CHAPTER 99--H.F.No. 2725

An act relating to state government; establishing a statutory procedure to assess the competency of a defendant to stand trial; providing for contested hearings; establishing continuing supervision for certain defendants found incompetent to stand trial; establishing requirements to restore certain defendants to competency; providing for administration of medication; establishing forensic navigators; requiring forensic navigators to provide services to certain defendants; establishing dismissal plans for certain defendants found incompetent to stand trial; providing for jail-based competency restoration programs; establishing the State Competency Restoration Board and certification advisory committee; creating and modifying certain mental health provisions; creating temporary medical permits; requiring a report; appropriating money; amending Minnesota Statutes 2020, sections 144.55, subdivisions 4, 6; 144.551, by adding a subdivision; 147.01, subdivision 7; 147.03, subdivisions 1, 2; 147.037; 147A.28; 147C.40, subdivision 5; 245.4661, as amended; 245.4882, by adding subdivisions; 253B.07, subdivision 2a; 256B.0946, subdivision 7; 480.182; Minnesota Statutes 2021 Supplement, sections 144.551, subdivision 1; 245.4885, subdivision 1; 245I.23, by adding a subdivision; 254B.05, subdivision 1a; 256B.0625, subdivision 56a; 256B.0946, subdivisions 1, 1a, 2, 3, 4, 6; 256B.763; Laws 2021, First Special Session chapter 7, article 17, section 12; proposing coding for new law in Minnesota Statutes, chapters 147A; 245; 245A; 611; repealing Minnesota Statutes 2020, sections 147.02, subdivision 2a; 245.4661, subdivision 8.

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

ARTICLE 1

MENTAL HEALTH POLICY

Section 1. Minnesota Statutes 2020, section 144.55, subdivision 4, is amended to read:

Subd. 4. **Routine inspections; presumption.** Any hospital surveyed and accredited under the standards of the hospital accreditation program of an approved accrediting organization that submits to the commissioner within a reasonable time copies of (a) its currently valid accreditation certificate and accreditation letter, together with accompanying recommendations and comments and (b) any further recommendations, progress reports and correspondence directly related to the accreditation is presumed to comply with application requirements of subdivision 1 and the standards requirements of subdivision 3 and no further routine inspections or accreditation information shall be required by the commissioner to determine compliance. Notwithstanding the provisions of sections 144.54 and 144.653, subdivisions 2 and 4, hospitals shall be inspected only as provided in this section. The provisions of section 144.653 relating to the assessment and collection of fines shall not apply to any hospital. The commissioner of health shall annually conduct, with notice, validation inspections of a selected sample of the number of hospitals accredited by an approved accrediting organization, not to exceed ten percent of accredited hospitals, for the purpose of determining compliance with the provisions of subdivision 3. If a validation survey discloses a failure to comply with subdivision 3, the provisions of section 144.653 relating to correction orders, reinspections, and notices of noncompliance shall apply. The commissioner shall also conduct any inspection necessary to determine whether hospital construction, addition, or remodeling projects comply with standards for construction promulgated in rules pursuant to subdivision 3. The commissioner may also conduct inspections to determine whether a hospital or hospital corporate system continues to satisfy the conditions on which a hospital construction moratorium exception was granted under section 144.551, subdivision 1a. Pursuant to section 144.653, the commissioner shall inspect any hospital that does not have a currently valid hospital accreditation certificate from an approved accrediting organization. Nothing in this subdivision shall be construed to limit the investigative powers of the Office of Health Facility Complaints as established in sections 144A.51 to 144A.54.

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

Sec. 2. Minnesota Statutes 2020, section 144.55, subdivision 6, is amended to read:

Subd. 6. **Suspension, revocation, and refusal to renew.** (a) The commissioner may refuse to grant or renew, or may suspend or revoke, a license on any of the following grounds:

(1) violation of any of the provisions of sections 144.50 to 144.56 or the rules or standards issued pursuant thereto, or Minnesota Rules, chapters 4650 and 4675;

(2) permitting, aiding, or abetting the commission of any illegal act in the institution;

(3) conduct or practices detrimental to the welfare of the patient; or

(4) obtaining or attempting to obtain a license by fraud or misrepresentation; or

(5) with respect to hospitals and outpatient surgical centers, if the commissioner determines that there is a pattern of conduct that one or more physicians or advanced practice registered nurses who have a "financial or economic interest," as defined in section 144.6521, subdivision 3, in the hospital or outpatient surgical center, have not provided the notice and disclosure of the financial or economic interest required by section 144.6521.

(b) The commissioner shall not renew a license for a boarding care bed in a resident room with more than four beds.

(c) The commissioner shall not renew licenses for hospital beds issued to a hospital or hospital corporate system pursuant to a hospital construction moratorium exception under section 144.551, subdivision 1a, if the commissioner determines the hospital or hospital corporate system is not satisfying the conditions on which the exception was granted.

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

Sec. 3. Minnesota Statutes 2021 Supplement, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; (iv) the relocation or redistribution does not involve the construction of a new hospital building; and (v) the transferred beds are used first to replace within the hospital corporate system the total number of beds previously used in the closed facility site or complex for mental health services and substance use disorder services. Only after the hospital corporate system has fulfilled the requirements of this item may the remainder of the available capacity of the closed facility site or complex be transferred for any other purpose;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human

services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds in an existing hospital in Carver County serving the southwest suburban metropolitan area;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

(19) a critical access hospital established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law;

(20) notwithstanding section 144.552, a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

(i) the project, including each hospital or health system that will own or control the entity that will hold the new hospital license, is approved by a resolution of the Maple Grove City Council as of March 1, 2006;

(ii) the entity that will hold the new hospital license will be owned or controlled by one or more not-for-profit hospitals or health systems that have previously submitted a plan or plans for a project in Maple Grove as required under section 144.552, and the plan or plans have been found to be in the public interest by the commissioner of health as of April 1, 2005;

(iii) the new hospital's initial inpatient services must include, but are not limited to, medical and surgical services, obstetrical and gynecological services, intensive care services, orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health services, and emergency room services;

(iv) the new hospital:

(A) will have the ability to provide and staff sufficient new beds to meet the growing needs of the Maple Grove service area and the surrounding communities currently being served by the hospital or health system that will own or control the entity that will hold the new hospital license;

(B) will provide uncompensated care;

(C) will provide mental health services, including inpatient beds;

(D) will be a site for workforce development for a broad spectrum of health-care-related occupations and have a commitment to providing clinical training programs for physicians and other health care providers;

(E) will demonstrate a commitment to quality care and patient safety;

(F) will have an electronic medical records system, including physician order entry;

(G) will provide a broad range of senior services;

(H) will provide emergency medical services that will coordinate care with regional providers of trauma services and licensed emergency ambulance services in order to enhance the continuity of care for emergency medical patients; and

(I) will be completed by December 31, 2009, unless delayed by circumstances beyond the control of the entity holding the new hospital license; and

(v) as of 30 days following submission of a written plan, the commissioner of health has not determined that the hospitals or health systems that will own or control the entity that will hold the new hospital license are unable to meet the criteria of this clause;

(21) a project approved under section 144.553;

(22) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board;

(23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility;

(24) notwithstanding section 144.552, a project for the construction and expansion of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients who are under 21 years of age on the date of admission. The commissioner conducted a public interest review of the mental health needs of Minnesota and the Twin Cities metropolitan area in 2008. No further public interest review shall be conducted for the construction or expansion project under this clause;

(25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city of Maple Grove, exclusively for patients who are under 21 years of age on the date of admission, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(ii) this project shall serve patients in the continuing care benefit program under section 256.9693. The project may also serve patients not in the continuing care benefit program; and

(iii) if the project ceases to participate in the continuing care benefit program, the commissioner must complete a subsequent public interest review under section 144.552. If the project is found not to be in the public interest, the license must be terminated six months from the date of that finding. If the commissioner of human services terminates the contract without cause or reduces per diem payment rates for patients under the continuing care benefit program below the rates in effect for services provided on December 31, 2015, the project may cease to participate in the continuing care benefit program and continue to operate without a subsequent public interest review;

(27) a project involving the addition of 21 new beds in an existing psychiatric hospital in Hennepin County that is exclusively for patients who are under 21 years of age on the date of admission;

(28) a project to add 55 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which 15 beds are to be used for inpatient mental health and 40 are to be used for other services. In addition, five unlicensed observation mental health beds shall be added;

(29) upon submission of a plan to the commissioner for public interest review under section 144.552 and the addition of the 15 inpatient mental health beds specified in clause (28), to its bed capacity, a project to add 45 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5. Five of the 45 additional beds authorized under this clause must be designated for use for inpatient mental health and must be added to the hospital's bed capacity before the remaining 40 beds are added. Notwithstanding section 144.552, the hospital may add licensed beds under this clause prior to completion of the public interest review, provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for the public interest review described in section 144.552; ~~or~~

(30) upon submission of a plan to the commissioner for public interest review under section 144.552, a project to add up to 30 licensed beds in an existing psychiatric hospital in Hennepin County that exclusively provides care to patients who are under 21 years of age on the date of admission. Notwithstanding section 144.552, the psychiatric hospital may add licensed beds under this clause prior to completion of the public interest review, provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for the public interest review described in section 144.552; or

(31) a project for a 144-bed psychiatric hospital on the site of the former Bethesda hospital in the city of Saint Paul, Ramsey County, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete. Following the completion of the construction project, the commissioner of health shall monitor the hospital, including by assessing the hospital's case mix and payer mix, patient transfers, and patient diversions. The hospital must have an intake and assessment area. The hospital must accommodate patients with acute mental health needs, whether they walk up to the facility, are delivered by ambulances or law enforcement, or are transferred from other facilities. The hospital must comply with subdivision 1a, paragraph (b). The hospital must annually submit de-identified data to the department in the format and manner defined by the commissioner.

Sec. 4. Minnesota Statutes 2020, section 144.551, is amended by adding a subdivision to read:

Subd. 1a. **Exception for increased mental health bed capacity.** (a) From August 1, 2022, to July 31, 2027, subdivision 1, paragraph (a), and sections 144.552 and 144.553, do not apply to:

(1) those portions of any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increase the mental health bed capacity of a hospital; or

(2) the establishment of a new psychiatric hospital.

(b) Any hospital that increases its bed capacity or is established under this subdivision must:

(1) use all the newly licensed beds exclusively for mental health services;

(2) accept medical assistance and MinnesotaCare enrollees;

(3) abide by the terms of the Minnesota Attorney General Hospital Agreement;

(4) have an arrangement with a tertiary care facility or a sufficient number of medical specialists to determine and arrange appropriate treatment of medical conditions; and

(5) submit to the commissioner requested information the commissioner deems necessary for the commissioner to conduct the study of inpatient mental health access and quality described in paragraph (e).

(c) The commissioner shall monitor the implementation of exceptions under this subdivision. Each hospital or hospital corporate system granted an exception under this subdivision shall submit to the commissioner each year a report on how the hospital or hospital corporate system continues to satisfy the conditions on which the exception was granted.

(d) Any hospital found to be in violation of this subdivision is subject to sanction under section 144.55, subdivision 6, paragraph (c).

(e) By January 15, 2027, the commissioner of health shall submit to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health a report containing the result of a study of inpatient mental health access and quality. The report must contain:

(1) the location of every hospital that has expanded its capacity or been established under this subdivision;

(2) summary data by location of the patient population served in the newly licensed beds, including age, duration of stay, and county of residence; and

(3) an analysis of the change in access and quality of inpatient mental health care in Minnesota resulting from the enactment of this subdivision.

A hospital that expands its capacity or is established under this subdivision must provide the information and data the commissioner requests to fulfill the requirements of this paragraph. For the purposes of section 144.55, subdivision 6, paragraph (c), a hospital's failure to provide data requested by the commissioner is a failure to satisfy the conditions on which an exception is granted under this subdivision.

(f) The commissioner may request from other hospitals information that the commissioner deems necessary to perform the analysis required under paragraph (e).

(g) No psychiatric hospital may be established on the site of the former Bethesda hospital in Saint Paul, Ramsey County, unless the commissioner determines that establishment of the hospital is in the public interest after completing a public interest review under section 144.552.

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

Sec. 5. **[245.096] CHANGES TO GRANT PROGRAMS.**

Prior to implementing any substantial changes to a grant funding formula disbursed through allocations administered by the commissioner, the commissioner must provide a report on the nature of the changes, the effect the changes will have, whether any funding will change, and other relevant information, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services. The report must be provided prior to the start of a regular session and the proposed changes cannot be implemented until after the adjournment of that regular session.

Sec. 6. Minnesota Statutes 2020, section 245.4661, as amended by Laws 2021, chapter 30, article 17, section 21, is amended to read:

245.4661 ~~PILOT PROJECTS;~~ ADULT MENTAL HEALTH INITIATIVE SERVICES.

Subdivision 1. **~~Authorization for pilot projects~~ Adult mental health initiative services.** ~~The commissioner of human services may approve pilot projects to provide alternatives to or enhance coordination of~~ Each county board, county boards acting jointly, or tribal government must provide or contract for sufficient infrastructure for the delivery of mental health services ~~required~~ under the Minnesota Comprehensive Adult Mental Health Act, sections 245.461 to 245.486.

Subd. 2. **Program design and implementation.** ~~The pilot projects~~ Adult mental health initiatives shall be ~~established to design, plan, and improve the~~ responsible for designing, planning, improving, and maintaining a mental health service delivery system for adults with serious and persistent mental illness that would:

(1) provide an expanded array of services from which clients can choose services appropriate to their needs;

(2) be based on purchasing strategies that improve access and coordinate services without cost shifting;

(3) prioritize evidence-based services and implement services that are promising practices or theory-based practices so that the service can be evaluated according to subdivision 5a;

~~(3)~~ (4) incorporate existing state facilities and resources into the community mental health infrastructure through creative partnerships with local vendors; and

~~(4)~~ (5) utilize existing categorical funding streams and reimbursement sources in combined and creative ways, except appropriations to regional treatment centers and all funds that are attributable to the operation of state-operated services are excluded unless appropriated specifically by the legislature for a purpose consistent with this section or section 246.0136, subdivision 1.

Subd. 3. **~~Program~~ Adult mental health initiative evaluation.** Evaluation of each ~~project~~ adult mental health initiative will be based on outcome evaluation criteria ~~negotiated with each project prior to implementation~~ determined by the commissioners of human services and management and budget after consultation with stakeholders.

Subd. 4. **Notice of ~~project~~ adult mental health initiative discontinuation.** Each ~~project~~ adult mental health initiative may be discontinued for any reason by the ~~project's~~ managing entity or the commissioner of human services, after 90 days' written notice to the other party.

Subd. 5. **Planning for ~~pilot projects~~ adult mental health initiatives.** ~~(a)~~ Each local plan for ~~a pilot project, with the exception of the placement of a Minnesota specialty treatment facility as defined in paragraph~~

~~(c),~~ adult mental health initiative services must be developed under the direction of the county board, or multiple county boards acting jointly, as the local mental health authority. The planning process for each ~~pilot~~ adult mental health initiative shall include, but not be limited to, mental health consumers, families, advocates, local mental health advisory councils, local and state providers, representatives of state and local public employee bargaining units, and the department of human services. As part of the planning process, the county board or boards shall designate a managing entity responsible for receipt of funds and management of ~~the pilot project~~ adult mental health initiatives.

