's health and developmental history and standardized test or clinical judgment to determine the child's developmental status or need for further assessment.

Subp. 10. **Sexual development.** A child must be evaluated to determine whether the child's sexual development is consistent with the child's chronological age. A female must receive a breast examination and pelvic examination when indicated. A male must receive a testicular examination when indicated. If it is in the best interest of a child, counseling on normal sexual development, information on birth control and sexually transmitted diseases, and prescriptions and tests must be offered to a child. If it is in the best interest of a child, a screening provider may refer the child to other resources for counseling or a pelvic examination.

Subp. 11. **Nutrition.** When the assessment of a child's physical growth performed according to subpart 3 indicates a nutritional risk condition, the child must be referred for further assessment, receive nutritional counseling, or be referred to a nutrition program such as the Special Supplemental Food Program for Women, Infants, and Children; food stamps or food support; Expanded Food and Nutrition Education Program; or Head Start.

Subp. 12. **Immunizations.** The immunization status of a child must be compared to the "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition. Immunizations that the comparison shows are needed must be offered to the child and given to the child if the child or parent of the child accepts the offer. The "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition, is developed and distributed by the Minnesota Department of Health, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440. The "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition, is incorporated by reference and is available at the State Law Library, Judicial Center, 25 Rev. Dr. Martin Luther King Jr. Blvd., Saint Paul, Minnesota 55155. It is subject to frequent change.

Subp. 13. **Laboratory tests.** Laboratory tests must be done according to items A to F.

A. A Mantoux test must be administered yearly to a child whose health history indicates ongoing exposure to tuberculosis, unless the child has previously tested positive. A child who tests positive must be referred for diagnosis and treatment.

B. A child aged one to five years must initially be screened for lead through the use of either an erythrocyte protoporphyrin (EP) test or a direct blood lead screening test until December 31, 1992. Beginning January 1, 1993, a child age one to five must initially be screened using a direct blood lead screening test. Either capillary or venous blood may be used as the specimen for the direct blood lead test. Blood tests must be performed at a

minimum of once at 12 months of age and once at 24 months of age or whenever the history indicates that there are risk factors for lead poisoning. When the result of the EP or capillary blood test is greater than the maximum allowable level set by the Centers for Disease Control of the United States Public Health Service, the child must be referred for a venous blood lead test. A child with a venous blood lead level greater than the maximum allowable level set by the Centers for Disease Control must be referred for diagnosis and treatment.

C. The urine of a child must be tested for the presence of glucose, ketones, protein, and other abnormalities. A female at or near the age of four and a female at or near the age of ten must be tested for bacteriuria.

D. Either a microhematocrit determination or a hemoglobin concentration test for anemia must be done.

E. A test for sickle cell or other hemoglobinopathy, or abnormal blood conditions must be offered to a child who is at risk of such abnormalities and who has not yet been tested. These tests must be provided if accepted or requested by the child or parent of the child. If the tests identify a hemoglobin abnormality or other abnormal blood condition, the child must be referred for genetic counseling.

F. Other laboratory tests such as those for cervical cancer, sexually transmitted diseases, pregnancy, and parasites must be performed when indicated by a child's medical or family history.

Subp. 14. **Oral examination.** An oral examination of a child's mouth must be performed to detect deterioration of hard tissue, and inflammation or swelling of soft tissue. Counseling about the systemic use of fluoride must be given to a child when fluoride is not available through the community water supply or school programs.

Subp. 14a. **Health education and health counseling.** Health education and health counseling concerning the child's health must be offered to the child who is being screened and to the child's parent or representative. The health education and health counseling are for the purposes of assisting the child or the parent or representative of the child to understand the expected growth and development of the child and of informing the child or the parent or representative of the child about the benefits of healthy lifestyles and about practices to promote accident and disease prevention.

Subp. 15. **Schedule of age related screening standards.** An early and periodic screening, diagnosis, and treatment screening for a child at a specific age must include, at a minimum, the screening requirements of subparts 2 to 14 as provided by the following schedule:

Schedule of age related screening standards

A. Infancy:

Standards	Ages					
	By 1 month	2 months	4 months	6 months	9 months	12 months
Health History	X	X	X	X	X	X
Assessment of Physical Growth:						
Height	X	X	X	X	X	X
Weight	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X
Physical Examination	X	X	X	X	X	X

Vision	X	X	X	X	X	X
Hearing	X	X	X	X	X	X
Development	X	X	X	X	X	X
Health Education/Counseling	X	X	X	X	X	X
Sexual Development	X	X	X	X	X	X
Nutrition	X	X	X	X	X	X
Immunizations/Review		X	X	X	X	X
Laboratory Tests:						
Tuberculin			if history indicates			
Lead Absorption			if history indicates			X
Urinalysis	←	←	←	X	←	←
Hematocrit or Hemoglobin	←	←	←	←	X	X
Sickle Cell				at parent's or child's request		
Other Laboratory Tests				as indicated		
Oral Examination	X	X	X	X	X	X

X = Procedure to be completed.

← = Procedure to be completed if not done at the previous visit, or on the first visit.

B. Early Childhood:

Standards	Ages				
	15 months	18 months	24 months	3 years	4 years
Health History	X	X	X	X	X
Assessment of Physical Growth:					
Height	X	X	X	X	X
Weight	X	X	X	X	X
Head Circumference	X	X	X	X	X
Physical Examination	X	X	X	X	X
Vision	X	X	X	X	X
Hearing	X	X	X	X	X
Blood Pressure				X	X
Development	X	X	X	X	X
Health Education/Counseling	X	X	X	X	X

Sexual Development	X	X	X	X	X
Nutrition	X	X	X	X	X
Immunizations/Review	X	X	X	X	X
Laboratory Tests:					
Tuberculin			if history indicates		
Lead Absorption	if history indicates		X	if history indicates	
Urinalysis	←	←	X	←	←
Bacteriuria (females)					X
Hematocrit or Hemoglobin	←	←	←	←	←
Sickle Cell			at parent's or child's request		
Other Laboratory Tests			as indicated		
Oral Examination	X	X	X	X	X

X = Procedure to be completed.

← = Procedure to be completed if not done at the previous visit, or on the first visit.

C. Late childhood:

Standards	Ages				
	5 years	6 years	8 years	10 years	12 years
Health History	X	X	X	X	X
Assessment of Physical Growth:					
Height	X	X	X	X	X
Weight	X	X	X	X	X
Physical Examination	X	X	X	X	X
Vision	X	X	X	X	X
Hearing	X	X	X	X	X
Blood Pressure	X	X	X	X	X
Development	X	X	X	X	X
Health Education/Counseling	X	X	X	X	X
Sexual Development	X	X	X	X	X
Nutrition	X	X	X	X	X
Immunizations/Review	X	X	X	X	X
Laboratory Tests:					
Tuberculin			if history indicates		

Lead Absorption	if history indicates				
Urinalysis	←	←	X	←	←
Bacteriuria (females)	←	←	X	←	←
Hemoglobin or Hematocrit	←	←	X	←	
Sickle Cell	at parent's or child's request				
Other Laboratory Tests	as indicated				
Oral Examination	X	X	X	X	X

X = Procedure to be completed.

