State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 1040

02/11/2021 Authored by Schultz and Liebling
The bill was read for the first time and referred to the Committee on Human Services Finance and Policy

A bill for an act

relating to state government; modifying provisions governing children and family services, community supports, direct care and treatment, health care, human services licensing and background studies, and chemical and mental health services; making forecast adjustments; requiring reports; transferring money; making technical and conforming changes; appropriating money; amending Minnesota Statutes 2020, sections 62A.152, subdivision 3; 62A.3094, subdivision 1; 62Q.096; 62V.05, by adding a subdivision; 119B.011, subdivision 15; 119B.025, subdivision 4; 119B.13, subdivision 1; 122A.18, subdivision 8; 144.651, subdivision 2; 144D.01, subdivision 4; 144G.08, subdivision 7, as amended; 148B.5301, subdivision 2; 148E.120, subdivision 2; 148F.11, subdivision 1; 174.30, subdivision 3; 245.462, subdivisions 1, 6, 8, 9, 14, 16, 17, 18, 21, 23, by adding a subdivision; 245.4661, subdivision 5; 245.4662, subdivision 1; 245.467, subdivisions 2, 3; 245.469, subdivisions 1, 2; 245.470, subdivision 1; 245.4712, subdivision 2; 245.472, subdivision 2; 245.4863; 245.4871, subdivisions 9a, 10, 11a, 17, 21, 26, 27, 29, 31, 32, 34, by adding a subdivision; 245.4876, subdivisions 2, 3; 245.4879, subdivision 1; 245.488, subdivision 1; 245.4901, subdivision 2; 245.62, subdivision 2; 245.735, subdivision 3; 245A.03, subdivision 7; 245A.04, subdivision 5; 245A.10, subdivision 4; 245A.65, subdivision 2; 245C.02, by adding subdivisions; 245C.03; 245C.05, subdivisions 1, 2, 2a, 2b, 4; 245C.08, by adding subdivisions; 245C.10, subdivision 15, by adding subdivisions; 245C.13, subdivision 2; 245C.14, by adding a subdivision; 245C.16, subdivisions 1, 2; 245C.17, subdivision 1, by adding a subdivision; 245C.18; 245D.02, subdivision 20; 246.54, subdivision 1b; 254B.05, subdivision 5; 256.042, subdivisions 2, 4; 256.043, subdivision 3; 256.9695, subdivision 1; 256.983; 256B.04, subdivisions 12, 14; 256B.057, subdivision 3; 256B.0615, subdivisions 1, 5; 256B.0616, subdivisions 1, 3, 5; 256B.0622, subdivisions 1, 2, 3a, 4, 7, 7a, 7b, 7c, 7d; 256B.0623, subdivisions 1, 2, 3, 4, 5, 6, 9, 12; 256B.0624; 256B.0625, subdivisions 3b, 5, 9, 13, 13e, 17, 17b, 18, 18b, 19c, 20, 28a, 42, 48, 49, 56a, 58; 256B.0757, subdivision 4c; 256B.0759, subdivisions 2, 4; 256B.092, subdivisions 4, 5, 12; 256B.0924, subdivision 6; 256B.094, subdivision 6; 256B.0941, subdivision 1; 256B.0943, subdivisions 1, 2, 3, 4, 5, 5a, 6, 7, 9, 11; 256B.0946, subdivisions 1, 1a, 2, 3, 4, 6; 256B.0947, subdivisions 1, 2, 3, 3a, 5, 6, 7; 256B.0949, subdivisions 2, 4, 5a, 13, by adding a subdivision; 256B.25, subdivision 3; 256B.49, subdivisions 11, 11a, 17, by adding a subdivision; 256B.4914, subdivisions 5, 6, 7, 8, 9, by adding a subdivision; 256B.69, subdivision 6d; 256B.75; 256B.76, subdivisions 2, 4; 256B.761; 256B.763; 256B.766; 256B.767; 256B.79, subdivisions 1, 3; 256D.03, by adding a subdivision; 256D.051, by adding subdivisions; 256D.0516, subdivision 2;

256E.30, subdivision 2; 256E.34, subdivision 1; 256I.03, subdivision 13; 256I.05, subdivisions 1a, 11; 256I.06, subdivisions 6, 8; 256J.08, subdivisions 71, 79; 256J.21, subdivisions 2, 3, 4; 256J.33, subdivisions 1, 2; 256J.37, subdivisions 3, 3a; 256J.626, subdivision 1; 256L.01, subdivision 5; 256L.04, subdivision 7b; 256L.05, subdivision 3a; 256L.11, subdivision 7; 256N.25, subdivisions 2, 3; 256N.26, subdivisions 11, 13; 256P.01, subdivision 6a, by adding a subdivision; 256P.04, subdivisions 4, 8; 256P.06, subdivision 3; 256P.07; 295.50, subdivision 9b; 325F.721, subdivision 1; Laws 2017, chapter 13, article 1, section 15, as amended; proposing coding for new law in Minnesota Statutes, chapters 245C; 256B; 256P; proposing coding for new law as Minnesota Statutes, chapter 245I; repealing Minnesota Statutes 2020, sections 245.462, subdivision 4a; 245.4879, subdivision 2; 245.62, subdivisions 3, 4; 245.69, subdivision 2; 245A.191; 245C.10, subdivisions 2, 2a, 3, 4, 5, 6, 7, 8, 9, 9a, 10, 11, 12, 13, 14, 16; 256B.0596; 256B.0615, subdivision 2; 256B.0616, subdivision 2; 256B.0622, subdivisions 3, 5a; 256B.0623, subdivisions 7, 8, 10, 11; 256B.0625, subdivisions 5l, 18c, 18d, 18e, 18h, 35a, 35b, 61, 62, 65; 256B.0916, subdivisions 2, 3, 4, 5, 8, 11, 12; 256B.0943, subdivisions 8, 10; 256B.0944; 256B.0946, subdivision 5; 256B.097; 256B.49, subdivisions 26, 27; 256D.051, subdivisions 1, 1a, 2, 2a, 3, 3a, 3b, 6b, 6c, 7, 8, 9, 18; 256D.052, subdivision 3; 256J.08, subdivisions 10, 53, 61, 62, 81, 83; 256J.30, subdivisions 5, 7, 8; 256J.33, subdivisions 3, 4, 5; 256J.34, subdivisions 1, 2, 3, 4; 256J.37, subdivision 10; 256L.11, subdivision 6a; Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020; 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090; 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160; 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; 9520.0230; 9520.0750; 9520.0760; 9520.0770; 9520.0780; 9520.0790; 9520.0800; 9520.0810; 9520.0820; 9520.0830; 9520.0840; 9520.0850; 9520.0860; 9520.0870.

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

ARTICLE 1

CHILDREN AND FAMILY SERVICES

Section 1. Minnesota Statutes 2020, section 119B.011, subdivision 15, is amended to read:

Subd. 15. **Income.** "Income" means earned income as defined under section 256P.01, subdivision 3, unearned income as defined under section 256P.01, subdivision 8, and public assistance cash benefits, including the Minnesota family investment program, diversionary work program, work benefit, Minnesota supplemental aid, general assistance, refugee cash assistance, at-home infant child care subsidy payments, and child support and maintenance distributed to ~~the~~ a family under section 256.741, subdivision 2a, and nonrecurring income over $60 per quarter unless earmarked and used for the purpose for which it was intended. The following are deducted from income: funds used to pay for health insurance premiums for family members, and child or spousal support paid to or on behalf of a person or persons who live outside of the household. Income sources that are not included in this subdivision and section 256P.06, subdivision 3, are not counted as income.

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

Sec. 2. Minnesota Statutes 2020, section 119B.025, subdivision 4, is amended to read:

Subd. 4. **Changes in eligibility.** (a) The county shall process a change in eligibility factors according to paragraphs (b) to (g).

(b) A family is subject to the reporting requirements in section 256P.07, subdivision 6.

(c) If a family reports a change or a change is known to the agency before the family's regularly scheduled redetermination, the county must act on the change. The commissioner shall establish standards for verifying a change.

(d) A change in income occurs on the day the participant received the first payment reflecting the change in income.

(e) During a family's 12-month eligibility period, if the family's income increases and remains at or below 85 percent of the state median income, adjusted for family size, there is no change to the family's eligibility. The county shall not request verification of the change. The co-payment fee shall not increase during the remaining portion of the family's 12-month eligibility period.

(f) During a family's 12-month eligibility period, if the family's income increases and exceeds 85 percent of the state median income, adjusted for family size, the family is not eligible for child care assistance. The family must be given 15 calendar days to provide verification of the change. If the required verification is not returned or confirms ineligibility, the family's eligibility ends following a subsequent 15-day adverse action notice.

(g) Notwithstanding Minnesota Rules, parts 3400.0040, subpart 3, and 3400.0170, subpart 1, if an applicant or participant reports that employment ended, the agency may accept a signed statement from the applicant or participant as verification that employment ended.

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

Sec. 3. Minnesota Statutes 2020, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) The maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be the greater of the ~~25th~~ 30th percentile of the ~~2018~~ most recent child care provider rate survey or the rates in effect at the time of the update. The rate increase shall be effective the first full service period on or after January 1 of the year following the provider rate survey. For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid for child care assistance shall be

equal to the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

(b) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(c) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

(d) If a child uses one provider, the maximum payment for one day of care must not exceed the daily rate. The maximum payment for one week of care must not exceed the weekly rate.

(e) If a child uses two providers under section 119B.097, the maximum payment must not exceed:

(1) the daily rate for one day of care;

(2) the weekly rate for one week of care by the child's primary provider; and

(3) two daily rates during two weeks of care by a child's secondary provider.

(f) Child care providers receiving reimbursement under this chapter must not be paid activity fees or an additional amount above the maximum rates for care provided during nonstandard hours for families receiving assistance.

(g) If the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

~~(h) All maximum provider rates changes shall be implemented on the Monday following the effective date of the maximum provider rate.~~

~~(i) Beginning September 21, 2020,~~ (h) The maximum registration fee paid for child care assistance in any county or county price cluster under the child care fund shall be the greater of the ~~25th~~ 30th percentile of the ~~2018~~ most recent child care provider rate survey or the registration fee in effect at the time of the update. Each maximum registration fee update must be implemented on the same schedule as maximum child care assistance rate increases under paragraph (a). Maximum registration fees must be set for licensed family child care

and for child care centers. For a child care provider located in the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum registration fee paid for child care assistance shall be equal to the maximum registration fee paid in the county with the highest maximum registration fee or the provider's charge, whichever is less.

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

Sec. 4. Minnesota Statutes 2020, section 256D.03, is amended by adding a subdivision to read:

Subd. 2b. **Budgeting and reporting.** County agencies shall determine eligibility and calculate benefit amounts for general assistance according to the provisions in sections 256P.06, 256P.07, 256P.09, and 256P.10.