~~(b) For Minnesota specialty treatment facilities, the commissioner shall issue a request for proposal for regions in which a need has been identified for services.~~

~~(c) For purposes of this section, "Minnesota specialty treatment facility" is defined as an intensive residential treatment service licensed under chapter 245I.~~

Subd. 5a. **Evaluations.** The commissioner of management and budget, in consultation with the commissioner of human services, and within available appropriations, shall create and maintain an inventory of adult mental health initiative services administered by the county boards, identifying evidence-based services and services that are theory-based or promising practices. The commissioner of management and budget, in consultation with the commissioner of human services, shall select adult mental health initiative services that are promising practices or theory-based activities for which the commissioner of management and budget shall conduct evaluations using experimental or quasi-experimental design. The commissioner of human services, in consultation with the commissioner of management and budget, shall encourage county boards to administer adult mental health initiative services to support experimental or quasi-experimental evaluation and shall require county boards to collect and report information that is needed to complete the inventory and evaluation for any adult mental health initiative service that is selected for an evaluation. The commissioner of management and budget, under section 15.08, may obtain additional relevant data to support the inventory and the experimental or quasi-experimental evaluation studies.

Subd. 6. **Duties of commissioner.** (a) For purposes of ~~the pilot projects~~ adult mental health initiatives, the commissioner shall facilitate integration of funds or other resources as needed and requested by each ~~project~~ adult mental health initiative. These resources may include:

(1) community support services funds administered under Minnesota Rules, parts 9535.1700 to 9535.1760;

(2) other mental health special project funds;

(3) medical assistance, MinnesotaCare, and housing support under chapter 256I if requested by the ~~project's~~ adult mental health initiative's managing entity, and if the commissioner determines this would be consistent with the state's overall health care reform efforts; and

(4) regional treatment center resources consistent with section 246.0136, subdivision 1.

(b) The commissioner shall consider the following criteria in awarding ~~start-up and implementation~~ grants for ~~the pilot projects~~ adult mental health initiatives:

(1) the ability of the ~~proposed projects~~ initiatives to accomplish the objectives described in subdivision 2;

(2) the size of the target population to be served; and

(3) geographical distribution.

(c) The commissioner shall review overall status of the ~~projects~~ initiatives at least every two years and recommend any legislative changes needed by January 15 of each odd-numbered year.

(d) The commissioner may waive administrative rule requirements ~~which~~ that are incompatible with the implementation of the ~~pilot project~~ adult mental health initiative.

(e) The commissioner may exempt the participating counties from fiscal sanctions for noncompliance with requirements in laws and rules ~~which~~ that are incompatible with the implementation of the ~~pilot project~~ adult mental health initiative.

(f) The commissioner may award grants to an entity designated by a county board or group of county boards to pay for start-up and implementation costs of the ~~pilot project~~ adult mental health initiative.

Subd. 7. **Duties of ~~county~~ adult mental health initiative board.** The ~~county~~ adult mental health initiative board, or other entity which is approved to administer ~~a pilot project~~ an adult mental health initiative, shall:

(1) administer the ~~project~~ initiative in a manner ~~which~~ that is consistent with the objectives described in subdivision 2 and the planning process described in subdivision 5;

(2) assure that no one is denied services ~~for which~~ that they would otherwise be eligible for; and

(3) provide the commissioner of human services with timely and pertinent information through the following methods:

(i) submission of mental health plans and plan amendments which are based on a format and timetable determined by the commissioner;

(ii) submission of social services expenditure and grant reconciliation reports, based on a coding format to be determined by mutual agreement between the ~~project's~~ initiative's managing entity and the commissioner; and

(iii) submission of data and participation in an evaluation of the ~~pilot projects~~ adult mental health initiatives, to be designed cooperatively by the commissioner and the ~~projects~~ initiatives.

Subd. 8. **Budget flexibility.** The commissioner may make budget transfers that do not increase the state share of costs to effectively implement the restructuring of adult mental health services.

Subd. 9. **Services and programs.** (a) The following three distinct grant programs are funded under this section:

(1) mental health crisis services;

(2) housing with supports for adults with serious mental illness; and

(3) projects for assistance in transitioning from homelessness (PATH program).

(b) In addition, the following are eligible for grant funds:

(1) community education and prevention;

(2) client outreach;

(3) early identification and intervention;

(4) adult outpatient diagnostic assessment and psychological testing;

(5) peer support services;

(6) community support program services (CSP);

(7) adult residential crisis stabilization;

(8) supported employment;

(9) assertive community treatment (ACT);

(10) housing subsidies;

(11) basic living, social skills, and community intervention;

(12) emergency response services;

(13) adult outpatient psychotherapy;

(14) adult outpatient medication management;

(15) adult mobile crisis services;

(16) adult day treatment;

(17) partial hospitalization;

(18) adult residential treatment;

(19) adult mental health targeted case management;

(20) intensive community rehabilitative services (ICRS); and

(21) transportation.

Subd. 10. **Commissioner duty to report on use of grant funds biennially.** By November 1, 2016, and biennially thereafter, the commissioner of human services shall provide sufficient information to the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under this section ~~of law~~. The commissioner shall provide, at a minimum, the following information:

(1) the amount of funding to adult mental health initiatives, what programs and services were funded in the previous two years, gaps in services that each initiative brought to the attention of the commissioner, and outcome data for the programs and services that were funded; and

(2) the amount of funding for other targeted services and the location of services.

Subd. 11. **Adult mental health initiative funding.** When implementing the funding formula to distribute adult mental health initiative funds, the commissioner shall ensure that no adult mental health initiative region receives less than the amount the region received in fiscal year 2022 in combined adult mental health initiative funding.

Sec. 7. **[245.4663] MENTAL HEALTH PROVIDER SUPERVISION GRANT PROGRAM.**

Subdivision 1. **Grant program established.** The commissioner shall award grants to licensed or certified mental health providers who meet the criteria in subdivision 2 to fund supervision of interns and clinical trainees who are working toward becoming a mental health professional and to subsidize the costs of licensing applications and examination fees for clinical trainees. For purposes of this section, an intern may include an individual who is working toward an undergraduate degree in the behavioral sciences or related field at an accredited educational institution.

Subd. 2. **Eligible providers.** In order to be eligible for a grant under this section, a mental health provider must:

(1) provide at least 25 percent of the provider's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303; or

(2) primarily serve underrepresented communities as defined in section 148E.010, subdivision 20.

Subd. 3. **Application; grant award.** A mental health provider seeking a grant under this section must apply to the commissioner at a time and in a manner specified by the commissioner. The commissioner shall review each application to determine if the application is complete, the mental health provider is eligible for a grant, and the proposed project is an allowable use of grant funds. The commissioner must determine the grant amount awarded to applicants that the commissioner determines will receive a grant.

Subd. 4. **Allowable uses of grant funds.** A mental health provider must use grant funds received under this section for one or more of the following:

(1) to pay for direct supervision hours for interns and clinical trainees, in an amount up to $7,500 per intern or clinical trainee;

(2) to establish a program to provide supervision to multiple interns or clinical trainees; or

(3) to pay licensing application and examination fees for clinical trainees.

Subd. 5. **Program oversight.** During the grant period, the commissioner may require grant recipients to provide the commissioner with information necessary to evaluate the program.

Sec. 8. Minnesota Statutes 2020, section 245.4882, is amended by adding a subdivision to read:

Subd. 2a. **Assessment requirements.** (a) A residential treatment service provider must complete a diagnostic assessment of a child within ten calendar days of the child's admission. If a diagnostic assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed.

(b) Notwithstanding the timeline requirements under Minnesota Rules, part 2960.0070, subpart 5, item C, subitems (1) and (2), the license holder must complete the screenings required by Minnesota Rules, part 2960.0070, subpart 5, item A, subitems (2), (3), (4), and (6), within ten calendar days. The license holder must complete the screenings required under Minnesota Rules, part 2960.0070, subpart 5, item A, subitems (1) and (5), according to the timelines in Minnesota Rules, part 2960.0070, subpart 5, item C, subitems (1) to (3).

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later.

Sec. 9. Minnesota Statutes 2020, section 245.4882, is amended by adding a subdivision to read:

Subd. 6. **Crisis admissions and stabilization.** (a) A child may be referred for residential treatment services under this section for the purpose of crisis stabilization by:

(1) a mental health professional as defined in section 245I.04, subdivision 2;

(2) a physician licensed under chapter 147 who is assessing a child in an emergency department; or

(3) a member of a mobile crisis team who meets the qualifications under section 256B.0624, subdivision 5.

(b) A provider making a referral under paragraph (a) must conduct an assessment of the child's mental health needs and make a determination that the child is experiencing a mental health crisis and is in need of residential treatment services under this section.

(c) A child may receive services under this subdivision for up to 30 days and must be subject to the screening and admissions criteria and processes under section 245.4885 thereafter.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2021 Supplement, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the case of an emergency, all children referred for treatment of severe emotional disturbance in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center shall undergo an assessment to determine the appropriate level of care if county funds are used to pay for the child's services. An emergency includes when a child is in need of and has been referred for crisis stabilization services under section 245.4882, subdivision 6. A child who has been referred to residential treatment for crisis stabilization services in a residential treatment center is not required to undergo an assessment under this section.

(b) The county board shall determine the appropriate level of care for a child when county-controlled funds are used to pay for the child's residential treatment under this chapter, including residential treatment provided in a qualified residential treatment program as defined in section 260C.007, subdivision 26d. When a county board does not have responsibility for a child's placement and the child is enrolled in a prepaid health program under section 256B.69, the enrolled child's contracted health plan must determine the appropriate level of care for the child. When Indian Health Services funds or funds of a tribally owned facility funded under the Indian Self-Determination and Education Assistance Act, Public Law 93-638, are used for the child, the Indian Health Services or 638 tribal health facility must determine the appropriate level of care for the child. When more than one entity bears responsibility for a child's coverage, the entities shall coordinate level of care determination activities for the child to the extent possible.

(c) The child's level of care determination shall determine whether the proposed treatment:

(1) is necessary;

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

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

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

(d) When a level of care determination is conducted, the county board or other entity may not determine that a screening of a child, referral, or admission to a residential treatment facility is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. The level of care determination must be based on a diagnostic assessment of a child that evaluates the child's family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care to the child. The validated tool must be approved by the commissioner of human services and may be the validated tool approved for the child's assessment under section 260C.704 if the juvenile treatment screening team recommended placement of the child in a qualified residential treatment program. If a diagnostic assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether these services are available and accessible to the child and the child's family. The child and the child's family must be invited to any meeting where the level of care determination is discussed and decisions regarding residential treatment are made. The child and the child's family may invite other relatives, friends, or advocates to attend these meetings.

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

(f) The level of care determination, placement decision, and recommendations for mental health services must be documented in the child's record and made available to the child's family, as appropriate.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. **[245.4905] FIRST EPISODE OF PSYCHOSIS GRANT PROGRAM.**

Subdivision 1. **Creation.** The first episode of psychosis grant program is established in the Department of Human Services to fund evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis and a public awareness campaign on the signs and symptoms of psychosis. First episode of psychosis services are eligible for children's mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause (15).

Subd. 2. **Activities.** (a) All first episode of psychosis grant programs must:

(1) provide intensive treatment and support for adolescents and adults experiencing or at risk of experiencing a first psychotic episode. Intensive treatment and support includes medication management, psychoeducation for an individual and an individual's family, case management, employment support,

education support, cognitive behavioral approaches, social skills training, peer support, crisis planning, and stress management;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinicians, on early psychosis symptoms, screening tools, and best practices;

(3) ensure access for individuals to first psychotic episode services under this section, including access for individuals who live in rural areas; and

(4) use all available funding streams.

(b) Grant money may also be used to pay for housing or travel expenses for individuals receiving services or to address other barriers preventing individuals and their families from participating in first psychotic episode services.

Subd. 3. **Eligibility.** Program activities must be provided to people 15 to 40 years old with early signs of psychosis.

Subd. 4. **Outcomes.** Evaluation of program activities must utilize evidence-based practices and must include the following outcome evaluation criteria:

(1) whether individuals experience a reduction in psychotic symptoms;

(2) whether individuals experience a decrease in inpatient mental health hospitalizations; and

(3) whether individuals experience an increase in educational attainment.

Subd. 5. **Federal aid or grants.** The commissioner of human services must comply with all conditions and requirements necessary to receive federal aid or grants.

Sec. 12. **[245A.26] CHILDREN'S RESIDENTIAL FACILITY CRISIS STABILIZATION SERVICES.**

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

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

(c) "License holder" means an individual, organization, or government entity that was issued a license by the commissioner of human services under this chapter for residential mental health treatment for children with emotional disturbance according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to 2960.0700, or shelter care services according to Minnesota Rules, parts 2960.0010 to 2960.0120 and 2960.0510 to 2960.0530.

(d) "Mental health professional" means an individual who is qualified under section 245I.04, subdivision 2.

Subd. 2. **Scope and applicability.** (a) This section establishes additional licensing requirements for a children's residential facility to provide children's residential crisis stabilization services to a client who is experiencing a mental health crisis and is in need of residential treatment services.

(b) A children's residential facility may provide residential crisis stabilization services only if the facility is licensed to provide:

(1) residential mental health treatment for children with emotional disturbance according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to 2960.0700; or

(2) shelter care services according to Minnesota Rules, parts 2960.0010 to 2960.0120 and 2960.0510 to 2960.0530.

(c) If a client receives residential crisis stabilization services for 35 days or fewer in a facility licensed according to paragraph (b), clause (1), the facility is not required to complete a diagnostic assessment or treatment plan under Minnesota Rules, part 2960.0180, subpart 2, and part 2960.0600.

(d) If a client receives residential crisis stabilization services for 35 days or fewer in a facility licensed according to paragraph (b), clause (2), the facility is not required to develop a plan for meeting the client's immediate needs under Minnesota Rules, part 2960.0520, subpart 3.

Subd. 3. **Eligibility for services.** An individual is eligible for children's residential crisis stabilization services if the individual is under 21 years of age and meets the eligibility criteria for crisis services under section 256B.0624, subdivision 3.

Subd. 4. **Required services; providers.** (a) A license holder providing residential crisis stabilization services must continually follow a client's individual crisis treatment plan to improve the client's functioning.

(b) The license holder must offer and have the capacity to directly provide the following treatment services to a client:

(1) crisis stabilization services as described in section 256B.0624, subdivision 7;

(2) mental health services as specified in the client's individual crisis treatment plan, according to the client's treatment needs;

(3) health services and medication administration, if applicable; and

(4) referrals for the client to community-based treatment providers and support services for the client's transition from residential crisis stabilization to another treatment setting.

(c) Children's residential crisis stabilization services must be provided by a qualified staff person listed in section 256B.0624, subdivision 8, according to the scope of practice for the individual staff person's position.

Subd. 5. **Assessment and treatment planning.** (a) Within 12 hours of a client's admission for residential crisis stabilization, the license holder must assess the client and document the client's immediate needs, including the client's:

(1) health and safety, including the need for crisis assistance;

(2) need for connection to family and other natural supports;

(3) if applicable, housing and legal issues; and

(4) if applicable, responsibilities for children, family, and other natural supports, and employers.

(b) Within 24 hours of a client's admission for residential crisis stabilization, the license holder must complete a crisis treatment plan for the client, according to the requirements for a crisis treatment plan under section 256B.0624, subdivision 11. The license holder must base the client's crisis treatment plan on the client's referral information and the assessment of the client's immediate needs under paragraph (a). A mental health professional or a clinical trainee under the supervision of a mental health professional must complete the crisis treatment plan. A crisis treatment plan completed by a clinical trainee must contain documentation of approval, as defined in section 245I.02, subdivision 2, by a mental health professional within five business days of initial completion by the clinical trainee.

(c) A mental health professional must review a client's crisis treatment plan each week and document the weekly reviews in the client's client file.

(d) For a client receiving children's residential crisis stabilization services who is 18 years of age or older, the license holder must complete an individual abuse prevention plan for the client, pursuant to section 245A.65, subdivision 2, as part of the client's crisis treatment plan.

Subd. 6. **Staffing requirements.** Staff members of facilities providing services under this section must have access to a mental health professional or clinical trainee within 30 minutes, either in person or by telephone. The license holder must maintain a current schedule of available mental health professionals or clinical trainees and include contact information for each mental health professional or clinical trainee. The schedule must be readily available to all staff members.