← = Procedure to be completed if not done at the previous visit, or on the first visit.

D. Adolescence:

Standards	Ages			
	14 years	16 years	18 years	20 years
Health History	X	X	X	X
Assessment of Physical Growth:				
Height	X	X	X	X
Weight	X	X	X	X
Physical Examination	X	X	X	X
Vision	X	X	X	X
Hearing	X	X	X	X
Blood Pressure	X	X	X	X
Development	X	X	X	X
Health Education/Counseling	X	X	X	X
Sexual Development	X	X	X	X
Nutrition	X	X	X	X
Immunizations/Review	X	X	X	X
Laboratory Tests:				
Tuberculin	if history indicates			
Lead Absorption	if history indicates			
Urinalysis	←		X	
Bacteriuria (females)	←		←	
Hemoglobin or Hematocrit	←		X	
Sickle Cell	at parent's or child's request			
Other Laboratory Tests	as indicated			

Oral Examination	X	X

X = Procedure to be completed.

← = Procedure to be completed if not done at the previous visit, or on the first visit.

Subp. 15a. **Additional screenings.** A child may have a partial or complete screening between the ages specified in the schedule under subpart 15 if the screening is medically necessary or a concern develops about the child's health or development.

9505.1724 PROVISION OF DIAGNOSIS AND TREATMENT.

Diagnosis and treatment identified as needed under part 9505.1718 shall be eligible for medical assistance payment subject to the provisions of parts 9505.0170 to 9505.0475.

9505.1727 INFORMING.

A local agency must inform each child or parent of a child about the EPSDT program no later than 60 days after the date the child is determined to be eligible for medical assistance. The information about the EPSDT program must be given orally and in writing, indicate the purpose and benefits of the EPSDT program, indicate that the EPSDT program is without cost to the child or parent of the child while the child is eligible for medical assistance, state the types of medical and dental services available under the EPSDT program, and state that the transportation and appointment scheduling assistance required under part 9505.1730 is available.

The department must send a written notice to a child or parent of a child who has been screened informing the child or parent that the child should be screened again. This notice must be sent at the following ages of the child: six months, nine months, one year, 18 months, two years, four years, and every three years after age four.

Each year, on the date the child was determined eligible for medical assistance entitlements, the department must send a written notice to a child or parent of a child who has never been screened informing the child or parent that the child is eligible to be screened.

9505.1730 ASSISTANCE WITH OBTAINING A SCREENING.

Within ten working days of receiving a request for screening from a child or parent of a child, a local agency must give or mail to the child or parent of the child:

A. a written list of EPSDT clinics in the area in which the child lives; and

B. a written offer of help in making a screening appointment and in transporting the child to the site of the screening.

If the child or parent of the child requests help, the local agency must provide it.

Transportation under this item must be provided according to part 9505.0140, subpart 1.

9505.1733 ASSISTANCE WITH OBTAINING DIAGNOSIS AND TREATMENT.

An EPSDT clinic must notify a child or parent of a child who is referred for diagnosis and treatment that the local agency will provide names and addresses of diagnosis and treatment providers and will help with appointment scheduling and transportation to the diagnosis and treatment provider. The notice must be on a form provided by the department and must be given to the child or parent of the child on the day the child is screened.

If a child or parent of a child asks a local agency for assistance with obtaining diagnosis and treatment, the local agency must provide that assistance within ten working days of the date of the request.

9505.1736 SPECIAL NOTIFICATION REQUIREMENT.

A local agency must effectively inform an individual who is blind or deaf, or who cannot read or understand the English language, about the EPSDT program.

9505.1739 CHILDREN IN FOSTER CARE.

Subpart 1. **Dependent or neglected state wards.** The local agency must provide early and periodic screening, diagnosis, and treatment services for a child in foster care who is a dependent or neglected state ward under parts 9560.0410 to 9560.0470, and who is eligible for medical assistance unless the early and periodic screening, diagnosis, and treatment services are not in the best interest of the child.

Subp. 2. **Other children in foster care.** The local agency must discuss the EPSDT program with a parent of a child in foster care who is under the legal custody or protective supervision of the local agency or whose parent has entered into a voluntary placement agreement with the local agency. The local agency must help the parent decide whether to accept early and periodic screening, diagnosis, and treatment services for the child. If a parent cannot be consulted, the local agency must decide whether to accept early and periodic screening, diagnosis, and treatment services for the child and must document the reasons for the decision.

Subp. 3. **Assistance with appointment scheduling and transportation.** The local agency must help a child in foster care with appointment scheduling and transportation for screening, diagnosis, and treatment as provided by parts 9505.1730 to 9505.1733.

Subp. 4. **Notification.** The department must send a written notice to the local agency stating that a child in foster care who has been screened should be screened again. This notice must be sent at the following ages of the child: six months, nine months, one year, 18 months, two years, four years, and every three years thereafter.

Each year, by the anniversary of the date the child was determined eligible for medical assistance entitlements, the department must send a written notice to the local agency that a child in foster care who has never been screened is eligible to be screened.

If a written notice under this subpart pertains to a child who is a dependent or neglected state ward, the local agency must proceed according to subpart 1. The local agency must proceed according to subpart 2 if the written notice pertains to a child who is not a dependent or neglected state ward.

9505.1742 DOCUMENTATION.

The local agency must document compliance with parts 9505.1693 to 9505.1748 on forms provided by the department.

9505.1745 INTERAGENCY COORDINATION.

The local agency must coordinate the EPSDT program with other programs that provide health services to children as provided by Code of Federal Regulations, title 42, section 441.61(c), as amended through October 1, 1986. Examples of such agencies are a public health nursing service, a Head Start agency, and a school district.

9505.1748 CONTRACTS FOR ADMINISTRATIVE SERVICES.

Subpart 1. **Authority.** A local agency may contract with a county public health nursing service, a community health clinic, a Head Start agency, a community action agency, or a school district for early and periodic screening, diagnosis, and treatment administrative services. Early and periodic screening, diagnosis, and treatment administrative services include outreach; notification; appointment scheduling and transportation; follow-up; and documentation. For purposes of this subpart, "community action agency" means an entity defined in Minnesota Statutes, section 256E.31, subdivision 1, and "school district" means

a school district as defined in Minnesota Statutes, section 120A.05, subdivisions 5, 10, and 14.

Subp. 2. **Federal financial participation.** The percent of federal financial participation for salaries, fringe benefits, and travel of skilled professional medical personnel and their supporting staff shall be paid as provided by Code of Federal Regulations, title 42, section 433.15(b)(5), as amended through October 1, 1986.

