

A bill for an act relating to human services; changing mental health provisions; amending criminal justice and public safety; creating public safety grants; amending children's mental health services; creating a loan forgiveness program; providing additional medical assistance coverage for mental health issues; providing rate increases; creating a fatality review team; requiring studies; amending mental health funding; providing criminal penalties; allowing rulemaking; appropriating money; amending Minnesota Statutes 2008, sections 43A.23, subdivision 1; 43A.316, by adding a subdivision; 120A.22, subdivision 12; 125A.15; 125A.51; 126C.44; 145.56, subdivisions 1, 2; 245.462, subdivision 18; 245.470, subdivision 1; 245.4871, subdivision 27; 245.488, subdivision 1; 256B.038; 256B.055, by adding a subdivision; 256B.0622, subdivisions 2, 6; 256B.0623, subdivisions 5, 8; 256B.0624, subdivisions 4, 5, 8; 256B.0625, subdivisions 13c, 13f, 38, 42, 43, 46; 256B.0943, subdivision 1, by adding subdivisions; 256B.763; 256D.03, subdivisions 3, 4; 256J.08, subdivision 73a; 256L.07, subdivision 3; 403.03; 403.05, subdivision 1; Laws 2007, chapter 147, article 7, section 71; proposing coding for new law in Minnesota Statutes, chapters 144; 256; 260C; 626; 641.

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

ARTICLE 1
CRIMINAL JUSTICE AND PUBLIC SAFETY

Section 1. Minnesota Statutes 2008, section 403.03, is amended to read:

403.03 911 SERVICES TO BE PROVIDED.

Services available through a 911 system shall include police, firefighting, and emergency medical and ambulance services. Other emergency and civil defense services may be incorporated into the 911 system at the discretion of the public agency operating the public safety answering point. The 911 system may include a referral to mental health crisis teams, where available.

Sec. 2. Minnesota Statutes 2008, section 403.05, subdivision 1, is amended to read:

Subdivision 1. **Operate and maintain.** Each county or any other governmental agency shall operate and maintain its 911 system to meet the requirements of governmental agencies whose services are available through the 911 system and to permit future expansion or enhancement of the system. Enhancement activities may include mental health crisis training. Each county or any other governmental agency shall ensure that a 911 emergency call made with a wireless access device is automatically connected to and answered by the appropriate public safety answering point.

Sec. 3. **[626.96] CRISIS INTERVENTION TEAM GRANTS.**

Subdivision 1. **Request for proposals.** The commissioner of public safety shall create a competitive grant process using request for proposals for crisis intervention team training for local police and sheriff departments. Before making grants under this section, the commissioner shall consult with the following organizations or individuals regarding the development of the request for proposals:

- (1) the Barbara Schneider Foundation;
- (2) the National Alliance on Mental Illness;
- (3) the Mental Health Association of Minnesota; and
- (4) national experts on crisis intervention team training.

Subd. 2. **Training requirements.** The training provided with grants made under this section must include, but is not limited to, the following components:

- (1) an overview of mental illnesses and the mental health system;
- (2) site visits to psychiatric receiving facilities;
- (3) an overview of mental health courts;
- (4) an overview of specific psychiatric conditions, their manifestations, and treatment; and
- (5) crisis intervention team reporting and data collection.

At least 20 percent of each training must involve scenario-based role play training with the use of a professional acting company with crisis intervention team training experience. Training provided under this subdivision must be at least 40 hours. The training must encourage and support the statewide development of crisis intervention teams for law enforcement. The training must promote the development of local collaboration among public safety professionals, community mental health and emergency medicine providers, and members of the public.

Sec. 4. **[641.156] COUNTY JAIL REENTRY PROJECTS; GRANTS.**

Subdivision 1. **Purpose.** The purpose of the reentry project is to promote public safety, prevent recidivism, and promote a successful reintegration into the community by providing services to individuals confined in jails and county regional jails who are identified as having mental illness, traumatic brain injury, chemical dependency, or being homeless.

Subd. 2. **Grants.** (a) The commissioner of corrections, in consultation with the commissioner of human services, shall award grants to county boards for two-year reentry pilot projects. At a minimum, one project must be located outside the seven-county metropolitan area. Projects will target prisoners in jails and county regional jails who have a release date and are identified as having:

(1) a mental illness, as defined in section 245.462, subdivision 20;

(2) a traumatic brain injury, as defined in section 256B.093, subdivision 4;

(3) chemical dependency, as defined in section 253B.02, subdivision 2; or

(4) a history of homelessness, as defined in section 116L.361, subdivision 5.

(b) The projects shall include a collaboration of county agencies and may provide a range of services including, but not limited to, screening and assessment, client-specific programming, discharge planning and follow-up assistance, and follow up for at least three months after the prisoner has reentered the community.

Subd. 3. **Applications.** A grant applicant shall prepare and submit to the commissioner of corrections a written proposal detailing the plan and strategies on how the applicant will implement the program. The application shall include a proposed evaluation component of outcome measures including, but not limited to, numbers of prisoners served, recidivism, and restoration of public benefits.

Sec. 5. **APPROPRIATIONS.**

Subdivision 1. **Grant program.** \$..... is appropriated from the general fund to the commissioner of corrections for fiscal year 2010 and \$..... for fiscal year 2011 to administer the grant program established in Minnesota Statutes, section 641.156.

Subd. 2. **Discharge planning.** \$..... is appropriated from the general fund to the commissioner of human services for the biennium beginning July 1, 2009, to fund discharge planning for offenders with serious and persistent mental illness as defined in Minnesota Statutes, section 245.462, subdivision 20, paragraph (c), who are pending release from correctional facilities.

Subd. 3. **Mental health courts.** \$..... for fiscal year 2010 and \$..... for fiscal year 2011 are appropriated from the general fund to the Supreme Court to develop and implement standards for mental health courts.

Subd. 4. **Crisis intervention training.** \$144,000 is appropriated for the biennium beginning July 1, 2009, from the general fund to the commissioner of public safety to fund grants to local police departments to conduct crisis intervention training under Minnesota Statutes, section 626.96. The commissioner may use up to 2.5 percent of the amount appropriated under this subdivision for costs of administering this grant program.

ARTICLE 2

CHILDREN'S MENTAL HEALTH

Section 1. [256.9961] COLLABORATIVE SERVICES FOR HIGH-RISK CHILDREN.

To provide early intervention collaborative services to children who are at high risk for child maltreatment, substance use, mental illness, and serious and violent offending, but not subject to the delinquency provisions of chapter 260B, the commissioner of human services shall fund one or more projects that identify and serve these children. The projects shall include the following program components:

- (1) multidimensional screening instruments;
- (2) multidisciplinary and multijurisdictional collaborative services;
- (3) integrated information systems;
- (4) intensive in-home and community casework;
- (5) continuous tracking of outcomes; and
- (6) multidimensional evaluations and cost-benefit analysis.

Projects must use all available funding streams.

Sec. 2. Minnesota Statutes 2008, section 256B.055, is amended by adding a subdivision to read:

Subd. 2a. **Foster children to age 21.** Foster children for whom the commissioner or counties have custody and financial responsibility on their 18th birthday must be enrolled in medical assistance upon the completion of an application and must be certified eligible for medical assistance by the commissioner until their 21st birthday. Once certified eligible, reapplication is not required.

Sec. 3. Minnesota Statutes 2008, section 256B.0943, is amended by adding a subdivision to read:

Subd. 14. Rate increase for children's therapeutic services and support.
Effective January 1, 2010, services that are provided as a component of children's therapeutic services and supports, when combined and delivered as a day treatment program, must be increased 15 percent over the rates in effect on January 1, 2009. The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect this increase. Prepaid medical assistance health plans must pass this increase to providers over the contracted rates in effect January 1, 2008.

Sec. 4. [260C.456] FOSTER CARE BENEFITS UNTIL AGE 21.

Upon the request of a person at any time between the ages of 18 and 21 who had been receiving foster care benefits in the six consecutive months prior to the person's 18th birthday, or who was discharged while on runaway status after age 15, or who had been under state guardianship as dependent or neglected, the local agency shall develop, in conjunction with the person and other appropriate parties, a specific plan related to that person's vocational, educational, social, or maturational needs and shall ensure that any foster care, housing, or counseling benefits are tied to that plan.

ARTICLE 3

MISCELLANEOUS MENTAL HEALTH

Section 1. [144.206] LOAN FORGIVENESS PROGRAM.

Subdivision 1. Establishment. (a) A loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program for individuals who are employed by a nonprofit agency that provides mental health services for cultural or ethnic minority clients.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of the biennium, any remaining balance in the account that is not committed by contract and is not needed to fulfill existing commitments shall cancel and be deposited in the general fund.

Subd. 2. Definition. For the purposes of this section, "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 education of a mental health professional.

Subd. 3. Eligibility. To be eligible to participate in the loan forgiveness program, an individual must be employed by a nonprofit agency that provides mental health services

for cultural or ethnic minority clients and must be of the same culture or ethnicity as the clients. An applicant selected to participate must sign a contract agreeing to remain employed with the nonprofit agency for a three-year full-time term, which must begin no later than 30 days following completion of the required training.

The commissioner may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required cultural or ethnic minority population. The commissioner shall give preference to applicants closest to completing their education.

Subd. 4. **Disbursements.** For each year that a participant meets the service obligation required under subdivision 3, the commissioner shall make annual disbursements directly to the participant equivalent to 25 percent of the participant's loan indebtedness, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements, and as requested, the participant and the employer must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivision 3. The participant must provide the commissioner with verification that the full amount of the loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made.

If a participant does not fulfill the minimum commitment of service under subdivision 3, the commissioner shall collect from the participant the full amount paid to the participant under the loan forgiveness program plus interest at the rate established under section 270C.40. The commissioner shall deposit the money collected in the general fund. The commissioner shall allow waivers of all or part of the money owed the commissioner as a result of nonfulfillment if emergency circumstances prevented fulfillment of the minimum service commitment.

Sec. 2. Minnesota Statutes 2008, section 145.56, subdivision 1, is amended to read:

Subdivision 1. **Suicide prevention plan.** The commissioner of health shall refine, coordinate, and implement the state's suicide prevention plan using an evidence-based, public health approach focused on prevention, in collaboration with the commissioner of human services; the commissioner of public safety; the commissioner of education; the chancellor of Minnesota State Colleges and Universities; the president of the University of Minnesota; and appropriate agencies, organizations, and institutions in the community.