Sec. 13. Minnesota Statutes 2021 Supplement, section 245I.23, is amended by adding a subdivision to read:

Subd. 19a. **Additional requirements for locked program facility.** (a) A license holder that prohibits clients from leaving the facility by locking exit doors or other permissible methods must meet the additional requirements of this subdivision.

(b) The license holder must meet all applicable building and fire codes to operate a building with locked exit doors. The license holder must have the appropriate license from the Department of Health, as determined by the Department of Health, for operating a program with locked exit doors.

(c) The license holder's policies and procedures must clearly describe the types of court orders that authorize the license holder to prohibit clients from leaving the facility.

(d) For each client present in the facility under a court order, the license holder must maintain documentation of the court order authorizing the license holder to prohibit the client from leaving the facility.

(e) Upon a client's admission to a locked program facility, the license holder must document in the client file that the client was informed:

(1) that the client has the right to leave the facility according to the client's rights under section 144.651, subdivision 21, if the client is not subject to a court order authorizing the license holder to prohibit the client from leaving the facility; or

(2) that the client cannot leave the facility due to a court order authorizing the license holder to prohibit the client from leaving the facility.

(f) If the license holder prohibits a client from leaving the facility, the client's treatment plan must reflect this restriction.

Sec. 14. Minnesota Statutes 2020, section 253B.07, subdivision 2a, is amended to read:

Subd. 2a. **Petition originating from criminal proceedings.** (a) If criminal charges are pending against a defendant, the court shall order simultaneous competency and civil commitment examinations in accordance with Minnesota Rules of Criminal Procedure, rule 20.04, when the following conditions are met:

(1) the prosecutor or defense counsel doubts the defendant's competency and a motion is made challenging competency, or the court on its initiative raises the issue under section 611.42 or Minnesota Rules of Criminal Procedure, rule 20.01; and

(2) the prosecutor and defense counsel agree simultaneous examinations are appropriate.

No additional examination under subdivision 3 is required in a subsequent civil commitment proceeding unless a second examination is requested by defense counsel appointed following the filing of any petition for commitment.

(b) Only a court examiner may conduct an assessment as described in section 611.43 or Minnesota Rules of Criminal Procedure, rules 20.01, subdivision 4, and 20.02, subdivision 2.

(c) Where a county is ordered to consider civil commitment following a determination of incompetency under section 611.45 or Minnesota Rules of Criminal Procedure, rule 20.01, the county in which the criminal matter is pending is responsible to conduct prepetition screening and, if statutory conditions for commitment are satisfied, to file the commitment petition in that county. By agreement between county attorneys, prepetition screening and filing the petition may be handled in the county of financial responsibility or the county where the proposed patient is present.

(d) Following an acquittal of a person of a criminal charge under section 611.026, the petition shall be filed by the county attorney of the county in which the acquittal took place and the petition shall be filed with the court in which the acquittal took place, and that court shall be the committing court for purposes of this chapter. When a petition is filed pursuant to subdivision 2 with the court in which acquittal of a criminal charge took place, the court shall assign the judge before whom the acquittal took place to hear the commitment proceedings unless that judge is unavailable.

Sec. 15. Minnesota Statutes 2021 Supplement, section 254B.05, subdivision 1a, is amended to read:

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

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

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

(3) is not a jail or prison;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 16. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 56a, is amended to read:

Subd. 56a. **Officer-involved community-based care coordination.** (a) Medical assistance covers officer-involved community-based care coordination for an individual who:

(1) has screened positive for benefiting from treatment for a mental illness or substance use disorder using a tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in officer-involved community-based care coordination.

(b) Officer-involved community-based care coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) Officer-involved community-based care coordination must be provided by an individual who is an employee of or is under contract with a county, or is an employee of or under contract with an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law

93-638 as a 638 facility to provide officer-involved community-based care coordination and is qualified under one of the following criteria:

(1) a mental health professional;

(2) a clinical trainee qualified according to section 245I.04, subdivision 6, working under the treatment supervision of a mental health professional according to section 245I.06;

(3) a mental health practitioner qualified according to section 245I.04, subdivision 4, working under the treatment supervision of a mental health professional according to section 245I.06;

(4) a mental health certified peer specialist qualified according to section 245I.04, subdivision 10, working under the treatment supervision of a mental health professional according to section 245I.06;

(5) an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5; or

(6) a recovery peer qualified under section 245G.11, subdivision 8, working under the supervision of an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of officer-involved community-based care coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure that services and payments provided under officer-involved community-based care coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

~~(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for officer-involved community-based care coordination services shall be provided by the county providing the services, from sources other than federal funds or funds used to match other federal funds.~~

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later.

Sec. 17. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) Subject to federal approval, medical assistance covers medically necessary intensive behavioral health treatment services when the services are provided by a provider entity certified under and meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) Intensive behavioral health treatment services to children with mental illness residing in foster family settings or with legal guardians that comprise specific required service components provided in clauses (1) to (6) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional or a clinical trainee;

(2) crisis planning;

(3) individual, family, and group psychoeducation services provided by a mental health professional or a clinical trainee;

(4) clinical care consultation provided by a mental health professional or a clinical trainee;

(5) individual treatment plan development as defined in Minnesota Rules, part 9505.0371, subpart 7; and

(6) service delivery payment requirements as provided under subdivision 4.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 18. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 1a, is amended to read:

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

(a) "At risk" means the child has experienced severe difficulty in managing mental health and behavior in multiple settings; has received a diagnosis of mental illness within the past 180 days; and meets one of the following criteria:

(1) has previously been in a residential or inpatient mental health treatment program, including a program licensed under Minnesota Rules, chapter 2960, for mental health issues within the past six months;

(2) has a history of threatening harm to self or others and has actively engaged in self-harming or threatening behavior in the past 30 days;

(3) has experienced interventions from mental health service programs, social services, mobile crisis programs, or law enforcement, or experienced the use of seclusion and restraints in school, to maintain safety in the child's home, community, or school within the past 60 days; or

(4) has a history of repeated intervention from mental health programs, social services, mobile crisis programs, or law enforcement to maintain safety in the child's home, community, or school within the past 60 days.

~~(a)~~ (b) "Clinical care consultation" means communication from a treating clinician to other providers working with the same client to inform, inquire, and instruct regarding the client's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, including but not limited to the client's school, social services, day care, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the client and family.

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

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

~~(d)~~ (e) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

~~(e)~~ (f) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

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

~~(g)~~ (h) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

~~(h)~~ (i) "Foster care" has the meaning given in section 260C.007, subdivision 18.

~~(i)~~ (j) "Foster family setting" means the foster home in which the license holder resides.

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

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

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

~~(m)~~ (n) "Mental illness" has the meaning given in section 245I.02, subdivision 29.

~~(n)~~ (o) "Parent" has the meaning given in section 260C.007, subdivision 25.

~~(o)~~ (p) "Psychoeducation services" means information or demonstration provided to an individual, family, or group to explain, educate, and support the individual, family, or group in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

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

~~(q)~~ (r) "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

~~(r)~~ (s) "Trauma" has the meaning given in section 245I.02, subdivision 38.

~~(s)~~ (t) "Treatment supervision" means the supervision described under section 245I.06.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 19. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 2, is amended to read:

Subd. 2. **Determination of client eligibility.** An eligible recipient is an individual, from birth through age 20, who is currently placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the regulations established by a federally recognized Minnesota Tribe, or who is residing in the legal guardian's home and is at risk, and has received: (1) a standard diagnostic assessment within 180 days before the start of service that documents that intensive behavioral health treatment services are medically necessary ~~within a foster family setting~~ to ameliorate identified symptoms and functional impairments; and (2) a level of care assessment as defined in section 245I.02, subdivision 19, that demonstrates that the individual requires intensive intervention without 24-hour medical monitoring, and a functional assessment as defined in section 245I.02, subdivision 17. The level of care assessment and the functional assessment must include information gathered from the placing county, Tribe, or case manager.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 3, is amended to read:

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for children's intensive ~~children's mental health~~ behavioral health services ~~in a foster family setting~~ must be certified by the state ~~and have a service provision contract with a county board or a reservation tribal council~~ and must be able to demonstrate the ability to provide all of the services required in this section and meet the standards in chapter 245I, as required in section 245I.011, subdivision 5.

(b) For purposes of this section, a provider agency must be:

(1) a county-operated entity certified by the state;

(2) an Indian Health Services facility operated by a Tribe or Tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

(3) a noncounty entity.

(c) Certified providers that do not meet the service delivery standards required in this section shall be subject to a decertification process.

(d) For the purposes of this section, all services delivered to a client must be provided by a mental health professional or a clinical trainee.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 4, is amended to read:

Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under this section, a provider must develop and practice written policies and procedures for children's intensive ~~treatment in foster care~~ behavioral health services, consistent with subdivision 1, paragraph (b), and comply with the following requirements in paragraphs (b) to (n).

(b) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received. This information must be reviewed and incorporated into the standard diagnostic assessment and team consultation and treatment planning review process.

(c) Each client receiving treatment must be assessed for a trauma history, and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

(d) The level of care assessment as defined in section 245I.02, subdivision 19, and functional assessment as defined in section 245I.02, subdivision 17, must be updated at least every 90 days or prior to discharge from the service, whichever comes first.

(e) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and approved every 90 days using the team consultation and treatment planning process.

(f) Clinical care consultation must be provided in accordance with the client's individual treatment plan.

(g) Each client must have a crisis plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.

(h) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week. If the mental health professional, client, and family agree, service units may be temporarily reduced for a period of no more than 60 days in order to meet the needs of the client and family, or as part of transition or on a discharge plan to another service or level of care. The reasons for service reduction must be identified, documented, and included in the treatment plan. Billing and payment are prohibited for days on which no services are delivered and documented.

(i) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

(j) Treatment must be developmentally and culturally appropriate for the client.

(k) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects.

(l) Parents, siblings, foster parents, legal guardians, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

(m) Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

(n) In order for a provider to receive the daily per-client encounter rate, at least one of the services listed in subdivision 1, paragraph (b), clauses (1) to (3), must be provided. The services listed in subdivision 1, paragraph (b), clauses (4) and (5), may be included as part of the daily per-client encounter rate.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 6, is amended to read:

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of children's intensive ~~treatment in foster care~~ behavioral health services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section 256B.0624;

(7) transportation; and

(8) mental health certified family peer specialist services under section 256B.0616.

(b) Children receiving intensive ~~treatment in foster care~~ behavioral health services are not eligible for medical assistance reimbursement for the following services while receiving children's intensive ~~treatment in foster care~~ behavioral health services:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section 256B.0943;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph (l);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) room and board costs as defined in section 256I.03, subdivision 6.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 23. Minnesota Statutes 2020, section 256B.0946, subdivision 7, is amended to read:

Subd. 7. **Medical assistance payment and rate setting.** The commissioner shall establish a single daily per-client encounter rate for children's intensive ~~treatment in foster care~~ behavioral health services. The rate must be constructed to cover only eligible services delivered to an eligible recipient by an eligible provider, as prescribed in subdivision 1, paragraph (b).

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 24. Minnesota Statutes 2021 Supplement, section 256B.763, is amended to read:

256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.

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

(1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

(2) community mental health centers under section 256B.0625, subdivision 5; and

(3) mental health clinics certified under section 245I.20, or hospital outpatient psychiatric departments that are designated as essential community providers under section 62Q.19.

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

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

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

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

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

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

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

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

~~(h)~~ (g) For services described in paragraphs (b), ~~(e)~~ (d), and ~~(g)~~ (f) and rendered on or after July 1, 2017, payment rates for mental health clinics certified under section 245I.20 that are not designated as essential community providers under section 62Q.19 shall be equal to payment rates for mental health clinics certified under section 245I.20 that are designated as essential community providers under section 62Q.19. In order to receive increased payment rates under this paragraph, a provider must demonstrate a commitment to serve low-income and underserved populations by:

(1) charging for services on a sliding-fee schedule based on current poverty income guidelines; and

(2) not restricting access or services because of a client's financial limitation.

(h) For services identified under this section that are rendered by providers identified under this section, managed care plans and county-based purchasing plans shall reimburse the providers at a rate that is at least equal to the fee-for-service payment rate. The commissioner shall monitor the effect of this requirement on the rate of access to the services delivered by mental health providers.

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

Sec. 25. Minnesota Statutes 2020, section 480.182, is amended to read:

480.182 STATE ASSUMPTION OF CERTAIN COURT COSTS.

Notwithstanding any law to the contrary, the state courts will pay for the following court-related programs and costs:

(1) court interpreter program costs, including the costs of hiring court interpreters;

(2) guardian ad litem program and personnel costs;

(3) examination costs, not including hospitalization or treatment costs, for mental commitments and related proceedings under chapter 253B;

(4) examination costs under chapter 611 or rule 20 of the Rules of Criminal Procedure;

(5) in forma pauperis costs;

(6) costs for transcripts mandated by statute, except in appeal cases and postconviction cases handled by the Board of Public Defense;

(7) jury program costs; and

(8) witness fees and mileage fees specified in sections 253B.23, subdivision 1; 260B.152, subdivision 2; 260B.331, subdivision 3, clause (1); 260C.152, subdivision 2; 260C.331, subdivision 3, clause (1); 357.24; 357.32; and 627.02.

Sec. 26. **[611.40] APPLICABILITY.**

Notwithstanding Rules of Criminal Procedure, rule 20.01, sections 611.40 to 611.59 shall govern the proceedings for adults when competency to stand trial is at issue. This section does not apply to juvenile courts. A competency examination ordered under Rules of Criminal Procedure, rule 20.04, must follow the procedure in section 611.43.

Sec. 27. **[611.41] DEFINITIONS.**

Subdivision 1. **Definitions.** For the purposes of sections 611.40 to 611.58, the following terms have the meanings given.

Subd. 2. **Alternative program.** "Alternative program" means any mental health or substance use disorder treatment or program that is not a certified competency restoration program but may assist a defendant in attaining competency.

Subd. 3. **Cognitive impairment.** "Cognitive impairment" means a condition that impairs a person's memory, perception, communication, learning, or other ability to think. Cognitive impairment may be caused by any factor including traumatic, developmental, acquired, infectious, and degenerative processes.

Subd. 4. **Community-based treatment program.** "Community-based treatment program" means treatment and services provided at the community level, including but not limited to community support services programs as defined in section 245.462, subdivision 6; day treatment services as defined in section 245.462, subdivision 8; mental health crisis services as defined in section 245.462, subdivision 14c; outpatient services as defined in section 245.462, subdivision 21; residential treatment services as defined in section 245.462, subdivision 23; assertive community treatment services provided under section 256B.0622; adult rehabilitation mental health services provided under section 256B.0623; home and community-based waivers; and supportive housing. Community-based treatment program does not include services provided by a state-operated treatment program.

Subd. 5. **Competency restoration program.** "Competency restoration program" means a structured program of clinical and educational services that is certified and designed to identify and address barriers to a defendant's ability to understand the criminal proceedings, consult with counsel, and participate in the defense.

Subd. 6. **Competency restoration services.** "Competency restoration services" means education provided by certified individuals to defendants found incompetent to proceed. Educational services must use the curriculum certified by the State Competency Restoration Board as the foundation for delivering competency restoration education. Competency restoration services does not include housing assistance or programs, social services, or treatment that must be provided by a licensed professional including mental health treatment, substance use disorder treatment, or co-occurring disorders treatment.

Subd. 7. **Court examiner.** "Court examiner" means a person appointed to serve the court, and who is a physician or licensed psychologist who has a doctoral degree in psychology.

Subd. 8. **Forensic navigator.** "Forensic navigator" means a person who meets the certification and continuing education requirements under section 611.55, subdivision 4, and provides the services under section 611.55, subdivision 3.