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

Sec. 5. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 20. **SNAP employment and training.** The commissioner shall implement a Supplemental Nutrition Assistance Program (SNAP) employment and training program that meets the SNAP employment and training participation requirements of the United States Department of Agriculture governed by Code of Federal Regulations, title 7, section 273.7. The commissioner shall operate a SNAP employment and training program in which SNAP recipients elect to participate. In order to receive SNAP assistance beyond the time limit, unless residing in an area covered by a time-limit waiver governed by Code of Federal Regulations, title 7, section 273.24, nonexempt SNAP recipients who do not meet federal SNAP work requirements must participate in an employment and training program. In addition to county and tribal agencies that administer SNAP, the commissioner may contract with third-party providers for SNAP employment and training services.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 6. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 21. **County and tribal agency duties.** County or tribal agencies that administer SNAP shall inform adult SNAP recipients about employment and training services and providers in the recipient's area. County or tribal agencies that administer SNAP may elect

to subcontract with a public or private entity approved by the commissioner to provide SNAP employment and training services.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 7. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 22. **Duties of commissioner.** In addition to any other duties imposed by law, the commissioner shall:

(1) supervise the administration of SNAP employment and training services to county, tribal, and contracted agencies under this section and Code of Federal Regulations, title 7, section 273.7;

(2) disburse money allocated and reimbursed for SNAP employment and training services to county, tribal, and contracted agencies;

(3) accept and supervise the disbursement of any funds that may be provided by the federal government or other sources for SNAP employment and training services;

(4) cooperate with other agencies, including any federal agency or agency of another state, in all matters concerning the powers and duties of the commissioner under this section;

(5) coordinate with the commissioner of employment and economic development to deliver employment and training services statewide;

(6) work in partnership with counties, tribes, and other agencies to enhance the reach and services of a statewide SNAP employment and training program; and

(7) identify eligible nonfederal funds to earn federal reimbursement for SNAP employment and training services.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 8. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 23. **Participant duties.** Unless residing in an area covered by a time-limit waiver, nonexempt SNAP recipients must meet federal SNAP work requirements to receive SNAP assistance beyond the time limit.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 9. Minnesota Statutes 2020, section 256D.051, is amended by adding a subdivision to read:

Subd. 24. **Program funding.** (a) The United States Department of Agriculture annually allocates SNAP employment and training funds to the commissioner of human services for the operation of the SNAP employment and training program.

(b) The United States Department of Agriculture authorizes the disbursement of SNAP employment and training reimbursement funds to the commissioner of human services for the operation of the SNAP employment and training program.

(c) Except for funds allocated for state program development and administrative purposes or designated by the United States Department of Agriculture for a specific project, the commissioner of human services shall disburse money allocated for federal SNAP employment and training to counties and tribes that administer SNAP based on a formula determined by the commissioner that includes but is not limited to the county's or tribe's proportion of adult SNAP recipients as compared to the statewide total.

(d) The commissioner of human services shall disburse federal funds that the commissioner receives as reimbursement for SNAP employment and training costs to the state agency, county, tribe, or contracted agency that incurred the costs being reimbursed.

(e) The commissioner of human services may reallocate unexpended money disbursed under this section to county, tribal, or contracted agencies that demonstrate a need for additional funds.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 10. Minnesota Statutes 2020, section 256D.0516, subdivision 2, is amended to read:

Subd. 2. **SNAP reporting requirements.** The commissioner of human services shall implement simplified reporting as permitted under the Food and Nutrition Act of 2008, as amended, and the SNAP regulations in Code of Federal Regulations, title 7, part 273. SNAP benefit recipient households required to report periodically shall not be required to report more often than one time every six months. ~~This provision shall not apply to households receiving food benefits under the Minnesota family investment program waiver.~~

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

Sec. 11. Minnesota Statutes 2020, section 256E.30, subdivision 2, is amended to read:

Subd. 2. **Allocation of money.** (a) State money appropriated and community service block grant money allotted to the state and all money transferred to the community service block grant from other block grants shall be allocated annually to community action agencies and Indian reservation governments under paragraphs (b) and (c), and to migrant and seasonal farmworker organizations under paragraph (d).

(b) The available annual money will provide base funding to all community action agencies and the Indian reservations. Base funding amounts per agency are as follows: for agencies with low income populations up to ~~1,999, $25,000; 2,000 to~~ 23,999, $50,000; and 24,000 or more, $100,000.

(c) All remaining money of the annual money available after the base funding has been determined must be allocated to each agency and reservation in proportion to the size of the poverty level population in the agency's service area compared to the size of the poverty level population in the state.

(d) Allocation of money to migrant and seasonal farmworker organizations must not exceed three percent of the total annual money available. Base funding allocations must be made for all community action agencies and Indian reservations that received money under this subdivision, in fiscal year 1984, and for community action agencies designated under this section with a service area population of 35,000 or greater.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 12. Minnesota Statutes 2020, section 256E.34, subdivision 1, is amended to read:

Subdivision 1. **Distribution of appropriation.** The commissioner must distribute funds appropriated to the commissioner by law for that purpose to Hunger Solutions, a statewide association of food shelves organized as a nonprofit corporation as defined under section 501(c)(3) of the Internal Revenue Code of 1986, to distribute to qualifying food shelves. A food shelf qualifies under this section if:

(1) it is a nonprofit corporation, or is affiliated with a nonprofit corporation, as defined in section 501(c)(3) of the Internal Revenue Code of 1986 or a federally recognized tribal nation;

(2) it distributes standard food orders without charge to needy individuals. The standard food order must consist of at least a two-day supply or six pounds per person of nutritionally balanced food items;

(3) it does not limit food distributions to individuals of a particular religious affiliation, race, or other criteria unrelated to need or to requirements necessary to administration of a fair and orderly distribution system;

(4) it does not use the money received or the food distribution program to foster or advance religious or political views; and

(5) it has a stable address and directly serves individuals.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 13. Minnesota Statutes 2020, section 256I.03, subdivision 13, is amended to read:

Subd. 13. **Prospective budgeting.** "Prospective budgeting" ~~means estimating the amount of monthly income a person will have in the payment month~~ has the meaning given in section 256P.01, subdivision 9.

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

Sec. 14. Minnesota Statutes 2020, section 256I.06, subdivision 6, is amended to read:

Subd. 6. **Reports.** Recipients must report changes in circumstances according to section 256P.07 ~~that affect eligibility or housing support payment amounts, other than changes in earned income, within ten days of the change~~. Recipients with countable earned income must complete a household report form at least once every six months according to section 256P.10. ~~If the report form is not received before the end of the month in which it is due, the county agency must terminate eligibility for housing support payments. The termination shall be effective on the first day of the month following the month in which the report was due. If a complete report is received within the month eligibility was terminated, the individual is considered to have continued an application for housing support payment effective the first day of the month the eligibility was terminated.~~

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

Sec. 15. Minnesota Statutes 2020, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the room and board rate for that same month. The housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

~~(b) For an individual with earned income under paragraph (a), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.~~

~~(c)~~ (b) For an individual who receives housing support payments under section 256I.04, subdivision 1, paragraph (c), the amount of the housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident.

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

Sec. 16. Minnesota Statutes 2020, section 256J.08, subdivision 71, is amended to read:

Subd. 71. **Prospective budgeting.** "Prospective budgeting" ~~means a method of determining the amount of the assistance payment in which the budget month and payment month are the same~~ has the meaning given in section 256P.01, subdivision 9.

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

Sec. 17. Minnesota Statutes 2020, section 256J.08, subdivision 79, is amended to read:

Subd. 79. **Recurring income.** "Recurring income" means a form of income which is:

(1) received periodically, and may be received irregularly when receipt can be anticipated even though the date of receipt cannot be predicted; and

(2) from the same source or of the same type that is received and budgeted in a prospective month ~~and is received in one or both of the first two retrospective months~~.

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

Sec. 18. Minnesota Statutes 2020, section 256J.21, subdivision 2, is amended to read:

Subd. 2. **Income exclusions.** The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9555.5050 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0654, payments for family foster care for children under section 260C.4411 or chapter 256N, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

(2) reimbursements for employment training received through the Workforce Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

(3) reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, employment, or informal carpooling arrangements directly related to employment;

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

(5) loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

(6) loans from private individuals, regardless of purpose, provided an applicant or participant documents that the lender expects repayment;

(7)(i) state income tax refunds; and

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

(iii) state homeowners and renters credits under chapter 290A; and

(iv) federal or state tax rebates;

(9) funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency, state or local government, or disaster assistance organizations, subsequent to a presidential declaration of disaster;

(10) the portion of an insurance settlement that is used to pay medical, funeral, and burial expenses, or to repair or replace insured property;

(11) reimbursements for medical expenses that cannot be paid by medical assistance;

(12) payments by a vocational rehabilitation program administered by the state under chapter 268A, except those payments that are for current living expenses;

(13) in-kind income, including any payments directly made by a third party to a provider of goods and services;

(14) assistance payments to correct underpayments, but only for the month in which the payment is received;

(15) payments for short-term emergency needs under section 256J.626, subdivision 2;

(16) funeral and cemetery payments as provided by section 256.935;

(17) nonrecurring cash gifts ~~of $30 or less, not exceeding $30 per participant in a calendar month~~;

(18) any form of energy assistance payment made through Public Law 97-35, Low-Income Home Energy Assistance Act of 1981, payments made directly to energy providers by other public and private agencies, and any form of credit or rebate payment issued by energy providers;

(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient;

(20) Minnesota supplemental aid, including retroactive payments;

(21) proceeds from the sale of real or personal property;

(22) adoption or kinship assistance payments under chapter 256N or 259A and Minnesota permanency demonstration title IV-E waiver payments;

(23) state-funded family subsidy program payments made under section 252.32 to help families care for children with developmental disabilities, consumer support grant funds under section 256.476, and resources and services for a disabled household member under one of the home and community-based waiver services programs under chapter 256B;

(24) interest payments and dividends from property that is not excluded from and that does not exceed the asset limit;

(25) rent rebates;

(26) income earned by a minor caregiver, minor child through age 6, or a minor child who is at least a half-time student in an approved elementary or secondary education program;

(27) income earned by a caregiver under age 20 who is at least a half-time student in an approved elementary or secondary education program;

(28) MFIP child care payments under section 119B.05;

(29) all other payments made through MFIP to support a caregiver's pursuit of greater economic stability;

(30) income a participant receives related to shared living expenses;

(31) reverse mortgages;

(32) benefits provided by the Child Nutrition Act of 1966, United States Code, title 42, chapter 13A, sections 1771 to 1790;

(33) benefits provided by the women, infants, and children (WIC) nutrition program, United States Code, title 42, chapter 13A, section 1786;

(34) benefits from the National School Lunch Act, United States Code, title 42, chapter 13, sections 1751 to 1769e;

(35) relocation assistance for displaced persons under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12, chapter 13, sections 1701 to 1750jj;

(36) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part 2, sections 2271 to 2322;

(37) war reparations payments to Japanese Americans and Aleuts under United States Code, title 50, sections 1989 to 1989d;

(38) payments to veterans or their dependents as a result of legal settlements regarding Agent Orange or other chemical exposure under Public Law 101-239, section 10405, paragraph (a)(2)(E);

(39) income that is otherwise specifically excluded from MFIP consideration in federal law, state law, or federal regulation;

(40) security and utility deposit refunds;

(41) American Indian tribal land settlements excluded under Public Laws 98-123, 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and Mille Lacs reservations and payments to members of the White Earth Band, under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

(42) all income of the minor parent's parents and stepparents when determining the grant for the minor parent in households that include a minor parent living with parents or stepparents on MFIP with other children;

(43) income of the minor parent's parents and stepparents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor parent's child in households that include a minor parent living with parents or stepparents

not on MFIP when determining the grant for the minor parent. The remainder of income is deemed as specified in section 256J.37, subdivision 1b;

(44) payments made to children eligible for relative custody assistance under section 257.85;

(45) vendor payments for goods and services made on behalf of a client unless the client has the option of receiving the payment in cash;

(46) the principal portion of a contract for deed payment;

(47) cash payments to individuals enrolled for full-time service as a volunteer under AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps National, and AmeriCorps NCCC;

(48) housing assistance grants under section 256J.35, paragraph (a); and

(49) child support payments of up to $100 for an assistance unit with one child and up to $200 for an assistance unit with two or more children.