Sec. 3. Minnesota Statutes 2008, section 145.56, subdivision 2, is amended to read:

Subd. 2. **Community-based programs.** To the extent funds are appropriated for the purposes of this subdivision, the commissioner shall establish a grant program to fund:

(1) community-based programs to provide education, outreach, and advocacy services to populations who may be at risk for suicide;

(2) community-based programs that educate community helpers and gatekeepers, such as family members, spiritual leaders, coaches, and business owners, employers, and coworkers on how to prevent suicide by encouraging help-seeking behaviors;

(3) community-based programs that educate populations at risk for suicide and community helpers and gatekeepers that must include information on the symptoms of depression and other psychiatric illnesses, the warning signs of suicide, skills for preventing suicides, and making or seeking effective referrals to intervention and community resources; and

(4) community-based programs to provide evidence-based suicide prevention and intervention education to school staff, parents, and students in grades kindergarten through 12, and for students attending Minnesota colleges and universities.

Sec. 4. Minnesota Statutes 2008, section 245.462, subdivision 18, is amended to read:

Subd. 18. **Mental health professional.** "Mental health professional" means a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285; and:

(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization; or

(ii) who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work: a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in psychology: an individual licensed by the Board of Psychology under sections 148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;

(4) in psychiatry: a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; ~~or~~

(6) in licensed professional clinical counseling: the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of postmaster's supervised experience in the delivery of clinical services in the treatment of mental illness; or

(7) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.

Sec. 5. Minnesota Statutes 2008, 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; by contract with privately operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; 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 ~~(4)~~ (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. 6. Minnesota Statutes 2008, section 245.4871, subdivision 27, is amended to read:

Subd. 27. **Mental health professional.** "Mental health professional" means a person providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:

(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;

(3) in psychology, the mental health professional must be an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;

(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; ~~or~~

(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000

hours of postmaster's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or

(7) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.

Sec. 7. Minnesota Statutes 2008, 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; by contract with privately operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; 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 ~~(4)~~ (6). A child or a child's parent may be required to pay a fee based in accordance with section 245.481. Outpatient services include:

- (1) conducting diagnostic assessments;
- (2) conducting psychological testing;
- (3) developing or modifying individual treatment plans;
- (4) making referrals and recommending placements as appropriate;
- (5) treating the child's mental health needs through therapy; and
- (6) prescribing and managing medication and evaluating the effectiveness of prescribed medication.

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

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

Sec. 8. Minnesota Statutes 2008, section 256B.0622, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Intensive nonresidential rehabilitative mental health services" means adult rehabilitative mental health services as defined in section 256B.0623, subdivision 2, paragraph (a), except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, the Fairweather Lodge treatment model, as defined by the standards established by the National Coalition for Community Living, and other evidence-based practices, and directed to recipients with a serious mental illness who require intensive services.

(b) "Intensive residential rehabilitative mental health services" means short-term, time-limited services provided in a residential setting to recipients 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 and must be consistent with the Fairweather Lodge treatment model as defined in paragraph (a), and other evidence-based practices.

(c) "Evidence-based practices" are nationally recognized mental health services that are proven by substantial research to be effective in helping individuals with serious mental illness obtain specific treatment goals.

(d) "Overnight staff" means a member of the intensive residential rehabilitative mental health treatment team who is responsible during hours when recipients are typically asleep.

(e) "Treatment team" means all staff who provide services under this section to recipients. At a minimum, this includes the clinical supervisor, mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to ~~(5)~~ (6); mental health practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision 5, clause (3); and certified peer specialists under section 256B.0615.

Sec. 9. Minnesota Statutes 2008, section 256B.0622, subdivision 6, is amended to read:

Subd. 6. Standards for intensive residential rehabilitative mental health services. (a) The provider of intensive residential 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 recipients given the recipient's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services

12.1 for chemical dependency, illness management services, and family education when
12.2 appropriate.

12.3 (b) At a minimum:

12.4 (1) staff must be available and provide direction and supervision whenever recipients
12.5 are present in the facility;

12.6 (2) staff must remain awake during all work hours;

12.7 (3) there must be a staffing ratio of at least one to nine recipients for each day and
12.8 evening shift. If more than nine recipients are present at the residential site, there must be
12.9 a minimum of two staff during day and evening shifts, one of whom must be a mental
12.10 health practitioner or mental health professional;

12.11 (4) if services are provided to recipients who need the services of a medical
12.12 professional, the provider shall assure that these services are provided either by the
12.13 provider's own medical staff or through referral to a medical professional; ~~and~~

12.14 (5) the provider must assure the timely availability of a licensed registered
12.15 nurse, either directly employed or under contract, who is responsible for ensuring the
12.16 effectiveness and safety of medication administration in the facility and assessing patients
12.17 for medication side effects and drug interactions; and

12.18 (6) for intensive residential rehabilitative mental health services, nothing in this
12.19 subdivision limits the provision of services to only those clients from the contracting
12.20 county.

12.21 Sec. 10. Minnesota Statutes 2008, section 256B.0623, subdivision 5, is amended to
12.22 read:

12.23 Subd. 5. **Qualifications of provider staff.** Adult rehabilitative mental health
12.24 services must be provided by qualified individual provider staff of a certified provider
12.25 entity. Individual provider staff must be qualified under one of the following criteria:

12.26 (1) a mental health professional as defined in section 245.462, subdivision 18,
12.27 clauses (1) to ~~(5)~~ (6). If the recipient has a current diagnostic assessment by a licensed
12.28 mental health professional as defined in section 245.462, subdivision 18, clauses (1) to ~~(5)~~
12.29 (6), recommending receipt of adult mental health rehabilitative services, the definition of
12.30 mental health professional for purposes of this section includes a person who is qualified
12.31 under section 245.462, subdivision 18, clause ~~(6)~~ (7), and who holds a current and valid
12.32 national certification as a certified rehabilitation counselor or certified psychosocial
12.33 rehabilitation practitioner;

- 13.1 (2) a mental health practitioner as defined in section 245.462, subdivision 17. The
13.2 mental health practitioner must work under the clinical supervision of a mental health
13.3 professional;
- 13.4 (3) a certified peer specialist under section 256B.0615. The certified peer specialist
13.5 must work under the clinical supervision of a mental health professional; or
- 13.6 (4) a mental health rehabilitation worker. A mental health rehabilitation worker
13.7 means a staff person working under the direction of a mental health practitioner or mental
13.8 health professional and under the clinical supervision of a mental health professional in
13.9 the implementation of rehabilitative mental health services as identified in the recipient's
13.10 individual treatment plan who:
- 13.11 (i) is at least 21 years of age;
- 13.12 (ii) has a high school diploma or equivalent;
- 13.13 (iii) has successfully completed 30 hours of training during the past two years in all
13.14 of the following areas: recipient rights, recipient-centered individual treatment planning,
13.15 behavioral terminology, mental illness, co-occurring mental illness and substance abuse,
13.16 psychotropic medications and side effects, functional assessment, local community
13.17 resources, adult vulnerability, recipient confidentiality; and
- 13.18 (iv) meets the qualifications in subitem (A) or (B):
- 13.19 (A) has an associate of arts degree in one of the behavioral sciences or human
13.20 services, or is a registered nurse without a bachelor's degree, or who within the previous
13.21 ten years has:
- 13.22 (1) three years of personal life experience with serious and persistent mental illness;
- 13.23 (2) three years of life experience as a primary caregiver to an adult with a serious
13.24 mental illness or traumatic brain injury; or
- 13.25 (3) 4,000 hours of supervised paid work experience in the delivery of mental health
13.26 services to adults with a serious mental illness or traumatic brain injury; or
- 13.27 (B)(1) is fluent in the non-English language or competent in the culture of the
13.28 ethnic group to which at least 20 percent of the mental health rehabilitation worker's
13.29 clients belong;
- 13.30 (2) receives during the first 2,000 hours of work, monthly documented individual
13.31 clinical supervision by a mental health professional;
- 13.32 (3) has 18 hours of documented field supervision by a mental health professional
13.33 or practitioner during the first 160 hours of contact work with recipients, and at least six
13.34 hours of field supervision quarterly during the following year;
- 13.35 (4) has review and cosignature of charting of recipient contacts during field
13.36 supervision by a mental health professional or practitioner; and

14.1 (5) has 40 hours of additional continuing education on mental health topics during
14.2 the first year of employment.

14.3 Sec. 11. Minnesota Statutes 2008, section 256B.0624, subdivision 4, is amended to
14.4 read:

14.5 Subd. 4. **Provider entity standards.** (a) A provider entity is an entity that meets
14.6 the standards listed in paragraph (b) and:

14.7 (1) is a county board operated entity; or

14.8 (2) is a provider entity that is under contract with the county board in the county
14.9 where the potential crisis or emergency is occurring. To provide services under this
14.10 section, the provider entity must directly provide the services; or if services are
14.11 subcontracted, the provider entity must maintain responsibility for services and billing.
14.12 Where crisis stabilization services are provided in a supervised, licensed residential
14.13 setting, nothing in this subdivision limits the provision of services to only those clients
14.14 from the contracting county.

14.15 (b) The adult mental health crisis response services provider entity must meet the
14.16 following standards:

14.17 (1) has the capacity to recruit, hire, and manage and train mental health professionals,
14.18 practitioners, and rehabilitation workers;

14.19 (2) has adequate administrative ability to ensure availability of services;

14.20 (3) is able to ensure adequate preservice and in-service training;

14.21 (4) is able to ensure that staff providing these services are skilled in the delivery of
14.22 mental health crisis response services to recipients;

14.23 (5) is able to ensure that staff are capable of implementing culturally specific
14.24 treatment identified in the individual treatment plan that is meaningful and appropriate as
14.25 determined by the recipient's culture, beliefs, values, and language;

14.26 (6) is able to ensure enough flexibility to respond to the changing intervention and
14.27 care needs of a recipient as identified by the recipient during the service partnership
14.28 between the recipient and providers;

14.29 (7) is able to ensure that mental health professionals and mental health practitioners
14.30 have the communication tools and procedures to communicate and consult promptly about
14.31 crisis assessment and interventions as services occur;

14.32 (8) is able to coordinate these services with county emergency services and mental
14.33 health crisis services;

14.34 (9) is able to ensure that mental health crisis assessment and mobile crisis
14.35 intervention services are available 24 hours a day, seven days a week;

(10) is able to ensure that services are coordinated with other mental health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the adult. Services must also be coordinated with the recipient's case manager if the adult is receiving case management services;

(11) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486;

(12) is able to submit information as required by the state;

(13) maintains staff training and personnel files;

(14) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction;

(15) is able to keep records as required by applicable laws;

(16) is able to comply with all applicable laws and statutes;

(17) 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.