Subd. 9. **Head of the program.** "Head of the program" means the head of the competency restoration program or the head of the facility or program where the defendant is being served.

Subd. 10. **Jail-based program.** "Jail-based program" means a competency restoration program that operates within a correctional facility licensed by the commissioner of corrections under section 241.021 that meets the capacity standards governing jail facilities. A jail-based program may not be granted a variance to exceed its operational capacity.

Subd. 11. **Locked treatment facility.** "Locked treatment facility" means a community-based treatment program, treatment facility, or state-operated treatment program that is locked and is licensed by the Department of Health or Department of Human Services.

Subd. 12. **Mental illness.** "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, or memory, that grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, that is manifested by instances of grossly disturbed behavior or faulty perceptions. Mental illness does not include disorders defined as cognitive impairments in subdivision 3; epilepsy; antisocial personality disorder; brief periods of intoxication caused by alcohol, drugs, or other mind-altering substances; or repetitive or problematic patterns of using any alcohol, drugs, or other mind-altering substances.

Subd. 13. **State-operated treatment program.** "State-operated treatment program" means any state-operated program, including community behavioral health hospitals, crisis centers, residential facilities, outpatient services, and other community-based services developed and operated by the state and under the control of the commissioner of human services, for a person who has a mental illness, developmental disability, or chemical dependency.

Subd. 14. **Suspend the criminal proceedings.** "Suspend the criminal proceedings" means nothing can be heard or decided on the merits of the criminal charges except that the court retains jurisdiction in all other matters, including but not limited to bail, conditions of release, probation conditions, no contact orders, and appointment of counsel.

Subd. 15. **Targeted misdemeanor.** "Targeted misdemeanor" has the meaning given in section 299C.10, subdivision 1, paragraph (e).

Subd. 16. **Treatment facility.** "Treatment facility" means a non-state-operated hospital, residential treatment provider, crisis residential withdrawal management center, or corporate foster care home qualified to provide care and treatment for persons who have a mental illness, developmental disability, or chemical dependency.

Sec. 28. **[611.42] COMPETENCY MOTION PROCEDURES.**

Subdivision 1. **Competency to stand trial.** A defendant is incompetent and shall not plead, be tried, or be sentenced if, due to a mental illness or cognitive impairment, the defendant lacks the ability to:

(1) rationally consult with counsel;

(2) understand the proceedings; or

(3) participate in the defense.

Subd. 2. **Waiver of counsel in competency proceedings.** (a) A defendant must not be allowed to waive counsel if the defendant lacks ability to:

(1) knowingly, voluntarily, and intelligently waive the right to counsel;

(2) appreciate the consequences of proceeding without counsel;

(3) comprehend the nature of the charge;

(4) comprehend the nature of the proceedings;

(5) comprehend the possible punishment; or

(6) comprehend any other matters essential to understanding the case.

(b) The court must not proceed under this law before a lawyer consults with the defendant and has an opportunity to be heard.

Subd. 3. **Competency motion.** (a) At any time, the prosecutor or defense counsel may make a motion challenging the defendant's competency, or the court on its initiative may raise the issue. The defendant's consent is not required to bring a competency motion. The motion shall be supported by specific facts but shall not include communications between the defendant and defense counsel if disclosure would violate attorney-client privilege. By bringing the motion, the defendant does not waive attorney-client privilege.

(b) If competency is at issue, the court shall appoint a forensic navigator to provide the forensic navigator services described in section 611.55 for the defendant, including development of a specific plan to identify appropriate housing and services if the defendant is released from custody or any charges are dismissed.

(c) In felony, gross misdemeanor, and targeted misdemeanor cases, if the court determines there is a reasonable basis to doubt the defendant's competence and there is probable cause for the charge, the court must suspend the criminal proceedings and order an examination of the defendant under section 611.43.

(d) In misdemeanor cases, other than cases involving a targeted misdemeanor, if the court determines there is a reasonable basis to doubt the defendant's competence and there is probable cause for the charge, the court must suspend the criminal proceedings. The court may order an examination of the defendant under section 611.43 if the examination is in the public interest. For purposes of this paragraph, an examination is in the public interest when it is necessary to assess whether the defendant has a cognitive impairment or mental illness; determine whether a defendant has the ability to access housing, food, income, disability verification, medications, and treatment for medical conditions; or whether a defendant has the ability to otherwise address any basic needs. The court shall order the forensic navigator to complete a bridge plan as described in section 611.55, subdivision 4, and submit it to the court. The court may dismiss the charge upon receipt of the bridge plan without holding a hearing unless either party objects.

Subd. 4. **Dismissal, referrals for services, and collaboration.** (a) Except as provided in this subdivision, when the court determines there is a reasonable basis to doubt the defendant's competence and orders an examination of the defendant, a forensic navigator must complete a bridge plan with the defendant as described in section 611.55, subdivision 4, submit the bridge plan to the court, and provide a written copy to the defendant before the court or prosecutor dismisses any charges based on a belief or finding that the defendant is incompetent.

(b) If for any reason a forensic navigator has not been appointed, the court must make every reasonable effort to coordinate with any resources available to the court and refer the defendant for possible assessment and social services, including but not limited to services for engagement under section 253B.041, before dismissing any charges based on a finding that the defendant is incompetent.

(c) If working with the forensic navigator or coordinating a referral to services would cause an unreasonable delay in the release of a defendant being held in custody, the court may release the defendant. If a defendant has not been engaged for assessment and referral before release, the court may coordinate with the forensic navigator or any resources available to the court to engage the defendant for up to 90 days after release.

(d) Courts may partner and collaborate with county social services, community-based programs, jails, and any other resource available to the court to provide referrals to services when a defendant's competency is at issue or a defendant has been found incompetent to proceed.

(e) Counsel for the defendant may bring a motion to dismiss the proceedings in the interest of justice at any stage of the proceedings.

Sec. 29. **[611.43] COMPETENCY EXAMINATION AND REPORT.**

Subdivision 1. **Competency examination.** (a) If the court orders an examination pursuant to section 611.42, subdivision 3, the court shall appoint a court examiner to examine the defendant and report to the court on the defendant's competency to proceed. A court examiner may obtain from court administration and review the report of any prior or subsequent examination under this section or under Minnesota Rules of Criminal Procedure, rule 20.

(b) If the defendant is not entitled to release, the court shall order the defendant to participate in an examination where the defendant is being held, or the court may order that the defendant be confined in a treatment facility, locked treatment facility, or a state-operated treatment facility until the examination is completed.

(c) If the defendant is entitled to release, the court shall order the defendant to appear for an examination. If the defendant fails to appear at an examination, the court may amend the conditions of release and bail pursuant to Minnesota Rules of Criminal Procedure, rule 6.

(d) A competency examination ordered under Minnesota Rules of Criminal Procedure, rule 20.04, shall proceed under subdivision 2.

Subd. 2. **Report of examination.** (a) The court-appointed examiner's written report shall be filed with the court and served on the prosecutor and defense counsel by the court. The report shall be filed no more than 30 days after the order for examination of a defendant in custody unless extended by the court for good cause. If the defendant is out of custody or confined in a noncorrectional program or treatment facility, the report shall be filed no more than 60 days after the order for examination, unless extended by the court for good cause. The report shall not include opinions concerning the defendant's mental condition at the time of the alleged offense or any statements made by the defendant regarding the alleged criminal conduct, unless necessary to support the examiner's opinion regarding competence or incompetence.

(b) The report shall include an evaluation of the defendant's mental health, cognition, and the factual basis for opinions about:

(1) any diagnoses made, and the results of any testing conducted with the defendant;

(2) the defendant's competency to stand trial;

(3) the level of care and education required for the defendant to attain, be restored to, or maintain competency;

(4) a recommendation of the least restrictive setting appropriate to meet the defendant's needs for restoration and immediate safety;

(5) the impact of any substance use disorder on the defendant, including the defendant's competency, and any recommendations for treatment;

(6) the likelihood the defendant will attain competency in the reasonably foreseeable future;

(7) whether the defendant poses a substantial likelihood of physical harm to self or others; and

(8) if the court examiner's opinion is that the defendant is incompetent to proceed, the report must include an opinion as to whether the defendant possesses capacity to make decisions regarding neuroleptic medication unless the examiner is unable to render an opinion on capacity. If the examiner is unable to render an opinion on capacity, the report must document the reasons why the examiner is unable to render that opinion.

(c) If the court examiner determines that the defendant presents an imminent risk of serious danger to another, is imminently suicidal, or otherwise needs emergency intervention, the examiner must promptly notify the court, prosecutor, defense counsel, and those responsible for the care and custody of the defendant.

(d) If the defendant appears for the examination but does not participate, the court examiner shall submit a report and, if sufficient information is available, may render an opinion on competency and an opinion as to whether the unwillingness to participate resulted from a mental illness, cognitive impairment, or other factors.

(e) If the court examiner determines the defendant would benefit from services for engagement in mental health treatment under section 253B.041 or any other referral to social services, the court examiner may recommend referral of the defendant to services where available.

Subd. 3. **Additional examination.** If either the prosecutor or defense counsel intends to retain an independent examiner, the party shall provide notice to the court and opposing counsel no later than ten days after the date of receipt of the court-appointed examiner's report. If an independent examiner is retained, the independent examiner's report shall be filed no more than 30 days after the date a party files notice of intent to retain an independent examiner, unless extended by the court for good cause.

Subd. 4. **Admissibility of defendant's statements.** When a defendant is examined under this section, any statement made by the defendant for the purpose of the examination and any evidence derived from the examination is admissible in the competency proceedings, but not in the criminal proceedings.

Sec. 30. **[611.44] CONTESTED HEARING PROCEDURES.**

Subdivision 1. **Request for hearing.** (a) The prosecutor or defense counsel may request a hearing on the court-appointed examiner's competency report by filing a written objection no later than ten days after the report is filed.

(b) A hearing shall be held as soon as possible but no longer than 30 days after the request, unless extended by agreement of the prosecutor and defense counsel, or by the court for good cause.

(c) If an independent court examiner is retained, the hearing may be continued up to 14 days after the date the independent court examiner's report is filed. The court may continue the hearing for good cause.

Subd. 2. **Competency hearing.** (a) The court may admit all relevant and reliable evidence at the competency hearing. The court-appointed examiner is considered the court's witness and may be called and questioned by the court, prosecutor, or defense counsel. The report of the court-appointed examiner shall be admitted into evidence without further foundation.

(b) Defense counsel may testify, subject to the prosecutor's cross-examination, but shall not violate attorney-client privilege. Testifying does not automatically disqualify defense counsel from continuing to represent the defendant. The court may inquire of defense counsel regarding the attorney-client relationship and the defendant's ability to communicate with counsel. The court shall not require counsel to divulge communications protected by attorney-client privilege, and the prosecutor shall not cross-examine defense counsel concerning responses to the court's inquiry.

Subd. 3. **Determination without hearing.** If neither party files an objection, the court shall determine the defendant's competency based on the reports of all examiners.

Subd. 4. **Burden of proof and decision.** The defendant is presumed incompetent unless the court finds by a preponderance of the evidence that the defendant is competent.

Sec. 31. **[611.45] COMPETENCY FINDINGS.**

Subdivision 1. **Findings.** (a) The court must rule on the defendant's competency to stand trial no more than 14 days after the examiner's report is submitted to the court. If there is a contested hearing, the court must rule no more than 30 days after the date of the hearing.

(b) If the court finds the defendant competent, the court shall enter an order and the criminal proceedings shall resume.

(c) If the court finds the defendant incompetent, the court shall enter a written order and suspend the criminal proceedings. The matter shall proceed under section 611.46.

Subd. 2. **Appeal.** Appeals under this chapter are governed by Minnesota Rules of Criminal Procedure, rule 28. A verbatim record shall be made in all competency proceedings.

Subd. 3. **Dismissal of criminal charge.** (a) If the court finds the defendant incompetent, and the charge is a misdemeanor other than a targeted misdemeanor, the charge must be dismissed.

(b) In targeted misdemeanor and gross misdemeanor cases, the charges must be dismissed 30 days after the date of the finding of incompetence, unless the prosecutor, before the expiration of the 30-day period, files a written notice of intent to prosecute when the defendant regains competency. If a notice has been filed and the charge is a targeted misdemeanor, charges must be dismissed within one year after the finding of incompetency. If a notice has been filed and the charge is a gross misdemeanor, charges must be dismissed within two years after the finding of incompetency.

(c) In felony cases, except as provided in paragraph (d), the charges must be dismissed three years after the date of the finding of incompetency, unless the prosecutor, before the expiration of the three-year period, files a written notice of intent to prosecute when the defendant regains competency. If a notice has been filed, charges must be dismissed within five years after the finding of incompetency or ten years if the maximum sentence for the crime with which the defendant is charged is ten years or more.

(d) The requirement that felony charges be dismissed under paragraph (c) does not apply if:

(1) the court orders continuing supervision pursuant to section 611.49, subdivision 3; or

(2) the defendant is charged with a violation of sections 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.2112 (criminal vehicular homicide); 609.2114, subdivision 1 (criminal vehicular operation, death to an unborn child); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.2664 (manslaughter of an unborn child in the first degree); or 609.2665 (manslaughter of an unborn child in the second degree); or a crime of violence as defined in section 624.712, subdivision 5, except for a violation of chapter 152.

Sec. 32. **[611.46] INCOMPETENT TO STAND TRIAL AND CONTINUING SUPERVISION.**

Subdivision 1. **Order to competency restoration.** (a) If the court finds the defendant incompetent and the charges have not been dismissed, the court shall order the defendant to participate in a competency restoration program to restore the defendant's competence. The court may order participation in a competency restoration program provided outside of a jail, a jail-based competency restoration program, or an alternative program. The court must determine the least-restrictive program appropriate to meet the defendant's needs and public safety. In making this determination, the court must consult with the forensic navigator and consider any recommendations of the court examiner. The court shall not order a defendant to participate in a jail-based program or a state-operated treatment program if the highest criminal charge is a misdemeanor or targeted misdemeanor.

(b) The court may only order the defendant to participate in competency restoration at an inpatient or residential treatment program under this section if the head of the treatment program determines that admission to the program is clinically appropriate and consents to the defendant's admission. The court may only order the defendant to participate in competency restoration at a state-operated treatment facility under this section if the commissioner of human services or a designee determines that admission of the defendant is clinically appropriate and consents to the defendant's admission. The court may require a certified competency program that qualifies as a locked facility or a state-operated treatment program to notify the court in writing of the basis for refusing consent for admission of the defendant in order to ensure transparency and maintain an accurate record. The court may not require personal appearance of any representative of a certified competency program. The court shall send a written request for notification to the locked facility or state-operated treatment program and the locked facility or state-operated treatment program shall provide a written response to the court within ten days of receipt of the court's request.

(c) If the defendant is confined in jail and has not received competency restoration services within 30 days of the finding of incompetency, the court shall review the case with input from the prosecutor and defense counsel and may:

(1) order the defendant to participate in an appropriate competency restoration program that takes place outside of a jail;

(2) conditionally release the defendant, including but not limited to conditions that the defendant participate in a competency restoration program when one becomes available and accessible;

(3) make a determination as to whether the defendant is likely to attain competency in the reasonably foreseeable future and proceed under section 611.49; or

(4) upon a motion, dismiss the charges in the interest of justice.

(d) Upon the order to a competency restoration program or alternative program, the court may order any hospital, treatment facility, or correctional facility that has provided care or supervision to the defendant in the previous two years to provide copies of the defendant's medical records to the competency restoration program or alternative program. This information shall be provided in a consistent and timely manner and pursuant to all applicable laws.

(e) If at any time the defendant refuses to participate in a competency restoration program or an alternative program, the head of the program shall notify the court and any entity responsible for supervision of the defendant.