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

Sec. 19. Minnesota Statutes 2020, section 256J.21, subdivision 3, is amended to read:

Subd. 3. **Initial income test.** The agency shall determine initial eligibility by considering all earned and unearned income that is not excluded under subdivision 2. To be eligible for MFIP, the assistance unit's countable income minus the earned income disregards in paragraph (a) and section 256P.03 must be below the family wage level according to section 256J.24, subdivision 7, for that size assistance unit.

(a) The initial eligibility determination must disregard the following items:

(1) the earned income disregard as determined in section 256P.03;

(2) dependent care costs must be deducted from gross earned income for the actual amount paid for dependent care up to a maximum of $200 per month for each child less than two years of age, and $175 per month for each child two years of age and older;

(3) all payments made according to a court order for spousal support or the support of children not living in the assistance unit's household shall be disregarded from the income of the person with the legal obligation to pay support; and

(4) an allocation for the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible and who lives with the caregiver according to section 256J.36.

(b) ~~After initial eligibility is established,~~ The income test is for a six-month period. The assistance payment calculation is based on ~~the monthly income test~~ prospective budgeting according to section 256P.09.

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

Sec. 20. Minnesota Statutes 2020, section 256J.21, subdivision 4, is amended to read:

Subd. 4. **~~Monthly~~ Income test and determination of assistance payment.** ~~The county agency shall determine ongoing eligibility and the assistance payment amount according to the monthly income test.~~ To be eligible for MFIP, the result of the computations in paragraphs (a) to (e) applied to prospective budgeting must be at least $1.

(a) Apply an income disregard as defined in section 256P.03, to gross earnings and subtract this amount from the family wage level. If the difference is equal to or greater than the MFIP transitional standard, the assistance payment is equal to the MFIP transitional standard. If the difference is less than the MFIP transitional standard, the assistance payment is equal to the difference. The earned income disregard in this paragraph must be deducted every month there is earned income.

(b) All payments made according to a court order for spousal support or the support of children not living in the assistance unit's household must be disregarded from the income of the person with the legal obligation to pay support.

(c) An allocation for the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible and who lives with the caregiver must be made according to section 256J.36.

(d) Subtract unearned income dollar for dollar from the MFIP transitional standard to determine the assistance payment amount.

(e) When income is both earned and unearned, the amount of the assistance payment must be determined by first treating gross earned income as specified in paragraph (a). After determining the amount of the assistance payment under paragraph (a), unearned income must be subtracted from that amount dollar for dollar to determine the assistance payment amount.

~~(f) When the monthly income is greater than the MFIP transitional standard after deductions and the income will only exceed the standard for one month, the county agency must suspend the assistance payment for the payment month.~~

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

Sec. 21. Minnesota Statutes 2020, section 256J.33, subdivision 1, is amended to read:

Subdivision 1. **Determination of eligibility.** A county agency must determine MFIP eligibility prospectively ~~for a payment month~~ based on ~~retrospectively~~ assessing income and the county agency's best estimate of the circumstances that will exist in the payment month.

~~Except as described in section 256J.34, subdivision 1, when prospective eligibility exists,~~ A county agency must calculate the amount of the assistance payment using ~~retrospective~~ prospective budgeting. To determine MFIP eligibility and the assistance payment amount, a county agency must apply countable income, described in ~~section~~ sections 256P.06 and 256J.37, subdivisions 3 to ~~10~~ 9, received by members of an assistance unit or by other persons whose income is counted for the assistance unit, described under sections 256J.21 and 256J.37, subdivisions 1 to 2.

This income must be applied to the MFIP standard of need or family wage level subject to this section and sections 256J.34 to 256J.36. Income received ~~in a calendar month~~ and not otherwise excluded under section 256J.21, subdivision 2, must be applied to the needs of an assistance unit. An assistance unit is not eligible when the countable income equals or exceeds the MFIP standard of need or the family wage level for the assistance unit.

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

Sec. 22. Minnesota Statutes 2020, section 256J.33, subdivision 2, is amended to read:

Subd. 2. **Prospective eligibility.** An agency must determine whether the eligibility requirements that pertain to an assistance unit, including those in sections 256J.11 to 256J.15 and 256P.02, will be met prospectively for the payment ~~month~~ period. ~~Except for the provisions in section 256J.34, subdivision 1,~~ The income test will be applied ~~retrospectively~~ prospectively.

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

Sec. 23. Minnesota Statutes 2020, section 256J.37, subdivision 3, is amended to read:

Subd. 3. **Earned income of wage, salary, and contractual employees.** The agency must include gross earned income less any disregards in the initial ~~and monthly~~ income test. Gross earned income received by persons employed on a contractual basis must be prorated over the period covered by the contract even when payments are received over a lesser period of time.

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

Sec. 24. Minnesota Statutes 2020, section 256J.37, subdivision 3a, is amended to read:

Subd. 3a. **Rental subsidies; unearned income.** (a) Effective July 1, 2003, the agency shall count $50 of the value of public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) as unearned income to the cash portion of the MFIP grant. The full amount of the subsidy must be counted as unearned income when the subsidy is less than $50. The income from this subsidy shall be budgeted according to section ~~256J.34~~ 256P.09.

(b) The provisions of this subdivision shall not apply to an MFIP assistance unit which includes a participant who is:

(1) age 60 or older;

(2) a caregiver who is suffering from an illness, injury, or incapacity that has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and severely limits the person's ability to obtain or maintain suitable employment; or

(3) a caregiver whose presence in the home is required due to the illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness or incapacity and the need for the participant's presence in the home has been certified by a qualified professional and is expected to continue for more than 30 days.

(c) The provisions of this subdivision shall not apply to an MFIP assistance unit where the parental caregiver is an SSI participant.

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

Sec. 25. Minnesota Statutes 2020, section 256J.626, subdivision 1, is amended to read:

Subdivision 1. **Consolidated fund.** The consolidated fund is established to support counties and tribes in meeting their duties under this chapter. Counties and tribes must use funds from the consolidated fund to develop programs and services that are designed to improve participant outcomes as measured in section 256J.751, subdivision 2. Counties and tribes that administer MFIP eligibility may use the funds for any allowable expenditures under subdivision 2, including case management. Tribes that do not administer MFIP eligibility may use the funds for any allowable expenditures under subdivision 2, including case management, except those in subdivision 2, paragraph (a), clauses (1) and (6).

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 26. Minnesota Statutes 2020, section 256N.25, subdivision 2, is amended to read:

Subd. 2. **Negotiation of agreement.** (a) When a child is determined to be eligible for Northstar kinship assistance or adoption assistance, the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, must negotiate with the caregiver to develop an agreement under subdivision 1. If and when the caregiver and agency reach concurrence as to the terms of the agreement, both parties shall sign the agreement. The agency must submit the agreement, along with the eligibility determination outlined in sections 256N.22, subdivision 7, and 256N.23, subdivision 7, to the commissioner for final review, approval, and signature according to subdivision 1.

(b) A monthly payment is provided as part of the adoption assistance or Northstar kinship assistance agreement to support the care of children unless the child is eligible for adoption assistance and determined to be an at-risk child, in which case no payment will be made unless and until the caregiver obtains written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself.

(1) The amount of the payment made on behalf of a child eligible for Northstar kinship assistance or adoption assistance is determined through agreement between the prospective relative custodian or the adoptive parent and the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, using the assessment tool established by the commissioner in section 256N.24, subdivision 2, and the associated benefit and payments outlined in section 256N.26. Except as provided under section 256N.24, subdivision 1, paragraph (c), the assessment tool establishes the monthly benefit level for a child under foster care. The monthly payment under a Northstar kinship assistance agreement or adoption assistance agreement may be negotiated up to the monthly benefit level under foster care. In no case may the amount of the payment under a Northstar kinship assistance agreement or adoption assistance agreement exceed the foster care maintenance payment which would have been paid during the month if the child with respect to whom the Northstar kinship assistance or adoption assistance payment is made had been in a foster family home in the state.

(2) The rate schedule for the agreement is determined based on the age of the child on the date that the prospective adoptive parent or parents or relative custodian or custodians sign the agreement.

(3) The income of the relative custodian or custodians or adoptive parent or parents must not be taken into consideration when determining eligibility for Northstar kinship assistance or adoption assistance or the amount of the payments under section 256N.26.

(4) With the concurrence of the relative custodian or adoptive parent, the amount of the payment may be adjusted periodically using the assessment tool established by the commissioner in section 256N.24, subdivision 2, and the agreement renegotiated under subdivision 3 when there is a change in the child's needs or the family's circumstances.

(5) An adoptive parent of an at-risk child with an adoption assistance agreement may request a reassessment of the child under section 256N.24, subdivision 10, and renegotiation of the adoption assistance agreement under subdivision 3 to include a monthly payment, if the caregiver has written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself. Documentation of the disability must be limited to evidence deemed appropriate by the commissioner.

(c) For Northstar kinship assistance agreements:

(1) the initial amount of the monthly Northstar kinship assistance payment must be equivalent to the foster care rate in effect at the time that the agreement is signed ~~less any offsets under section 256N.26, subdivision 11~~, or a lesser negotiated amount if agreed to by the prospective relative custodian and specified in that agreement, unless the Northstar kinship assistance agreement is entered into when a child is under the age of six; and

(2) the amount of the monthly payment for a Northstar kinship assistance agreement for a child who is under the age of six must be as specified in section 256N.26, subdivision 5.

(d) For adoption assistance agreements:

(1) for a child in foster care with the prospective adoptive parent immediately prior to adoptive placement, the initial amount of the monthly adoption assistance payment must be equivalent to the foster care rate in effect at the time that the agreement is signed ~~less any offsets in section 256N.26, subdivision 11~~, or a lesser negotiated amount if agreed to by the prospective adoptive parents and specified in that agreement, unless the child is identified as at-risk or the adoption assistance agreement is entered into when a child is under the age of six;

(2) for an at-risk child who must be assigned level A as outlined in section 256N.26, no payment will be made unless and until the potential disability manifests itself, as documented by an appropriate professional, and the commissioner authorizes commencement of payment by modifying the agreement accordingly;

(3) the amount of the monthly payment for an adoption assistance agreement for a child under the age of six, other than an at-risk child, must be as specified in section 256N.26, subdivision 5;

(4) for a child who is in the Northstar kinship assistance program immediately prior to adoptive placement, the initial amount of the adoption assistance payment must be equivalent to the Northstar kinship assistance payment in effect at the time that the adoption assistance agreement is signed or a lesser amount if agreed to by the prospective adoptive parent and specified in that agreement, unless the child is identified as an at-risk child; and

(5) for a child who is not in foster care placement or the Northstar kinship assistance program immediately prior to adoptive placement or negotiation of the adoption assistance agreement, the initial amount of the adoption assistance agreement must be determined using the assessment tool and process in this section and the corresponding payment amount outlined in section 256N.26.