Sec. 12. Minnesota Statutes 2008, section 256B.0624, subdivision 5, is amended to read:

Subd. 5. **Mobile crisis 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 ~~(5)~~ (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. 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 such as the county social services agency, mental health services, and local law enforcement when necessary.

Sec. 13. Minnesota Statutes 2008, section 256B.0624, subdivision 8, is amended to read:

Subd. 8. **Adult crisis stabilization staff qualifications.** (a) Adult mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. Individual provider staff must have the following qualifications:

(1) be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to ~~(5)~~ (6);

(2) be a mental health practitioner as defined in section 245.462, subdivision 17.

The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) be a mental health rehabilitation worker who meets the criteria in section 256B.0623, subdivision 5, clause (3); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional.

(b) Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Sec. 14. Minnesota Statutes 2008, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary committee.** The commissioner, shall provide a notice of vacancies and post an application for appointment to the formulary committee on the department's Web site. After reviewing the applications and receiving recommendations input from professional medical associations and, professional pharmacy associations, and consumer groups, the commissioner shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four 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; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; a clinical researcher; and one three consumer representative representatives; the remainder to be made up of health care or mental health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee

17.1 members shall serve three-year terms and may be reappointed once by the commissioner
17.2 for a total of two consecutive terms. The Formulary Committee shall meet at least
17.3 quarterly. The commissioner may require more frequent Formulary Committee meetings
17.4 as needed. Meeting notices and drugs to be considered shall be conspicuously posted on
17.5 the department's Web site at least 14 days prior to a meeting. An honorarium of \$100
17.6 per meeting and reimbursement for mileage shall be paid to each committee member
17.7 in attendance.

17.8 Sec. 15. Minnesota Statutes 2008, section 256B.0625, subdivision 13f, is amended to
17.9 read:

17.10 Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and
17.11 recommend drugs which require prior authorization. The Formulary Committee shall
17.12 establish general criteria to be used for the prior authorization of brand-name drugs for
17.13 which generically equivalent drugs are available, but the committee is not required to
17.14 review each brand-name drug for which a generically equivalent drug is available.

17.15 (b) Prior authorization may be required by the commissioner before certain
17.16 formulary drugs are eligible for payment. The Formulary Committee may recommend
17.17 drugs for prior authorization directly to the commissioner. The commissioner may also
17.18 request that the Formulary Committee review a drug for prior authorization. Before the
17.19 commissioner may require prior authorization for a drug:

17.20 (1) the commissioner must provide information to the Formulary Committee on the
17.21 impact that placing the drug on prior authorization may have on the quality of patient care
17.22 and on program costs, information regarding whether the drug is subject to clinical abuse
17.23 or misuse, and relevant data from the state Medicaid program if such data is available;

17.24 (2) the Formulary Committee must review the drug, taking into account medical and
17.25 clinical data and the information provided by the commissioner or other sources; and

17.26 (3) the Formulary Committee must hold a public forum and receive public comment
17.27 for an additional 15 days. Notice of the forum must be published in the State Register.

17.28 The commissioner must provide a 15-day notice period before implementing the prior
17.29 authorization.

17.30 (c) Prior authorization shall not be required or utilized for any atypical antipsychotic
17.31 drug prescribed for the treatment of mental illness ~~if~~.

17.32 (d) Prior authorization shall not be required or utilized for any other medication used
17.33 to treat mental illness if:

17.34 (1) there is no generically equivalent drug available; ~~and~~

(2) the drug ~~was initially prescribed for the recipient prior to July 1, 2003~~ provides a new method of delivery, longevity, or dosage; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

~~(d)~~ (e) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner.

~~(e)~~ (f) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

~~(f)~~ (g) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

Sec. 16. Minnesota Statutes 2008, 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 section 245.462, subdivision 18, ~~clause~~ clauses (5) and (6); or 245.4871, subdivision 27, ~~clause~~ clauses (5) and (6), for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Sec. 17. Minnesota Statutes 2008, 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. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.

(c) "County board" means the county board of commissioners or board established under sections 402.01 to 402.10 or 471.59.

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

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

(f) "Day treatment program" for children means a site-based structured program consisting of group psychotherapy for more than three individuals and other intensive therapeutic services provided by a multidisciplinary team, under the clinical supervision of a mental health professional.

(g) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision 11.

(h) "Direct service time" means the time that a mental health professional, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family. Direct service time includes time in which the provider obtains a client's history 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, maintaining clinical records, consulting with others about the client's mental health status, preparing reports, receiving clinical supervision

directly related to the client's psychotherapy session, and revising the client's individual treatment plan.

(i) "Direction of mental health behavioral aide" means the activities of a mental health professional or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

(j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15. For persons at least age 18 but under age 21, mental illness has the meaning given in section 245.462, subdivision 20, paragraph (a).

(k) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or mental health practitioner, under the clinical supervision of a mental health professional, to guide the work of the mental health behavioral aide.

(l) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21.

(m) "Mental health professional" means an individual as defined in section 245.4871, subdivision 27, clauses (1) to ~~(5)~~ (6), or tribal vendor as defined in section 256B.02, subdivision 7, paragraph (b).

(n) "Preschool program" means a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and supports provider to provide a structured treatment program to a child who is at least 33 months old but who has not yet attended the first day of kindergarten.

(o) "Skills training" means individual, family, or group training designed to improve the basic functioning of the child with emotional disturbance and the child's family in the activities of daily living and community living, and to improve the social functioning of the child and the child's family in areas important to the child's maintaining or reestablishing residency in the community. Individual, family, and group skills training must:

(1) consist of activities designed to promote skill development of the child and the child's family in the use of age-appropriate daily living skills, interpersonal and family relationships, and leisure and recreational services;

(2) consist of activities that will assist the family's understanding of normal child development and to use parenting skills that will help the child with emotional disturbance achieve the goals outlined in the child's individual treatment plan; and

21.1 (3) promote family preservation and unification, promote the family's integration
21.2 with the community, and reduce the use of unnecessary out-of-home placement or
21.3 institutionalization of children with emotional disturbance.

21.4 Sec. 18. Minnesota Statutes 2008, section 256D.03, subdivision 3, is amended to read:

21.5 Subd. 3. **General assistance medical care; eligibility.** (a) General assistance
21.6 medical care may be paid for any person who is not eligible for medical assistance under
21.7 chapter 256B, including eligibility for medical assistance based on a spenddown of excess
21.8 income according to section 256B.056, subdivision 5, or MinnesotaCare as defined in
21.9 paragraph (b), except as provided in paragraph (c), and:

21.10 (1) who is receiving assistance under section 256D.05, except for families with
21.11 children who are eligible under Minnesota family investment program (MFIP), or who is
21.12 having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

21.13 (2) who is a resident of Minnesota; and

21.14 (i) who has gross countable income not in excess of 75 percent of the federal poverty
21.15 guidelines for the family size, using a six-month budget period and whose equity in assets
21.16 is not in excess of \$1,000 per assistance unit. General assistance medical care is not
21.17 available for applicants or enrollees who are otherwise eligible for medical assistance but
21.18 fail to verify their assets. Enrollees who become eligible for medical assistance shall be
21.19 terminated and transferred to medical assistance. Exempt assets, the reduction of excess
21.20 assets, and the waiver of excess assets must conform to the medical assistance program in
21.21 section 256B.056, subdivisions 3 and 3d, with the following exception: the maximum
21.22 amount of undistributed funds in a trust that could be distributed to or on behalf of the
21.23 beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the
21.24 terms of the trust, must be applied toward the asset maximum;

21.25 (ii) who has gross countable income above 75 percent of the federal poverty
21.26 guidelines but not in excess of 175 percent of the federal poverty guidelines for the
21.27 family size, using a six-month budget period, whose equity in assets is not in excess
21.28 of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient
21.29 hospitalization; or

21.30 (iii) the commissioner shall adjust the income standards under this section each July
21.31 1 by the annual update of the federal poverty guidelines following publication by the
21.32 United States Department of Health and Human Services.

21.33 (b) Effective for applications and renewals processed on or after September 1, 2006,
21.34 general assistance medical care may not be paid for applicants or recipients who are adults

with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (e).

(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month general assistance medical care eligibility period, until their six-month renewal.

(d) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph (c), an individual must complete a new application.

(e) Applicants and recipients eligible under paragraph (a), clause (1), are exempt from the MinnesotaCare enrollment requirements in this subdivision if they:

(1) have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration;

(2) fail to meet the requirements of section 256L.09, subdivision 2;

(3) are homeless as defined by United States Code, title 42, section 11301, et seq.;

(4) are classified as end-stage renal disease beneficiaries in the Medicare program;

(5) are enrolled in private health care coverage as defined in section 256B.02, subdivision 9;

(6) are eligible under paragraph (j);

(7) receive treatment funded pursuant to section 254B.02; or

(8) reside in the Minnesota sex offender program defined in chapter 246B.

(f) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization.

(g) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph (c) and submitted to the county agency shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare,

23.1 notice of termination for eligibility for general assistance medical care shall be sent to
23.2 an applicant or recipient. If all other eligibility requirements of this subdivision are
23.3 met, eligibility for general assistance medical care shall be available until enrollment in
23.4 MinnesotaCare subject to the provisions of paragraphs (c), (e), and (f).

23.5 (h) The date of an initial Minnesota health care program application necessary to
23.6 begin a determination of eligibility shall be the date the applicant has provided a name,
23.7 address, and Social Security number, signed and dated, to the county agency or the
23.8 Department of Human Services. If the applicant is unable to provide a name, address,
23.9 Social Security number, and signature when health care is delivered due to a medical
23.10 condition or disability, a health care provider may act on an applicant's behalf to establish
23.11 the date of an initial Minnesota health care program application by providing the county
23.12 agency or Department of Human Services with provider identification and a temporary
23.13 unique identifier for the applicant. The applicant must complete the remainder of the
23.14 application and provide necessary verification before eligibility can be determined. The
23.15 county agency must assist the applicant in obtaining verification if necessary.