(f) At any time, the head of the program may discharge the defendant from the program or facility. The head of the program must notify the court, prosecutor, defense counsel, and any entity responsible for the supervision of the defendant prior to any planned discharge. Absent emergency circumstances, this notification shall be made five days prior to the discharge if the defendant is not being discharged to jail or a correctional facility. Upon the receipt of notification of discharge or upon the request of either party in response to notification of discharge, the court may order that a defendant who is subject to bail or unmet conditions of release be returned to jail upon being discharged from the program or facility. If the court orders a defendant returned to jail, the court shall notify the parties and head of the program at least one day before the defendant's planned discharge, except in the event of an emergency discharge where one day notice is not possible. The court must hold a review hearing within seven days of the defendant's return to jail. The forensic navigator must be given notice of the hearing and be allowed to participate.

(g) If the defendant is discharged from the program or facility under emergency circumstances, notification of emergency discharge shall include a description of the emergency circumstances and may include a request for emergency transportation. The court shall make a determination on a request for emergency transportation within 24 hours. Nothing in this section prohibits a law enforcement agency from transporting a defendant pursuant to any other authority.

Subd. 2. **Supervision.** (a) Upon a finding of incompetency, if the defendant is entitled to release, the court must determine whether the defendant requires pretrial supervision. The court must weigh public safety risks against the defendant's interests in remaining free from supervision while presumed innocent in the criminal proceedings. The court may use a validated and equitable risk assessment tool to determine whether supervision is necessary.

(b) If the court determines that the defendant requires pretrial supervision, the court shall direct the forensic navigator to conduct pretrial supervision and report violations to the court. The forensic navigator shall be responsible for the supervision of the defendant until ordered otherwise by the court.

(c) Upon application by the prosecutor, the entity or its designee assigned to supervise the defendant, or court services alleging that the defendant violated a condition of release and is a risk to public safety, the court shall follow the procedures under Rules of Criminal Procedure, rule 6. Any hearing on the alleged violation of release conditions shall be held no more than 15 days after the date of issuance of a summons or within 72 hours if the defendant is apprehended on a warrant.

(d) If the court finds a violation, the court may revise the conditions of release and bail as appropriate pursuant to Minnesota Rules of Criminal Procedure, including but not limited to consideration of the defendant's need for ongoing access to a competency restoration program or alternative program under this section.

(e) The court must review conditions of release and bail on request of any party and may amend the conditions of release or make any other reasonable order upon receipt of information that the pretrial detention of a defendant has interfered with the defendant attaining competency.

Subd. 3. **Certified competency restoration programs; procedure.** (a) If the court orders a defendant to participate in a competency restoration program that takes place outside of a jail, or an alternative program that the court has determined is providing appropriate competency restoration services to the defendant, the court shall specify whether the program is a community-based treatment program or provided in a locked treatment facility.

(b) If the court finds that the defendant continues to be incompetent at a review hearing held after the initial determination of competency, the court must hold a review hearing pursuant to section 611.49 and consider any changes to the defendant's conditions of release or competency restoration programming to restore the defendant's competency in the least restrictive program appropriate.

(c) If the court orders the defendant to a locked treatment facility or jail-based program, the court must calculate the defendant's custody credit and cannot order the defendant to a locked treatment facility or jail-based program for a period that would cause the defendant's custody credit to exceed the maximum sentence for the underlying charge.

Subd. 4. **Jail-based competency restoration programs; procedure.** (a) A defendant is eligible to participate in a jail-based competency restoration program when the underlying charge is a gross misdemeanor or felony and either:

(1) the defendant has been found incompetent, the defendant has not met the conditions of release ordered pursuant to rule 6.02 of Minnesota Rules of Criminal Procedure, including posting bail, and either a court-appointed examiner has recommended jail-based competency restoration as the least restrictive setting to meet the person's needs, or the court finds that after a reasonable effort by the forensic navigator, there has not been consent by another secure setting to the defendant's placement; or

(2) the defendant is in custody and is ordered to a certified competency restoration program that takes place outside of a jail, a jail-based competency restoration program is available within a reasonable distance to the county where the defendant is being held, and the court ordered a time-limited placement in a jail-based program until transfer to a certified competency restoration program that takes place outside of a jail.

(b) A defendant may not be ordered to participate in a jail-based competency restoration program for more than 90 days without a review hearing. If after 90 days of the order to a jail-based program the defendant has not attained competency, the court must review the case with input from the prosecutor and defense counsel and may:

(1) order the defendant to participate in an appropriate certified competency restoration program that takes place outside of a locked facility; or

(2) determine whether, after a reasonable effort by the forensic navigator, there is consent to the defendant's placement by another locked facility. If court determines that a locked facility is the least restrictive program appropriate and no appropriate locked facility is available, it may order the defendant to the jail-based program for an additional 90 days.

(c) Nothing in this section prohibits the court from ordering the defendant transferred to a certified competency restoration program that takes place outside of a jail if the court determines that transition is appropriate, or the defendant satisfies the conditions of release or bail. Before the defendant is transitioned to a certified competency restoration program that takes place outside of a jail or an alternative program, the court shall notify the prosecutor and the defense counsel, and the provisions of subdivision 2 shall apply.

(d) The court may require a certified competency program that qualifies as a locked facility to notify the court in writing of the basis for refusing consent of the defendant in order to ensure transparency and maintain an accurate record. The court may not require personal appearance of any representative of a certified competency program.

Subd. 5. **Alternative programs; procedure.** (a) A defendant is eligible to participate in an alternative program if the defendant has been found incompetent, the defendant is entitled to release, and a certified competency restoration program outside of a jail is not available.

(b) As soon as the forensic navigator has reason to believe that no certified competency restoration program outside of a jail will be available within a reasonable time, the forensic navigator shall determine if there are available alternative programs that are likely to assist the defendant in attaining competency. Upon notification by the forensic navigator, the court may order the defendant to participate in an appropriate alternative program and notify the prosecutor and the defense counsel.

(c) If at any time while the defendant is participating in an alternative program, an appropriate certified competency restoration program that takes place outside of a jail becomes available, the forensic navigator must notify the court. The court must notify the prosecutor and the defense counsel and must order the defendant to participate in an appropriate certified competency restoration program, unless the court determines that the defendant is receiving appropriate competency restoration services in the alternative program. If appropriate and in the public interest, the court may order the defendant to participate in the certified competency restoration program and an alternative program.

(d) At any time, the head of the alternative program or the forensic navigator may notify the court that the defendant is receiving appropriate competency restoration services in the alternative program, and recommend that remaining in the alternative program is in the best interest of the defendant and the defendant's progress in attaining competency. The court may order the defendant to continue programming in the alternative program and proceed under subdivision 3.

(e) If after 90 days of the order to an alternative program the defendant has not attained competency and the defendant is not participating in a certified competency restoration program, the court must hold a review hearing pursuant to section 611.49.

Subd. 6. **Reporting to the court.** (a) The court examiner must provide an updated report to the court at least once every six months, unless the court and the parties agree to a longer period that is not more than 12 months, as to the defendant's competency and a description of the efforts made to restore the defendant to competency.

(b) At any time, the head of the program may notify the court and recommend that a court examiner provide an updated competency examination and report.

(c) The court shall furnish copies of the report to the prosecutor, defense counsel, and the facility or program where the defendant is being served.

(d) The report may make recommendations for continued services to ensure continued competency. If the defendant is found guilty, these recommendations may be considered by the court in imposing a sentence, including any conditions of probation.

Subd. 7. **Contested hearings.** The prosecutor or defense counsel may request a hearing on the court examiner's competency opinion by filing written objections to the competency report no later than ten days after receiving the report. All parties are entitled to notice before the hearing. If the hearing is held, it shall conform with the procedures of section 611.44.

Subd. 8. **Competency determination.** (a) The court must determine whether the defendant is competent based on the updated report from the court examiner no more than 14 days after receiving the report.

(b) If the court finds the defendant competent, the court must enter an order and the criminal proceedings shall resume.

(c) If the court finds the defendant incompetent, the court may order the defendant to continue participating in a program as provided in this section.

(d) Counsel for the defendant may bring a motion to dismiss the proceedings in the interest of justice at any stage of the proceedings.

Sec. 33. **[611.47] ADMINISTRATION OF MEDICATION.**

Subdivision 1. **Motion.** When a court finds that a defendant is incompetent or any time thereafter, upon the motion of the prosecutor or treating medical provider, the court shall hear and determine whether the defendant lacks capacity to make decisions regarding the administration of neuroleptic medication.

Subd. 2. **Certification report.** (a) If the defendant's treating medical practitioner is of the opinion that the defendant lacks capacity to make decisions regarding neuroleptic medication, the treating medical practitioner shall certify in a report that the lack of capacity exists and which conditions under subdivision 3 are applicable. The certification report shall contain an assessment of the current mental status of the defendant and the opinion of the treating medical practitioner that involuntary neuroleptic medication has become medically necessary and appropriate under subdivision 3, paragraph (b), clause (1) or (2), or in the patient's best medical interest under subdivision 3, paragraph (b), clause (3). The certification report shall be filed with the court when a motion for a hearing is made under this section.

(b) A certification report made pursuant to this section shall include a description of the neuroleptic medication proposed to be administered to the defendant and its likely effects and side effects, including effects on the defendant's condition or behavior that would affect the defendant's ability to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a reasonable manner.

(c) Any defendant subject to an order under subdivision 3 of this section or the state may request review of that order.

(d) The court may appoint a court examiner to examine the defendant and report to the court and parties as to whether the defendant lacks capacity to make decisions regarding the administration of neuroleptic medication. If the patient refuses to participate in an examination, the court examiner may rely on the patient's clinically relevant medical records in reaching an opinion.

(e) The defendant is entitled to a second court examiner under this section, if requested by the defendant.

Subd. 3. **Determination.** (a) The court shall consider opinions in the reports prepared under subdivision 2 as applicable to the issue of whether the defendant lacks capacity to make decisions regarding the administration of neuroleptic medication and shall proceed under paragraph (b).

(b) The court shall hear and determine whether any of the following is true:

(1) the defendant lacks capacity to make decisions regarding neuroleptic medication, as defined in section 253B.092, subdivision 5, the defendant's mental illness requires medical treatment with neuroleptic medication, and, if the defendant's mental illness is not treated with neuroleptic medication, it is probable that serious harm to the physical or mental health of the patient will result. Probability of serious harm to the physical or mental health of the defendant requires evidence that the defendant is presently suffering adverse effects to the defendant's physical or mental health, or the defendant has previously suffered these effects as a result of a mental illness and the defendant's condition is substantially deteriorating or likely to deteriorate without administration of neuroleptic medication. The fact that a defendant has a diagnosis of a mental illness does not alone establish probability of serious harm to the physical or mental health of the defendant;

(2) the defendant lacks capacity to make decisions regarding neuroleptic medication, as defined in section 253B.092, subdivision 5, neuroleptic medication is medically necessary, and the defendant is a danger to others, in that the defendant has inflicted, attempted to inflict, or made a serious threat of inflicting substantial bodily harm on another while in custody, or the defendant had inflicted, attempted to inflict, or made a serious threat of inflicting substantial bodily harm on another that resulted in being taken into custody, and the defendant presents, as a result of mental illness or cognitive impairment, a demonstrated danger of inflicting substantial bodily harm on others. Demonstrated danger may be based on an assessment of the defendant's present mental condition, including a consideration of past behavior of the defendant and other relevant information; or

(3) the defendant lacks capacity to make decisions regarding neuroleptic medication, as defined in section 253B.092, subdivision 5, and the state has shown by clear and convincing evidence that:

(i) the state has charged the defendant with a serious crime against the person or property;

(ii) involuntary administration of neuroleptic medication is substantially likely to render the defendant competent to stand trial;

(iii) the medication is unlikely to have side effects that interfere with the defendant's ability to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a reasonable manner;

(iv) less intrusive treatments are unlikely to have substantially the same results and involuntary medication is necessary; and

(v) neuroleptic medication is in the patient's best medical interest in light of the patient's medical condition.

(c) In ruling on a petition under this section, the court shall also take into consideration any evidence on:

(1) what the patient would choose to do in the situation if the patient had capacity, including evidence such as a durable power of attorney for health care under chapter 145C;

(2) the defendant's family, community, moral, religious, and social values;

(3) the medical risks, benefits, and alternatives to the proposed treatment;

(4) past efficacy and any extenuating circumstances of past use of neuroleptic medications; and

(5) any other relevant factors.

(d) In determining whether the defendant possesses capacity to consent to neuroleptic medications, the court:

(1) must apply a rebuttable presumption that a defendant has the capacity to make decisions regarding administration of neuroleptic medication;

(2) must find that a defendant has the capacity to make decisions regarding the administration of neuroleptic medication if the defendant:

(i) has an awareness of the nature of the defendant's situation and the possible consequences of refusing treatment with neuroleptic medications;

(ii) has an understanding of treatment with neuroleptic medications and the risks, benefits, and alternatives; and

(iii) communicates verbally or nonverbally a clear choice regarding treatment with neuroleptic medications that is a reasoned one not based on a symptom of the defendant's mental illness, even though it may not be in the defendant's best interests; and

(3) must not conclude that a defendant's decision is unreasonable based solely on a disagreement with the medical practitioner's recommendation.

(e) If consideration of the evidence presented on the factors in paragraph (c) weighs in favor of authorizing involuntary administration of neuroleptic medication, and the court finds any of the conditions described in paragraph (b) to be true, the court shall issue an order authorizing involuntary administration of neuroleptic medication to the defendant when and as prescribed by the defendant's medical practitioner, including administration by a treatment facility or correctional facility. The court order shall specify which medications are authorized and may limit the maximum dosage of neuroleptic medication that may be administered. The order shall be valid for no more than one year. An order may be renewed by filing another petition under this section and following the process in this section. The order shall terminate no later than the closure of the criminal case in which it is issued. The court shall not order involuntary administration of neuroleptic medication under paragraph (b), clause (3), unless the court has first found that the defendant does not meet the criteria for involuntary administration of neuroleptic medication under paragraph (b), clause (1), and does not meet the criteria under paragraph (b), clause (2).

(f) A copy of the order must be given to the defendant, the defendant's attorney, the county attorney, and the treatment facility or correctional facility where the defendant is being served. The treatment facility, correctional facility, or treating medical practitioner may not begin administration of the neuroleptic medication until it notifies the patient of the court's order authorizing the treatment.

Subd. 4. **Emergency administration.** A treating medical practitioner may administer neuroleptic medication to a defendant who does not have capacity to make a decision regarding administration of the medication if the defendant is in an emergency situation. Medication may be administered for so long as the emergency continues to exist, up to 14 days, if the treating medical practitioner determines that the medication is necessary to prevent serious, immediate physical harm to the patient or to others. If a request for authorization to administer medication is made to the court within the 14 days, the treating medical practitioner may continue the medication through the date of the first court hearing, if the emergency continues to exist. The treating medical practitioner shall document the emergency in the defendant's medical record in specific behavioral terms.

Subd. 5. **Administration without judicial review.** Neuroleptic medications may be administered without judicial review under this subdivision if:

(1) the defendant has been prescribed neuroleptic medication prior to admission to a facility or program, but lacks the present capacity to consent to the administration of that neuroleptic medication; continued administration of the medication is in the patient's best interest; and the defendant does not refuse administration of the medication. In this situation, the previously prescribed neuroleptic medication may be continued for up to 14 days while the treating medical practitioner is requesting a court order authorizing administering neuroleptic medication or an amendment to a current court order authorizing administration of neuroleptic medication. If the treating medical practitioner requests a court order under this section within 14 days, the treating medical practitioner may continue administering the medication to the patient through the hearing date or until the court otherwise issues an order; or

(2) the defendant does not have the present capacity to consent to the administration of neuroleptic medication, but prepared a health care power of attorney or a health care directive under chapter 145C requesting treatment or authorizing an agent or proxy to request treatment, and the agent or proxy has requested the treatment.

