SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 1174

(SENATE AUTHORS: MORRISON, Hoffman, Boldon and Coleman)

DATE	D-PG	OFFICIAL STATUS
02/02/2023		Introduction and first reading
		Referred to Health and Human Services

A bill for an act

relating to human services; expanding child care assistance to certain families; expanding and modifying grants and rules regarding children's mental health; modifying the transition to community initiative; modifying training requirements for mental health staff; modifying covered transportation services; covering children's care coordination; modifying rules regarding children's long-term stays in the emergency room; establishing the rural family response and stabilization services pilot program; requiring reports; appropriating money; amending Minnesota Statutes 2022, sections 119B.05, subdivision 1; 245.4662; 245.4889, subdivision 1; 254B.05, subdivision 1a; 256.478; 256B.0616, subdivisions 4, 5, by adding a subdivision; 256B.0622, subdivision 2a; 256B.0624, subdivisions 5, 8; 256B.0625, subdivisions 17, 45a; 256B.0659, subdivisions 1, 17a; 256B.0943, subdivisions 1, 2, 9, by adding a subdivision; 256B.0946, subdivision 7; 256B.0947, subdivision 7, by adding a subdivision; 260C.007, subdivision 6; 260C.708; proposing coding for new law in Minnesota Statutes, chapter 144.

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

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

Subdivision 1. **Eligible participants.** Families eligible for child care assistance under the MFIP child care program are:

(1) MFIP participants who are employed or in job search and meet the requirements of section 119B.10;

(2) persons who are members of transition year families under section 119B.011, subdivision 20, and meet the requirements of section 119B.10;

(3) families who are participating in employment orientation or job search, or other employment or training activities that are included in an approved employability development plan under section 256J.95;

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

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

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

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

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

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

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

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

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

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

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

245.4662 MENTAL HEALTH INNOVATION GRANT PROGRAM.

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

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

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

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

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

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

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

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

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

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

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

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

(iv) a traumatic brain injury;

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

(vi) severe emotional dysregulation and schizophrenia.

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

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

(1) a description of the purpose or project for which grant funds will be used;

(2) a description of the specific problem the grant funds will address;

(3) a letter of support from the local mental health authority;

(4) a description of achievable objectives, a work plan, and a timeline for implementation and completion of processes or projects enabled by the grant; and

(5) a process for documenting and evaluating results of the grant.

(b) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to paragraph (c), the commissioner shall establish criteria including, but not limited to: the eligibility of the project; the applicant's thoroughness and clarity in describing the problem grant funds are intended to address; a description of the applicant's proposed project; a description of the population demographics and service area of the proposed project; the manner in which the applicant will demonstrate the effectiveness of any projects undertaken; the proposed project's longevity and demonstrated financial sustainability after the initial grant period; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also consider other relevant factors. In evaluating applications, the commissioner may request additional information regarding a proposed project, including information on project cost. An applicant's failure to provide the information requested disqualifies an applicant. The commissioner shall determine the number of grants awarded.

(c) Eligible applicants may receive grants under this section for purposes including, but not limited to, the following:

(1) intensive residential treatment services or psychiatric residential treatment services providing time-limited mental health services in a residential setting;

(2) the creation of stand-alone urgent care centers for mental health and psychiatric consultation services, crisis residential services, or collaboration between crisis teams and critical access hospitals;

(3) establishing new community mental health services or expanding the capacity of existing services, including supportive housing; and

(4) other innovative projects that improve options for mental health services in community settings and reduce the number of:

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

(ii) children who have boarded in an emergency room or discharge is delayed because no other options for their care are available.

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

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

(1) counties;

(2) Indian tribes;

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

(4) mental health service providers.

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

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

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

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

(4) children's mental health crisis services;

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

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

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

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

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

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

(11) mental health first aid training;

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

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

(14) early childhood mental health consultation;

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

(16) psychiatric consultation for primary care practitioners; and

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

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

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

Sec. 5. Minnesota Statutes 2022, section 254B.05, subdivision 1a, is amended to read:

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

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

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

(3) is not a jail or prison;

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

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site 24 hours per day;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Programs providing children's mental health crisis admissions and stabilization under section 245.4882, subdivision 6, are eligible vendors of room and board.

(d) Programs providing children's residential services under section 245.4882, except services for individuals who have a placement under chapter 260C or 260D, are eligible vendors of room and board.