Sec. 27. Minnesota Statutes 2020, section 256N.25, subdivision 3, is amended to read:

Subd. 3. **Renegotiation of agreement.** (a) A relative custodian or adoptive parent of a child with a Northstar kinship assistance or adoption assistance agreement may request renegotiation of the agreement when there is a change in the needs of the child or in the family's circumstances. When a relative custodian or adoptive parent requests renegotiation of the agreement, a reassessment of the child must be completed consistent with section 256N.24, subdivisions 10 and 11. If the reassessment indicates that the child's level has changed, the financially responsible agency or, if there is no financially responsible agency, the agency designated by the commissioner or the commissioner's designee, and the caregiver must renegotiate the agreement to include a payment with the level determined through the reassessment process. The agreement must not be renegotiated unless the commissioner, the financially responsible agency, and the caregiver mutually agree to the changes. The effective date of any renegotiated agreement must be determined by the commissioner.

(b) An adoptive parent of an at-risk child with an adoption assistance agreement may request renegotiation of the agreement to include a monthly payment under section 256N.26 if the caregiver has written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself. Documentation of the disability must be limited to evidence deemed appropriate by the commissioner. Prior to renegotiating the agreement, a reassessment of the child must be conducted as outlined in section 256N.24, subdivision 10. The reassessment must be used to renegotiate the agreement to include an appropriate monthly payment. The agreement must not be

renegotiated unless the commissioner, the financially responsible agency, and the caregiver mutually agree to the changes. The effective date of any renegotiated agreement must be determined by the commissioner.

~~(c) Renegotiation of a Northstar kinship assistance or adoption assistance agreement is required when one of the circumstances outlined in section 256N.26, subdivision 13, occurs.~~

Sec. 28. Minnesota Statutes 2020, section 256N.26, subdivision 11, is amended to read:

Subd. 11. **Child income or income attributable to the child.** (a) A monthly Northstar kinship assistance or adoption assistance payment must be considered as income and resources attributable to the child. Northstar kinship assistance and adoption assistance are exempt from garnishment, except as permissible under the laws of the state where the child resides.

(b) When a child is placed into foster care, any income and resources attributable to the child are treated as provided in sections 252.27 and 260C.331, or 260B.331, as applicable to the child being placed.

(c) ~~Consideration of income and resources attributable to the child must be part of the negotiation process outlined in section 256N.25, subdivision 2. In some circumstances, the receipt of other income on behalf of the child may impact the amount of the monthly payment received by the relative custodian or adoptive parent on behalf of the child through Northstar Care for Children.~~ Supplemental Security Income (SSI), retirement survivor's disability insurance (RSDI), veteran's benefits, railroad retirement benefits, and black lung benefits are considered income and resources attributable to the child.

Sec. 29. Minnesota Statutes 2020, section 256N.26, subdivision 13, is amended to read:

Subd. 13. **Treatment of retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, and black lung benefits.** ~~(a)~~ If a child placed in foster care receives retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits at the time of foster care placement or subsequent to placement in foster care, the financially responsible agency may apply to be the payee for the child for the duration of the child's placement in foster care. If it is anticipated that a child will be eligible to receive retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits after finalization of the adoption or assignment of permanent legal and physical custody, the permanent caregiver shall apply to be the payee of those benefits on the child's behalf. ~~The monthly amount of the other~~

~~benefits must be considered an offset to the amount of the payment the child is determined eligible for under Northstar Care for Children.~~

~~(b) If a child becomes eligible for retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits, after the initial amount of the payment under Northstar Care for Children is finalized, the permanent caregiver shall contact the commissioner to redetermine the payment under Northstar Care for Children. The monthly amount of the other benefits must be considered an offset to the amount of the payment the child is determined eligible for under Northstar Care for Children.~~

~~(c) If a child ceases to be eligible for retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits after the initial amount of the payment under Northstar Care for Children is finalized, the permanent caregiver shall contact the commissioner to redetermine the payment under Northstar Care for Children. The monthly amount of the payment under Northstar Care for Children must be the amount the child was determined to be eligible for prior to consideration of any offset.~~

~~(d) If the monthly payment received on behalf of the child under retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits changes after the adoption assistance or Northstar kinship assistance agreement is finalized, the permanent caregiver shall notify the commissioner as to the new monthly payment amount, regardless of the amount of the change in payment. If the monthly payment changes by $75 or more, even if the change occurs incrementally over the duration of the term of the adoption assistance or Northstar kinship assistance agreement, the monthly payment under Northstar Care for Children must be adjusted without further consent to reflect the amount of the increase or decrease in the offset amount. Any subsequent change to the payment must be reported and handled in the same manner. A change of monthly payments of less than $75 is not a permissible reason to renegotiate the adoption assistance or Northstar kinship assistance agreement under section 256N.25, subdivision 3. The commissioner shall review and revise the limit at which the adoption assistance or Northstar kinship assistance agreement must be renegotiated in accordance with subdivision 9.~~

Sec. 30. Minnesota Statutes 2020, section 256P.01, is amended by adding a subdivision to read:

Subd. 9. **Prospective budgeting.** "Prospective budgeting" means estimating the amount of monthly income that an assistance unit will have in the payment month.

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

Sec. 31. Minnesota Statutes 2020, section 256P.04, subdivision 4, is amended to read:

Subd. 4. **Factors to be verified.** (a) The agency shall verify the following at application:

(1) identity of adults;

(2) age, if necessary to determine eligibility;

(3) immigration status;

(4) income;

(5) spousal support and child support payments made to persons outside the household;

(6) vehicles;

(7) checking and savings accounts;

(8) inconsistent information, if related to eligibility;

(9) residence; and

(10) Social Security number~~; and~~.

~~(11) use of nonrecurring income under section 256P.06, subdivision 3, clause (2), item (ix), for the intended purpose for which it was given and received.~~

(b) Applicants who are qualified noncitizens and victims of domestic violence as defined under section 256J.08, subdivision 73, clause (7), are not required to verify the information in paragraph (a), clause (10). When a Social Security number is not provided to the agency for verification, this requirement is satisfied when each member of the assistance unit cooperates with the procedures for verification of Social Security numbers, issuance of duplicate cards, and issuance of new numbers which have been established jointly between the Social Security Administration and the commissioner.

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

Sec. 32. Minnesota Statutes 2020, section 256P.04, subdivision 8, is amended to read:

Subd. 8. **Recertification.** The agency shall recertify eligibility ~~in an annual interview with the participant. The interview may be conducted by telephone, by Internet telepresence, or face-to-face in the county office or in another location mutually agreed upon. A participant must be given the option of a telephone interview or Internet telepresence to recertify eligibility~~ annually. During ~~the interview~~ recertification and reporting under section 256P.10, the agency shall verify the following:

(1) income, unless excluded, including self-employment earnings;

(2) assets when the value is within $200 of the asset limit; and

(3) inconsistent information, if related to eligibility.

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

Sec. 33. Minnesota Statutes 2020, section 256P.06, subdivision 3, is amended to read:

Subd. 3. **Income inclusions.** The following must be included in determining the income of an assistance unit:

(1) earned income; and

(2) unearned income, which includes:

(i) interest and dividends from investments and savings;

(ii) capital gains as defined by the Internal Revenue Service from any sale of real property;

(iii) proceeds from rent and contract for deed payments in excess of the principal and interest portion owed on property;

(iv) income from trusts, excluding special needs and supplemental needs trusts;

(v) interest income from loans made by the participant or household;

(vi) cash prizes and winnings according to guidance provided for the Supplemental Nutrition Assistance Program;

(vii) unemployment insurance income that is received by an adult member of the assistance unit unless the individual receiving unemployment insurance income is:

(A) 18 years of age and enrolled in a secondary school; or

(B) 18 or 19 years of age, a caregiver, and is enrolled in school at least half-time;

(viii) retirement, survivors, and disability insurance payments;

~~(ix) nonrecurring income over $60 per quarter unless earmarked and used for the purpose for which it is intended. Income and use of this income is subject to verification requirements under section 256P.04;~~

~~(x)~~ (ix) retirement benefits;

~~(xi)~~ (x) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I, and 256J;

~~(xii)~~ (xi) tribal per capita payments unless excluded by federal and state law;

~~(xiii)~~ (xii) income and payments from service and rehabilitation programs that meet or exceed the state's minimum wage rate;

~~(xiv)~~ (xiii) income from members of the United States armed forces unless excluded from income taxes according to federal or state law;

~~(xv)~~ (xiv) all child support payments for programs under chapters 119B, 256D, and 256I;

~~(xvi)~~ (xv) the amount of child support received that exceeds $100 for assistance units with one child and $200 for assistance units with two or more children for programs under chapter 256J; and

~~(xvii)~~ (xvi) spousal support.

EFFECTIVE DATE. This section is effective March 1, 2023, except subdivision 3, paragraph (2), clause (vii), which is effective the day following final enactment.

Sec. 34. Minnesota Statutes 2020, section 256P.07, is amended to read:

256P.07 REPORTING OF ~~INCOME AND~~ CHANGES.

Subdivision 1. **Exempted programs.** Participants who receive Supplemental Security Income and qualify for Minnesota supplemental aid under chapter 256D ~~and~~ or for housing support under chapter 256I ~~on the basis of eligibility for Supplemental Security Income~~ are exempt from ~~this section~~ reporting income.

Subd. 1a. **Child care assistance programs.** Participants who qualify for child care assistance programs under chapter 119B are exempt from this section except for the reporting requirements in subdivision 6.

Subd. 2. **Reporting requirements.** An applicant or participant must provide information on an application and any subsequent reporting forms about the assistance unit's circumstances that affect eligibility or benefits. An applicant or assistance unit must report changes identified in ~~subdivision~~ subdivisions 3, 4, 5, 7, 8, and 9 during the application period or by the tenth of the month following the month that the change occurred. When information is not accurately reported, both an overpayment and a referral for a fraud investigation may result. When information or documentation is not provided, the receipt of any benefit may be delayed or denied, depending on the type of information required and its effect on eligibility.

Subd. 3. **Changes that must be reported.** ~~An assistance unit must report the changes or anticipated changes specified in clauses (1) to (12) within ten days of the date they occur, at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or~~

~~within eight calendar days of a reporting period, whichever occurs first. An assistance unit must report other changes at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or at the end of a reporting period, as applicable. When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under clauses (1) to (12) had not occurred, the agency must determine whether a timely notice could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under section 119B.11, subdivision 2a, or 256P.08. Changes in circumstances that must be reported within ten days must also be reported for the reporting period in which those changes occurred. Within ten days, an assistance unit must report:~~

~~(1) a change in earned income of $100 per month or greater with the exception of a program under chapter 119B;~~

~~(2) a change in unearned income of $50 per month or greater with the exception of a program under chapter 119B;~~

~~(3) a change in employment status and hours with the exception of a program under chapter 119B;~~

~~(4) a change in address or residence;~~

~~(5) a change in household composition with the exception of programs under chapter 256I;~~

~~(6) a receipt of a lump-sum payment with the exception of a program under chapter 119B;~~

~~(7) an increase in assets if over $9,000 with the exception of programs under chapter 119B;~~

~~(8) a change in citizenship or immigration status;~~

~~(9) a change in family status with the exception of programs under chapter 256I;~~

~~(10) a change in disability status of a unit member, with the exception of programs under chapter 119B;~~

~~(11) a new rent subsidy or a change in rent subsidy with the exception of a program under chapter 119B; and~~

~~(12) a sale, purchase, or transfer of real property with the exception of a program under chapter 119B.~~ An assistance unit must report changes or anticipated changes as described in this section.