Subp. 3. **State reimbursement.** State reimbursement for contracts for EPSDT administrative services under this part shall be as provided by Minnesota Statutes, section 256B.19, subdivision 1, except for the provisions under subdivision 1 that pertain to a prepaid health plan.

Subp. 4. **Approval.** A contract for administrative services must be approved by the local agency and submitted to the department for approval by November 1 of the year before the beginning of the calendar year in which the contract will be effective. A contract must contain items A to L to be approved by the department for reimbursement:

A. names of the contracting parties;

B. purpose of the contract;

C. beginning and ending dates of the contract;

D. amount of the contract, budget breakdown, and a clause that stipulates that the department's procedures for certifying expenditures will be followed by the local agency;

E. the method by which the contract may be amended or terminated;

F. a clause that stipulates that the contract will be renegotiated if federal or state program regulations or federal financial reimbursement regulations change;

G. a clause that stipulates that the contracting parties will provide program and fiscal records and maintain all nonpublic data required by the contract according to the Minnesota Government Data Practices Act and will cooperate with state and federal program reviews;

H. a description of the services contracted for and the agency that will perform them;

I. methods by which the local agency will monitor and evaluate the contract;

J. signatures of the representatives of the contracting parties with the authority to obligate the parties by contract and dates of those signatures;

K. a clause that stipulates that the services provided under contract must be performed by or under the supervision of skilled medical personnel; and

L. a clause that stipulates that the contracting parties will comply with state and federal requirements for the receipt of medical assistance funds.

9520.0010 STATUTORY AUTHORITY AND PURPOSE.

Parts 9520.0010 to 9520.0230 provide methods and procedures relating to the establishment and operation of area-wide, comprehensive, community-based mental health, developmental disability, and chemical dependency programs under state grant-in-aid as provided under Minnesota Statutes, sections 245.61 to 245.69. Minnesota Statutes, sections 245.61 to 245.69 are entitled The Community Mental Health Services Act. For purposes of these parts, "community mental health services" includes services to persons who have mental or emotional disorders or other psychiatric disabilities, developmental disabilities, and chemical dependency, including drug abuse and alcoholism.

9520.0020 BOARD DUTIES.

The community mental health board has the responsibility for ensuring the planning, development, implementation, coordination, and evaluation of the community comprehensive mental health program for the mentally ill/behaviorally disabled, developmentally disabled, and chemically dependent populations in the geographic area it serves. It also has the responsibility for ensuring delivery of services designated by statute.

9520.0030 DEFINITIONS.

Parts 9520.0040 and 9520.0050 also set forth definitions of community mental health centers and community mental health clinics.

9520.0040 COMMUNITY MENTAL HEALTH CENTER.

A community mental health center means an agency which includes all of the following:

A. Established under the provision of Minnesota Statutes, sections 245.61 to 245.69.

B. Provides as a minimum the following services for individuals with mental or emotional disorders, developmental disabilities, alcoholism, drug abuse, and other psychiatric conditions. The extent of each service to be provided by the center shall be indicated in the program plan, which is to reflect the problems, needs, and resources of the community served:

(1) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, developmental disability, alcoholism, drug abuse, and other psychiatric disorders;

(2) informational and educational services to schools, courts, health and welfare agencies, both public and private;

(3) informational and educational services to the general public, lay, and professional groups;

(4) consultative services to schools, courts, and health and welfare agencies, both public and private;

(5) outpatient diagnostic and treatment services; and

(6) rehabilitative services, particularly for those who have received prior treatment in an inpatient facility.

C. Provides or contracts for detoxification, evaluation, and referral for chemical dependency services (Minnesota Statutes, section 254A.08).

D. Provides specific coordination for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. (Minnesota Statutes, sections 254A.07 and 245.61).

E. Has a competent multidisciplinary mental health/developmental disability/chemical dependency professional team whose members meet the professional standards in their respective fields.

F. The professional mental health team is qualified by specific mental health training and experience and shall include as a minimum the services of each of the following:

(1) a licensed physician, who has completed an approved residency program in psychiatry; and

(2) a doctoral clinical, counseling, or health care psychologist, who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

(3) a clinical social worker with a master's degree in social work from an accredited college or university; and/or

(4) a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health nursing with mental health major, maternal and child health with mental health major, etc.

G. The multidisciplinary staff shall be sufficient in number to implement and operate the described program of the center. In addition to the above, this team should include other professionals, paraprofessionals, and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner. If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the center, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts to acquire such staff and show evidence of how the specialized functions of the required professionals are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0050 COMMUNITY MENTAL HEALTH CLINIC.

Subpart 1. **Definitions.** A community mental health clinic is an agency which devotes, as its major service, at least two-thirds of its resources for outpatient mental health diagnosis, treatment, and consultation by a multidisciplinary professional mental health team. The multidisciplinary professional mental health team is qualified by special mental health training and experience and shall include as a minimum the services of each of the following:

A. a licensed physician, who has completed an approved residency program in psychiatry; and

B. a doctoral clinical, or counseling or health care psychologist who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

C. a clinical social worker with a master's degree in social work from an accredited college or university; and/or

D. a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health with a mental health major, maternal and child health with a mental health major.

Subp. 2. **Other members of multidisciplinary team.** The multidisciplinary team shall be sufficient in number to implement and operate the described program of the clinic. In addition to the above, this team should include other professionals, paraprofessionals and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner.

Subp. 3. **Efforts to acquire staff.** If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the clinic, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts to acquire such staff and evidence of how the specialized functions of the required professional positions are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0060 ANNUAL PLAN AND BUDGET.

On or before the date designated by the commissioner, each year the chair of the community mental health board or director of the community mental health program, provided for in Minnesota Statutes, section 245.62, shall submit an annual plan identifying

program priorities in accordance with state grant-in-aid guidelines, and a budget on prescribed report forms for the next state fiscal year, together with the recommendations of the community mental health board, to the commissioner of human services for approval as provided under Minnesota Statutes, section 245.63.

9520.0070 FISCAL AFFILIATES.

Other providers of community mental health services may affiliate with the community mental health center and may be approved and eligible for state grant-in-aid funds. The state funding for other community mental health services shall be contingent upon appropriate inclusion in the center's community mental health plan for the continuum of community mental health services and conformity with the state's appropriate disability plan for mental health, developmental disability, or chemical dependency. Fiscal affiliates (funded contracting agencies) providing specialized services under contract must meet all rules and standards that apply to the services they are providing.

9520.0080 OTHER REQUIRED REPORTS.

The program director of the community mental health program shall provide the commissioner of human services with such reports of program activities as the commissioner may require.