~~(d)~~ (e) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

Sec. 6. Minnesota Statutes 2022, section 256.478, is amended to read:

256.478 CHILD AND ADULT TRANSITION TO COMMUNITY INITIATIVE.

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 7. Minnesota Statutes 2022, section 256B.0616, subdivision 4, is amended to read:

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

Sec. 8. Minnesota Statutes 2022, section 256B.0616, subdivision 5, is amended to read:

Subd. 5. **Certified family peer specialist training and certification.** The commissioner shall develop a or approve the use of an existing training and certification process for certified family peer specialists. 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. Training for family peer support specialists can be delivered by the commissioner or by organizations approved by the commissioner.

Sec. 9. Minnesota Statutes 2022, section 256B.0616, is amended by adding a subdivision to read:

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

Sec. 10. Minnesota Statutes 2022, section 256B.0622, subdivision 2a, is amended to read:

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

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

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

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

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

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

(iii) significant difficulty maintaining a safe living situation;

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

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

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

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

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

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

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

(vii) significant difficulty meeting basic survival needs;

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

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

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

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

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

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

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

(5) there are no indications that other available community-based services would be equally or more effective as evidenced by consistent and extensive efforts to treat the individual; 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 assertive community treatment is not provided.

Sec. 11. Minnesota Statutes 2022, section 256B.0624, subdivision 5, is amended to read:

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

(1) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health certified peer specialist.

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

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

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

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

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

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

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

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

(8) youth substance use.

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

Sec. 12. Minnesota Statutes 2022, section 256B.0624, subdivision 8, is amended to read:

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

(1) mental health professional;

(2) certified rehabilitation specialist;

(3) clinical trainee;

(4) mental health practitioner;

(5) mental health certified family peer specialist;

(6) mental health certified peer specialist; or

(7) mental health rehabilitation worker.

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

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

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

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

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

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

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

(8) youth substance use.

Sec. 13. Minnesota Statutes 2022, section 256B.0625, subdivision 17, is amended to read:

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

(b) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) adhere to the policies defined by the commissioner;

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

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

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

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

(g) The commissioner may use an order by the recipient's attending physician, advanced practice registered nurse, physician assistant, or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's 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.

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) The administrative agency shall use the level of service process established by the commissioner to determine the client's most appropriate mode of transportation. Clients 20 years of age or younger are eligible for assisted transport, unless they meet the requirements for lift-equipped transport, ramp transport, or stretcher transport. 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) 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)~~ to (o) 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) The commissioner shall:

(1) 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) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (h), 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 and mileage rate for nonemergency medical transportation services is equal to 125 percent of the respective base and mileage rate in paragraph (m), clauses (4) and (5), when the client is 20 years old or younger and provided by a type III vehicle, as defined in section 169.011, subdivision 71, paragraph (h).

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

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

Sec. 14. Minnesota Statutes 2022, section 256B.0625, subdivision 45a, is amended to read:

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

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

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

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

Sec. 15. Minnesota Statutes 2022, section 256B.0659, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 16. Minnesota Statutes 2022, section 256B.0659, subdivision 17a, is amended to read:

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

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

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

Sec. 17. Minnesota Statutes 2022, 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 care coordination" means the activities required to coordinate care across settings and providers for a child in order to deliver quality care and ensure seamless transitions across the full spectrum of health services. Children's care coordination includes documenting a plan of care for medical care, behavioral health, and social services and supports in the individual treatment plan; assisting with obtaining appointments; confirming that clients attend appointments; developing a crisis plan; tracking medication; and implementing treatment goals with providers involved, including the child's caregivers. Children's care coordination includes care coordination activities done by members of a

child's treatment team who are supporting treatment and services for the individual child and family.

~~(a)~~ (b) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed emotional disturbance, as defined in section 245.4871, subdivision 15, or a diagnosed mental illness, as defined in section 245.462, subdivision 20. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

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

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

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

~~(e)~~ (f) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for three or more individuals and individual or group skills training provided by a team, under the treatment supervision of a mental health professional.

~~(f)~~ (g) "Standard diagnostic assessment" means the assessment described in 245I.10, subdivision 6.

~~(g)~~ (h) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered services through telehealth as defined under section 256B.0625, subdivision 3b. Direct service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

~~(h)~~ (i) "Direction of mental health behavioral aide" means the activities of a mental health professional, clinical trainee, or mental health practitioner in guiding the mental

health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individual treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (7).

