

SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 1174

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DATE	D-PG	OFFICIAL STATUS
02/02/2023	600	Introduction and first reading
		Referred to Health and Human Services
02/27/2023	1147	Author added Mann

1.1 A bill for an act

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

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

1.4 modifying the transition to community initiative; modifying training requirements

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

1.6 children's care coordination; modifying rules regarding children's long-term stays

1.7 in the emergency room; establishing the rural family response and stabilization

1.8 services pilot program; requiring reports; appropriating money; amending

1.9 Minnesota Statutes 2022, sections 119B.05, subdivision 1; 245.4662; 245.4889,

1.10 subdivision 1; 254B.05, subdivision 1a; 256.478; 256B.0616, subdivisions 4, 5,

1.11 by adding a subdivision; 256B.0622, subdivision 2a; 256B.0624, subdivisions 5,

1.12 8; 256B.0625, subdivisions 17, 45a; 256B.0659, subdivisions 1, 17a; 256B.0943,

1.13 subdivisions 1, 2, 9, by adding a subdivision; 256B.0946, subdivision 7; 256B.0947,

1.14 subdivision 7, by adding a subdivision; 260C.007, subdivision 6; 260C.708;

1.15 proposing coding for new law in Minnesota Statutes, chapter 144.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.21 (iv) a traumatic brain injury;

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

3.23 (vi) severe emotional dysregulation and schizophrenia.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.20 determine the number of grants awarded.

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

4.22 not limited to, the following:

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

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

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

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

4.27 critical access hospitals;

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

4.29 existing services, including supportive housing; and

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

4.31 settings and reduce the number of:

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

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

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

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

5.8 (1) counties;

5.9 (2) Indian tribes;

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

5.11 (4) mental health service providers.

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

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

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

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

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

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

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

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

- 6.1 (8) school-linked mental health services under section 245.4901;
- 6.2 (9) building evidence-based mental health intervention capacity for children birth to age
6.3 five;
- 6.4 (10) suicide prevention and counseling services that use text messaging statewide;
- 6.5 (11) mental health first aid training;
- 6.6 (12) training for parents, collaborative partners, and mental health providers on the
6.7 impact of adverse childhood experiences and trauma and development of an interactive
6.8 website to share information and strategies to promote resilience and prevent trauma;
- 6.9 (13) transition age services to develop or expand mental health treatment and supports
6.10 for adolescents and young adults 26 years of age or younger;
- 6.11 (14) early childhood mental health consultation;
- 6.12 (15) evidence-based interventions for youth at risk of developing or experiencing a first
6.13 episode of psychosis, and a public awareness campaign on the signs and symptoms of
6.14 psychosis;
- 6.15 (16) psychiatric consultation for primary care practitioners; and
- 6.16 (17) providers to begin operations and meet program requirements when establishing a
6.17 new children's mental health program. These may be start-up grants.
- 6.18 (c) Services under paragraph (b) must be designed to help each child to function and
6.19 remain with the child's family in the community and delivered consistent with the child's
6.20 treatment plan. Transition services to eligible young adults under this paragraph must be
6.21 designed to foster independent living in the community.
- 6.22 (d) As a condition of receiving grant funds, a grantee shall obtain all available third-party
6.23 reimbursement sources, if applicable.
- 6.24 Sec. 5. Minnesota Statutes 2022, section 254B.05, subdivision 1a, is amended to read:
- 6.25 Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000,
6.26 vendors of room and board are eligible for behavioral health fund payment if the vendor:
- 6.27 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals
6.28 while residing in the facility and provide consequences for infractions of those rules;
- 6.29 (2) is determined to meet applicable health and safety requirements;
- 6.30 (3) is not a jail or prison;