23.16 (i) County agencies are authorized to use all automated databases containing
23.17 information regarding recipients' or applicants' income in order to determine eligibility for
23.18 general assistance medical care or MinnesotaCare. Such use shall be considered sufficient
23.19 in order to determine eligibility and premium payments by the county agency.

23.20 (j) General assistance medical care is not available for a person in a correctional
23.21 facility unless the person is detained by law for less than one year in a county correctional
23.22 or detention facility as a person accused or convicted of a crime, or admitted as an
23.23 inpatient to a hospital on a criminal hold order, and the person is a recipient of general
23.24 assistance medical care at the time the person is detained by law or admitted on a criminal
23.25 hold order and as long as the person continues to meet other eligibility requirements
23.26 of this subdivision.

23.27 (k) General assistance medical care is not available for applicants or recipients who
23.28 do not cooperate with the county agency to meet the requirements of medical assistance.

23.29 (l) In determining the amount of assets of an individual eligible under paragraph
23.30 (a), clause (2), item (i), there shall be included any asset or interest in an asset, including
23.31 an asset excluded under paragraph (a), that was given away, sold, or disposed of for
23.32 less than fair market value within the 60 months preceding application for general
23.33 assistance medical care or during the period of eligibility. Any transfer described in this
23.34 paragraph shall be presumed to have been for the purpose of establishing eligibility for
23.35 general assistance medical care, unless the individual furnishes convincing evidence to
23.36 establish that the transaction was exclusively for another purpose. For purposes of this

paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(m) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(n) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services.

(o) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(p) Effective July 1, 2003, general assistance medical care emergency services end.

(q) Effective July 1, 2009, individuals in a correctional facility who have been diagnosed with a mental illness as defined in section 245.462, subdivision 20, are eligible for general assistance medical care for three months from the date of release from confinement.

Sec. 19. Minnesota Statutes 2008, section 256J.08, subdivision 73a, is amended to read:

Subd. 73a. **Qualified professional.** (a) For physical illness, injury, or incapacity, a "qualified professional" means a licensed physician, a physician's assistant, a nurse practitioner, or a licensed chiropractor.

(b) For developmental disability and intelligence testing, a "qualified professional" means an individual qualified by training and experience to administer the tests necessary to make determinations, such as tests of intellectual functioning, assessments of adaptive behavior, adaptive skills, and developmental functioning. These professionals include licensed psychologists, certified school psychologists, or certified psychometrists working under the supervision of a licensed psychologist.

(c) For learning disabilities, a "qualified professional" means a licensed psychologist or school psychologist with experience determining learning disabilities.

(d) For mental health, a "qualified professional" means a licensed physician or a qualified mental health professional. A "qualified mental health professional" means:

(1) for children, in psychiatric nursing, a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) for adults, in psychiatric nursing, a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in adult psychiatric and mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in clinical social work, a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(4) in psychology, an individual licensed by the Board of Psychology under sections 148.88 to 148.98, who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;

(5) in psychiatry, a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry; ~~and~~

(6) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39, with at least

two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; and

(7) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of postmaster's supervised experience in the delivery of clinical services in the treatment of mental illness.

Sec. 20. **ADULT MENTAL HEALTH FATALITY REVIEW TEAM.**

Subdivision 1. Pilot project authorized; purpose. (a) The commissioner of human services shall work with Hennepin County to establish a mental health fatality review team and resource panel as a 30-month pilot project in Hennepin County to review adult mental health fatalities that have occurred in Hennepin County during or after contact with law enforcement, courts, or corrections systems.

(b) The purpose of the resource panel is to make recommendations to the state and to county agencies for improving the mental health, criminal justice, health care, and social service systems, including modifications in statute, rule, policy, and procedure.

(c) The commissioner shall work with Hennepin County to establish procedures for conducting local reviews and may require that all professionals with knowledge of a mental health fatality case participate in the review. In this section, "professional" means a person licensed to perform or a person performing a specific service in the systems that respond to individuals with a mental illness. Professional includes law enforcement personnel, social service agency attorneys, educators, and social service, health care, and mental health care providers.

(d) The purpose of the review team is to analyze adult mental health-related fatalities, review public policies and procedures, and try to prevent future fatalities.

Subd. 2. Definition of mental health fatality. "Mental health fatality" means the unexpected death of a person with a diagnosed mental illness where mental illness was a significant contributing factor in the death.

Subd. 3. Selection of cases for review. Cases for review must be selected by Hennepin County.

Subd. 4. Membership. (a) Hennepin County shall convene an appropriate mental health fatality review team to review the selected cases. The review team members shall include a core panel with representatives of the following disciplines: psychiatry, medical examiner, community hospital, county human services, attorney, law enforcement, public health nursing, chemical health, and mental health advocacy. These members shall attend all meetings.

27.1 (b) A second group of individuals comprises the resource panel, which includes
27.2 representatives from emergency medicine, developmental disabilities, adult mental health,
27.3 suicide prevention, professionals from communities of color or immigrant communities,
27.4 corrections, and other fields. Members of this group are invited to attend meetings for
27.5 which their program or clinical expertise is needed in specific reviews. Other disciplines
27.6 must be identified as needed by the committee.

27.7 (c) Resource panel membership is based on legal requirements and the need for
27.8 specific clinical and program reviewer expertise. Each of the core and resource positions
27.9 is appointed by Hennepin County to serve for a period of one year, subject to renewal.

27.10 Subd. 5. **Disclosure of records.** (a) Notwithstanding the data's classification in the
27.11 possession of any agency, data shall be disclosed to the mental health fatality review team
27.12 as necessary to carry out the purpose of the team, but data shall retain its data classification
27.13 and will under no circumstances be disclosed to anyone not a part of the review. No data
27.14 used or findings arrived at shall be used in a court proceeding. Findings must only be used
27.15 to recommend institutional reforms to prevent future fatalities.

27.16 (b) Cases must be selected for review only after they are closed to any further
27.17 legal activity, including opportunities for appeal. The commissioner has access to not
27.18 public data under Minnesota Statutes, chapter 13, maintained by state agencies, statewide
27.19 systems, or political subdivisions that are related to the death or circumstances surrounding
27.20 the response of professionals to the person in question with a mental illness.

27.21 (c) The commissioner shall also have access to records of private hospitals as
27.22 necessary to carry out the duties prescribed by this section. Access to data under this
27.23 paragraph is limited to police investigative data; autopsy records and coroner or medical
27.24 examiner investigative data; hospital, public health, or other medical records of the person
27.25 with a mental illness; hospital and other medical records of the person's parent that relate to
27.26 prenatal care; and records created by social service agencies that provided services to the
27.27 person or family within three years preceding the person's death. A state agency, statewide
27.28 system, or political subdivision shall provide the data upon request of the commissioner.

27.29 (d) Not public data may be shared with members of the mental health fatality review
27.30 team in connection with an individual case. Notwithstanding the data's classification
27.31 in the possession of any other agency, data acquired by a mental health fatality review
27.32 team in the exercise of its duties is protected nonpublic or confidential data as defined in
27.33 Minnesota Statutes, section 13.02, and may be disclosed only as necessary to carry out the
27.34 purposes of the review panel. It is a misdemeanor to disclose this information. The data
27.35 is not subject to subpoena or discovery. The commissioner may disclose conclusions of
27.36 the review team, but shall not disclose data that was classified as confidential or private

data on decedents, under Minnesota Statutes, section 13.10, or private, confidential, or protected nonpublic data in the disseminating agency, except that the commissioner may disclose local social service agency data as provided in Minnesota Statutes, section 626.556, subdivision 11d, on individual cases involving a fatality or near fatality of a person served by the local social service agency prior to the date of death.

(e) A person attending a mental health fatality review team meeting shall not disclose what transpired at the meeting, except to carry out the purposes of the review panel. The proceedings and records of the review panel are protected nonpublic data, as defined in Minnesota Statutes, section 13.02, subdivision 13, and are not subject to discovery or introduction into evidence in a civil or criminal action against a professional, the state, or a county agency arising out of the matters the panel is reviewing. Information, documents, and records otherwise available from other sources are not immune from discovery or use in a civil or criminal action solely because they were presented during proceedings of the review panel. A person who presented information before the review team or who is a member of the team shall not be prevented from testifying about matters within the person's knowledge. However, in a civil or criminal proceeding, a person shall not be questioned about the person's presentation of information to the review team or opinions formed by the person as a result of the review team meetings.

Subd. 6. **Immunity.** Members of the mental health fatality review team, when acting within the scope of their duties, are immune from civil and criminal liability.

Subd. 7. **Evaluation and report.** (a) The ombudsman for mental health shall develop, by December 31, 2010, a system for evaluating the effectiveness of this pilot project and shall focus on identifiable goals and outcomes. An evaluation must contain data components as well as input from individuals involved in the review process.

(b) The mental health fatality review team shall convene by July 1, 2010, and shall issue two annual reports during the pilot project, one on or before December 31, 2010, and one on or before December 31, 2011. The reports shall be developed collaboratively with the ombudsman for mental health and must consist of the written aggregate recommendations of the review team without reference to specific cases. The December 31, 2011, report must include recommendations for legislation. The reports must be made available upon request. Reports must be distributed to the legislature, governor, attorney general, Supreme Court, county board, and the district court.

Sec. 21. EVIDENCE-BASED PRACTICE.

The commissioner of human services shall consult with stakeholder groups to examine possible budget-neutral changes that include and support evidence-based

practices. The commissioner has the authority to make budget-neutral changes to medical assistance coverage and benefits to implement evidence-based practices as defined by the Agency for Healthcare Research and Quality Practice Guidelines, and the Substance Abuse and Mental Health Services Administration.

Sec. 22. **DUAL DIAGNOSIS.**

The commissioner of human services shall fund up to three programs, within the available appropriation, that provide services for high-risk adults with serious mental illness and co-occurring substance abuse problems. The services must include, but not be limited to, the following:

(1) housing services, including rent or housing subsidies, housing with clinical staff, or housing support;

(2) assertive outreach services; and

(3) intensive direct therapeutic, rehabilitative, and care management services oriented to harm reduction.