9520.0090 FUNDING.

All state community mental health funding shall go directly to the community mental health board or to a human service board established pursuant to Laws of Minnesota 1975, chapter 402, which itself provides or contracts with another agency to provide the community mental health program. Such programs must meet the standards and rules for community mental health programs as enunciated in parts 9520.0010 to 9520.0230 in accordance with Laws of Minnesota 1975, chapter 402.

9520.0100 OPERATION OF OTHER PROGRAMS.

When the governing authority of the community mental health program operates other programs, services, or activities, only the community mental health center program shall be subject to these parts.

9520.0110 APPLICATIONS AND AGREEMENTS BY LOCAL COUNTIES.

New applications for state assistance or applications for renewal of support must be accompanied by an agreement executed by designated signatories on behalf of the participating counties that specifies the involved counties, the amount and source of local funds in each case, and the period of support. The local funds to be used to match state grant-in-aid must be assured in writing on Department of Human Services forms by the local funding authority(ies).

9520.0120 USE OF MATCHING FUNDS.

Funds utilized by the director as authorized by the community mental health board to match a state grant-in-aid must be available to that director for expenditures for the same general purpose as the state grant-in-aid funds.

9520.0130 QUARTERLY REPORTS.

The director of the community mental health program shall, within 20 days after the end of the quarter, submit quarterly prescribed reports to the commissioner of human services (controller's office), containing all receipts, expenditures, and cash balance, subject to an annual audit by the commissioner or his/her designee.

9520.0140 PAYMENTS.

Payments on approved grants will be made subsequent to the department's receipt of the program's quarterly reporting forms, unless the commissioner of human services has determined that funds allocated to a program are not needed for that program. Payments shall be in an amount of at least equal to the quarterly allocation minus any unexpended balance from the previous quarter providing this payment does not exceed the program grant award. In the event the program does not report within the prescribed time, the department will withhold the process of the program's payment until the next quarterly cycle.

9520.0150 FEES.

No fees shall be charged until the director with approval of the community mental health board has established fee schedules for the services rendered and they have been submitted to the commissioner of human services at least two months prior to the effective date thereof and have been approved by him/her. All fees shall conform to the approved schedules, which are accessible to the public.

9520.0160 SUPPLEMENTAL AWARDS.

The commissioner of human services may make supplemental awards to the community mental health boards.

9520.0170 WITHDRAWAL OF FUNDS.

The commissioner of human services may withdraw funds from any program that is not administered in accordance with its approved plan and budget. Written notice of such intended action will be provided to the director and community mental health board. Opportunity for hearing before the commissioner or his/her designee shall be provided.

9520.0180 BUDGET TRANSFERS.

Community mental health boards may make budget transfers within specified limits during any fiscal year without prior approval of the department. The specified limit which can be transferred in any fiscal year between program activity budgets shall be up to ten percent or up to $5,000 whichever is less. Transfers within an activity can be made into or out of line items with a specified limit of up to ten percent or up to $5,000 whichever is less. No line item can be increased or decreased by more than $5,000 or ten percent in a fiscal year without prior approval of the commissioner. Transfers above the specified limits can be made with prior approval from the commissioner. All transfers within and into program budget activities and/or line items must have prior approval by the community mental health board and this approval must be reflected in the minutes of its meeting, it must be reported to the commissioner with the reasons therefor, including a statement of how the transfer will affect program objectives.

9520.0190 BUDGET ADJUSTMENTS.

Budget adjustments made necessary by funding limitations shall be made by the commissioner and provided in writing to the director and board of the community mental health center.

9520.0200 CENTER DIRECTOR.

Every community mental health board receiving state funds for a community mental health program shall have a center director, who is the full-time qualified professional staff member who serves as the executive officer. To be considered qualified, the individual must have professional training to at least the level of graduate degree in his/her clinical and/or administrative discipline, which is relevant to MH-DD-CD and a minimum of two years experience in community mental health programs. The center director is responsible for the

planning/design, development, coordination, and evaluation of a comprehensive, area-wide program and for the overall administration of services operated by the board.

The center director shall be appointed by the community mental health board and shall be approved by the commissioner of human services.

9520.0210 DEADLINE FOR APPROVAL OR DENIAL OF REQUEST FOR APPROVAL STATUS.

The commissioner shall approve or deny, in whole or in part, an application for state financial assistance within 90 days of receipt of the grant-in-aid application or by the beginning of the state fiscal year, whichever is the later.

9520.0230 ADVISORY COMMITTEE.

Subpart 1. **Purpose.** To assist the community mental health board in meeting its responsibilities as described in Minnesota Statutes, section 245.68 and to provide opportunity for broad community representation necessary for effective comprehensive mental health, developmental disability, and chemical dependency program planning, each community mental health board shall appoint a separate advisory committee in at least the three disability areas of mental health, developmental disability, and chemical dependency.

Subp. 2. **Membership.** The advisory committees shall consist of residents of the geographic area served who are interested and knowledgeable in the area governed by such committee.

Subp. 3. **Nominations for membership.** Nominations for appointments as members of the advisory committees are to be made to the community mental health board from agencies, organizations, groups, and individuals within the area served by the community mental health center. Appointments to the advisory committees are made by the community mental health board.

Subp. 4. **Board member on committee.** One community mental health board member shall serve on each advisory committee.

Subp. 5. **Nonprovider members.** Each advisory committee shall have at least one-half of its membership composed of individuals who are not providers of services to the three disability groups.

Subp. 6. **Representative membership.** Membership of each advisory committee shall generally reflect the population distribution of the service delivery area of the community mental health center.

Subp. 7. **Chairperson appointed.** The community mental health board shall appoint a chairperson for each advisory committee. The chairperson shall not be a community mental health board member nor a staff member. The power to appoint the chairperson may be delegated by the community mental health board to the individual advisory committee.

Subp. 8. **Committee responsibility to board.** Each advisory committee shall be directly responsible to the community mental health board. Direct communication shall be effected and maintained through contact between the chairperson of the particular advisory committee, or his/her designee, and the chairperson of the community mental health board, or his/her designee.

Subp. 9. **Staff.** Staff shall be assigned by the director to serve the staffing needs of each advisory committee.

Subp. 10. **Study groups and task forces.** Each advisory committee may appoint study groups and task forces upon consultation with the community mental health board. It is strongly recommended that specific attention be given to the aging and children and youth populations.

Subp. 11. **Quarterly meetings required.** Each advisory committee shall meet at least quarterly.

Subp. 12. **Annual report required.** Each advisory committee must make a formal written and oral report on its work to the community mental health board at least annually.

Subp. 13. **Minutes.** Each advisory committee shall submit copies of minutes of their meetings to the community mental health board and to the Department of Human Services (respective disability group program divisions).

Subp. 14. **Duties of advisory committee.** The advisory committees shall be charged by the community mental health board with assisting in the identification of the community's needs for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. The advisory committee also assists the community mental health board in determining priorities for the community programs. Based on the priorities, each advisory committee shall recommend to the community mental health board ways in which the limited available community resources (work force, facilities, and finances) can be put to maximum and optimal use.