(a) An assistance unit must report:

(1) a change in eligibility for Supplemental Security Income, Retirement Survivors Disability Insurance, or another federal income support;

(2) a change in address or residence;

(3) a change in household composition with the exception of programs under chapter 256I;

(4) cash prizes and winnings according to guidance provided for the Supplemental Nutrition Assistance Program;

(5) a change in citizenship or immigration status;

(6) a change in family status with the exception of programs under chapter 256I; and

(7) assets when the value is at or above the asset limit.

(b) When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified in clauses (1) to (7) had not occurred, the agency must determine whether a timely notice could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to the notice must be considered a client error overpayment under section 256P.08.

Subd. 4. **MFIP-specific reporting.** In addition to subdivision 3, an assistance unit under chapter 256J, ~~within ten days of the change,~~ must report:

(1) a pregnancy not resulting in birth when there are no other minor children; ~~and~~

(2) a change in school attendance of a parent under 20 years of age ~~or of an employed child.~~; and

(3) an individual who is 18 or 19 years of age attending high school who graduates or drops out of school.

Subd. 5. **DWP-specific reporting.** In addition to subdivisions 3 and 4, an assistance unit participating in the diversionary work program under section 256J.95 must report on an application:

(1) shelter expenses; and

(2) utility expenses.

Subd. 6. **Child care assistance programs-specific reporting.** (a) ~~In addition to subdivision 3,~~ An assistance unit under chapter 119B, within ten days of the change, must report:

(1) a change in a parentally responsible individual's custody schedule for any child receiving child care assistance program benefits;

(2) a permanent end in a parentally responsible individual's authorized activity; ~~and~~

(3) if the unit's family's annual included income exceeds 85 percent of the state median income, adjusted for family size~~.~~;

(4) a change in address or residence;

(5) a change in household composition;

(6) a change in citizenship or immigration status; and

(7) a change in family status.

(b) An assistance unit subject to section 119B.095, subdivision 1, paragraph (b), must report a change in the unit's authorized activity status.

(c) An assistance unit must notify the county when the unit wants to reduce the number of authorized hours for children in the unit.

Subd. 7. **Minnesota supplemental aid-specific reporting.** (a) In addition to subdivision 3 and notwithstanding the exemption in subdivision 1, an assistance unit participating in the Minnesota supplemental aid program under ~~section 256D.44, subdivision 5, paragraph (g), within ten days of the change,~~ chapter 256D must report ~~shelter expenses.~~:

(1) a change in unearned income of $50 per month or greater; and

(2) a change in earned income of $100 per month or greater.

(b) An assistance unit receiving housing assistance under section 256D.44, subdivision 5, paragraph (g), including assistance units who also receive Supplemental Security Income, must report:

(1) a change in shelter expenses; and

(2) a new rent subsidy or a change in a rent subsidy.

Subd. 8. **Housing support-specific reporting.** (a) In addition to subdivision 3, an assistance unit participating in the housing support program under chapter 256I must report:

(1) a change in unearned income of $50 per month or greater; and

(2) a change in earned income of $100 per month or greater, with the exception of participants already subject to six-month reporting requirements in section 256P.10.

(b) Notwithstanding the exemptions in subdivisions 1 and 3, an assistance unit receiving housing support under chapter 256I, including an assistance unit that receives Supplemental Security Income, must report:

(1) a new rent subsidy or a change in a rent subsidy;

(2) a change in the disability status of a unit member; and

(3) a change in household composition if the assistance unit is a participant in housing support under section 256I.04, subdivision 3, paragraph (a), clause (3).

Subd. 9. **General assistance-specific reporting.** In addition to subdivision 3, an assistance unit participating in the general assistance program under chapter 256D must report:

(1) a change in unearned income of $50 per month or greater;

(2) a change in earned income of $100 per month or greater, with the exception of participants who are already subject to six-month reporting requirements in section 256P.10; and

(3) changes in any condition that would result in the loss of a basis for eligibility in section 256D.05, subdivision 1, paragraph (a).

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

Sec. 35. **[256P.09] PROSPECTIVE BUDGETING OF BENEFITS.**

Subdivision 1. **Exempted programs.** Assistance units who qualify for child care assistance programs under chapter 119B; housing support assistance units under chapter 256I who are not subject to reporting under section 256P.10; and assistance units who qualify for Minnesota Supplemental Aid under chapter 256D are exempt from this section.

Subd. 2. **Prospective budgeting of benefits.** An agency must use prospective budgeting to calculate an assistance payment amount.

Subd. 3. **Income changes.** Prospective budgeting must be used to determine the amount of the assistance unit's benefit for the following six-month period. An increase in income shall not affect an assistance unit's eligibility or benefit amount until the next case review

unless otherwise required by section 256P.07. A decrease in income shall be effective on the date that the change occurs.

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

Sec. 36. **[256P.10] SIX-MONTH REPORTING.**

Subdivision 1. **Exempted programs.** Assistance units who qualify for child care assistance programs under chapter 119B; assistance units who qualify for Minnesota Supplemental Aid under chapter 256D; and assistance units who qualify for housing support under chapter 256I and also receive Supplemental Security Income are exempt from this section.

Subd. 2. **Reporting.** (a) Every six months, an assistance unit that qualifies for the Minnesota family investment program under chapter 256J; an assistance unit that qualifies for general assistance under chapter 256D with earned income of $100 per month or greater; or an assistance unit that qualifies for housing support under chapter 256I with earned income of $100 per month or greater is subject to six month case reviews. The initial reporting period may be shorter than six months in order to align with other program reporting periods.

(b) An assistance unit that qualifies for the Minnesota family investment program and an assistance unit that qualifies for general assistance as described in paragraph (a) must complete household report forms as prescribed by the commissioner for redetermination of benefits.

(c) An assistance unit that qualifies for housing support as described in paragraph (a) must complete household report forms as prescribed by the commissioner to provide information about earned income.

(d) An assistance unit that qualifies for housing support and also receives assistance through the Minnesota family investment program shall be subject to the requirements of this section for purposes of the Minnesota family investment program but not for housing support.

(e) An assistance unit must submit a household report form in compliance with the provisions in section 256P.04, subdivision 11.

(f) An assistance unit may choose to report changes under this section at any time.

Subd. 3. **When to terminate assistance.** (a) An agency must end benefits when the participant fails to submit the household report form before the end of the six month review

period. If the participant submits the household report form within 30 days of the termination of benefits, benefits must be reinstated and made available retroactively for the full benefit month.

(b) When an assistance unit is determined to be ineligible for assistance according to this section and chapter 256D, 256I, or 256J, the agency must terminate assistance

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

Sec. 37. **DIRECTION TO THE COMMISSIONER; CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATION.**

(a) The commissioner shall allocate $10,948,000 in fiscal year 2022, $36,571,000 in fiscal year 2023, $35,522,000 in fiscal year 2024, and $49,710,000 in fiscal year 2025 from the child care development block grant amount in the federal fund for the rate increase under Minnesota Statutes, section 119B.13, subdivision 1, paragraph (a).

(b) Each year an amount equal to at least 88 percent of the federal discretionary funding in the Child Care Development Block Grant of 2014, Public Law 113-186, in federal fiscal year 2018 above the amounts authorized in federal fiscal year 2017 shall be allocated to pay the cost of rate adjustments based on the most recent market survey.

(c) When increased federal discretionary child care development block grant funding is used to pay for the rate increase under paragraph (a), the commissioner, in consultation with the commissioner of management and budget, may adjust the amount of working family credit expenditures as needed to meet the state's maintenance of effort requirements for the TANF block grant.

Sec. 38. **REPEALER.**

(a) Minnesota Statutes 2020, sections 256D.051, subdivisions 1, 1a, 2, 2a, 3, 3a, 3b, 6b, 6c, 7, 8, 9, and 18; and 256D.052, subdivision 3, are repealed.

(b) Minnesota Statutes 2020, sections 256J.08, subdivisions 10, 53, 61, 62, 81, and 83; 256J.30, subdivisions 5, 7, and 8; 256J.33, subdivisions 3, 4, and 5; 256J.34, subdivisions 1, 2, 3, and 4; and 256J.37, subdivision 10, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective August 1, 2021. Paragraph (b) is effective March 1, 2023.

ARTICLE 2
COMMUNITY SUPPORTS

Section 1. Minnesota Statutes 2020, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (h), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; ~~or~~

(5) new foster care licenses or community residential setting licenses for people receiving services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and for which a license is required. This exception does not apply to people living in their own

home. For purposes of this clause, there is a presumption that a foster care or community residential setting license is required for services provided to three or more people in a dwelling unit when the setting is controlled by the provider. A license holder subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2018. This exception is available when:

(i) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and

(ii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the unlicensed setting as determined by the lead agency~~.~~; or

(6) new foster care licenses or community residential setting licenses for people receiving customized living or 24-hour customized living services under the brain injury or community access for disability inclusion waiver plans under section 256B.49 and residing in the customized living setting before July 1, 2022, for which a license is required. A customized living service provider subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2023. This exception is available when:

(i) the person's customized living services are provided in a customized living service setting serving four or fewer people under the brain injury or community access for disability inclusion waiver plans under section 256B.49 in a single-family home operational on or before June 30, 2021. Operational is defined in section 256B.49, subdivision 28;

(ii) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and

(iii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the customized living setting as determined by the lead agency.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination,

the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department may decrease the statewide licensed capacity for adult foster care settings.

(d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (c) shall be exempt if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity determined under section 256B.493 will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet the informed decisions of those people who want to move out of corporate foster care or community residential settings, long-term service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term services and supports reports and statewide data and information.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(g) License holders of foster care homes identified under paragraph (f) that are not the primary residence of the license holder and that also provide services in the foster care home

that are covered by a federally approved home and community-based services waiver, as authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services.

(h) The commissioner may adjust capacity to address needs identified in section 144A.351. Under this authority, the commissioner may approve new licensed settings or delicense existing settings. Delicensing of settings will be accomplished through a process identified in section 256B.493. Annually, by August 1, the commissioner shall provide information and data on capacity of licensed long-term services and supports, actions taken under the subdivision to manage statewide long-term services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over the health and human services budget.

(i) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds. If a request for reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

(j) The commissioner shall not issue an initial license for children's residential treatment services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter for a program that Centers for Medicare and Medicaid Services would consider an institution for mental diseases. Facilities that serve only private pay clients are exempt from the moratorium described in this paragraph. The commissioner has the authority to manage existing statewide capacity for children's residential treatment services subject to the moratorium under this paragraph and may issue an initial license for such facilities if the initial license would not increase the statewide capacity for children's residential treatment services subject to the moratorium under this paragraph.