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

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

~~(k)~~ (l) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a mental health behavioral aide qualified according to section 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

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

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

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

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

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

(2) administering and reporting the standardized outcome measurements in section 245I.10, subdivision 6, paragraph (d), clauses (3) and (4), and other standardized outcome measurements approved by the commissioner, as periodically needed to evaluate the effectiveness of treatment.

~~(p)~~ (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).

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

~~(r)~~ (s) "Rehabilitative services" or "psychiatric rehabilitation services" means interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had

been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement.

~~(s)~~ (t) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

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

Sec. 18. Minnesota Statutes 2022, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports when the services are provided by an eligible provider entity certified under and meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) The service components of children's therapeutic services and supports are:

(1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional, clinical trainee, or mental health practitioner;

(3) crisis planning;

(4) mental health behavioral aide services;

(5) direction of a mental health behavioral aide;

(6) mental health service plan development; ~~and~~

(7) children's day treatment~~.~~; and

(8) children's care coordination.

Sec. 19. Minnesota Statutes 2022, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) the provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a team under the treatment supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) To be eligible for medical assistance payment, a provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver or arrange for medically necessary psychotherapy unless the child's parent or caregiver chooses not to receive it or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(A) one mental health professional, clinical trainee, or mental health practitioner must work with a group of three to eight clients; or

(B) any combination of two mental health professionals, clinical trainees, or mental health practitioners must work with a group of nine to 12 clients;

(iv) a mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client; and

(v) for group skills training, when a skills group that meets the minimum group size requirement temporarily falls below the minimum group size because of a group member's temporary absence, the provider may conduct the session for the group members in attendance;

(3) crisis planning to a child and family must include development of a written plan that anticipates the particular factors specific to the child that may precipitate a psychiatric crisis

for the child in the near future. The written plan must document actions that the family should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for direct intervention and support services to the child and the child's family. Crisis planning must include preparing resources designed to address abrupt or substantial changes in the functioning of the child or the child's family when sudden change in behavior or a loss of usual coping mechanisms is observed, or the child begins to present a danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan.

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with an emotional disturbance or a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies; ~~and~~

(5) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to approve the individual treatment plan. Medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development~~.~~; and

(6) providers of children's care coordination services must be supervised by and enrolled with Minnesota health care programs and have responsibility for composing and implementing services related to the child's individual care plan. For children transitioning out of qualified residential treatment under sections 260C.70 to 260C.83, children's care coordination must support implementation of recommendations outlined in the individual transition service plan. The commissioner must cover children's care coordination activities by client and treatment plan need and shall not be a cap coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) is abandoned or without parent, guardian, or custodian. Abandoned does not include a parent who cannot take their child home from an emergency room because appropriate services are not in place or available to keep the child, other family members, or other people in the home safe;

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

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

(4) is without the special care made necessary by a physical, mental, or emotional condition because the child's parent, guardian, or custodian is unable or unwilling to provide that care. This does not include when required and appropriate care for the child is not available in the mental health system;

(5) is medically neglected, which includes, but is not limited to, the withholding of medically indicated treatment from an infant with a disability with a life-threatening

condition. The term "withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening conditions by providing treatment, including appropriate nutrition, hydration, and medication which, in the treating physician's, advanced practice registered nurse's, or physician assistant's reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all conditions, except that the term does not include the failure to provide treatment other than appropriate nutrition, hydration, or medication to an infant when, in the treating physician's, advanced practice registered nurse's, or physician assistant's reasonable medical judgment:

(i) the infant is chronically and irreversibly comatose;

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

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

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

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

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

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

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

(11) is a sexually exploited youth;

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

(13) is a runaway;

(14) is a habitual truant;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) The agency must provide aftercare services as defined by the federal Family First Prevention Services Act to the child for the six months following discharge from the qualified residential treatment program. The services may include children's care coordination as

defined in section 256B.0943, subdivision 1, paragraph (a), and family peer specialists under section 256B.0616.

Sec. 26. **RURAL FAMILY RESPONSE AND STABILIZATION SERVICES PILOT PROGRAM.**

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

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

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

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

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

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

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

(2) reducing emergency department utilization;

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

(4) reducing law enforcement and juvenile justice involvement.