Subp. 15. **Recommendations.** The advisory committee recommendations made to the community mental health board shall be included as a separate section in the grant-in-aid request submitted to the Department of Human Services by the community mental health board.

Subp. 16. **Assessment of programs.** The advisory committees shall assist the community mental health board in assessing the programs carried on by the community mental health board, and make recommendations regarding the reordering of priorities and modifying of programs where necessary.

9520.0750 PURPOSE.

Parts 9520.0750 to 9520.0870 establish standards for approval of mental health centers and mental health clinics for purposes of insurance and subscriber contract reimbursement under Minnesota Statutes, section 62A.152.

9520.0760 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9520.0760 to 9520.0870, the following terms have the meanings given them.

Subp. 2. **Application.** "Application" means the formal statement by a center to the commissioner, on the forms created for this purpose, requesting recognition as meeting the requirements of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 3. **Approval.** "Approval" means the determination by the commissioner that the applicant center has met the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870, and is therefore eligible to claim reimbursement for outpatient clinical services under the terms of Minnesota Statutes, section 62A.152. Approval of a center under these parts does not mean approval of a multidisciplinary staff person of such center to claim reimbursement from medical assistance or other third-party payors when practicing privately. Approval of a center under these parts does not mean approval of such center to claim reimbursement from medical assistance.

Subp. 4. **Case review.** "Case review" means a consultation process thoroughly examining a client's condition and treatment. It includes review of the client's reason for seeking treatment, diagnosis and assessment, and the individual treatment plan; review of the appropriateness, duration, and outcome of treatment provided; and treatment recommendations.

Subp. 5. **Center.** "Center" means a public or private health and human services facility which provides clinical services in the treatment of mental illness. It is an abbreviated term

used in place of "mental health center" or "mental health clinic" throughout parts 9520.0750 to 9520.0870.

Subp. 6. **Client.** "Client" means a person accepted by the center to receive clinical services in the diagnosis and treatment of mental illness.

Subp. 7. **Clinical services.** "Clinical services" means services provided to a client to diagnose, describe, predict, and explain that client's status relative to a disabling condition or problem, and where necessary, to treat the client to reduce impairment due to that condition. Clinical services also include individual treatment planning, case review, record keeping required for treatment, peer review, and supervision.

Subp. 8. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or a designated representative.

Subp. 9. **Competent.** "Competent" means having sufficient knowledge of and proficiency in a specific mental illness assessment or treatment service, technique, method, or procedure, documented by experience, education, training, and certification, to be able to provide it to a client with little or no supervision.

Subp. 10. **Consultation.** "Consultation" means the process of deliberating or conferring between multidisciplinary staff regarding a client and the client's treatment.

Subp. 11. **Deferral.** "Deferral" means the determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 and is not approved, but is granted a period of time to comply with these standards and receive a second review without reapplication.

Subp. 12. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 13. **Disapproval or withdrawal of approval.** "Disapproval" or "withdrawal of approval" means a determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 14. **Discipline.** "Discipline" means a branch of professional knowledge or skill acquired through a specific course of study and training and usually documented by a specific educational degree or certification of proficiency. Examples of the mental health disciplines include but are not limited to psychiatry, psychology, clinical social work, and psychiatric nursing.

Subp. 15. **Documentation.** "Documentation" means the automatically or manually produced and maintained evidence that can be read by person or machine, and that will attest to the compliance with requirements of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 16. **Individual treatment plan.** "Individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results for a specific client, and updated as necessary. The plan specifies the goals and objectives in measurable terms, states the treatment strategy, and identifies responsibilities of multidisciplinary staff.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a staff person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

A. by having a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and 2,000 hours of supervised experience in the delivery of clinical services in the treatment of mental illness;

B. by having 6,000 hours of supervised experience in the delivery of clinical services in the treatment of mental illness;

C. by being a graduate student in one of the behavioral sciences or related fields formally assigned to the center for clinical training by an accredited college or university; or

D. by having a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university.

Documentation of compliance with part 9520.0800, subpart 4, item B is required for designation of work as supervised experience in the delivery of clinical services. Documentation of the accreditation of a college or university shall be a listing in Accredited Institutions of Postsecondary Education Programs, Candidates for the year the degree was issued. The master's degree in behavioral sciences or related fields shall include a minimum of 28 semester hours of graduate course credit in mental health theory and supervised clinical training, as documented by an official transcript.

Subp. 18. **Mental health professional.** "Mental health professional" has the meaning given in Minnesota Statutes, section 245.462, subdivision 18.

Subp. 19. **Mental illness.** "Mental illness" means a condition which results in an inability to interpret the environment realistically and in impaired functioning in primary aspects of daily living such as personal relations, living arrangements, work, and recreation, and which is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), Ninth Revision (1980), code range 290.0-302.99 or 306.0-316, or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III), Third Edition (1980), Axes I, II or III. These publications are available from the State Law Library.

Subp. 20. **Multidisciplinary staff.** "Multidisciplinary staff" means the mental health professionals and mental health practitioners employed by or under contract to the center to provide outpatient clinical services in the treatment of mental illness.

Subp. 21. **Serious violations of policies and procedures.** "Serious violations of policies and procedures" means a violation which threatens the health, safety, or rights of clients or center staff; the repeated nonadherence to center policies and procedures; and the nonadherence to center policies and procedures which result in noncompliance with Minnesota Statutes, section 245.69, subdivision 2 and parts 9520.0760 to 9520.0870.

Subp. 22. **Treatment strategy.** "Treatment strategy" means the particular form of service delivery or intervention which specifically addresses the client's characteristics and mental illness, and describes the process for achievement of individual treatment plan goals.

9520.0770 ORGANIZATIONAL STRUCTURE OF CENTER.

Subpart 1. **Basic unit.** The center or the facility of which it is a unit shall be legally constituted as a partnership, corporation, or government agency. The center shall be either the entire facility or a clearly identified unit within the facility which is administratively and clinically separate from the rest of the facility. All business shall be conducted in the name of the center or facility, except medical assistance billing by individually enrolled providers when the center is not enrolled.

Subp. 2. **Purpose, services.** The center shall document that the prevention, diagnosis, and treatment of mental illness are the main purposes of the center. If the center is a unit within a facility, the rest of the facility shall not provide clinical services in the outpatient treatment of mental illness. The facility may provide services other than clinical services in the treatment of mental illness, including medical services, chemical dependency services, social services, training, and education. The provision of these additional services is not reviewed in granting approval to the center under parts 9520.0760 to 9520.0870.

Subp. 3. **Governing body.** The center shall have a governing body. The governing body shall provide written documentation of its source of authority. The governing body shall be legally responsible for the implementation of the standards set forth in Minnesota

Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 through the establishment of written policy and procedures.