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

Sec. 2. Minnesota Statutes 2020, section 245C.03, is amended by adding a subdivision to read:

Subd. 15. **Early intensive developmental and behavioral intervention providers.** The commissioner shall conduct background studies according to this chapter when initiated by an early intensive developmental and behavioral intervention provider under section 256B.0949.

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

Sec. 3. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 17. **Early intensive developmental and behavioral intervention providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 15, for the purposes of early intensive developmental and behavioral intervention under section 256B.0949, through a fee of no more than $20 per study charged to the enrolled agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

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

Sec. 4. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

(3) care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) medication-assisted therapy services that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(9) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(12) room and board facilities that meet the requirements of subdivision 1a.

~~(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:~~

~~(1) programs that serve parents with their children if the program:~~

~~(i) provides on-site child care during the hours of treatment activity that:~~

~~(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or~~

~~(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or~~

~~(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:~~

~~(A) a child care center under Minnesota Rules, chapter 9503; or~~

~~(B) a family child care home under Minnesota Rules, chapter 9502;~~

~~(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:~~

~~(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;~~

~~(ii) is governed with significant input from individuals of that specific background; and~~

~~(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve;~~

~~(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and~~

~~(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:~~

~~(i) the program meets the co-occurring requirements in section 245G.20;~~

~~(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;~~

~~(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;~~

~~(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;~~

~~(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and~~

~~(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.~~

~~(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.~~

~~(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).~~

~~(f)~~ (e) Subject to federal approval, ~~chemical dependency~~ substance use disorder services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video according to section 256B.0625, subdivision 3b. ~~The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.~~

~~(g)~~ (f) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

(g) Payment for outpatient substance use disorder services that are licensed according to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless prior authorization of a greater number of hours is obtained from the commissioner.

Sec. 5. Minnesota Statutes 2020, section 256.042, subdivision 2, is amended to read:

Subd. 2. **Membership.** (a) The council shall consist of the following ~~19~~ 28 voting members, appointed by the commissioner of human services except as otherwise specified, and three nonvoting members:

(1) two members of the house of representatives, appointed in the following sequence: the first from the majority party appointed by the speaker of the house and the second from the minority party appointed by the minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area, and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(2) two members of the senate, appointed in the following sequence: the first from the majority party appointed by the senate majority leader and the second from the minority party appointed by the senate minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(3) one member appointed by the Board of Pharmacy;

(4) one member who is a physician appointed by the Minnesota Medical Association;

(5) one member representing opioid treatment programs, sober living programs, or substance use disorder programs licensed under chapter 245G;

(6) one member appointed by the Minnesota Society of Addiction Medicine who is an addiction psychiatrist;

(7) one member representing professionals providing alternative pain management therapies, including, but not limited to, acupuncture, chiropractic, or massage therapy;

(8) one member representing nonprofit organizations conducting initiatives to address the opioid epidemic, with the commissioner's initial appointment being a member representing the Steve Rummler Hope Network, and subsequent appointments representing this or other organizations;

(9) one member appointed by the Minnesota Ambulance Association who is serving with an ambulance service as an emergency medical technician, advanced emergency medical technician, or paramedic;

(10) one member representing the Minnesota courts who is a judge or law enforcement officer;

(11) one public member who is a Minnesota resident and who is in opioid addiction recovery;

(12) ~~two~~ 11 members representing Indian tribes, one representing ~~the Ojibwe tribes and one representing the Dakota tribes~~ each of Minnesota's tribal nations;

(13) one public member who is a Minnesota resident and who is suffering from chronic pain, intractable pain, or a rare disease or condition;

(14) one mental health advocate representing persons with mental illness;

(15) one member appointed by the Minnesota Hospital Association;

(16) one member representing a local health department; and

(17) the commissioners of human services, health, and corrections, or their designees, who shall be ex officio nonvoting members of the council.

(b) The commissioner of human services shall coordinate the commissioner's appointments to provide geographic, racial, and gender diversity, and shall ensure that at least one-half of council members appointed by the commissioner reside outside of the seven-county metropolitan area. Of the members appointed by the commissioner, to the extent practicable, at least one member must represent a community of color disproportionately affected by the opioid epidemic.

(c) The council is governed by section 15.059, except that members of the council shall serve three-year terms and shall receive no compensation other than reimbursement for expenses. Notwithstanding section 15.059, subdivision 6, the council shall not expire.

(d) The chair shall convene the council at least quarterly, and may convene other meetings as necessary. The chair shall convene meetings at different locations in the state to provide geographic access, and shall ensure that at least one-half of the meetings are held at locations outside of the seven-county metropolitan area.

(e) The commissioner of human services shall provide staff and administrative services for the advisory council.

(f) The council is subject to chapter 13D.

Sec. 6. Minnesota Statutes 2020, section 256.042, subdivision 4, is amended to read:

Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the grants proposed by the advisory council to be awarded for the upcoming ~~fiscal~~ calendar year to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by March 1 of each year, beginning March 1, 2020.

(b) The commissioner of human services shall award grants from the opiate epidemic response fund under section 256.043. The grants shall be awarded to proposals selected by the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1) to (4), unless otherwise appropriated by the legislature. No more than three percent of the grant amount may be used by a grantee for administration.

Sec. 7. Minnesota Statutes 2020, section 256.043, subdivision 3, is amended to read:

Subd. 3. **Appropriations from fund.** (a) After the appropriations in Laws 2019, chapter 63, article 3, section 1, paragraphs (e), (f), (g), and (h) are made, $249,000 is appropriated to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph (e).

(b) $126,000 is appropriated to the Board of Pharmacy for the collection of the registration fees under section 151.066.

(c) $672,000 is appropriated to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

(d) After the appropriations in paragraphs (a) to (c) are made, 50 percent of the remaining amount is appropriated to the commissioner of human services for distribution to county social service and tribal social service agencies to provide child protection services to children and families who are affected by addiction. The commissioner shall distribute this money proportionally to counties and tribal social service agencies based on out-of-home placement episodes where parental drug abuse is the primary reason for the out-of-home placement using data from the previous calendar year. County and tribal social service agencies receiving funds from the opiate epidemic response fund must annually report to the commissioner on how the funds were used to provide child protection services, including measurable outcomes, as determined by the commissioner. County social service agencies and tribal social service agencies must not use funds received under this paragraph to supplant current state or local funding received for child protection services for children and families who are affected by addiction.

(e) After making the appropriations in paragraphs (a) to (d), the remaining amount in the fund is appropriated to the commissioner to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise appropriated by the legislature.

(f) Beginning in fiscal year 2022 and each year thereafter, funds for county social service and tribal social service agencies under paragraph (d) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph (e) shall be distributed on a calendar year basis.

Sec. 8. Minnesota Statutes 2020, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative or a contact by interactive video that meets the requirements of subdivision 20b; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 20b with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county ~~or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe~~ must be calculated in accordance with section 256B.076, subdivision 2. Payment for mental health case management provided by vendors who contract with a tribe must be based on a monthly rate negotiated by the tribe. The ~~negotiated~~ rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the ~~county or tribe may negotiate a team rate with a vendor who is a member of the team. The~~ team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of

responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include the federal earnings, the state share, and the county share.

(m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(p) If the recipient is receiving care in a hospital, nursing facility, or residential setting licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week, mental health targeted case management services must actively support identification of community alternatives for the recipient and discharge planning.

Sec. 9. Minnesota Statutes 2020, section 256B.0759, subdivision 2, is amended to read:

Subd. 2. **Provider participation.** (a) Outpatient substance use disorder treatment providers may elect to participate in the demonstration project and meet the requirements of subdivision 3. To participate, a provider must notify the commissioner of the provider's

intent to participate in a format required by the commissioner and enroll as a demonstration project provider.

(b) Programs licensed by the Department of Human Services as a residential treatment program according to section 245G.21 and that receive payment under this chapter must enroll as a demonstration project provider and meet the requirements of subdivision 3 by January 1, 2022. Programs that do not meet the requirements under this paragraph are ineligible for payment for services provided under section 256B.0625.

(c) Programs licensed by the Department of Human Services as a withdrawal management program according to chapter 245F and that receive payment under this chapter must enroll as a demonstration project provider and meet the requirements of subdivision 3 by January 1, 2022. Programs that do not meet the requirements under this paragraph are ineligible for payment for services provided under section 256B.0625.

(d) Out-of-state residential substance use disorder treatment programs that receive payment under this chapter must enroll as a demonstration project provider and meet the requirements of subdivision 3 by January 1, 2022. Programs that do not meet the requirements under this paragraph are ineligible for payment for services provided under section 256B.0625.

(e) Tribally licensed programs may elect to participate in the demonstration project and meet the requirements of subdivision 3. The Department of Human Services must consult with tribal nations to discuss participation in the substance use disorder demonstration project.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 10. Minnesota Statutes 2020, section 256B.0759, subdivision 4, is amended to read:

Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must be increased for services provided to medical assistance enrollees. To receive a rate increase, participating providers must meet demonstration project requirements, provider standards under subdivision 3, and provide evidence of formal referral arrangements with providers delivering step-up or step-down levels of care.

(b) The commissioner may temporarily suspend payments to the provider according to section 256B.04, subdivision 21, paragraph (d), if the requirements in paragraph (a) are not met. Payments withheld from the provider must be made once the commissioner determines that the requirements in paragraph (a) are met.

~~(b)~~ (c) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clause (8), provided on or after July 1, 2020, payment rates must be increased by 15 percent over the rates in effect on December 31, 2019.

~~(c)~~ (d) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clauses (1), (6), and (7), and adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on or after January 1, 2021, payment rates must be increased by ten percent over the rates in effect on December 31, 2020.

~~(d)~~ (e) Effective January 1, 2021, and contingent on annual federal approval, managed care plans and county-based purchasing plans must reimburse providers of the substance use disorder services meeting the criteria described in paragraph (a) who are employed by or under contract with the plan an amount that is at least equal to the fee-for-service base rate payment for the substance use disorder services described in paragraphs ~~(b)~~ (c) and ~~(c)~~ (d). The commissioner must monitor the effect of this requirement on the rate of access to substance use disorder services and residential substance use disorder rates. Capitation rates paid to managed care organizations and county-based purchasing plans must reflect the impact of this requirement. This paragraph expires if federal approval is not received at any time as required under this paragraph.

~~(e)~~ (f) Effective July 1, 2021, contracts between managed care plans and county-based purchasing plans and providers to whom paragraph ~~(d)~~ (e) applies must allow recovery of payments from those providers if, for any contract year, federal approval for the provisions of paragraph ~~(d)~~ (e) is not received, and capitation rates are adjusted as a result. Payment recoveries must not exceed the amount equal to any decrease in rates that results from this provision.

Sec. 11. **[256B.076] CASE MANAGEMENT SERVICES.**

Subdivision 1. **Generally.** (a) It is the policy of this state to ensure that individuals on medical assistance receive cost-effective and coordinated care, including efforts to address the profound effects of housing instability, food insecurity, and other social determinants of health. Therefore, subject to federal approval, medical assistance covers targeted case management services as described in this section.