Sec. 27. **DIRECTION TO THE COMMISSIONER.**

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

Sec. 28. **DIRECTION TO THE COMMISSIONER TO MAXIMIZE EXISTING MEDICAID BENEFITS TO DELIVER FAMILY-FOCUSED CHILDREN'S MENTAL HEALTH CARE.**

The commissioner shall assemble experts in children's mental health and the Minnesota state Medicaid plan to conduct a thorough review of the state Medicaid plan to identify

opportunities to utilize existing benefits to deliver family-focused children's mental health care that includes family in-treatment planning, skill building, and services as appropriate to optimize outcomes for children. The commissioner shall include service leaders in areas of outpatient and residential service delivery and administration, mental health advocates representing family and youth voices, county children's mental health service leaders, and state Medicaid plan experts to review and identify where approved authority in the state Medicaid plan can further support service delivery to children within a family-centered mental health framework. The commissioner shall develop and report a summary of findings to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance by January 1, 2024.

Sec. 29. **DIRECTION TO COMMISSIONER; COLLABORATIVE INTENSIVE BRIDGING SERVICES.**

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

Sec. 30. **APPROPRIATION.**

$..... in fiscal year 2024 and $..... in fiscal year 2025 are appropriated from the general fund to the commissioner of human services for additional funding for grants awarded under the child and adult transition to community initiative in Minnesota Statutes, section 256.478.

Sec. 31. **APPROPRIATION; RESPITE CARE SERVICES.**

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

Sec. 32. **APPROPRIATION; CHILDREN'S SCHOOL-LINKED MENTAL HEALTH GRANTS.**

$..... in fiscal year 2024 and $..... in fiscal year 2025 are appropriated from the general fund to the commissioner of human services for children's school-linked mental health services. At least 25 percent of the new funding must be targeted to providers that can serve

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

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

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

Sec. 34. **APPROPRIATION.**

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

Sec. 35. **APPROPRIATION.**

$..... in fiscal year 2024 and $..... in fiscal year 2025 are appropriated from the general fund to the commissioner of human services to expand early childhood mental health services under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (9), and early childhood mental health consultation grants under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (14). Mental health consultation grants must be to early learning programs in schools, family home visiting programs, public health programs, and health care settings. Mental health consultation includes a mental health professional with early childhood competency providing training, regular on-site consultation to staff serving high-risk and low-income families, and referrals to clinical services for parents and children struggling with mental health conditions. The commissioner shall award money proportionately among current grantees based on the number of regions a grantee serves.

Sec. 36. **APPROPRIATION.**

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

Sec. 37. **APPROPRIATION.**

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

Sec. 38. **APPROPRIATION.**

$..... in fiscal year 2024 is appropriated from the general fund to the commissioner of human services for a grant to fund a family response and stabilization services pilot project in rural Minnesota. The department must develop a request for proposal for counties and adult mental health initiatives in rural Minnesota to meet the requirements of the pilot program. A county or adult mental health initiative may serve multiple counties provided the grantee can respond in-person within one hour in the established service area.

Sec. 39. **APPROPRIATION; PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES.**

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

Sec. 40. **APPROPRIATION; TRAINING GRANTS FOR INTENSIVE IN-HOME SERVICES.**

$1,250,000 in fiscal year 2024 is appropriated from the general fund to the commissioner of human services for grants for training of staff providing intensive in-home children's mental health care under Minnesota Statutes, sections 256B.0943, 256B.0946, and 256B.0947. Grant money shall be to reimburse certified providers for training on

evidence-based practices, trauma-informed approaches, and de-escalation and train-the-trainer models to equip staff and families accessing intensive mental health care models to effectively care for children while they access treatment and maintain safety.

Sec. 41. **APPROPRIATION; COLLABORATIVE INTENSIVE BRIDGING SERVICES.**

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

(1) maintaining current levels of collaborative intensive bridging services and evaluation;

(2) limited expansions of collaborative intensive bridging services and evaluation; and

(3) training and technical assistance by an expert contractor with experience in collaborative intensive bridging services to counties and service providers on maintaining fidelity to the collaborative intensive bridging services model.

Sec. 42. **APPROPRIATION; CHILDREN'S MENTAL HEALTH DISCHARGE OPTIONS.**

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

Sec. 43. **APPROPRIATION; CHILD FIRST PROGRAMS.**

$810,000 in fiscal year 2024 and $1,800,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of human services for grants to start up, expand, or sustain child first programs in metropolitan and rural areas of the state to serve families in accordance with the child first model as defined by the National Service Office for Nurse-Family Partnership and Child First. Grants must be provided to community-based mental health organizations, family service organizations, hospital systems and pediatric providers, early care and education providers, and university-based family or mental health programs.