Subd. 6. **Defendants with capacity to make informed decision.** If the court finds that the defendant has the capacity to decide whether to take neuroleptic medication, a facility or program may not administer medication without the patient's informed written consent or without the declaration of an emergency, or until further review by the court.

Subd. 7. **Procedure when patient defendant refuses medication.** If physical force is required to administer the neuroleptic medication, the facility or program may only use injectable medications. If physical force is needed to administer the medication, medication may only be administered in a setting where the person's condition can be reassessed and medical personnel qualified to administer medication are available, including in the community or a correctional facility. The facility or program may not use a nasogastric tube to administer neuroleptic medication involuntarily.

Sec. 34. **[611.48] REVIEW HEARINGS.**

The prosecutor or defense counsel may apply to the court for a hearing to review the defendant's competency restoration programming. All parties are entitled to notice before the hearing. The hearing shall be held no later than 30 days after the date of the request, unless extended upon agreement of the prosecutor and defense counsel or by the court for good cause.

Sec. 35. **[611.49] LIKELIHOOD TO ATTAIN COMPETENCY.**

Subdivision 1. **Applicability.** (a) The court may hold a hearing on its own initiative or upon request of either party to determine whether the defendant is likely to attain competency in the foreseeable future when the most recent court examiner's report states that the defendant is unlikely to attain competency in the foreseeable future, and either:

(1) defendant has not been restored to competence after participating and cooperating with court ordered competency restoration programming for at least one year; or

(2) the defendant has not received timely competency restoration services under section 611.46 after one year.

(b) The court cannot find a defendant unlikely to attain competency based upon a defendant's refusal to cooperate with or remain at a certified competency program or cooperate with an examination.

(c) The parties are entitled to 30 days of notice prior to the hearing and, unless the parties agree to a longer time period, the court must determine within 30 days after the hearing whether there is a substantial probability that the defendant will attain competency within the foreseeable future.

Subd. 2. **Procedure.** (a) If the court finds that there is a substantial probability that the defendant will attain competency within the reasonably foreseeable future, the court shall find the defendant incompetent and proceed under section 611.46.

(b) If the court finds that there is not a substantial probability the defendant will attain competency within the reasonably foreseeable future, the court may not order the defendant to participate in or continue to participate in a competency restoration program in a locked treatment facility. The court must release the defendant from any custody holds pertaining to the underlying criminal case and require the forensic navigator to develop a bridge plan.

(c) If the court finds that there is not a substantial probability the defendant will attain competency within the foreseeable future, the court may issue an order to the designated agency in the county of financial responsibility or the county where the defendant is present to conduct a prepetition screening pursuant to section 253B.07.

(d) If a hearing is held under this subdivision and the criteria pursuant to subdivision 1, paragraphs (a) and (b) are satisfied, a party attempting to demonstrate that there is a substantial probability that the defendant will attain competency within the foreseeable future must prove by a preponderance of the evidence.

(e) If the court finds that there is not a substantial probability that the defendant will attain competency within the foreseeable future, the court must dismiss the case unless:

(1) the person is charged with a violation of section 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.2112 (criminal vehicular homicide); 609.2114, subdivision 1 (criminal vehicular operation, death to an unborn child); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.2664 (manslaughter of an unborn child in the first degree); or 609.2665 (manslaughter of an unborn child in the second degree); or a crime of violence as defined in section 624.712, subdivision 5, except for a violation of chapter 152; or

(2) there is a showing of a danger to public safety if the matter is dismissed.

(f) If the court does not dismiss the charges, the court must order continued supervision under subdivision 3.

Subd. 3. **Continued supervision.** (a) If the court orders the continued supervision of a defendant, any party may request a hearing on the issue of continued supervision by filing a notice no more than ten days after the order for continued supervision.

(b) When continued supervision is ordered, the court must identify the supervisory agency responsible for the supervision of the defendant, including but not limited to directing a forensic navigator as the responsible entity.

(c) Notwithstanding the reporting requirements of section 611.46, subdivision 6, the court examiner must provide an updated report to the court one year after the initial order for continued supervision as to the defendant's competency and a description of the efforts made to restore the defendant to competency. The court shall hold a review hearing within 30 days of receipt of the report.

(d) If continued supervision is ordered at the review hearing under paragraph (c), the court must set a date for a review hearing no later than two years after the most recent order for continuing supervision. The court must order review of the defendant's status, including an updated competency examination and report by the court examiner. The court examiner must submit the updated report to the court. At the review hearing, the court must determine if the defendant has attained competency, whether there is a substantial probability that the defendant will attain competency within the foreseeable future, and whether the absence of continuing supervision of the defendant is a danger to public safety. Notwithstanding subdivision 2, paragraph (e), the court may hear any motions to dismiss pursuant to the interest of justice at the review hearing.

(e) The court may not order continued supervision for more than ten years unless the defendant is charged with a violation of section 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.2112 (criminal vehicular homicide); 609.2114, subdivision 1 (criminal vehicular operation, death to an unborn child); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.2664 (manslaughter of an unborn child in the first degree); or 609.2665 (manslaughter of an unborn child in the second degree); or a crime of violence as defined in section 624.712, subdivision 5, except for a violation of chapter 152.

(f) At any time, the head of the program may discharge the defendant from the program or facility. The head of the program must notify the court, prosecutor, defense counsel, forensic navigator, and any entity responsible for the supervision of the defendant prior to any planned discharge. Absent emergency circumstances, this notification shall be made five days prior to the discharge. If the defendant is discharged from the program or facility under emergency circumstances, notification of emergency discharge shall include a description of the emergency circumstances and may include a request for emergency transportation. The court shall make a determination on a request for emergency transportation within 24 hours. Nothing in this section prohibits a law enforcement agency from transporting a defendant pursuant to any other authority.

(g) The court may provide, partner, or contract for pretrial supervision services or continued supervision if the defendant is found incompetent and unlikely to attain competency in the foreseeable future.

Sec. 36. **[611.50] DEFENDANT'S PARTICIPATION AND CONDUCT OF HEARINGS.**

Subdivision 1. **Place of hearing.** Upon request of the prosecutor, defense counsel, or head of the treatment facility and approval by the court and the treatment facility, a hearing may be held at a treatment facility. A hearing may be conducted by interactive video conference consistent with the Minnesota Rules of Criminal Procedure.

Subd. 2. **Absence permitted.** When a medical professional treating the defendant submits a written report stating that participating in a hearing under this statute is not in the best interest of the defendant and would be detrimental to the defendant's mental or physical health, the court shall notify the defense counsel and the defendant and allow the hearing to proceed without the defendant's participation.

Subd. 3. **Disruption of hearing.** At any hearing required under this section, the court, on its motion or on the motion of any party, may exclude or excuse a defendant who is seriously disruptive, refuses to participate, or who is incapable of comprehending and participating in the proceedings. In such instances, the court shall, with specificity on the record, state the behavior of the defendant or other circumstances which justify proceeding in the absence of the defendant.

Subd. 4. **Issues not requiring defendant's participation.** The defendant's incompetence does not preclude the defense counsel from making an objection or defense before trial that can be fairly determined without the defendant's participation.

Sec. 37. **[611.51] CREDIT FOR CONFINEMENT.**

If the defendant is convicted, any time spent confined in a secured setting while being assessed and restored to competency must be credited as time served.

Sec. 38. **[611.55] FORENSIC NAVIGATOR SERVICES.**

Subdivision 1. **Definition.** As used in this section, "board" means the State Competency Restoration Board established in section 611.56.

Subd. 2. **Availability of forensic navigator services.** The board must provide or contract for enough forensic navigator services to meet the needs of adult defendants in each judicial district who are found incompetent to proceed.

Subd. 3. **Duties.** (a) Forensic navigators shall be impartial in all legal matters relating to the criminal case. Nothing shall be construed to permit the forensic navigator to provide legal counsel as a representative of the court, prosecutor, or defense counsel. Forensic navigators shall be required to report compliance and noncompliance with pretrial supervision and any orders of the court.

(b) Forensic navigators shall provide services to assist defendants with mental illnesses and cognitive impairments. Services may include, but are not limited to:

(1) developing bridge plans;

(2) assisting defendants in participating in court-ordered examinations and hearings;

(3) coordinating timely placement in court-ordered competency restoration programs;

(4) providing competency restoration education;

(5) reporting to the court on the progress of defendants found incompetent to stand trial;

(6) providing coordinating services to help defendants access needed mental health, medical, housing, financial, social, transportation, precharge and pretrial diversion, and other necessary services provided by other programs and community service providers;

(7) communicating with and offering supportive resources to defendants and family members of defendants; and

(8) providing consultation and education to court officials on emerging issues and innovations in serving defendants with mental illnesses in the court system.

(c) If a defendant's charges are dismissed, the appointed forensic navigator may continue assertive outreach with the individual for up to 90 days to assist in attaining stability in the community.

Subd. 4. **Bridge plans.** (a) The forensic navigator must prepare bridge plans with the defendant and submit them to the court. Bridge plans must be submitted before the time the court makes a competency finding pursuant to section 611.45. The bridge plan must include:

(1) a confirmed housing address the defendant will use upon release, including but not limited to emergency shelters;

(2) if possible, the dates, times, locations, and contact information for any appointments made to further coordinate support and assistance for the defendant in the community, including but not limited to mental health and substance use disorder treatment, or a list of referrals to services; and

(3) any other referrals, resources, or recommendations the forensic navigator or court deems necessary.

(b) Bridge plans and any supporting records or other data submitted with those plans are not accessible to the public.

Sec. 39. **[611.56] STATE COMPETENCY RESTORATION BOARD.**

Subdivision 1. **Establishment; membership.** (a) The State Competency Restoration Board is established in the judicial branch. The board is not subject to the administrative control of the judiciary. The board shall consist of seven members, including:

(1) three members appointed by the supreme court, at least one of whom must be a defense attorney, one a county attorney, and one public member; and

(2) four members appointed by the governor, at least one of whom must be a mental health professional with experience in competency restoration.

(b) The appointing authorities may not appoint an active judge to be a member of the board, but may appoint a retired judge.

(c) All members must demonstrate an interest in maintaining a high quality, independent forensic navigator program and a thorough process for certification of competency restoration programs. Members shall be familiar with the Minnesota Rules of Criminal Procedure, particularly rule 20; chapter 253B; and sections 611.40 to 611.59. Following the initial terms of appointment, at least one member appointed by the supreme court must have previous experience working as a forensic navigator. At least three members of the board shall live outside the First, Second, Fourth, and Tenth Judicial Districts. The terms, compensation, and removal of members shall be as provided in section 15.0575. The members shall elect the chair from among the membership for a term of two years.

Subd. 2. **Duties and responsibilities.** (a) The board shall create and administer a statewide, independent competency restoration system that certifies competency restoration programs and uses forensic navigators to promote prevention and diversion of people with mental illnesses and cognitive impairments from entering the legal system, support defendants with mental illness and cognitive impairments, support defendants in the competency process, and assist courts and partners in coordinating competency restoration services.

(b) The board shall:

(1) approve and recommend to the legislature a budget for the board and the forensic navigator program;

(2) establish procedures for distribution of funding under this section to the forensic navigator program;

(3) establish forensic navigator standards, administrative policies, procedures, and rules consistent with statute, rules of court, and laws that affect a forensic navigator's work;

(4) establish certification requirements for competency restoration programs; and

(5) carry out the programs under sections 611.57, 611.58, and 611.59.

(c) The board may:

(1) adopt standards, policies, or procedures necessary to ensure quality assistance for defendants found incompetent to stand trial and charged with a felony, gross misdemeanor, or targeted misdemeanor, or for defendants found incompetent to stand trial who have recurring incidents;

(2) establish district forensic navigator offices as provided in subdivision 4; and

(3) propose statutory changes to the legislature and rule changes to the supreme court that would facilitate the effective operation of the forensic navigator program.

Subd. 3. **Administrator.** The board shall appoint a program administrator who serves at the pleasure of the board. The program administrator shall attend all meetings of the board and the Certification Advisory Committee, but may not vote, and shall:

(1) carry out all administrative functions necessary for the efficient and effective operation of the board and the program, including but not limited to hiring, supervising, and disciplining program staff and forensic navigators;

(2) implement, as necessary, resolutions, standards, rules, regulations, and policies of the board;

(3) keep the board fully advised as to its financial condition, and prepare and submit to the board the annual program and budget and other financial information as requested by the board;

(4) recommend to the board the adoption of rules and regulations necessary for the efficient operation of the board and the program; and

(5) perform other duties prescribed by the board.

Subd. 4. **District offices.** The board may establish district forensic navigator offices in counties, judicial districts, or other areas where the number of defendants receiving competency restoration services requires more than one full-time forensic navigator and establishment of an office is fiscally responsible and in the best interest of defendants found to be incompetent.

Subd. 5. **Administration.** The board may contract with the Office of State Court Administrator for administrative support services for the fiscal years following fiscal year 2022.

Subd. 6. **Fees and costs; civil actions on contested case.** Sections 15.039 and 15.471 to 15.474 apply to the State Competency Restoration Board.

Subd. 7. **Access to records.** Access to records of the board is subject to the Rules of Public Access for Records of the Judicial Branch. The board may propose amendments for supreme court consideration.

Sec. 40. **[611.57] CERTIFICATION ADVISORY COMMITTEE.**

Subdivision 1. **Establishment.** The Certification Advisory Committee is established to provide the State Competency Restoration Board with advice and expertise related to the certification of competency restoration programs, including jail-based programs.

Subd. 2. **Membership.** (a) The Certification Advisory Committee consists of the following members:

(1) a mental health professional, as defined in section 245I.02, subdivision 27, with community behavioral health experience, appointed by the governor;

(2) a board-certified forensic psychiatrist with experience in competency evaluations, providing competency restoration services, or both, appointed by the governor;

(3) a board-certified forensic psychologist with experience in competency evaluations, providing competency restoration services, or both, appointed by the governor;

(4) the president of the Minnesota Corrections Association or a designee;

(5) the direct care and treatment deputy commissioner or a designee;

(6) the president of the Minnesota Association of County Social Service Administrators or a designee;

(7) the president of the Minnesota Association of Community Mental Health Providers or a designee;

(8) the president of the Minnesota Sheriffs' Association or a designee; and

(9) the executive director of the National Alliance on Mental Illness Minnesota or a designee.

(b) Members of the advisory committee serve without compensation and at the pleasure of the appointing authority. Vacancies shall be filled by the appointing authority consistent with the qualifications of the vacating member required by this subdivision.

Subd. 3. **Meetings.** At its first meeting, the advisory committee shall elect a chair and may elect a vice-chair. The advisory committee shall meet at least monthly or upon the call the chair. The advisory committee shall meet sufficiently enough to accomplish the tasks identified in this section.

Subd. 4. **Duties.** The Certification Advisory Committee shall consult with the Department of Human Services, the Department of Health, and the Department of Corrections; make recommendations to the State Competency Restoration Board regarding competency restoration curriculum, certification requirements for competency restoration programs including jail-based programs, and certification of individuals to provide competency restoration services; and provide information and recommendations on other issues relevant to competency restoration as requested by the board.

Sec. 41. **[611.58] COMPETENCY RESTORATION CURRICULUM AND CERTIFICATION.**

Subdivision 1. **Curriculum.** (a) By January 1, 2023, the board must recommend a competency restoration curriculum to educate and assist defendants found incompetent in attaining the ability to:

(1) rationally consult with counsel;

(2) understand the proceedings; and

(3) participate in the defense.

(b) The curriculum must be flexible enough to be delivered in community and correctional settings by individuals with various levels of education and qualifications, including but not limited to professionals in criminal justice, health care, mental health care, and social services. The board must review and update the curriculum as needed.