The commissioner shall work with housing providers to ensure proper licensure or certification to meet medical assistance or third-party payor reimbursement requirements.

Sec. 23. **STUDY MEDICAL ASSISTANCE MENTAL HEALTH REIMBURSEMENT METHODS THAT INTERFERE WITH BEST PRACTICES.**

The commissioner of human services, in consultation with mental health provider associations and knowledgeable experts, must identify and propose solutions to resolve medical assistance unnecessary claims, payment edits, and reimbursement methods that negatively interfere with best practices.

Sec. 24. **APPROPRIATIONS.**

Subdivision 1. **Suicide intervention and prevention grant.** \$..... is appropriated for the biennium beginning July 1, 2009, from the general fund to the commissioner of human services for grants for institutions of higher education in the state of Minnesota to coordinate implementation of youth suicide early intervention and prevention strategies.

Subd. 2. **Bridges rental housing assistance program.** \$3,400,000 is appropriated for the biennium beginning July 1, 2009, from the general fund to the Housing Finance Agency for the Bridges rental housing assistance program under Minnesota Statutes, section 462A.2097. These appropriations are in addition to any base appropriations for this purpose and shall become part of the agency's base.

Subd. 3. **Dual diagnosis; demonstration project.** \$..... is appropriated for the biennium beginning July 1, 2009, from the general fund to the commissioner of human services to fund the dual diagnosis demonstration projects under section 22.

Subd. 4. **Adult mental health fatality review team.** \$20,000 is appropriated for the biennium beginning July 1, 2009, from the general fund to the commissioner of human services to be transferred to Hennepin County to conduct case identification, payment for records that are requested, and administrative expenses needed to establish and operate the adult mental health fatality review team pilot under section 20.

ARTICLE 4

MENTAL HEALTH FUNDING

Section 1. Minnesota Statutes 2008, section 256B.038, is amended to read:

256B.038 PROVIDER RATE INCREASES AFTER JUNE 30, 1999.

(a) For fiscal years beginning on or after July 1, 1999, the commissioner of finance shall include an annual inflationary adjustment in payment rates for the services listed in paragraph (b) as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11. The adjustment shall be accomplished by indexing the rates in effect for inflation based on the change in the Consumer Price Index-All Items (United States city average)(CPI-U) as forecasted by Data Resources, Inc., in the fourth quarter of the prior year for the calendar year during which the rate increase occurs.

(b) Within the limits of appropriations specifically for this purpose, the commissioner shall apply the rate increases in paragraph (a) to home and community-based waiver services for persons with developmental disabilities under section 256B.501; home and community-based waiver services for the elderly under section 256B.0915; waived services under community alternatives for disabled individuals under section 256B.49; community alternative care waived services under section 256B.49; traumatic brain injury waived services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with developmental disabilities under sections 252.40 to 252.46; physical therapy services under sections 256B.0625, subdivision 8, and 256D.03, subdivision 4; occupational therapy services under sections 256B.0625, subdivision 8a, and 256D.03, subdivision 4; speech-language therapy services under section 256D.03, subdivision

4, and Minnesota Rules, part 9505.0390; respiratory therapy services under section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0295; physician services under section 256B.0625, subdivision 3; dental services under sections 256B.0625, subdivision 9, and 256D.03, subdivision 4; alternative care services under section 256B.0913; adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000; adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760; ~~and~~ semi-independent living services under section 252.275, including SILS funding under county social services grants formerly funded under chapter 256I; adult rehabilitative mental health services under section 256B.0623; children's therapeutic services and support services under section 256B.0943; community mental health center services under section 256B.0625; and crisis services under section 256B.0624.

(c) The commissioner shall increase prepaid medical assistance program capitation rates as appropriate to reflect the rate increases in this section.

(d) In implementing this section, the commissioner shall consider proposing a schedule to equalize rates paid by different programs for the same service.

Sec. 2. Minnesota Statutes 2008, section 256B.0623, subdivision 8, is amended to read:

Subd. 8. **Diagnostic assessment.** (a) 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. A diagnostic assessment must be reimbursed at the same rate as an assessment under section 256B.0655, subdivision 8. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within 180 days preceding admission, an update must be completed. An update shall include 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. For initial implementation of adult rehabilitative mental health services, until June 30, 2005, a diagnostic assessment that reflects the recipient's current status and has been completed within the past three years preceding admission is acceptable.

(b) When the commissioner implements changes to the definition of a service unit for diagnostic assessment to comply with requirements of the federal Health Insurance Portability and Accountability Act (HIPAA), the commissioner shall include coverage of clinically related activities required by this section and under Code of Federal Regulations, title 42, parts 440 and 441, including diagnostic evaluation, functional assessment,

32.1 screening to determine appropriateness for program, development, or modification of a
32.2 rehabilitative service plan, identification of appropriate services, direction of a mental
32.3 health practitioner or rehabilitation worker, periodic reassessment and service plan
32.4 revision, and consumer education to foster engagement, understanding, and commitment to
32.5 service plan. This may be implemented either as an enhanced rate for assessments required
32.6 under this section or as separate reimbursable components provided by a community
32.7 mental health center under section 256B.0625, subdivision 5, or under contract agreement
32.8 with an adult rehabilitative mental health service provider entity under section 256B.0623.

32.9 Sec. 3. Minnesota Statutes 2008, section 256B.0625, subdivision 38, is amended to
32.10 read:

32.11 Subd. 38. **Payments for mental health services.** (a) Payments for mental
32.12 health services covered under the medical assistance program that are provided by
32.13 masters-prepared mental health professionals shall be 80 percent of the rate paid to
32.14 doctoral-prepared professionals. Payments for mental health services covered under
32.15 the medical assistance program that are provided by masters-prepared mental health
32.16 professionals employed by community mental health centers shall be 100 percent of the
32.17 rate paid to doctoral-prepared professionals. ~~For purposes of reimbursement of mental~~
32.18 ~~health professionals under the medical assistance program, all~~

32.19 (b) Payments for mental health services covered under the medical assistance
32.20 program that are provided by social workers who:

32.21 (1) have received a master's degree in social work from a program accredited by the
32.22 Council on Social Work Education;

32.23 (2) are licensed at the level of graduate social worker or independent social worker;

32.24 **and**

32.25 (3) are practicing clinical social work under appropriate supervision, as defined by
32.26 chapter 148D; and

32.27 (4) meet all requirements under Minnesota Rules, part 9505.0323, subpart 24, ~~and.~~
32.28 Payments under this paragraph shall be paid ~~accordingly~~ according to Minnesota Rules,
32.29 part 9505.0323, subpart 24, unless paragraph (c) is applicable.

32.30 (c) Payments for mental health services covered under the medical assistance
32.31 program that are provided by an individual who is employed by a community mental
32.32 health center and:

32.33 (1) who is a licensed graduate social worker under section 148D.055, subdivision 3,
32.34 or a licensed independent social worker under section 148D.055, subdivision 4;

(2) who has completed all requirements for licensure or board certification as a mental health professional except for the requirements for supervised experience in the delivery of mental health services; or

(3) who is 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 shall be reimbursed at 100 percent of the rate paid to the supervising professional.
The individual providing the service under this paragraph must be under the clinical supervision of a fully qualified mental health professional.

(d) Subject to federal approval, medical assistance covers clinical supervision of mental health practitioners by a mental health professional when clinical supervision is required as part of other medical assistance services.

Sec. 4. Minnesota Statutes 2008, section 256B.0625, subdivision 43, is amended to read:

Subd. 43. **Mental health provider travel time.** Medical assistance covers provider travel time if a recipient's individual treatment plan requires the provision of mental health services outside of the provider's normal place of business. This does not include any travel time which is included in other billable services, and is only covered when the mental health service being provided to a recipient is covered under medical assistance. In order for the per minute rate for travel time to include the cost of staff time plus reasonable practice expenses related to mileage or vehicle expenses, the per minute reimbursement will be 75 percent of the rate in section 256B.0625, subdivision 17.

Sec. 5. Minnesota Statutes 2008, section 256B.0625, subdivision 46, is amended to read:

Subd. 46. **Mental health telemedicine.** 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. Use of two-way interactive video 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 and shall include payment for the originating facility fee at a rate no less than the rate allowed under Code of Federal Regulations, title 42, part 410.78. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Sec. 6. Minnesota Statutes 2008, section 256B.0943, is amended by adding a subdivision to read:

Subd. 11a. **Reimbursement of diagnostic assessments.** When the commissioner implements changes to the definition of a service unit for diagnostic assessment to comply with requirements of the federal Health Insurance Portability and Accountability Act (HIPAA), the commissioner shall include coverage of clinically related activities required by this section and Code of Federal Regulations, title 42, parts 440 and 441, including diagnostic evaluation, functional assessment, screening to determine appropriateness for program, development or modification of a rehabilitative service plan, identification of appropriate services, direction of a mental health practitioner or rehabilitation worker, periodic reassessment and service plan revision, and consumer education to foster engagement, understanding, and commitment to service plan. This may be implemented either as an enhanced rate for assessments required under this section or as separate reimbursable components provided by a community mental health center under section 256B.0625, subdivision 5, or children's therapeutic services and supports under section 256B.0943.

Sec. 7. Minnesota Statutes 2008, section 256B.763, is amended to read:

256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.

(a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;
(2) community mental health centers under section 256B.0625, subdivision 5; and
(3) mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments that are designated as essential community providers under section 62Q.19.

(b) This increase applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

(c) This increase does not apply to rates that are governed by section 256B.0625, subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

(d) The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in paragraphs (a), (e), and (f). The prepaid health plan must pass this rate increase to the providers identified in paragraphs (a), (e), (f), and (g).

(e) Payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007, for:

(1) medication education services provided on or after January 1, 2008, by adult rehabilitative mental health services providers certified under section 256B.0623; and

(2) mental health behavioral aide services provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943 and not already included in paragraph (a), payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007.

(g) Payment rates shall be increased by 2.3 percent over the rates in effect on December 31, 2007, for individual and family skills training provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(h) Effective January 1, 2010, payment rates for all services not included in paragraph (b) shall increase 23.7 percent over rates in effect on January 1, 2009, for all services by community mental health centers under section 256B.0625, subdivision 5.