- 7.1 (4) is not concurrently receiving funds under chapter 256I for the recipient;
- 7.2 (5) admits individuals who are 18 years of age or older;
- 7.3 (6) is registered as a board and lodging or lodging establishment according to section
7.4 157.17;
- 7.5 (7) has awake staff on site 24 hours per day;
- 7.6 (8) has staff who are at least 18 years of age and meet the requirements of section
7.7 245G.11, subdivision 1, paragraph (b);
- 7.8 (9) has emergency behavioral procedures that meet the requirements of section 245G.16;
- 7.9 (10) meets the requirements of section 245G.08, subdivision 5, if administering
7.10 medications to clients;
- 7.11 (11) meets the abuse prevention requirements of section 245A.65, including a policy on
7.12 fraternization and the mandatory reporting requirements of section 626.557;
- 7.13 (12) documents coordination with the treatment provider to ensure compliance with
7.14 section 254B.03, subdivision 2;
- 7.15 (13) protects client funds and ensures freedom from exploitation by meeting the
7.16 provisions of section 245A.04, subdivision 13;
- 7.17 (14) has a grievance procedure that meets the requirements of section 245G.15,
7.18 subdivision 2; and
- 7.19 (15) has sleeping and bathroom facilities for men and women separated by a door that
7.20 is locked, has an alarm, or is supervised by awake staff.
- 7.21 (b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from
7.22 paragraph (a), clauses (5) to (15).
- 7.23 (c) Programs providing children's mental health crisis admissions and stabilization under
7.24 section 245.4882, subdivision 6, are eligible vendors of room and board.
- 7.25 (d) Programs providing children's residential services under section 245.4882, except
7.26 services for individuals who have a placement under chapter 260C or 260D, are eligible
7.27 vendors of room and board.
- 7.28 ~~(d)~~(e) Licensed programs providing intensive residential treatment services or residential
7.29 crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors
7.30 of room and board and are exempt from paragraph (a), clauses (6) to (15).

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

8.2 **256.478 CHILD AND ADULT TRANSITION TO COMMUNITY INITIATIVE.**

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

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

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

8.9 ~~(2)~~ (3) build or maintain relationships with family and friends; and

8.10 ~~(3)~~ (4) participate in community life.

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

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

8.21 (1) the person otherwise meets the criteria under section 256B.092, subdivision 13, or
8.22 256B.49, subdivision 24;

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

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

8.31 (4)(i) the person is receiving customized living services reimbursed under section
8.32 256B.4914, 24-hour customized living services reimbursed under section 256B.4914, or

9.1 community residential services reimbursed under section 256B.4914; (ii) the person expresses
9.2 a desire to move; and (iii) the person has received approval from the commissioner; or
9.3 (5) the person can demonstrate that individual needs are beyond the scope of current
9.4 service designs and grant funding can support the inclusion of additional supports for the
9.5 child or adult to access appropriate treatment and services in the least restrictive environment.

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

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

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

9.13 Subd. 5. **Certified family peer specialist training and certification.** The commissioner
9.14 shall develop ~~a~~ or approve the use of an existing training and certification process for certified
9.15 family peer specialists. The candidates must have raised or be currently raising a child with
9.16 a mental illness, have had experience navigating the children's mental health system, and
9.17 ~~must~~ demonstrate leadership and advocacy skills and a strong dedication to family-driven
9.18 and family-focused services. The training curriculum must teach participating family peer
9.19 specialists specific skills relevant to providing peer support to other parents. In addition to
9.20 initial training and certification, the commissioner shall develop ongoing continuing
9.21 educational workshops on pertinent issues related to family peer support counseling. Training
9.22 for family peer support specialists can be delivered by the commissioner or by organizations
9.23 approved by the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.3 (vii) significant difficulty meeting basic survival needs;

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

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

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

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

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

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

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

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

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

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

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

11.27 (1) mental health professional;

11.28 (2) clinical trainee;

11.29 (3) mental health practitioner;

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

12.1 (5) mental health certified peer specialist.

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

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

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

12.12 (1) developmental tasks of childhood and adolescence;

12.13 (2) family relationships;

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

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

12.17 (5) positive behavior support;

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

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

12.21 (8) youth substance use.

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

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

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

12.30 (1) mental health professional;

13.1 (2) certified rehabilitation specialist;

13.2 (3) clinical trainee;

13.3 (4) mental health practitioner;

13.4 (5) mental health certified family peer specialist;

13.5 (6) mental health certified peer specialist; or

13.6 (7) mental health rehabilitation worker.

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

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

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

13.10 risk of suicide and self-injurious behavior.