Subd. 2. **Certification and distribution.** By January 1, 2023, the board must develop a process for certifying individuals to deliver the competency restoration curriculum and make the curriculum available to every certified competency restoration program and forensic navigator in the state. Each competency restoration program in the state must use the competency restoration curriculum under this section as the foundation for delivering competency restoration education and must not substantially alter the content.

Sec. 42. **[611.59] COMPETENCY RESTORATION PROGRAMS.**

Subdivision 1. **Availability and certification.** The board must provide or contract for enough competency restoration services to meet the needs of adult defendants in each judicial district who are found incompetent to proceed and do not have access to competency restoration services as a part of any other programming in which they are ordered to participate. The board, in consultation with the Certification Advisory Committee, shall develop procedures to certify that the standards in this section are met, including procedures for regular recertification of competency restoration programs. The board shall maintain a list of certified competency restoration programs on the board's website to be updated at least once every year.

Subd. 2. **Competency restoration provider standards.** Except for jail-based programs, a competency restoration provider must:

(1) be able to provide the appropriate mental health or substance use disorder treatment ordered by the court, including but not limited to treatment in inpatient, residential, and home-based settings;

(2) ensure that competency restoration education certified by the board is provided to defendants and that regular assessments of defendants' progress in attaining competency are documented;

(3) designate a head of the program knowledgeable in the processes and requirements of the competency to stand trial procedures; and

(4) develop staff procedures or designate a person responsible to ensure timely communication with the court system.

Subd. 3. **Jail-based competency restoration standards.** Jail-based competency restoration programs must be housed in correctional facilities licensed by the Department of Corrections under section 241.021 and must:

(1) have a designated program director who meets minimum qualification standards set by the board, including understanding the requirements of competency to stand trial procedures;

(2) provide minimum mental health services including:

(i) multidisciplinary staff sufficient to monitor defendants and provide timely assessments, treatment, and referrals as needed, including at least one medical professional licensed to prescribe psychiatric medication;

(ii) prescribing, dispensing, and administering any medication deemed clinically appropriate by qualified medical professionals; and

(iii) policies and procedures for the administration of involuntary medication;

(3) ensure that competency restoration education certified by the board is provided to defendants and regular assessments of defendants' progress in attaining competency to stand trial are documented;

(4) develop staff procedures or designate a person responsible to ensure timely communication with the court system; and

(5) designate a space in the correctional facility for the program.

Subd. 4. **Program evaluations.** (a) The board shall collect the following data:

(1) the total number of competency examinations ordered in each judicial district separated by county;

(2) the age, race, and number of unique defendants and for whom at least one competency examination was ordered in each judicial district separated by county;

(3) the age, race, and number of unique defendants found incompetent at least once in each judicial district separated by county; and

(4) all available data on the level of charge and adjudication of cases with a defendant found incompetent and whether a forensic navigator was assigned to the case.

(b) By February 15 of each year, the board must report to the legislative committees and divisions with jurisdiction over human services, public safety, and the judiciary on the data collected under this subdivision and may include recommendations for statutory or funding changes related to competency restoration.

Sec. 43. Laws 2021, First Special Session chapter 7, article 17, section 12, is amended to read:

Sec. 12. **~~PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY AND CHILD AND ADOLESCENT~~ ADULT AND CHILDREN'S MOBILE TRANSITION ~~UNIT~~ UNITS.**

(a) This act includes $2,500,000 in fiscal year 2022 and $2,500,000 in fiscal year 2023 for the commissioner of human services to create adult and children's mental health transition and support teams to facilitate transition back to the community ~~of children~~ or to the least restrictive level of care from inpatient psychiatric settings, emergency departments, residential treatment facilities, and child and adolescent behavioral health hospitals. The general fund base included in this act for this purpose is $1,875,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) Beginning April 1, 2024, counties may fund and continue conducting activities funded under this section.

(c) This section expires March 31, 2024.

Sec. 44. **MENTAL HEALTH URGENCY ROOM PILOT PROJECT.**

Subdivision 1. **Establishment.** (a) The commissioner of human services shall establish a pilot project that addresses emergency mental health needs by creating urgency rooms to be used as a first contact resource for youths under the age of 26 who are experiencing a mental health crisis.

(b) The commissioner shall provide Ramsey County with the first opportunity to operate the pilot project. If Ramsey County declines or fails to respond by January 1, 2023, the commissioner shall issue a request for proposals for the operation of the pilot project. Eligible applicants shall include counties, medical providers, and nonprofit organizations as specified in subdivision 2, paragraph (a). An applicant must have the capabilities specified in subdivision 2, paragraphs (b) through (d), and must provide the commissioner as part of the request for proposal process the information specified in subdivision 3.

Subd. 2. **Eligibility.** (a) To participate in the pilot project, the county or applicant may partner with:

(1) a medical provider, including hospitals or emergency rooms;

(2) a nonprofit organization that provides mental health services; or

(3) a nonprofit organization serving an underserved or rural community if applicable that will partner with an existing medical provider or nonprofit organization that provides mental health services.

(b) The partnering entity or entities must have the capability to:

(1) perform a medical evaluation and mental health evaluation upon a youth's admittance to an urgency room;

(2) accommodate a youth's stay for up to 14 days;

(3) conduct a substance use disorder screening;

(4) conduct a mental health crisis assessment;

(5) provide peer support services;

(6) provide crisis stabilization services;

(7) provide access to crisis psychiatry; and

(8) provide access to care planning and case management.

(c) The entity or entities must have staff who are licensed mental health professionals as defined under Minnesota Statutes, section 245I.02, subdivision 27, and must have a connection to inpatient and outpatient mental health services, including the ability to provide physical health screenings.

(d) The entity or entities must agree to accept patients regardless of their insurance status or their ability to pay.

Subd. 3. **Application.** (a) The county or applicant must provide the commissioner with the following:

(1) a detailed service plan, including the services that will be provided, and the staffing requirements needed for these services;

(2) an estimated cost of operating the project; and

(3) verification of financial sustainability by detailing sufficient funding sources and the capacity to obtain third-party payments for services provided, including private insurance and federal Medicaid and Medicare financial participation.

(b) The county or applicant and partnering entities must demonstrate an ability and willingness to build on existing resources in the community, and must agree to an evaluation of services and financial viability by the commissioner.

Subd. 4. **Grant activities.** Grant funds from the pilot project may be used for:

(1) expanding current space to create an urgency room;

(2) performing medical or mental health evaluations;

(3) developing a care plan for the youth; and

(4) providing recommendations for further care, either at an inpatient or outpatient facility.

Subd. 5. **Reporting.** (a) The county or grantee must submit a report to the commissioner in a manner and on a timeline specified by the commissioner on the following:

(1) how grant funds were spent;

(2) how many youths were served; and

(3) how the county or grantee met the goal of the pilot project.

(b) The commissioner shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services regarding pilot project activities no later than January 15, 2026, on the results of the pilot project, including the information specified in paragraph (a).

Sec. 45. **ONLINE MUSIC INSTRUCTION GRANT PROGRAM.**

(a) The commissioner of health shall award a grant to a community music education and performance center to partner with schools and early childhood centers to provide online music instruction to students and children for the purpose of increasing student self-confidence, providing students with a sense of community, and reducing individual stress. In applying for the grant, an applicant must commit to providing at least a 30 percent match of any grant funds received. The applicant must also include in the application the measurable outcomes the applicant intends to accomplish with the grant funds.

(b) The grantee shall use grant funds to partner with schools or early childhood centers that are designated Title I schools or centers or are located in rural Minnesota, and may use the funds in consultation with the music or early childhood educators in each school or early childhood center to provide individual or small group music instruction, sectional ensembles, or other group music activities, music workshops, or early childhood music activities. At least half of the online music programs must be in partnership with schools or early childhood centers located in rural Minnesota. A grantee may use the funds awarded to supplement or enhance an existing online music program within a school or early childhood center that meets the criteria described in this paragraph.

(c) The grantee must contract with a third-party entity to evaluate the success of the online music program. The evaluation must include interviews with the music educators and students at the schools and early childhood centers where an online music program was established. The results of the evaluation must be submitted to the commissioner of health and to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health policy and finance by December 15, 2025.

Sec. 46. **MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

Subdivision 1. **Grants authorized.** (a) The commissioner of health shall develop a grant program to award grants to health care entities, including but not limited to health care systems, hospitals, nursing facilities, community health clinics or consortium of clinics, federally qualified health centers, rural health clinics, or health professional associations for the purpose of establishing or expanding programs focused on improving the mental health of health care professionals.

(b) Grants shall be awarded for programs that are evidenced-based or evidenced-informed and are focused on addressing the mental health of health care professionals by:

(1) identifying and addressing the barriers to and stigma among health care professionals associated with seeking self-care, including mental health and substance use disorder services;

(2) encouraging health care professionals to seek support and care for mental health and substance use disorder concerns;

(3) identifying risk factors associated with suicide and other mental health conditions; or

(4) developing and making available resources to support health care professionals with self-care and resiliency.

Subd. 2. **Allocation of grants.** (a) To receive a grant, a health care entity must submit an application to the commissioner by the deadline established by the commissioner. An application must be on a form and contain information as specified by the commissioner and at a minimum must contain:

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

(2) a description of the achievable objectives of the program and how these objectives will be met; and

(3) a process for documenting and evaluating the results of the program.

(b) The commissioner shall give priority to programs that involve peer-to-peer support.

Subd. 3. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the grant program by conducting a periodic evaluation of the impact and outcomes of the grant program on health care professional burnout and retention. The commissioner shall submit the results of the evaluation and any recommendations for improving the grant program to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by October 15, 2024.

Sec. 47. **DIRECTION TO COMMISSIONER.**

The commissioner must update the behavioral health fund room and board rate schedule to include programs providing children's mental health crisis admissions and stabilization under Minnesota Statutes, section 245.4882, subdivision 6. The commissioner must establish room and board rates commensurate with current room and board rates for adolescent programs licensed under Minnesota Statutes, section 245G.18.

Sec. 48. **REVISOR INSTRUCTION.**

The revisor of statutes shall change the term "intensive treatment in foster care" or similar terms to "children's intensive behavioral health services" wherever they appear in Minnesota Statutes and Minnesota Rules when referring to those providers and services regulated under Minnesota Statutes, section 256B.0946. The revisor shall make technical and grammatical changes related to the changes in terms.

Sec. 49. **REPEALER.**

Minnesota Statutes 2020, section 245.4661, subdivision 8, is repealed.

Sec. 50. **EFFECTIVE DATE.**

Sections 26 to 37 are effective July 1, 2023, and apply to competency determinations initiated on or after that date.

ARTICLE 2

BOARD OF MEDICAL PRACTICE; TEMPORARY PERMITS

Section 1. Minnesota Statutes 2020, section 147.01, subdivision 7, is amended to read:

Subd. 7. **Physician application and license fees.** (a) The board may charge the following nonrefundable application and license fees processed pursuant to sections 147.02, 147.03, 147.037, 147.0375, and 147.38:

(1) physician application fee, $200;

(2) physician annual registration renewal fee, $192;

(3) physician endorsement to other states, $40;

(4) physician emeritus license, $50;

~~(5) physician temporary license, $60;~~

~~(6)~~ (5) physician late fee, $60;

~~(7)~~ (6) duplicate license fee, $20;

~~(8)~~ (7) certification letter fee, $25;

~~(9)~~ (8) education or training program approval fee, $100;

~~(10)~~ (9) report creation and generation fee, $60 per hour;

~~(11)~~ (10) examination administration fee (half day), $50;

~~(12)~~ (11) examination administration fee (full day), $80;

~~(13)~~ (12) fees developed by the Interstate Commission for determining physician qualification to register and participate in the interstate medical licensure compact, as established in rules authorized in and pursuant to section 147.38, not to exceed $1,000; and

~~(14)~~ (13) verification fee, $25.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fee must be deposited in an account in the state government special revenue fund.

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

Sec. 2. Minnesota Statutes 2020, section 147.03, subdivision 1, is amended to read:

Subdivision 1. **Endorsement; reciprocity.** (a) The board may issue a license to practice medicine to any person who satisfies the requirements in paragraphs (b) to (e).

(b) The applicant shall satisfy all the requirements established in section 147.02, subdivision 1, paragraphs (a), (b), (d), (e), and (f), or section 147.037, subdivision 1, paragraphs (a) to (e).

(c) The applicant shall:

(1) have passed an examination prepared and graded by the Federation of State Medical Boards, the National Board of Medical Examiners, or the United States Medical Licensing Examination (USMLE) program in accordance with section 147.02, subdivision 1, paragraph (c), clause (2); the National Board of Osteopathic Medical Examiners; or the Medical Council of Canada; and

(2) have a current license from the equivalent licensing agency in another state or Canada and, if the examination in clause (1) was passed more than ten years ago, either:

(i) pass the Special Purpose Examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

(ii) have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada; or

(3) if the applicant fails to meet the requirement established in section 147.02, subdivision 1, paragraph (c), clause (2), because the applicant failed to pass each of steps one, two, and three of the USMLE within the required three attempts, the applicant may be granted a license provided the applicant:

(i) has passed each of steps one, two, and three with passing scores as recommended by the USMLE program within no more than four attempts for any of the three steps;

(ii) is currently licensed in another state; and

(iii) has current certification by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

(d) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

(e) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph (d). If an applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions or limitations the board considers appropriate.

(f) Upon the request of an applicant, the board may conduct the final interview of the applicant by teleconference.

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

Sec. 3. Minnesota Statutes 2020, section 147.03, subdivision 2, is amended to read:

Subd. 2. **Temporary permit.** (a) An applicant for licensure under this section may request the board to issue a temporary permit in accordance with this subdivision. Upon receipt of the application for licensure, a request for a temporary permit, and a nonrefundable physician application fee specified under section 147.01, subdivision 7, the board may issue a temporary permit to practice medicine ~~to~~ as a physician ~~eligible for licensure under this section only if the application for licensure is complete, all requirements in subdivision 1 have been met, and a nonrefundable fee set by the board has been paid~~ if the applicant is:

(1) currently licensed in good standing to practice medicine as a physician in another state, territory, or Canadian province; and

(2) not the subject of a pending investigation or disciplinary action in any state, territory, or Canadian province.

~~The permit remains~~ (b) A temporary permit issued under this subdivision is nonrenewable and shall be valid ~~only~~ until ~~the meeting of the board at which~~ a decision is made on the physician's application for licensure or for 90 days, whichever occurs first.

(c) The board may revoke a temporary permit that has been issued under this subdivision if the physician is the subject of an investigation or disciplinary action, or is disqualified for licensure for any other reason.

(d) Notwithstanding section 13.41, subdivision 2, the board may release information regarding action taken by the board pursuant to this subdivision.

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

Sec. 4. Minnesota Statutes 2020, section 147.037, is amended to read:

147.037 LICENSING OF FOREIGN MEDICAL SCHOOL GRADUATES~~; TEMPORARY PERMIT~~.

Subdivision 1. **Requirements.** The board shall issue a license to practice medicine to any person who satisfies the requirements in paragraphs (a) to (g).

(a) The applicant shall satisfy all the requirements established in section 147.02, subdivision 1, paragraphs (a), (e), (f), (g), and (h).

(b) The applicant shall present evidence satisfactory to the board that the applicant is a graduate of a medical or osteopathic school approved by the board as equivalent to accredited United States or Canadian schools based upon its faculty, curriculum, facilities, accreditation, or other relevant data. If the applicant is a graduate of a medical or osteopathic program that is not accredited by the Liaison Committee for Medical Education or the American Osteopathic Association, the applicant may use the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS) or its successor. If the applicant uses this service as allowed under this paragraph, the physician application fee may be less than $200 but must not exceed the cost of administering this paragraph.

(c) The applicant shall present evidence satisfactory to the board that the applicant has been awarded a certificate by the Educational Council for Foreign Medical Graduates, and the applicant has a working ability in the English language sufficient to communicate with patients and physicians and to engage in the practice of medicine.