Sec. 8. Minnesota Statutes 2008, section 256D.03, subdivision 4, is amended to read:

Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

- 36.1 (9) laboratory and X-ray services;
- 36.2 (10) physician's services;
- 36.3 (11) medical transportation except special transportation;
- 36.4 (12) chiropractic services as covered under the medical assistance program;
- 36.5 (13) podiatric services;
- 36.6 (14) dental services as covered under the medical assistance program;
- 36.7 (15) mental health services covered under chapter 256B;
- 36.8 (16) prescribed medications for persons who have been diagnosed as mentally ill as
- 36.9 necessary to prevent more restrictive institutionalization;
- 36.10 (17) medical supplies and equipment, and Medicare premiums, coinsurance and
- 36.11 deductible payments;
- 36.12 (18) medical equipment not specifically listed in this paragraph when the use of
- 36.13 the equipment will prevent the need for costlier services that are reimbursable under
- 36.14 this subdivision;
- 36.15 (19) services performed by a certified pediatric nurse practitioner, a certified family
- 36.16 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological
- 36.17 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse
- 36.18 practitioner in independent practice, if (1) the service is otherwise covered under this
- 36.19 chapter as a physician service, (2) the service provided on an inpatient basis is not included
- 36.20 as part of the cost for inpatient services included in the operating payment rate, and (3) the
- 36.21 service is within the scope of practice of the nurse practitioner's license as a registered
- 36.22 nurse, as defined in section 148.171;
- 36.23 (20) services of a certified public health nurse or a registered nurse practicing in
- 36.24 a public health nursing clinic that is a department of, or that operates under the direct
- 36.25 authority of, a unit of government, if the service is within the scope of practice of the
- 36.26 public health nurse's license as a registered nurse, as defined in section 148.171;
- 36.27 (21) telemedicine consultations, to the extent they are covered under section
- 36.28 256B.0625, subdivision 3b;
- 36.29 (22) care coordination and patient education services provided by a community
- 36.30 health worker according to section 256B.0625, subdivision 49; ~~and~~
- 36.31 (23) regardless of the number of employees that an enrolled health care provider
- 36.32 may have, sign language interpreter services when provided by an enrolled health care
- 36.33 provider during the course of providing a direct, person-to-person covered health care
- 36.34 service to an enrolled recipient who has a hearing loss and uses interpreting services;
- 36.35 (24) up to six hours of service per client, per year, without authorization, of
- 36.36 consultation and care coordination as directed by an individual treatment plan, and as a

component of children's therapeutic services and support, adult rehabilitative mental health services, or community mental health services; and

(25) up to six hours of service per client, per year for collateral contacts as a component of children's therapeutic services and support, adult rehabilitative mental health services, or community mental health services. These services must be directed by an individual treatment plan and are solely for the purpose of assisting parents and others toward understanding, accommodating, and better caregiving of the person with mental illness or emotional disturbance.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A \$1,000 deductible is required for each inpatient hospitalization.

(b) Effective August 1, 2005, sex reassignment surgery is not covered under this subdivision.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Effective January 1, 2008, drug coverage under general assistance medical care is limited to prescription drugs that:

(i) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(ii) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with the agreements. Prescription drug coverage under general assistance medical care must conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13g.

(e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following co-payments for services provided on or after October 1, 2003, and before January 1, 2009:

(1) \$25 for eyeglasses;

(2) \$25 for nonemergency visits to a hospital-based emergency room;

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

(4) 50 percent coinsurance on restorative dental services.

(f) Recipients eligible under subdivision 3, paragraph (a), shall include the following co-payments for services provided on or after January 1, 2009:

(1) \$25 for nonemergency visits to a hospital-based emergency room; and

(2) \$3 per brand-name drug prescription and \$1 per generic drug prescription, subject to a \$7 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(g) MS 2007 Supp [Expired]

(h) Effective January 1, 2009, co-payments shall be limited to one per day per provider for nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the \$7 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

(i) General assistance medical care reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of the co-payments effective January 1, 2009.

(j) Any county may, from its own resources, provide medical payments for which state payments are not made.

(k) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

(l) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(m) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

(n) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (l).

(o) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

(p) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

(q) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

(r) Fee-for-service payments for nonpreventive visits shall be reduced by \$3 for services provided on or after January 1, 2006. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse, audiologist, optician, or optometrist.

(s) Payments to managed care plans shall not be increased as a result of the removal of the \$3 nonpreventive visit co-payment effective January 1, 2006.

(t) Payments for mental health services added as covered benefits after December 31, 2007, are not subject to the reductions in paragraphs (l), (n), (o), and (p).

Sec. 9. Minnesota Statutes 2008, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled ~~or for at least four months prior to application and renewal~~. Children enrolled in the original children's health plan and children in families with income equal to or less than 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

40.1 (ii) medical-surgical insurance;
40.2 (iii) prescription drug coverage;
40.3 (iv) dental coverage; ~~or~~
40.4 (v) vision coverage; or
40.5 (vi) mental health coverage or mental health coverage that provides fewer services
40.6 than the mental health services covered under chapter 256B;

40.7 (2) requires a deductible of \$100 or more per person per year; or

40.8 (3) lacks coverage because the child has exceeded the maximum coverage for a
40.9 particular diagnosis or the policy excludes a particular diagnosis.

40.10 The commissioner may change this eligibility criterion for sliding scale premiums
40.11 in order to remain within the limits of available appropriations. The requirement of no
40.12 health coverage does not apply to newborns.

40.13 (b) Medical assistance, general assistance medical care, and the Civilian Health and
40.14 Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under
40.15 United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or
40.16 health coverage for purposes of the four-month requirement described in this subdivision.

40.17 (c) For purposes of this subdivision, an applicant or enrollee who is entitled to
40.18 Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social
40.19 Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to
40.20 have health coverage. An applicant or enrollee who is entitled to premium-free Medicare
40.21 Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility
40.22 for MinnesotaCare.

40.23 (d) Applicants who were recipients of medical assistance or general assistance
40.24 medical care within one month of application must meet the provisions of this subdivision
40.25 and subdivision 2.

40.26 (e) Cost-effective health insurance that was paid for by medical assistance is not
40.27 considered health coverage for purposes of the four-month requirement under this
40.28 section, except if the insurance continued after medical assistance no longer considered it
40.29 cost-effective or after medical assistance closed.

40.30 Sec. 10. Laws 2007, chapter 147, article 7, section 71, is amended to read:

40.31 Sec. 71. **PROVIDER RATE INCREASES.**

40.32 (a) The commissioner of human services shall increase allocations, reimbursement
40.33 rates, or rate limits, as applicable, by 2.0 percent beginning October 1, 2007, and by 2.0
40.34 percent beginning July 1, 2008, effective for services rendered on or after those dates.
40.35 County contracts for services specified in this section must be amended to pass through

41.1 these rate adjustments within 60 days of the effective date of the increase and must be
41.2 retroactive from the effective date of the rate adjustment.

41.3 (b) The annual rate increases described in this section must be provided to:

41.4 (1) home and community-based waived services for persons with developmental
41.5 disabilities or related conditions, including consumer-directed community supports, under
41.6 Minnesota Statutes, section 256B.501;

41.7 (2) home and community-based waived services for the elderly, including
41.8 consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

41.9 (3) waived services under community alternatives for disabled individuals,
41.10 including consumer-directed community supports, under Minnesota Statutes, section
41.11 256B.49;

41.12 (4) community alternative care waived services, including consumer-directed
41.13 community supports, under Minnesota Statutes, section 256B.49;

41.14 (5) traumatic brain injury waived services, including consumer-directed
41.15 community supports, under Minnesota Statutes, section 256B.49;

41.16 (6) nursing services and home health services under Minnesota Statutes, section
41.17 256B.0625, subdivision 6a;

41.18 (7) personal care services and qualified professional supervision of personal care
41.19 services under Minnesota Statutes, section 256B.0625, subdivision 19a;

41.20 (8) private duty nursing services under Minnesota Statutes, section 256B.0625,
41.21 subdivision 7;

41.22 (9) day training and habilitation services for adults with developmental disabilities
41.23 or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the
41.24 additional cost of rate adjustments on day training and habilitation services, provided as a
41.25 social service under Minnesota Statutes, section 256M.60;

41.26 (10) alternative care services under Minnesota Statutes, section 256B.0913;

41.27 (11) adult residential program grants under Minnesota Statutes, section 245.73;

41.28 (12) children's community-based mental health services grants and adult community
41.29 support and case management services grants under Minnesota Rules, parts 9535.1700
41.30 to 9535.1760;

41.31 (13) the group residential housing supplementary service rate under Minnesota
41.32 Statutes, section 256I.05, subdivision 1a;

41.33 (14) adult mental health integrated fund grants under Minnesota Statutes, section
41.34 245.4661;

42.1 (15) semi-independent living services (SILS) under Minnesota Statutes, section
42.2 252.275, including SILS funding under county social services grants formerly funded
42.3 under Minnesota Statutes, chapter 256I;

42.4 (16) community support services for deaf and hard-of-hearing adults with mental
42.5 illness who use or wish to use sign language as their primary means of communication
42.6 under Minnesota Statutes, section 256.01, subdivision 2; and deaf and hard-of-hearing
42.7 grants under Minnesota Statutes, sections 256C.233 and 256C.25; Laws 1985, chapter 9,
42.8 article 1; and Laws 1997, First Special Session chapter 5, section 20;

42.9 (17) living skills training programs for persons with intractable epilepsy who need
42.10 assistance in the transition to independent living under Laws 1988, chapter 689;

42.11 (18) physical therapy services under Minnesota Statutes, sections 256B.0625,
42.12 subdivision 8, and 256D.03, subdivision 4;

42.13 (19) occupational therapy services under Minnesota Statutes, sections 256B.0625,
42.14 subdivision 8a, and 256D.03, subdivision 4;

42.15 (20) speech-language therapy services under Minnesota Statutes, section 256D.03,
42.16 subdivision 4, and Minnesota Rules, part 9505.0390;

42.17 (21) respiratory therapy services under Minnesota Statutes, section 256D.03,
42.18 subdivision 4, and Minnesota Rules, part 9505.0295;

42.19 (22) adult rehabilitative mental health services under Minnesota Statutes, section
42.20 256B.0623;

42.21 (23) children's therapeutic services and support services under Minnesota Statutes,
42.22 section 256B.0943;

42.23 (24) tier I chemical health services under Minnesota Statutes, chapter 254B;

42.24 (25) consumer support grants under Minnesota Statutes, section 256.476;

42.25 (26) family support grants under Minnesota Statutes, section 252.32;

42.26 (27) grants for case management services to persons with HIV or AIDS under
42.27 Minnesota Statutes, section 256.01, subdivision 19; ~~and~~

42.28 (28) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917,
42.29 and 256B.0928;

42.30 (29) community mental health center services under Minnesota Statutes, section
42.31 256B.0625, subdivision 5; and

42.32 (30) crisis services under Minnesota Statutes, sections 256B.0624 and 256B.0944.