Subp. 4. **Chart or statement of organization.** The center shall have an organizational chart or statement which specifies the relationships among the governing body, any administrative and support staff, mental health professional staff, and mental health practitioner staff; their respective areas of responsibility; the lines of authority involved; the formal liaison between administrative and clinical staff; and the relationship of the center to the rest of the facility and any additional services provided.

9520.0780 SECONDARY LOCATIONS.

Subpart 1. **Main and satellite offices.** The center shall notify the commissioner of all center locations. If there is more than one center location, the center shall designate one as the main office and all secondary locations as satellite offices. The main office as a unit and the center as a whole shall be in compliance with part 9520.0810. The main office shall function as the center records and documentation storage area and house most administrative functions for the center. Each satellite office shall:

A. be included as a part of the legally constituted entity;

B. adhere to the same clinical and administrative policies and procedures as the main office;

C. operate under the authority of the center's governing body;

D. store all center records and the client records of terminated clients at the main office;

E. ensure that a mental health professional is at the satellite office and competent to supervise and intervene in the clinical services provided there, whenever the satellite office is open;

F. ensure that its multidisciplinary staff have access to and interact with main center staff for consultation, supervision, and peer review; and

G. ensure that clients have access to all clinical services provided in the treatment of mental illness and the multidisciplinary staff of the center.

Subp. 2. **Noncompliance.** If the commissioner determines that a secondary location is not in compliance with subpart 1, it is not a satellite office. Outpatient clinical services in the treatment of mental illness delivered by the center or facility of which it is a unit shall cease at that location, or the application shall be disapproved.

9520.0790 MINIMUM TREATMENT STANDARDS.

Subpart 1. **Multidisciplinary approach.** The center shall document that services are provided in a multidisciplinary manner. That documentation shall include evidence that staff interact in providing clinical services, that the services provided to a client involve all needed disciplines represented on the center staff, and that staff participate in case review and consultation procedures as described in subpart 6.

Subp. 2. **Intake and case assignment.** The center shall establish an intake or admission procedure which outlines the intake process, including the determination of the appropriateness of accepting a person as a client by reviewing the client's condition and need for treatment, the clinical services offered by the center, and other available resources. The center shall document that case assignment for assessment, diagnosis, and treatment is made to a multidisciplinary staff person who is competent in the service, in the recommended treatment strategy and in treating the individual client characteristics. Responsibility for each case shall remain with a mental health professional.

Subp. 3. **Assessment and diagnostic process.** The center shall establish an assessment and diagnostic process that determines the client's condition and need for clinical services.

The assessment of each client shall include clinical consideration of the client's general physical, medical, developmental, family, social, psychiatric, and psychological history and current condition. The diagnostic statement shall include the diagnosis based on the codes in the International Classification of Diseases or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and refer to the pertinent assessment data. The diagnosis shall be by or under the supervision of and signed by a psychiatrist or licensed psychologist. The diagnostic assessment, as defined by Minnesota Statutes, sections 245.462, subdivision 9, for adults, and 245.4871, subdivision 11, for children, must be provided by a licensed mental health professional in accordance with Minnesota Statutes, section 245.467, subdivision 2.

Subp. 4. **Treatment planning.** The individual treatment plan, based upon a diagnostic assessment of mental illness, shall be jointly developed by the client and the mental health professional. This planning procedure shall ensure that the client has been informed in the following areas: assessment of the client condition; treatment alternatives; possible outcomes and side effects of treatment; treatment recommendations; approximate length, cost, and hoped-for outcome of treatment; the client's rights and responsibilities in implementation of the individual treatment plan; staff rights and responsibilities in the treatment process; the Government Data Practices Act; and procedures for reporting grievances and alleged violation of client rights. If the client is considering chemotherapy, hospitalization, or other medical treatment, the appropriate medical staff person shall inform the client of the treatment alternatives, the effects of the medical procedures, and possible side effects. Clinical services shall be appropriate to the condition, age, sex, socioeconomic, and ethnic background of the client, and provided in the least restrictive manner. Clinical services shall be provided according to the individual treatment plan and existing professional codes of ethics.

Subp. 5. **Client record.** The center shall maintain a client record for each client. The record must document the assessment process, the development and updating of the treatment plan, the treatment provided and observed client behaviors and response to treatment, and serve as data for the review and evaluation of the treatment provided to a client. The record shall include:

A. a statement of the client's reason for seeking treatment;

B. a record of the assessment process and assessment data;

C. the initial diagnosis based upon the assessment data;

D. the individual treatment plan;

E. a record of all medication prescribed or administered by multidisciplinary staff;

F. documentation of services received by the client, including consultation and progress notes;

G. when necessary, the client's authorization to release private information, and client information obtained from outside sources;

H. at the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome; and

I. correspondence and other necessary information.

Subp. 6. **Consultation; case review.** The center shall establish standards for case review and encourage the ongoing consultation among multidisciplinary staff. The multidisciplinary staff shall attend staff meetings at least twice monthly for a minimum of four hours per month, or a minimum of two hours per month if the multidisciplinary staff person provides clinical services in the treatment of mental illness less than 15 hours per week. The purpose of these meetings shall be case review and consultation. Written minutes of the meeting shall be maintained at the center for at least three years after the meeting.

Subp. 7. **Referrals.** If the necessary treatment or the treatment desired by the client is not available at the center, the center shall facilitate appropriate referrals. The

multidisciplinary staff person shall discuss with the client the reason for the referral, potential treatment resources, and what the process will involve. The staff person shall assist in the process to ensure continuity of the planned treatment.

Subp. 8. **Emergency service.** The center shall ensure that clinical services to treat mental illness are available to clients on an emergency basis.

Subp. 9. **Access to hospital.** The center shall document that it has access to hospital admission for psychiatric inpatient care, and shall provide that access when needed by a client. This requirement for access does not require direct hospital admission privileges on the part of qualified multidisciplinary staff.

9520.0800 MINIMUM QUALITY ASSURANCE STANDARDS.

Subpart 1. **Policies and procedures.** The center shall develop written policies and procedures and shall document the implementation of these policies and procedures for each treatment standard and each quality assurance standard in subparts 2 to 7. The policies shall be approved by the governing body. The procedures shall indicate what actions or accomplishments are to be performed, who is responsible for each action, and any documentation or required forms. Multidisciplinary staff shall have access to a copy of the policies and procedures at all times.

Subp. 2. **Peer review.** The center shall have a multidisciplinary peer review system to assess the manner in which multidisciplinary staff provide clinical services in the treatment of mental illness. Peer review shall include the examination of clinical services to determine if the treatment provided was effective, necessary, and sufficient and of client records to determine if the recorded information is necessary and sufficient. The system shall ensure review of a randomly selected sample of five percent or six cases, whichever is less, of the annual caseload of each mental health professional by other mental health professional staff. Peer review findings shall be discussed with staff involved in the case and followed up by any necessary corrective action. Peer review records shall be maintained at the center.