(d) The applicant shall present evidence satisfactory to the board of the completion of one year of graduate, clinical medical training in a program accredited by a national accrediting organization approved by the board or other graduate training approved in advance by the board as meeting standards similar to those of a national accrediting organization. This requirement does not apply:

(1) to an applicant who is admitted as a permanent immigrant to the United States on or before October 1, 1991, as a person of exceptional ability in the sciences according to Code of Federal Regulations, title 20, section 656.22(d); or

(2) to an applicant holding a valid license to practice medicine in another country and issued a permanent immigrant visa after October 1, 1991, as a person of extraordinary ability in the field of science or as an outstanding professor or researcher according to Code of Federal Regulations, title 8, section 204.5(h) and (i), or a temporary nonimmigrant visa as a person of extraordinary ability in the field of science according to Code of Federal Regulations, title 8, section 214.2(o),

provided that a person under clause (1) or (2) is admitted pursuant to rules of the United States Department of Labor.

(e) The applicant must:

(1) have passed an examination prepared and graded by the Federation of State Medical Boards, the United States Medical Licensing Examination program in accordance with section 147.02, subdivision 1, paragraph (c), clause (2), or the Medical Council of Canada; and

(2) if the examination in clause (1) was passed more than ten years ago, either:

(i) pass the Special Purpose Examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

(ii) have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association, of the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada; or

(3) if the applicant fails to meet the requirement established in section 147.02, subdivision 1, paragraph (c), clause (2), because the applicant failed to pass each of steps one, two, and three of the USMLE within the required three attempts, the applicant may be granted a license provided the applicant:

(i) has passed each of steps one, two, and three with passing scores as recommended by the USMLE program within no more than four attempts for any of the three steps;

(ii) is currently licensed in another state; and

(iii) has current certification by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

(f) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

(g) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph (f). If an applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions or limitations the board considers appropriate.

~~Subd. 1a.~~ ~~**Temporary permit.**~~ ~~The board may issue a temporary permit to practice medicine to a physician eligible for licensure under this section only if the application for licensure is complete, all requirements in subdivision 1 have been met, and a nonrefundable fee set by the board has been paid. The permit remains valid only until the meeting of the board at which a decision is made on the physician's application for licensure.~~

Subd. 2. **Medical school review.** The board may contract with any qualified person or organization for the performance of a review or investigation, including site visits if necessary, of any medical or osteopathic school prior to approving the school under section 147.02, subdivision 1, paragraph (b), or subdivision 1, paragraph (b), of this section. To the extent possible, the board shall require the school being reviewed to pay the costs of the review or investigation.

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

Sec. 5. **[147A.025] TEMPORARY PERMIT.**

(a) An applicant for licensure under section 147A.02, may request the board to issue a temporary permit in accordance with this section. Upon receipt of the application for licensure, a request for a temporary permit, and a nonrefundable physician assistant application fee as specified under section 147A.28, the board may issue a temporary permit to practice as a physician assistant if the applicant is:

(1) currently licensed in good standing to practice as a physician assistant in another state, territory, or Canadian province; and

(2) not subject to a pending investigation or disciplinary action in any state, territory, or Canadian province.

(b) A temporary permit issued under this section is nonrenewable and shall be valid until a decision is made on the physician assistant's application for licensure or for 90 days, whichever occurs first.

(c) The board may revoke the temporary permit that has been issued under this section if the applicant is the subject of an investigation or disciplinary action or is disqualified for licensure for any other reason.

(d) Notwithstanding section 13.41, subdivision 2, the board may release information regarding any action taken by the board pursuant to this section.

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

Sec. 6. Minnesota Statutes 2020, section 147A.28, is amended to read:

147A.28 PHYSICIAN ASSISTANT APPLICATION AND LICENSE FEES.

(a) The board may charge the following nonrefundable fees:

(1) physician assistant application fee, $120;

~~(2) physician assistant annual registration renewal fee (prescribing authority), $135;~~

~~(3)~~ (2) physician assistant annual ~~registration~~ license renewal fee ~~(no prescribing authority)~~, $115;

~~(4) physician assistant temporary registration, $115;~~

~~(5) physician assistant temporary permit, $60;~~

~~(6)~~ (3) physician assistant locum tenens permit, $25;

~~(7)~~ (4) physician assistant late fee, $50;

~~(8)~~ (5) duplicate license fee, $20;

~~(9)~~ (6) certification letter fee, $25;

~~(10)~~ (7) education or training program approval fee, $100;

~~(11)~~ (8) report creation and generation fee, $60 per hour; and

~~(12)~~ (9) verification fee, $25.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

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

Sec. 7. Minnesota Statutes 2020, section 147C.40, subdivision 5, is amended to read:

Subd. 5. **Respiratory therapist application and license fees.** (a) The board may charge the following nonrefundable fees:

(1) respiratory therapist application fee, $100;

(2) respiratory therapist annual registration renewal fee, $90;

(3) respiratory therapist inactive status fee, $50;

(4) respiratory therapist temporary registration fee, $90;

~~(5) respiratory therapist temporary permit, $60;~~

~~(6)~~ (5) respiratory therapist late fee, $50;

~~(7)~~ (6) duplicate license fee, $20;

~~(8)~~ (7) certification letter fee, $25;

~~(9)~~ (8) education or training program approval fee, $100;

~~(10)~~ (9) report creation and generation fee, $60 per hour; and

~~(11)~~ (10) verification fee, $25.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

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

Sec. 8. **REPEALER.**

Minnesota Statutes 2020, section 147.02, subdivision 2a, is repealed.

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

ARTICLE 3

APPROPRIATIONS

Section 1. **APPROPRIATION BASE ESTABLISHED; COMPETENCY RESTORATION.**

Subdivision 1. **Department of Corrections.** The general fund appropriation base for the commissioner of corrections is $202,000 in fiscal year 2024 and $202,000 in fiscal year 2025 for correctional facilities inspectors.

Subd. 2. **District courts.** The general fund appropriation base for the district courts is $5,042,000 in fiscal year 2024 and $5,042,000 in fiscal year 2025 for costs associated with additional competency examination costs.

Subd. 3. **State Competency Restoration Board.** The general fund appropriation base for the State Competency Restoration Board is $11,350,000 in fiscal year 2024 and $10,900,000 in fiscal year 2025 for staffing and other costs needed to establish and perform the duties of the State Competency Restoration Board, including providing educational services necessary to restore defendants to competency, or contracting or partnering with other organizations to provide those services.

Sec. 2. **APPROPRIATION; ADULT MENTAL HEALTH INITIATIVE GRANTS.**

(a) The general fund base for adult mental health initiative services under Minnesota Statutes, section 245.4661, is increased by $10,233,000 in fiscal year 2025 and thereafter, and is increased by an additional $10,140,000 in fiscal year 2026 and thereafter.

(b) The general fund base for administration of adult mental health initiative services grants is increased by $135,000 in fiscal year 2025.

(c) $400,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of management and budget to create and maintain an inventory of adult mental health initiative services and to conduct evaluations of adult mental health initiative services that are promising practices or theory-based activities under Minnesota Statutes, section 245.4661, subdivision 5a.

Sec. 3. **APPROPRIATION; AFRICAN AMERICAN COMMUNITY MENTAL HEALTH CENTER.**

(a) $1,000,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services for a grant to an African American mental health service provider that is a licensed community mental health center specializing in services for African American children and families. The mental health center must offer culturally specific, comprehensive, trauma-informed, practice- and evidence-based, person- and family-centered mental health and substance use disorder services; supervision and training; and care coordination to all ages, regardless of ability to pay or place of residence. Upon request, the commissioner shall make information regarding the use of this grant funding available to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services. This is a onetime appropriation and is available until June 30, 2025.

(b) The general fund base for this appropriation for administration of the grant in paragraph (a) is $104,000 in fiscal year 2024, $104,000 in fiscal year 2025, and $0 in fiscal year 2026 and thereafter.

Sec. 4. **APPROPRIATION; CHILDREN'S FIRST EPISODE OF PSYCHOSIS.**

(a) $6,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services to implement a children's first episode of psychosis grant under Minnesota Statutes, section 245.4905. The base for this appropriation is $480,000 in fiscal year 2024 and $480,000 in fiscal year 2025.

(b) Of this appropriation, $6,000 in fiscal year 2023 is for grants for children's first episode of psychosis.

(c) The general fund base for administration is $119,000 in fiscal year 2024 and $119,000 in fiscal year 2025. The general fund base for grants for children's first episode of psychosis is $361,000 in fiscal year 2024 and $361,000 in fiscal year 2025.

Sec. 5. **APPROPRIATION; CHILDREN'S INTENSIVE BEHAVIORAL HEALTH TREATMENT SERVICES.**

(a) $101,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services for children's intensive behavioral health treatment services. The base for this appropriation is $474,000 in fiscal year 2024 and $3,204,000 in fiscal year 2025.

(b) Of this appropriation, $101,000 in fiscal year 2023 is for administration.

(c) The general fund base for administration is $228,000 in fiscal year 2024 and $228,000 in fiscal year 2025. The general fund base for children's intensive behavioral health treatment services is $246,000 in fiscal year 2024 and $2,976,000 in fiscal year 2025.

Sec. 6. **APPROPRIATION; CHILDREN'S RESIDENTIAL FACILITY CRISIS STABILIZATION SERVICES.**

(a) $203,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services for children's residential facility crisis stabilization services under Minnesota Statutes, section 245A.26. The general fund base for this appropriation is $495,000 in fiscal year 2024 and $559,000 in fiscal year 2025.

(b) Of this appropriation, $53,000 in fiscal year 2023 is for children's residential facility crisis stabilization services, $105,000 in fiscal year 2023 is for administration, and $45,000 in fiscal year 2023 is for systems costs.

(c) The general fund base for children's residential facility crisis stabilization services is $367,000 in fiscal year 2024 and $431,000 in fiscal year 2025. The general fund base for administration is $119,000 in fiscal year 2024 and $119,000 in fiscal year 2025. The general fund base for systems is $9,000 in fiscal year 2024 and $9,000 in fiscal year 2025.

Sec. 7. **APPROPRIATION; INTENSIVE RESIDENTIAL TREATMENT SERVICES.**

(a) $2,914,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services to provide start-up funds to intensive residential treatment service providers to provide treatment in locked facilities for patients who have been transferred from a jail or who have been deemed incompetent to stand trial and a judge has determined that the patient needs to be in a secure facility. The base for this appropriation is $180,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) Of this appropriation, $115,000 in fiscal year 2023 is for administration and $3,000 in fiscal year 2023 is for systems costs.

(c) The base for administration is $179,000 in fiscal year 2024 and is available until June 30, 2025. The base for systems costs is $1,000 in fiscal year 2024 and $0 in fiscal year 2025.

Sec. 8. **APPROPRIATION; MANAGED CARE MINIMUM RATE FOR MENTAL HEALTH SERVICES.**

$28,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services to monitor the mental health services rate paid to providers under Minnesota Statutes, section 256B.763. The general fund base for this appropriation is $32,000 in fiscal year 2024 and $32,000 in fiscal year 2025.

Sec. 9. **APPROPRIATION; MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

$1,000,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of health for the health care professionals mental health grant program. This is a onetime appropriation.

Sec. 10. **APPROPRIATION; MENTAL HEALTH PROFESSIONAL LOAN FORGIVENESS.**

Notwithstanding the priorities and distribution requirements under Minnesota Statutes, section 144.1501, $1,600,000 is appropriated in fiscal year 2023 from the general fund to the commissioner of health for the health professional loan forgiveness program to be used for loan forgiveness only for individuals who are eligible mental health professionals under Minnesota Statutes, section 144.1501. Notwithstanding Minnesota Statutes, section 144.1501, subdivision 2, paragraph (b), if the commissioner of health does not receive enough qualified applicants within each biennium, the remaining funds shall be carried over to the next biennium and allocated proportionally among the other eligible professions in accordance with Minnesota Statutes, section 144.1501, subdivision 2.

Sec. 11. **APPROPRIATION; MENTAL HEALTH PROVIDER SUPERVISION GRANT PROGRAM.**

$2,500,000 is appropriated in fiscal year 2023 from the general fund to the commissioner of human services for the mental health provider supervision grant program under Minnesota Statutes, section 245.4663.

Sec. 12. **APPROPRIATION; MENTAL HEALTH URGENCY ROOM PILOT PROJECT.**

(a) $1,215,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services for a mental health urgency room pilot project. The general fund base for this appropriation is $247,000 in fiscal year 2024, $247,000 in fiscal year 2025, and $0 in fiscal year 2026 and thereafter.

(b) Of this appropriation, $1,000,000 in fiscal year 2023 is for a grant for a mental health urgency room pilot project and $215,000 in fiscal year 2023 is for administration.

(c) The general fund base for administration is $247,000 in fiscal year 2024, $247,000 in fiscal year 2025, and $0 in fiscal year 2026 and thereafter.

(d) Any amount of this appropriation that is not encumbered on January 1, 2024, shall cancel and be added to the base amount in fiscal year 2024 for mobile crisis grants.

Sec. 13. **APPROPRIATION; MOBILE CRISIS SERVICES.**

The general fund base for grants for adult mobile crisis services under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (b), clause (15), is increased by $4,000,000 in fiscal year 2024 and increased by $5,600,000 in fiscal year 2025.

Sec. 14. **APPROPRIATION; MOBILE TRANSITION UNITS AND PERSON CENTERED DISCHARGE PLANNING.**

(a) $796,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services for a person-centered discharge planning process for adults and children being discharged from psychiatric residential treatment facilities, child and adolescent behavioral health hospitals, and hospital settings. The base for this appropriation is $1,010,000 in fiscal year 2024 and $1,010,000 in fiscal year 2025.

(b) Of this appropriation, $546,000 in fiscal year 2023 is for administration and $250,000 is for grants to develop and support a person-centered discharge planning process for adults and children being discharged from psychiatric residential treatment facilities, child and adolescent behavioral health hospitals, and hospital settings.

(c) The general fund base for administration is $760,000 in fiscal year 2024 and $760,000 in fiscal year 2025. The general fund base is $250,000 in fiscal year 2024 and $250,000 in fiscal year 2025 for grants to develop and support a person-centered discharge planning process for adults and children being discharged from psychiatric residential treatment facilities, child and adolescent behavioral health hospitals, and hospital settings.

Sec. 15. **APPROPRIATION; MONITORING OF A PSYCHIATRIC HOSPITAL.**

$15,000 in fiscal year 2023 is appropriated from the state government special revenue fund to the commissioner of health for collecting data and monitoring the 144-bed psychiatric hospital in the city of Saint Paul, Ramsey County, per Minnesota Statutes, described in section 144.551, subdivision 1, paragraph (b), clause (31).

Sec. 16. **APPROPRIATION; OFFICER-INVOLVED COMMUNITY-BASED CARE COORDINATION.**

$11,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services for medical assistance expenditures for officer-involved community-based care coordination. The general fund base for this appropriation is $10,000 in fiscal year 2024 and $15,000 in fiscal year 2025.

Sec. 17. **APPROPRIATION; ONLINE MUSIC INSTRUCTION GRANT.**

$300,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of health for a grant for the online music instruction grant program. This is a onetime appropriation and is available until June 30, 2025.

Sec. 18. **APPROPRIATION; SCHOOL-LINKED BEHAVIORAL HEALTH GRANTS.**

$2,000,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services for school-linked behavioral health grants under Minnesota Statutes, section 245.4901.

Sec. 19. **APPROPRIATION; SHELTER-LINKED MENTAL HEALTH GRANTS.**

$2,000,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services for shelter-linked youth mental health grants under Minnesota Statutes, section 256K.46.

Presented to the governor May 24, 2022

Signed by the governor June 2, 2022, 2:09 p.m.