(b) The commissioner, in collaboration with tribes, counties, providers, and individuals served, must propose further modifications to targeted case management services to ensure a program that complies with all federal requirements, delivers services in a cost-effective

and efficient manner, creates uniform expectations for targeted case management services, addresses health disparities, and promotes person- and family-centered services.

Subd. 2. **Rate setting.** (a) The commissioner must develop and implement a statewide rate methodology for any county that subcontracts targeted case management services to a vendor. On January 1, 2022, or upon federal approval, whichever is later, a county must use this methodology for any targeted case management services paid by medical assistance and delivered through a subcontractor.

(b) In setting this rate, the commissioner must include the following:

(1) prevailing wages;

(2) employee-related expense factor;

(3) paid time off and training factors;

(4) supervision and span of control;

(5) distribution of time factor;

(6) administrative factor;

(7) absence factor;

(8) program support factor; and

(9) caseload sizes as described in subdivision 3.

(c) A county may request that the commissioner authorize a rate based on a lower caseload size when a subcontractor is assigned to serve individuals with needs, such as homelessness or specific linguistic or cultural needs, that significantly exceed other eligible populations. A county must include the following in the request:

(1) the number of clients to be served by a full-time equivalent staffer;

(2) the specific factors that require a case manager to provide significantly more hours of reimbursable services to a client; and

(3) how the county intends to monitor case size and outcomes.

(d) The commissioner must adjust only the factor for caseload in paragraph (b), clause (9), in response to a request under paragraph (c).

Subd. 3. **Caseload sizes.** A county-subcontracted provider of targeted case management services to the following populations must not exceed the following limits:

(1) for children with severe emotional disturbance, 15 clients to one full-time equivalent case manager;

(2) for adults with severe and persistent mental illness, 30 clients to one full-time equivalent case manager;

(3) for child welfare targeted case management, 45 clients to one full-time equivalent case manager; and

(4) for vulnerable adults and adults who have developmental disabilities, 45 clients to one full-time equivalent case manager.

Sec. 12. Minnesota Statutes 2020, section 256B.092, subdivision 4, is amended to read:

Subd. 4. **Home and community-based services for developmental disabilities.** (a) The commissioner shall make payments to approved vendors participating in the medical assistance program to pay costs of providing home and community-based services, including case management service activities provided as an approved home and community-based service, to medical assistance eligible persons with developmental disabilities who have been screened under subdivision 7 and according to federal requirements. Federal requirements include those services and limitations included in the federally approved application for home and community-based services for persons with developmental disabilities and subsequent amendments.

~~(b) Effective July 1, 1995, contingent upon federal approval and state appropriations made available for this purpose, and in conjunction with Laws 1995, chapter 207, article 8, section 40, the commissioner of human services shall allocate resources to county agencies for home and community-based waivered services for persons with developmental disabilities authorized but not receiving those services as of June 30, 1995, based upon the average resource need of persons with similar functional characteristics. To ensure service continuity for service recipients receiving home and community-based waivered services for persons with developmental disabilities prior to July 1, 1995, the commissioner shall make available to the county of financial responsibility home and community-based waivered services resources based upon fiscal year 1995 authorized levels.~~

~~(c) Home and community-based resources for all recipients shall be managed by the county of financial responsibility within an allowable reimbursement average established for each county. Payments for home and community-based services provided to individual recipients shall not exceed amounts authorized by the county of financial responsibility. For specifically identified former residents of nursing facilities, the commissioner shall be~~

~~responsible for authorizing payments and payment limits under the appropriate home and community-based service program. Payment is available under this subdivision only for persons who, if not provided these services, would require the level of care provided in an intermediate care facility for persons with developmental disabilities.~~

~~(d)~~ (b) The commissioner shall comply with the requirements in the federally approved transition plan for the home and community-based services waivers for the elderly authorized under this section.

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. 13. Minnesota Statutes 2020, section 256B.092, subdivision 5, is amended to read:

Subd. 5. **Federal waivers.** (a) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation under United States Code, title 42, sections 1396 et seq., as amended, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a regional treatment center or a community intermediate care facility for persons with developmental disabilities. The commissioner may seek amendments to the waivers or apply for additional waivers under United States Code, title 42, sections 1396 et seq., as amended, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative services under the federal waiver plan shall not exceed the cost of intermediate care services including day training and habilitation services that would have been provided without the waivered services.

The commissioner shall seek an amendment to the 1915c home and community-based waiver to allow properly licensed adult foster care homes to provide residential services to up to five individuals with developmental disabilities. If the amendment to the waiver is approved, adult foster care providers that can accommodate five individuals shall increase their capacity to five beds, provided the providers continue to meet all applicable licensing requirements.

(b) The commissioner, in administering home and community-based waivers for persons with developmental disabilities, shall ensure that day services for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of day services by the residential service provider. The coordinated service and support plan for individuals who choose to have their residential service provider provide their day services

must describe how health, safety, protection, and habilitation needs will be met, including how frequent and regular contact with persons other than the residential service provider will occur. The coordinated service and support plan must address the provision of services during the day outside the residence on weekdays.

(c) When a lead agency is evaluating denials, reductions, or terminations of home and community-based services under section 256B.0916 for an individual, the lead agency shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the coordinated service and support plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

(d) The commissioner shall seek approval to allow for the reconfiguration of the 1915(c) home and community-based waivers in this section, as authorized under section 1915(c) of the federal Social Security Act, to implement a two-waiver program structure.

(e) The commissioner shall seek approval for the 1915(c) home and community-based waivers in this section, as authorized under section 1915(c) of the federal Social Security Act, to implement an individual resource allocation methodology.

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. 14. Minnesota Statutes 2020, section 256B.092, subdivision 12, is amended to read:

Subd. 12. **Waivered services statewide priorities.** (a) The commissioner shall establish statewide priorities for individuals on the waiting list for developmental disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

(1) no longer require the intensity of services provided where they are currently living; or

(2) make a request to move from an institutional setting.

(b) After the priorities in paragraph (a) are met, priority must also be given to individuals who meet at least one of the following criteria:

(1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;

(2) are moving from an institution due to bed closures;

(3) experience a sudden closure of their current living arrangement;

(4) require protection from confirmed abuse, neglect, or exploitation;

(5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or

(6) meet other priorities established by the department.

(c) When allocating new enrollment resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities ~~and the lead agencies' current use of waiver funds and existing service options~~. ~~The commissioner has the authority to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe.~~

Sec. 15. Minnesota Statutes 2020, section 256B.0924, subdivision 6, is amended to read:

Subd. 6. **Payment for targeted case management.** (a) Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis. In order to receive payment for an eligible adult, the provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact with the adult or the adult's legal representative, family, primary caregiver, or other relevant persons identified as necessary to the development or implementation of the goals of the personal service plan.

(b) Payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of December 31, 2001. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

(c) Payment for targeted case management provided by county-contracted vendors shall be based on a monthly rate ~~negotiated by the host county~~ calculated in accordance with

section 256B.076, subdivision 2. The ~~negotiated~~ rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the ~~county may negotiate a team rate with a vendor who is a member of the team. The~~ team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

(d) If the service is provided by a team that includes contracted vendors and county staff, the costs for county staff participation on the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the recipient's file, the need for team targeted case management and a description of the different roles of the team members.

(e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for targeted case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(f) The commissioner may suspend, reduce, or terminate reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal disallowances. The county may share this responsibility with its contracted vendors.

(g) The commissioner shall set aside five percent of the federal funds received under this section for use in reimbursing the state for costs of developing and implementing this section.

(h) Payments to counties for targeted case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to contracted vendors shall include both the federal earnings and the county share.

(i) Notwithstanding section 256B.041, county payments for the cost of case management services provided by county staff shall not be made to the commissioner of management and budget. For the purposes of targeted case management services provided by county staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for targeted case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(k) Payment for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(l) Any growth in targeted case management services and cost increases under this section shall be the responsibility of the counties.

Sec. 16. Minnesota Statutes 2020, section 256B.094, subdivision 6, is amended to read:

Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical assistance reimbursement for services under this section shall be made on a monthly basis. Payment is based on face-to-face or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. These contacts must meet the minimum standards in clauses (1) and (2):

(1) there must be a face-to-face contact at least once a month except as provided in clause (2); and

(2) for a client placed outside of the county of financial responsibility, or a client served by tribal social services placed outside the reservation, in an excluded time facility under section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of Children, section 260.93, and the placement in either case is more than 60 miles beyond the county or reservation boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face contact.

(b) Except as provided under paragraph (c), the payment rate is established using time study data on activities of provider service staff and reports required under sections 245.482 and 256.01, subdivision 2, paragraph (p).

(c) Payments for tribes may be made according to section 256B.0625 or other relevant federally approved rate setting methodology for child welfare targeted case management provided by Indian health services and facilities operated by a tribe or tribal organization.

(d) Payment for case management provided by county ~~or tribal social services~~ contracted vendors ~~shall be based on a monthly rate negotiated by the host county or tribal social services~~ must be calculated in accordance with section 256B.076, subdivision 2. Payment for case management provided by vendors who contract with a tribe must be based on a monthly rate negotiated by the tribe. The ~~negotiated~~ rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the ~~county or tribal social services may negotiate a team rate with a vendor who is a member of the team. The~~ team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribal social services, except to reimburse the county or tribal social services for advance funding provided by the county or tribal social services to the vendor.

(e) If the service is provided by a team that includes contracted vendors and county or tribal social services staff, the costs for county or tribal social services staff participation in the team shall be included in the rate for county or tribal social services provided services. In this case, the contracted vendor and the county or tribal social services may each receive separate payment for services provided by each entity in the same month. To prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles and services of the team members.

Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study, or under paragraph (c), shall be distributed according to earnings, to counties, reservations, or groups of counties or reservations which have the same payment rate under this subdivision, and to the group of counties or reservations which are not certified providers under section 256F.10. The commissioner shall modify the requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.

Sec. 17. Minnesota Statutes 2020, section 256B.0949, is amended by adding a subdivision to read:

Subd. 16a. **Background studies.** The requirements for background studies under this section shall be met by an early intensive developmental and behavioral intervention services agency through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 15, and 245C.10, subdivision 17.

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

Sec. 18. Minnesota Statutes 2020, section 256B.49, subdivision 11, is amended to read:

Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and community-based service waivers, as authorized under section 1915(c) of the federal Social Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided in a hospital. The commissioner shall apply for the home and community-based waivers in order to:

(1) promote the support of persons with disabilities in the most integrated settings;

(2) expand the availability of services for persons who are eligible for medical assistance;

(3) promote cost-effective options to institutional care; and

(4) obtain federal financial participation.

(b) The provision of waivered services to medical assistance recipients with disabilities shall comply with the requirements outlined in the federally approved applications for home and community-based services and subsequent amendments, including provision of services according to a service plan designed to meet the needs of the individual. For purposes of this section, the approved home and community-based application is considered the necessary federal requirement.

(c) The commissioner shall provide interested persons serving on agency advisory committees, task forces, the Centers for Independent Living, and others who request to be on a list to receive, notice of, and an opportunity to comment on, at least 30 days before any effective dates, (1) any substantive changes to the state's disability services program manual, or (2) changes or amendments to the federally approved applications for home and community-based waivers, prior to their submission to the federal Centers for Medicare and Medicaid Services.