Subp. 3. **Internal utilization review.** The center shall have a system of internal utilization review to examine the quality and efficiency of resource usage and clinical service delivery. The center shall develop and carry out a review procedure consistent with its size and organization which includes collection or review of information, analysis or interpretation of information, and application of findings to center operations. The review procedure shall minimally include, within any three year period of time, review of the appropriateness of intake, the provision of certain patterns of services, and the duration of treatment. Criteria may be established for treatment length and the provision of services for certain client conditions. Utilization review records shall be maintained, with an annual report to the governing body for applicability of findings to center operations.

Subp. 4. **Staff supervision.** Staff supervision:

A. The center shall have a clinical evaluation and supervision procedure which identifies each multidisciplinary staff person's areas of competence and documents that each multidisciplinary staff person receives the guidance and support needed to provide clinical services for the treatment of mental illness in the areas they are permitted to practice.

B. A mental health professional shall be responsible for the supervision of the mental health practitioner, including approval of the individual treatment plan and bimonthly case review of every client receiving clinical services from the practitioner. This supervision shall include a minimum of one hour of face-to-face, client-specific supervisory contact for each 40 hours of clinical services in the treatment of mental illness provided by the practitioner.

Subp. 5. **Continuing education.** The center shall require that each multidisciplinary staff person attend a minimum of 36 clock hours every two years of academic or practical course work and training. This education shall augment job-related knowledge, understanding, and skills to update or enhance staff competencies in the delivery of clinical services to treat

mental illness. Continued licensure as a mental health professional may be substituted for the continuing education requirement of this subpart.

Subp. 6. **Violations of standards.** The center shall have procedures for the reporting and investigating of alleged unethical, illegal, or grossly negligent acts, and of the serious violation of written policies and procedures. The center shall document that the reported behaviors have been reviewed and that responsible disciplinary or corrective action has been taken if the behavior was substantiated. The procedures shall address both client and staff reporting of complaints or grievances regarding center procedures, staff, and services. Clients and staff shall be informed they may file the complaint with the department if it was not resolved to mutual satisfaction. The center shall have procedures for the reporting of suspected abuse or neglect of clients, in accordance with Minnesota Statutes, sections 611A.32, subdivision 5; 626.556; and 626.557.

Subp. 7. **Data classification.** Client information compiled by the center, including client records and minutes of case review and consultation meetings, shall be protected as private data under the Minnesota Government Data Practices Act.

9520.0810 MINIMUM STAFFING STANDARDS.

Subpart 1. **Required staff.** Required staff:

A. The multidisciplinary staff of a center shall consist of at least four mental health professionals. At least two of the mental health professionals shall each be employed or under contract for a minimum of 35 hours a week by the center. Those two mental health professionals shall be of different disciplines.

B. The mental health professional staff shall include a psychiatrist and a licensed psychologist.

C. The mental health professional employed or under contract to the center to meet the requirement of item B shall be at the main office of the center and providing clinical services in the treatment of mental illness at least eight hours every two weeks.

Subp. 2. **Additional staff; staffing balance.** Additional mental health professional staff may be employed by or under contract to the center provided that no single mental health discipline or combination of allied fields shall comprise more than 60 percent of the full-time equivalent mental health professional staff. This provision does not apply to a center with fewer than six full-time equivalent mental health professional staff. Mental health practitioners may also be employed by or under contract to a center to provide clinical services for the treatment of mental illness in their documented area of competence. Mental health practitioners shall not comprise more than 25 percent of the full-time equivalent multidisciplinary staff. In determination of full-time equivalence, only time spent in clinical services for the treatment of mental illness shall be considered.

Subp. 3. **Multidisciplinary staff records.** The center shall maintain records sufficient to document that the center has determined and verified the clinical service qualifications of each multidisciplinary staff person, and sufficient to document each multidisciplinary staff person's terms of employment.

Subp. 4. **Credentialed occupations.** The center shall adhere to the qualifications and standards specified by rule for any human service occupation credentialed under Minnesota Statutes, section 214.13 and employed by or under contract to the center.

9520.0820 APPLICATION PROCEDURES.

Subpart 1. **Form.** A facility seeking approval as a center for insurance reimbursement of its outpatient clinical services in treatment of mental illness must make formal application to the commissioner for such approval. The application form for this purpose may be obtained from the Mental Illness Program Division of the department. The application form shall require only information which is required by statute or rule, and shall require the applicant

center to explain and provide documentation of compliance with the minimum standards in Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 2. **Fee.** Each application shall be accompanied by payment of the nonrefundable application fee. The fee shall be established and adjusted in accordance with Minnesota Statutes, section 16A.128 to cover the costs to the department in implementing Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 3. **Completed application.** The application is considered complete on the date the application fee and all information required in the application form are received by the department.

Subp. 4. **Coordinator.** The center shall designate in the application a mental health professional as the coordinator for issues surrounding compliance with parts 9520.0760 to 9520.0870.

9520.0830 REVIEW OF APPLICANT CENTERS.

Subpart 1. **Site visit.** The formal review shall begin after the completed application has been received, and shall include an examination of the written application and a visit to the center. The applicant center shall be offered a choice of site visit dates, with at least one date falling within 60 days of the date on which the department receives the complete application. The site visit shall include interviews with multidisciplinary staff and examination of a random sample of client records, consultation minutes, quality assurance reports, and multidisciplinary staff records.

Subp. 2. **Documentation.** If implementation of a procedure is too recent to be reliably documented, a written statement of the planned implementation shall be accepted as documentation on the initial application. The evidence of licensure or accreditation through another regulating body shall be accepted as documentation of a specific procedure when the required minimum standard of that body is the same or higher than a specific provision of parts 9520.0760 to 9520.0870.

9520.0840 DECISION ON APPLICATION.

Subpart 1. **Written report.** Upon completion of the site visit, a report shall be written. The report shall include a statement of findings, a recommendation to approve, defer, or disapprove the application, and the reasons for the recommendation.

Subp. 2. **Written notice to center.** The applicant center shall be sent written notice of approval, deferral, or disapproval within 30 days of the completion of the site visit. If the decision is a deferral or a disapproval, the notice shall indicate the specific areas of noncompliance.

Subp. 3. **Noncompliance with statutes and rules.** An application shall be disapproved or deferred if it is the initial application of a center, when the applicant center is not in compliance with Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 4. **Deferral of application.** If an application is deferred, the length of deferral shall not exceed 180 days. If the areas of noncompliance stated in the deferral notice are not satisfactorily corrected by the end of the deferral period, the application shall be disapproved. The applicant center shall allow the commissioner to inspect the center at any time during the deferral period, whether or not the site visit has been announced in advance. A site visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center. At any time during the deferral period, the applicant center may submit documentation indicating correction of noncompliance. The application shall then be approved or disapproved. At any time during the deferral period, the applicant center may submit a written request to the commissioner to change the application status to disapproval. The request shall be complied with within 14 days of receiving this written

request. The applicant center is not an approved center for purposes of Minnesota Statutes, section 62A.152 during a deferral period.