42.33 (c) For services funded through Minnesota disability health options, the rate
42.34 increases under this section apply to all medical assistance payments, including former
42.35 group residential housing supplementary rates under Minnesota Statutes, chapter 256I.

(d) The commissioner may recoup payments made under this section from a provider that does not comply with paragraphs (f) and (g).

(e) A managed care plan receiving state payments for the services in this section must include these increases in their payments to providers on a prospective basis, effective on January 1 following the effective date of the rate increase.

(f) Providers that receive a rate increase under this section shall use 75 percent of the additional revenue to increase compensation-related costs for employees directly employed by the program on or after the effective date of the rate adjustments, except:

(1) the administrator;

(2) persons employed in the central office of a corporation or entity that has an ownership interest in the provider or exercises control over the provider; and

(3) persons paid by the provider under a management contract.

Compensation-related costs include: wages and salaries; FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation; and the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions.

(g) Two-thirds of the money available under paragraph (f) must be used for wage increases for all employees directly employed by the provider on or after the effective date of the rate adjustments, except those listed in paragraph (f), clauses (1) to (3). The wage adjustment that employees receive under this paragraph must be paid as an equal hourly percentage wage increase for all eligible employees. All wage increases under this paragraph must be effective on the same date. This paragraph shall not apply to employees covered by a collective bargaining agreement.

(h) For public employees, the increase for wages and benefits for certain staff is available and pay rates must be increased only to the extent that they comply with laws governing public employees collective bargaining. Money received by a provider for pay increases under this section may be used only for increases implemented on or after the first day of the rate period in which the increase is available and must not be used for increases implemented prior to that date.

(i) The commissioner shall amend state grant contracts that include direct personnel-related grant expenditures to include the allocation for the portion of the contract that is employee compensation related. Grant contracts for compensation-related services must be amended to pass through these adjustments within 60 days of the effective date of the increase and must be retroactive to the effective date of the rate adjustment.

(j) The Board on Aging and its Area Agencies on Aging shall amend their grants that include direct personnel-related grant expenditures to include the rate

adjustment for the portion of the grant that is employee compensation related. Grants for compensation-related services must be amended to pass through these adjustments within 60 days of the effective date of the increase and must be retroactive to the effective date of the rate adjustment.

(k) The calendar year 2008 rate for vendors reimbursed under Minnesota Statutes, chapter 254B, shall be at least 2.0 percent above the rate in effect on January 1, 2007. The calendar year 2009 rate shall be at least 2.0 percent above the rate in effect on January 1, 2008.

(l) Providers that receive a rate adjustment under paragraph (a) that is subject to paragraphs (f) and (g) shall provide to the commissioner, and those counties with whom they have a contract, within six months after the effective date of each rate adjustment, a letter, in a format specified by the commissioner, that provides assurances that the provider has developed and implemented a compensation plan and complied with paragraphs (f) and (g). The provider shall keep on file, and produce for the commissioner or county upon request, its plan, which must specify:

(1) an estimate of the amounts of money that must be used as specified in paragraphs (f) and (g); and

(2) a detailed distribution plan specifying the allowable compensation-related and wage increases the provider will implement to use the funds available in clause (1).

(m) Within six months after the effective date of each rate adjustment, the provider shall post this plan, excluding the information required in paragraph (l), clause (1), for a period of at least six weeks in an area of the provider's operation to which all eligible employees have access and provide instructions for employees who believe they have not received the wage and other compensation-related increases specified in paragraph (l), clause (2). Instructions must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative. Providers shall also make assurances to the commissioner and counties with whom they have a contract that they have complied with the requirement in this paragraph.

ARTICLE 5

EMPLOYMENT SUPPORT

Section 1. EMPLOYMENT SUPPORT.

(a) The commissioner of employment and economic development shall fund special projects providing employment support to:

(1) young people with mental illness who are transitioning from school to work;

(2) people with a serious mental illness who are receiving services through a mental health court; and

(3) people with serious mental illness who are receiving services through a civil commitment court.

(b) Projects under paragraph (a) must demonstrate interagency collaboration.

Sec. 2. **APPROPRIATION.**

(a) \$..... is appropriated for the biennium beginning July 1, 2009, from the general fund to the commissioner of employment and economic development to fund special projects focused on providing employment support under section 1.

(b) \$..... is appropriated for the biennium beginning July 1, 2009, from the general fund to the commissioner of employment and economic development for the extended employment-serious mental illness program under section 1.

ARTICLE 6

EMPLOYEE RELATIONS; HEALTH INSURANCE COVERAGE

Section 1. Minnesota Statutes 2008, section 43A.23, subdivision 1, is amended to read:

Subdivision 1. **General.** (a) The commissioner is authorized to request proposals or to negotiate and to enter into contracts with parties which in the judgment of the commissioner are best qualified to provide service to the benefit plans. Contracts entered into are not subject to the requirements of sections 16C.16 to 16C.19. The commissioner may negotiate premium rates and coverage. The commissioner shall consider the cost of the plans, conversion options relating to the contracts, service capabilities, character, financial position, and reputation of the carriers, and any other factors which the commissioner deems appropriate. Each benefit contract must be for a uniform term of at least one year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. A carrier licensed under chapter 62A is exempt from the taxes imposed by chapter 297I on premiums paid to it by the state.

(b) All self-insured hospital and medical service products must comply with coverage mandates, data reporting, and consumer protection requirements applicable to the licensed carrier administering the product, had the product been insured, including chapters 62J, 62M, and 62Q. Any self-insured products that limit coverage to a network of providers or provide different levels of coverage between network and nonnetwork providers shall comply with section 62D.123 and geographic access standards for health maintenance organizations adopted by the commissioner of health in rule under chapter 62D.

~~(c) Notwithstanding paragraph (b), A self-insured hospital and medical product offered under sections 43A.22 to 43A.30 is not required to extend dependent coverage to an eligible employee's unmarried child under the age of 25 to the full extent required under chapters 62A and 62L. Dependent coverage must, at a minimum, extend to an eligible employee's unmarried child who is under the age of 19 or an unmarried child under the age of 25 who is a full-time student. The definition of "full-time student" for purposes of this paragraph includes any student who by reason of illness, injury, or physical or mental disability as documented by a physician is unable to carry what the educational institution considers a full-time course load so long as the student's course load is at least 60 percent of what otherwise is considered by the institution to be a full-time course load. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this definition of "full-time student."~~

(d) Beginning January 1, 2010, the health insurance benefit plans offered in the commissioner's plan under section 43A.18, subdivision 2, and the managerial plan under section 43A.18, subdivision 3, must include an option for a health plan that is compatible with the definition of a high-deductible health plan in section 223 of the United States Internal Revenue Code.

Sec. 2. Minnesota Statutes 2008, section 43A.316, is amended by adding a subdivision to read:

Subd. 6b. **Mental health services.** All benefits provided by the program or a successor program relating to expenses incurred for mental health treatment must include all mental health benefits consistent with chapter 256B.

ARTICLE 7

EDUCATION-RELATED MENTAL HEALTH PROVISION

Section 1. Minnesota Statutes 2008, section 120A.22, subdivision 12, is amended to read:

Subd. 12. **Legitimate exemptions.** A parent, guardian, or other person having control of a child may apply to a school district to have the child excused from attendance for the whole or any part of the time school is in session during any school year. Application may be made to any member of the board, a truant officer, a principal, or the superintendent. The school district may state in its school attendance policy that it may ask the student's parent or legal guardian to verify in writing the reason for the child's absence from school. A note from a physician or a licensed mental health professional stating that the child cannot attend school is a valid excuse. The board of the district in which the

child resides may approve the application upon the following being demonstrated to the satisfaction of that board:

(1) that the child's ~~body~~ physical or mental condition ~~health~~ is such as to prevent attendance at school or application to study for the period required, which includes:

(i) child illness, medical, dental, orthodontic, or counseling appointments;

(ii) family emergencies;

(iii) the death or serious illness or funeral of an immediate family member;

(iv) active duty in any military branch of the United States; ~~or~~

(v) the child has a condition that requires ongoing treatment for a mental health diagnosis; or

(vi) other exemptions included in the district's school attendance policy;

(2) that the child has already completed state and district standards required for graduation from high school; or

(3) that it is the wish of the parent, guardian, or other person having control of the child, that the child attend for a period or periods not exceeding in the aggregate three hours in any week, a school for religious instruction conducted and maintained by some church, or association of churches, or any Sunday school association incorporated under the laws of this state, or any auxiliary thereof. This school for religious instruction must be conducted and maintained in a place other than a public school building, and it must not, in whole or in part, be conducted and maintained at public expense. However, a child may be absent from school on such days as the child attends upon instruction according to the ordinances of some church.

Sec. 2. Minnesota Statutes 2008, section 125A.15, is amended to read:

125A.15 PLACEMENT IN ANOTHER DISTRICT; RESPONSIBILITY.

The responsibility for special instruction and services for a child with a disability temporarily placed in another district for care and treatment shall be determined in the following manner:

(a) The district of residence of a child shall be the district in which the child's parent resides, if living, or the child's guardian, or the district designated by the commissioner if neither parent nor guardian is living within the state.

(b) When a child is temporarily placed for care and treatment in a day program located in another district and the child continues to live within the district of residence during the care and treatment, the district of residence is responsible for providing transportation to and from the care and treatment facility and an appropriate educational program for the child. Transportation shall only be provided by the district during regular

operating hours of the district. The district may provide the educational program at a school within the district of residence, at the child's residence, or in the district in which the day treatment center is located by paying tuition to that district.