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

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

13.13 following topics:

13.14 (1) developmental tasks of childhood and adolescence;

13.15 (2) family relationships;

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

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

13.18 queer youth;

13.19 (5) positive behavior support;

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

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

13.22 therapy; and

13.23 (8) youth substance use.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14.26 (2) the provider has initiated background studies on the individuals specified in section
 14.27 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

- 15.1 (1) adhere to the policies defined by the commissioner;
- 15.2 (2) pay nonemergency medical transportation providers for services provided to
15.3 Minnesota health care programs beneficiaries to obtain covered medical services;
- 15.4 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
15.5 trips, and number of trips by mode; and
- 15.6 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
15.7 administrative structure assessment tool that meets the technical requirements established
15.8 by the commissioner, reconciles trip information with claims being submitted by providers,
15.9 and ensures prompt payment for nonemergency medical transportation services.
- 15.10 (f) Until the commissioner implements the single administrative structure and delivery
15.11 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
15.12 commissioner or an entity approved by the commissioner that does not dispatch rides for
15.13 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).
- 15.14 (g) The commissioner may use an order by the recipient's attending physician, advanced
15.15 practice registered nurse, physician assistant, or a medical or mental health professional to
15.16 certify that the recipient requires nonemergency medical transportation services.
- 15.17 Nonemergency medical transportation providers shall perform driver-assisted services for
15.18 eligible individuals, when appropriate. Driver-assisted service includes passenger pickup
15.19 at and return to the individual's residence or place of business, assistance with admittance
15.20 of the individual to the medical facility, and assistance in passenger securement or in securing
15.21 of wheelchairs, child seats, or stretchers in the vehicle.
- 15.22 Nonemergency medical transportation providers must take clients to the health care
15.23 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
15.24 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
15.25 authorization from the local agency.
- 15.26 Nonemergency medical transportation providers may not bill for separate base rates for
15.27 the continuation of a trip beyond the original destination. Nonemergency medical
15.28 transportation providers must maintain trip logs, which include pickup and drop-off times,
15.29 signed by the medical provider or client, whichever is deemed most appropriate, attesting
15.30 to mileage traveled to obtain covered medical services. Clients requesting client mileage
15.31 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
15.32 services.

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

16.7 (i) The covered modes of transportation are:

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

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

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

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

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

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

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

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

17.1 18e. The local agency's financial obligation is limited to funds provided by the state or
17.2 federal government.

17.3 (k) The commissioner shall:

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

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

17.6 (3) investigate all complaints and appeals.

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

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

17.16 (1) \$0.22 per mile for client reimbursement;

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

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

17.22 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

17.23 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

17.24 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

17.25 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
17.26 an additional attendant if deemed medically necessary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19.32 ~~or~~

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

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

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

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

20.15 (j) "Managing employee" has the same definition as Code of Federal Regulations, title
20.16 42, section 455.

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

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

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

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

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

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

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

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

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

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

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

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

21.21 Sec. 17. Minnesota Statutes 2022, section 256B.0943, subdivision 1, is amended to read:

21.22 Subdivision 1. **Definitions.** For purposes of this section, the following terms have the
21.23 meanings given them.

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

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

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

22.10 ~~(b)~~ (c) "Clinical trainee" means a staff person who is qualified according to section
22.11 245I.04, subdivision 6.

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

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

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

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

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

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

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

23.4 ~~(i)~~ (j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision
 23.5 15.

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

23.8 ~~(k)~~ (l) "Mental health behavioral aide services" means medically necessary one-on-one
 23.9 activities performed by a mental health behavioral aide qualified according to section
 23.10 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously
 23.11 trained by a mental health professional, clinical trainee, or mental health practitioner and
 23.12 as described in the child's individual treatment plan and individual behavior plan. Activities
 23.13 involve working directly with the child or child's family as provided in subdivision 9,
 23.14 paragraph (b), clause (4).

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

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

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

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

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

23.23 (2) administering and reporting the standardized outcome measurements in section
 23.24 245I.10, subdivision 6, paragraph (d), clauses (3) and (4), and other standardized outcome
 23.25 measurements approved by the commissioner, as periodically needed to evaluate the
 23.26 effectiveness of treatment.

23.27 ~~(p)~~ (q) "Mental illness," for persons at least age 18 but under age 21, has the meaning
 23.28 given in section 245.462, subdivision 20, paragraph (a).

23.29 ~~(q)~~ (r) "Psychotherapy" means the treatment described in section 256B.0671, subdivision
 23.30 11.

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

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

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

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

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

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

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

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

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

24.28 (3) crisis planning;

24.29 (4) mental health behavioral aide services;

24.30 (5) direction of a mental health behavioral aide;

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

24.32 (7) children's day treatment; and

25.1 (8) children's care coordination.