Subp. 5. **Effective date of decision.** The effective date of a decision is the date the commissioner signs a letter notifying the applicant center of that decision.

9520.0850 APPEALS.

If an application is disapproved or approval is withdrawn, a contested case hearing and judicial review as provided in Minnesota Statutes, sections 14.48 to 14.69, may be requested by the center within 30 days of the commissioner's decision.

9520.0860 POSTAPPROVAL REQUIREMENTS.

Subpart 1. **Duration of approval.** Initial approval of an application is valid for 12 months from the effective date, subsequent approvals for 24 months, except when approval is withdrawn according to the criteria in subpart 4.

Subp. 2. **Reapplication.** The center shall contact the department for reapplication forms, and submit the completed application at least 90 days prior to the expected expiration date. If an approved center has met the conditions of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870, including reapplication when required, its status as an approved center shall remain in effect pending department processing of the reapplication.

Subp. 3. **Restrictions.** The approval is issued only for the center named in the application and is not transferable or assignable to another center. The approval is issued only for the center location named in the application and is not transferable or assignable to another location. If the commissioner is notified in writing at least 30 days in advance of a change in center location and can determine that compliance with all provisions of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 are maintained, the commissioner shall continue the approval of the center at the new location.

Subp. 4. **Noncompliance.** Changes in center organization, staffing, treatment, or quality assurance procedures that affect the ability of the center to comply with the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 shall be reported in writing by the center to the commissioner within 15 days of occurrence. Review of the change shall be conducted by the commissioner. A center with changes resulting in noncompliance in minimum standards shall receive written notice and may have up to 180 days to correct the areas of noncompliance before losing approval status. Interim procedures to resolve the noncompliance on a temporary basis shall be developed and submitted in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. Nonreporting within 15 days of occurrence of a change that results in noncompliance, failure to develop an approved interim procedure within 30 days of the determination of the noncompliance, or nonresolution of the noncompliance within 180 days shall result in the immediate withdrawal of approval status.

Serious violation of policies or procedures, professional association or board sanctioning or loss of licensure for unethical practices, or the conviction of violating a state or federal statute shall be reported in writing by the center to the commissioner within ten days of the substantiation of such behavior. Review of this report and the action taken by the center shall be conducted by the commissioner. Approval shall be withdrawn immediately unless the commissioner determines that: the center acted with all proper haste and thoroughness in investigating the behavior, the center acted with all proper haste and thoroughness in taking appropriate disciplinary and corrective action, and that no member of the governing body was a party to the behavior. Failure to report such behavior within ten days of its substantiation shall result in immediate withdrawal of approval.

Subp. 5. **Compliance reports.** The center may be required to submit written information to the department during the approval period to document that the center has

maintained compliance with the rule and center procedures. The center shall allow the commissioner to inspect the center at any time during the approval period, whether or not the site visit has been announced in advance. A site visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center.

9520.0870 VARIANCES.

Subpart 1. **When allowed.** The standards and procedures established by parts 9520.0760 to 9520.0860 may be varied by the commissioner. Standards and procedures established by statute shall not be varied.

Subp. 2. **Request procedure.** A request for a variance must be submitted in writing to the commissioner, accompanying or following the submission of a completed application for approval under Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870. The request shall state:

A. the standard or procedure to be varied;

B. the specific reasons why the standard or procedure cannot be or should not be complied with; and

C. the equivalent standard or procedure the center will establish to achieve the intent of the standard or procedure to be varied.

Subp. 3. **Decision procedure.** Upon receiving the variance request, the commissioner shall consult with a panel of experts in the mental health disciplines regarding the request. Criteria for granting a variance shall be the commissioner's determination that subpart 2, items A to C are met. Hardship shall not be a sufficient reason to grant a variance. No variance shall be granted that would threaten the health, safety, or rights of clients. Variances granted by the commissioner shall specify in writing the alternative standards or procedures to be implemented and any specific conditions or limitations imposed on the variance by the commissioner. Variances denied by the commissioner shall specify in writing the reason for the denial.

Subp. 4. **Notification.** The commissioner shall send the center a written notice granting or not granting the variance within 90 days of receiving the written variance request. This notice shall not be construed as approval or disapproval of the center under Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

9530.6800 ASSESSMENT OF NEED FOR TREATMENT PROGRAMS.

Subpart 1. **Assessment of need required for licensure.** Before a license or a provisional license may be issued, the need for the chemical dependency treatment or rehabilitation program must be determined by the commissioner. Need for an additional or expanded chemical dependency treatment program must be determined, in part, based on the recommendation of the county board of commissioners of the county in which the program will be located and the documentation submitted by the applicant at the time of application.

If the county board fails to submit a statement to the commissioner within 60 days of the county board's receipt of the written request from an applicant, as required under part 9530.6810, the commissioner shall determine the need for the applicant's proposed chemical dependency treatment program based on the documentation submitted by the applicant at the time of application.

Subp. 2. **Documentation of need requirements.** An applicant for licensure under parts 9530.2500 to 9530.4000 and Minnesota Statutes, chapter 245G, must submit the documentation in items A and B to the commissioner with the application for licensure:

A. The applicant must submit documentation that it has requested the county board of commissioners of the county in which the chemical dependency treatment program will be located to submit to the commissioner both a written statement that supports or does not

support the need for the program and documentation of the rationale used by the county board to make its determination.

B. The applicant must submit a plan for attracting an adequate number of clients to maintain its proposed program capacity, including:

(1) a description of the geographic area to be served;

(2) a description of the target population to be served;

(3) documentation that the capacity or program designs of existing programs are not sufficient to meet the service needs of the chemically abusing or chemically dependent target population if that information is available to the applicant;

(4) a list of referral sources, with an estimation as to the number of clients the referral source will refer to the applicant's program in the first year of operation; and

(5) any other information available to the applicant that supports the need for new or expanded chemical dependency treatment capacity.

9530.6810 COUNTY BOARD RESPONSIBILITY TO REVIEW PROGRAM NEED.

When an applicant for licensure under parts 9530.2500 to 9530.4000 or Minnesota Statutes, chapter 245G, requests a written statement of support for a proposed chemical dependency treatment program from the county board of commissioners of the county in which the proposed program is to be located, the county board, or the county board's designated representative, shall submit a statement to the commissioner that either supports or does not support the need for the applicant's program. The county board's statement must be submitted in accordance with items A and B:

A. the statement must be submitted within 60 days of the county board's receipt of a written request from the applicant for licensure; and

B. the statement must include the rationale used by the county board to make its determination.