(c) When a child is temporarily placed in a residential program for care and treatment, the nonresident district in which the child is placed is responsible for providing an appropriate educational program for the child and necessary transportation while the child is attending the educational program; and must bill the district of the child's residence for the actual cost of providing the program, as outlined in section 125A.11, except as provided in paragraph (d). However, the board, lodging, and treatment costs incurred in behalf of a child with a disability placed outside of the school district of residence by the commissioner of human services or the commissioner of corrections or their agents, for reasons other than providing for the child's special educational needs must not become the responsibility of either the district providing the instruction or the district of the child's residence. For the purposes of this section, the state correctional facilities operated on a fee-for-service basis are considered to be residential programs for care and treatment.

(d) A privately owned and operated residential facility may enter into a contract to obtain appropriate educational programs for special education children and services with a joint powers entity. The entity with which the private facility contracts for special education services shall be the district responsible for providing students placed in that facility an appropriate educational program in place of the district in which the facility is located. If a privately owned and operated residential facility does not enter into a contract under this paragraph, then paragraph (c) applies.

(e) A child with a disability who is in day treatment or a residential facility during the summer must be automatically eligible for a summer school program under section 123B.02, subdivision 10.

(f) The district of residence shall pay tuition and other program costs, not including transportation costs, to the district providing the instruction and services. The district of residence may claim general education aid for the child as provided by law. Transportation costs must be paid by the district responsible for providing the transportation and the state must pay transportation aid to that district.

Sec. 3. Minnesota Statutes 2008, section 125A.51, is amended to read:

**125A.51 PLACEMENT OF CHILDREN WITHOUT DISABILITIES;
EDUCATION AND TRANSPORTATION.**

The responsibility for providing instruction and transportation for a pupil without a disability who has a short-term or temporary physical or emotional illness or disability, as

determined by the standards of the commissioner, and who is temporarily placed for care and treatment for that illness or disability, must be determined as provided in this section.

(a) The school district of residence of the pupil is the district in which the pupil's parent or guardian resides.

(b) When parental rights have been terminated by court order, the legal residence of a child placed in a residential or foster facility for care and treatment is the district in which the child resides.

(c) Before the placement of a pupil for care and treatment, the district of residence must be notified and provided an opportunity to participate in the placement decision.

When an immediate emergency placement is necessary and time does not permit resident district participation in the placement decision, the district in which the pupil is temporarily placed, if different from the district of residence, must notify the district of residence of the emergency placement within 15 days of the placement.

(d) When a pupil without a disability is temporarily placed for care and treatment in a day program and the pupil continues to live within the district of residence during the care and treatment, the district of residence must provide instruction and necessary transportation to and from the treatment facility for the pupil. Transportation shall only be provided by the district during regular operating hours of the district. The district may provide the instruction at a school within the district of residence, at the pupil's residence, or in the case of a placement outside of the resident district, in the district in which the day treatment program is located by paying tuition to that district. The district of placement may contract with a facility to provide instruction by teachers licensed by the state Board of Teaching.

(e) When a pupil without a disability is temporarily placed in a residential program for care and treatment, the district in which the pupil is placed must provide instruction for the pupil and necessary transportation while the pupil is receiving instruction, and in the case of a placement outside of the district of residence, the nonresident district must bill the district of residence for the actual cost of providing the instruction for the regular school year and for summer school, excluding transportation costs.

(f) A child who is in day treatment or a residential facility during the summer must be automatically eligible for a summer school program under section 123B.02, subdivision 10.

(g) Notwithstanding paragraph (e), if the pupil is homeless and placed in a public or private homeless shelter, then the district that enrolls the pupil under section 127A.47, subdivision 2, shall provide the transportation, unless the district that enrolls the pupil and the district in which the pupil is temporarily placed agree that the district in which

the pupil is temporarily placed shall provide transportation. When a pupil without a disability is temporarily placed in a residential program outside the district of residence, the administrator of the court placing the pupil must send timely written notice of the placement to the district of residence. The district of placement may contract with a residential facility to provide instruction by teachers licensed by the state Board of Teaching. For purposes of this section, the state correctional facilities operated on a fee-for-service basis are considered to be residential programs for care and treatment.

~~(g)~~ (h) The district of residence must include the pupil in its residence count of pupil units and pay tuition as provided in section 123A.488 to the district providing the instruction. Transportation costs must be paid by the district providing the transportation and the state must pay transportation aid to that district. For purposes of computing state transportation aid, pupils governed by this subdivision must be included in the disabled transportation category if the pupils cannot be transported on a regular school bus route without special accommodations.

Sec. 4. Minnesota Statutes 2008, section 126C.44, is amended to read:

126C.44 SAFE SCHOOLS LEVY.

(a) Each district may make a levy on all taxable property located within the district for the purposes specified in this section. The maximum amount which may be levied for all costs under this section shall be equal to \$30 multiplied by the district's adjusted marginal cost pupil units for the school year. The proceeds of the levy must be reserved and used for directly funding the following purposes or for reimbursing the cities and counties who contract with the district for the following purposes: (1) to pay the costs incurred for the salaries, benefits, and transportation costs of peace officers and sheriffs for liaison in services in the district's schools; (2) to pay the costs for a drug abuse prevention program as defined in section 609.101, subdivision 3, paragraph (e), in the elementary schools; (3) to pay the costs for a gang resistance education training curriculum in the district's schools; (4) to pay the costs for security in the district's schools and on school property; (5) to pay the costs for other crime prevention, drug abuse, student and staff safety, voluntary opt-in suicide prevention tools, and violence prevention measures taken by the school district; ~~or~~ (6) to pay costs for licensed school counselors, licensed school nurses, licensed school social workers, licensed school psychologists, and licensed alcohol and chemical dependency counselors to help provide early responses to problems; or (7) to pay for the costs of mental health crisis intervention team training for peace officers and sheriffs who serve as liaisons under clause (1). For expenditures under clause (1), the district must initially attempt to contract for services to be provided by peace officers or

sheriffs with the police department of each city or the sheriff's department of the county within the district containing the school receiving the services. If a local police department or a county sheriff's department does not wish to provide the necessary services, the district may contract for these services with any other police or sheriff's department located entirely or partially within the school district's boundaries.

(b) A school district that is a member of an intermediate school district may include in its authority under this section the costs associated with safe schools activities authorized under paragraph (a) for intermediate school district programs. This authority must not exceed \$10 times the adjusted marginal cost pupil units of the member districts. This authority is in addition to any other authority authorized under this section. Revenue raised under this paragraph must be transferred to the intermediate school district.

(c) A school district must set aside at least \$3 per adjusted marginal cost pupil unit of the safe schools levy proceeds for the purposes authorized under paragraph (a), clause (6). The district must annually certify that its total spending on services provided by the employees listed in paragraph (a), clause (6), is not less than the sum of its expenditures for these purposes, excluding amounts spent under this section, in the previous year plus the amount spent under this section.

Sec. 5. HIGHER EDUCATION STUDENT HEALTH INSURANCE PROGRAM.

The commissioner of human services shall study, in consultation with the Office of Higher Education, and provide to the legislature, different options for ensuring that all full-time and part-time students enrolled in a public or private institution of higher education in the state are participating in a qualifying student health insurance program or are covered under another health insurance plan. The commissioner shall determine how institutions of higher education will monitor student participation and require each institution to provide documentation to determine if the institution is complying with the mandatory health insurance program requirements. The commissioner shall also propose exceptions to the requirement for students who do not have insurance coverage due to religious beliefs. The commissioner must recommend in the report to the legislature a penalty for institutions that fail to carry out the responsibilities of the mandatory student health insurance program. The commissioner shall also provide in the report to the legislature an analysis of the number of higher education students in the state who are lacking health insurance, and the costs to the students and the institutions of providing a qualifying student health insurance program, or requiring the students to enroll in other available health insurance, and the costs of monitoring student compliance with the program. The commissioner shall also include a proposed method of meeting those costs.

52.1 The analysis, report, and draft legislation are due to the legislative committees having
52.2 jurisdiction over higher education issues and health care issues by January 15, 2010.

52.3 Sec. 6. **TRANSITION PROGRAMS FOR STUDENTS WITH EMOTIONAL**
52.4 **OR BEHAVIORAL DIFFICULTIES.**

52.5 The commissioner of education shall provide grants to school districts to develop
52.6 a service delivery system for transition-aged youth and young adults with emotional or
52.7 behavioral difficulties to assist them in making a successful transition into adulthood, with
52.8 all of them achieving within their potential their personal goals in the transition domains
52.9 of employment, education, living situation, personal effectiveness, and community life
52.10 functioning.

52.11 Grants must be provided to school districts using research-based approaches that:

52.12 (1) engage young people through relationship development, person-centered
52.13 planning, and a focus on their futures;

52.14 (2) tailor services and supports to be accessible, coordinated, and developmentally
52.15 appropriate, and build on strengths to enable the young people to pursue their goals across
52.16 all transition domains;

52.17 (3) acknowledge and develop personal choice and social responsibility with young
52.18 people;

52.19 (4) ensure a safety net of support by involving a young person's parents, family
52.20 members, and other informal and formal key players;

52.21 (5) enhance young persons' competencies to assist them in achieving greater
52.22 self-sufficiency and confidence;

52.23 (6) maintain an outcome focus in the trade, industry, and profession charters system
52.24 at the young person, program, and community levels; and

52.25 (7) involve young people, parents, and other community partners in the trade,
52.26 industry, and profession charters system at the practice, program, and community levels.

52.27 Grant funds may be used to hire transition facilitators who use a coaching style of
52.28 intervention across four major intervention components:

52.29 (1) strength and needs assessment;

52.30 (2) transition domain planning;

52.31 (3) coaching and service support coordination; and

52.32 (4) informal and community supports.

52.33 Funds may also be used to support a community-based steering committee to provide
52.34 advice on the system development, assist in the identification of successes and barriers,
52.35 assist in the education of the community, and to strengthen the interagency and community

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53.1 network to improve the availability and access to transition services and supports
53.2 appropriate to these youth and young adults. The committee must be composed of a
53.3 culturally ethnically diverse membership of representatives from service sectors, such as
53.4 child and adults mental health, public school district, vocational rehabilitation, child
53.5 welfare, juvenile justice, corrections and probation, housing, homeless and runaway
53.6 centers, community colleges, youth and parents, and chamber of commerce.

APPENDIX
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