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

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

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

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

25.11 (3) a day treatment program is provided to a group of clients by a team under the treatment
25.12 supervision of a mental health professional. The day treatment program must be provided
25.13 in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation
25.14 of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community
25.15 mental health center under section 245.62; or (iii) an entity that is certified under subdivision
25.16 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and
25.17 Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize
25.18 the client's mental health status while developing and improving the client's independent
25.19 living and socialization skills. The goal of the day treatment program must be to reduce or
25.20 relieve the effects of mental illness and provide training to enable the client to live in the
25.21 community. The remainder of the structured treatment program may include patient and/or
25.22 family or group psychotherapy, and individual or group skills training, if included in the
25.23 client's individual treatment plan. Day treatment programs are not part of inpatient or
25.24 residential treatment services. When a day treatment group that meets the minimum group
25.25 size requirement temporarily falls below the minimum group size because of a member's
25.26 temporary absence, medical assistance covers a group session conducted for the group
25.27 members in attendance. A day treatment program may provide fewer than the minimally
25.28 required hours for a particular child during a billing period in which the child is transitioning
25.29 into, or out of, the program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28.3 Subd. 14. **At-home services rate enhancement.** The commissioner shall implement a
28.4 30 percent rate increase to providers of children's therapeutic services and supports for all
28.5 services provided directly to the child or family in their home.

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

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

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

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

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

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

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

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

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

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

28.29 and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30.27 (11) is a sexually exploited youth;

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

30.30 (13) is a runaway;

30.31 (14) is a habitual truant;

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

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

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

31.11 **260C.708 OUT-OF-HOME PLACEMENT PLAN FOR QUALIFIED**
31.12 **RESIDENTIAL TREATMENT PROGRAM PLACEMENTS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32.28 (c) The agency must file the out-of-home placement plan with the court as part of the
32.29 60-day court order under section 260C.71.

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

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

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

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

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

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

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

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

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

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

33.16 (2) reducing emergency department utilization;

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

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

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

33.20 The commissioner of human services must update the behavioral health fund room and
33.21 board rate schedule to include services provided under Minnesota Statutes, section 245.4882,
33.22 for individuals who do not have a placement under Minnesota Statutes, chapter 260C or
33.23 260D. The commissioner must establish room and board rates commensurate with current
33.24 room and board rates for adolescent programs licensed under Minnesota Statutes, section
33.25 245G.18.

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

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

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

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

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

34.18 **Sec. 30. APPROPRIATION.**

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

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

34.23 \$350,000 in fiscal year 2024 and \$350,000 in fiscal year 2025 are appropriated from the
 34.24 general fund to the commissioner of human services for children's mental health grants
 34.25 under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (3), to
 34.26 provide respite care services to families of children with serious mental illness.

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

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

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

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

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

35.15 **Sec. 34. APPROPRIATION.**

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

35.20 **Sec. 35. APPROPRIATION.**

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

36.1 **Sec. 36. APPROPRIATION.**

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

36.6 **Sec. 37. APPROPRIATION.**

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

36.11 **Sec. 38. APPROPRIATION.**

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

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

36.20 \$2,000,000 in fiscal year 2024 and \$1,500,000 in fiscal year 2025 are appropriated from
36.21 the general fund to the commissioner of human services for start-up and capacity development
36.22 grants to psychiatric residential treatment facilities as described in Minnesota Statutes,
36.23 section 256B.0941. Grantees may use grant money to increase capacity in existing facilities,
36.24 support additional training and equipment to serve specialized child needs, and address the
36.25 emergency workforce shortage.

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

36.28 \$1,250,000 in fiscal year 2024 is appropriated from the general fund to the commissioner
36.29 of human services for grants for training of staff providing intensive in-home children's
36.30 mental health care under Minnesota Statutes, sections 256B.0943, 256B.0946, and
36.31 256B.0947. Grant money shall be to reimburse certified providers for training on

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

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

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

- 37.9 (1) maintaining current levels of collaborative intensive bridging services and evaluation;
37.10 (2) limited expansions of collaborative intensive bridging services and evaluation; and
37.11 (3) training and technical assistance by an expert contractor with experience in
37.12 collaborative intensive bridging services to counties and service providers on maintaining
37.13 fidelity to the collaborative intensive bridging services model.

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

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

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

37.21 \$810,000 in fiscal year 2024 and \$1,800,000 in fiscal year 2025 are appropriated from
37.22 the general fund to the commissioner of human services for grants to start up, expand, or
37.23 sustain child first programs in metropolitan and rural areas of the state to serve families in
37.24 accordance with the child first model as defined by the National Service Office for
37.25 Nurse-Family Partnership and Child First. Grants must be provided to community-based
37.26 mental health organizations, family service organizations, hospital systems and pediatric
37.27 providers, early care and education providers, and university-based family or mental health
37.28 programs.