(d) The commissioner shall seek approval, as authorized under section 1915(c) of the federal Social Security Act, to allow medical assistance eligibility under this section for children under age 21 without deeming of parental income or assets.

(e) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Act, to allow medical assistance eligibility under this section for individuals under age 65 without deeming the spouse's income or assets.

(f) The commissioner shall comply with the requirements in the federally approved transition plan for the home and community-based services waivers authorized under this section.

(g) The commissioner shall seek approval to reconfigure the 1915(c) home and community-based waivers in this section to implement a two-waiver program structure.

(h) The commissioner shall seek approval for the 1915(c) home and community-based waivers in this section, as authorized under section 1915(c) of the federal Social Security Act, to implement an individual resource allocation methodology.

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. 19. Minnesota Statutes 2020, section 256B.49, subdivision 11a, is amended to read:

Subd. 11a. **Waivered services statewide priorities.** (a) The commissioner shall establish statewide priorities for individuals on the waiting list for community alternative care, community access for disability inclusion, and brain injury waiver services, as of January 1, 2010. The statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

(1) no longer require the intensity of services provided where they are currently living; or

(2) make a request to move from an institutional setting.

(b) After the priorities in paragraph (a) are met, priority must also be given to individuals who meet at least one of the following criteria:

(1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;

(2) are moving from an institution due to bed closures;

(3) experience a sudden closure of their current living arrangement;

(4) require protection from confirmed abuse, neglect, or exploitation;

(5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or

(6) meet other priorities established by the department.

(c) When allocating new enrollment resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities ~~and the lead agencies' current use of waiver funds and existing service options~~. ~~The commissioner has the authority to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe.~~

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. 20. Minnesota Statutes 2020, section 256B.49, subdivision 17, is amended to read:

Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure that the average per capita expenditures estimated in any fiscal year for home and community-based waiver recipients does not exceed the average per capita expenditures that would have been made to provide institutional services for recipients in the absence of the waiver.

~~(b) The commissioner shall implement on January 1, 2002, one or more aggregate, need-based methods for allocating to local agencies the home and community-based waivered service resources available to support recipients with disabilities in need of the level of care provided in a nursing facility or a hospital. The commissioner shall allocate resources to single counties and county partnerships in a manner that reflects consideration of:~~

~~(1) an incentive-based payment process for achieving outcomes;~~

~~(2) the need for a state-level risk pool;~~

~~(3) the need for retention of management responsibility at the state agency level; and~~

~~(4) a phase-in strategy as appropriate.~~

~~(c) Until the allocation methods described in paragraph (b) are implemented, the annual allowable reimbursement level of home and community-based waiver services shall be the greater of:~~

~~(1) the statewide average payment amount which the recipient is assigned under the waiver reimbursement system in place on June 30, 2001, modified by the percentage of any provider rate increase appropriated for home and community-based services; or~~

~~(2) an amount approved by the commissioner based on the recipient's extraordinary needs that cannot be met within the current allowable reimbursement level. The increased~~

~~reimbursement level must be necessary to allow the recipient to be discharged from an institution or to prevent imminent placement in an institution. The additional reimbursement may be used to secure environmental modifications; assistive technology and equipment; and increased costs for supervision, training, and support services necessary to address the recipient's extraordinary needs. The commissioner may approve an increased reimbursement level for up to one year of the recipient's relocation from an institution or up to six months of a determination that a current waiver recipient is at imminent risk of being placed in an institution.~~

~~(d)~~ (b) Beginning July 1, 2001, medically necessary home care nursing services will be authorized under this section as complex and regular care according to sections 256B.0651 to 256B.0654 and 256B.0659. The rate established by the commissioner for registered nurse or licensed practical nurse services under any home and community-based waiver as of January 1, 2001, shall not be reduced.

~~(e)~~ (c) Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009 legislature adopts a rate reduction that impacts payment to providers of adult foster care services, the commissioner may issue adult foster care licenses that permit a capacity of five adults. The application for a five-bed license must meet the requirements of section 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care services, the county must negotiate a revised per diem rate for room and board and waiver services that reflects the legislated rate reduction and results in an overall average per diem reduction for all foster care recipients in that home. The revised per diem must allow the provider to maintain, as much as possible, the level of services or enhanced services provided in the residence, while mitigating the losses of the legislated rate reduction.

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. 21. Minnesota Statutes 2020, section 256B.49, is amended by adding a subdivision to read:

Subd. 28. **Customized living moratorium for brain injury and community access for disability inclusion waivers.** (a) Notwithstanding section 245A.03, subdivision 2, paragraph (a), clause (23), the commissioner shall not enroll new customized living settings serving four or fewer people in a single-family home to deliver customized living services as defined under the brain injury or community access for disability inclusion waiver plans

under section 256B.49 to prevent new developments of customized living settings that otherwise meet the residential program definition under section 245A.02, subdivision 14.

(b) The commissioner may approve an exception to paragraph (a) when:

(1) a customized living setting with a change in ownership at the same address is in existence and operational on or before June 30, 2021; and

(2) a customized living setting is serving four or fewer people in a multiple-family dwelling if each person has their own self-contained living unit that contains living, sleeping, eating, cooking, and bathroom areas.

(c) Customized living settings operational on or before June 30, 2021, are considered existing customized living settings.

(d) For any new customized living settings operational on or after July 1, 2021, serving four or fewer people in a single-family home to deliver customized living services as defined in paragraph (a), the authorizing lead agency is financially responsible for all home and community-based service payments in the setting.

(e) For purposes of this subdivision, "operational" means customized living services are authorized and delivered to a person on or before June 30, 2021, in the customized living setting.

EFFECTIVE DATE. This section is effective July 1, 2021. This section applies only to customized living services as defined under the brain injury or community access for disability inclusion waiver plans under section Minnesota Statutes, section 256B.49.

Sec. 22. Minnesota Statutes 2020, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC

code 31-1014); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for adult day services, 70 percent of the median wage for nursing assistant (SOC code 31-1014); and 30 percent of the median wage for personal care aide (SOC code 39-9021);

(3) for day services, day support services, and prevocational services, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(4) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota for large employers, except in a family foster care setting, the wage is 36 percent of the minimum wage in Minnesota for large employers;

(5) for positive supports analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(6) for positive supports professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(7) for positive supports specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(8) for supportive living services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(9) for housing access coordination staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099);

(10) for in-home family support and individualized home supports with family training staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent

of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for individualized home supports with training services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(12) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(13) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(14) for employment exploration services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(15) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(16) for individualized home support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(17) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(18) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(19) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(20) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(21) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of positive supports professional, positive supports analyst, and positive supports specialists, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(22) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

(23) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for corporate foster care services, corporate supportive living services daily, community residential services, and integrated community support services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

(c) Component values for family foster care are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 3.3 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence factor: 1.7 percent.

(d) Component values for day training and habilitation, day support services, and prevocational services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: ten percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(e) Component values for day support services and prevocational services delivered remotely are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 7.67 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

~~(e)~~ (f) Component values for adult day services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 7.4 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

~~(f)~~ (g) Component values for unit-based services with programming are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan supports ratio: 15.5 percent;

(6) client programming and supports ratio: 4.7 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 6.1 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(h) Component values for unit-based services with programming delivered remotely are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan supports ratio: 5.6 percent;

(6) client programming and supports ratio: 1.53 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 6.1 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

~~(g)~~ (i) Component values for unit-based services without programming except respite are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 7.0 percent;

(6) client programming and support ratio: 2.3 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(j) Component values for unit-based services without programming delivered remotely, except respite, are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 1.3 percent;

(6) client programming and support ratio: 1.14 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

~~(h)~~ (k) Component values for unit-based services without programming for respite are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 2.9 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

~~(i)~~ (l) On July 1, 2022, and every two years thereafter, the commissioner shall update the base wage index in paragraph (a) based on wage data by SOC from the Bureau of Labor Statistics available 30 months and one day prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

~~(j)~~ (m) Beginning February 1, 2021, and every two years thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance an analysis of the competitive workforce factor. The report must include recommendations to update the competitive workforce factor using:

(1) the most recently available wage data by SOC code for the weighted average wage for direct care staff for residential services and direct care staff for day services;

(2) the most recently available wage data by SOC code of the weighted average wage of comparable occupations; and

(3) workforce data as required under subdivision 10a, paragraph (g).

The commissioner shall not recommend an increase or decrease of the competitive workforce factor from the current value by more than two percentage points. If, after a biennial analysis for the next report, the competitive workforce factor is less than or equal to zero, the commissioner shall recommend a competitive workforce factor of zero.

~~(k)~~ (n) On July 1, 2022, and every two years thereafter, the commissioner shall update the framework components in paragraph (d), clause (6); paragraph (e), clause (6); paragraph (f), clause (6); ~~and~~ paragraph (g), clause (6); paragraph (h), clause (6); paragraph (i), clause 6; and paragraph (j), clause (6); subdivision 6, paragraphs (b), clauses (9) and (10), and (e), clause (10); and subdivision 7, clauses (11), (17), and (18), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the data available 30 months and one day prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

~~(l)~~ (o) Upon the implementation of the updates under paragraphs ~~(i)~~ (l) and ~~(k)~~ (n), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013, chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall be removed from service rates calculated under this section.

~~(m)~~ (p) Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section shall be

removed from rate calculations upon implementation of the updates under paragraphs ~~(i)~~ (l) and ~~(k)~~ (n).

~~(n)~~ (q) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

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

Sec. 23. Minnesota Statutes 2020, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Payments for residential support services.** (a) For purposes of this subdivision, residential support services includes 24-hour customized living services, community residential services, customized living services, family residential services, foster care services, integrated community supports, and supportive living services daily.

(b) Payments for community residential services, corporate foster care services, corporate supportive living services daily, family residential services, and family foster care services must be calculated as follows:

(1) determine the number of shared staffing and individual direct staff hours to meet a recipient's needs provided on site or through monitoring technology;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (b), clause (1);

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages;

(6) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span

of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (3). This is defined as the direct staffing cost;

(8) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (4);

(9) for client programming and supports, the commissioner shall add $2,179; and

(10) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport, based on the resident with the highest assessed need.

(c) The total rate must be calculated using the following steps:

(1) subtotal paragraph (b), clauses (8) to (10), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause (8);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(d) The payment methodology for customized living, 24-hour customized living, and residential care services must be the customized living tool. Revisions to the customized living tool must be made to reflect the services and activities unique to disability-related recipient needs. <u>The commissioner shall establish acuity-based input limits, based on case mix, for customized living and 24-hour customized living rates determined under this section.</u>

(e) Payments for integrated community support services must be calculated as follows:

(1) the base shared staffing shall be eight hours divided by the number of people receiving support in the integrated community support setting;

(2) the individual staffing hours shall be the average number of direct support hours provided directly to the service recipient;

(3) the personnel hourly wage rate must be based on the most recent Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(4) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (3) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (b), clause (1);

(5) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (4);

(6) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the appropriate staff wages;

(7) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the product of the supervisory span of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervisory wage in subdivision 5, paragraph (a), clause (21);

(8) combine the results of clauses (6) and (7) and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (3). This is defined as the direct staffing cost;

(9) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (4); and

(10) for client programming and supports, the commissioner shall add $2,260.21 divided by 365.

(f) The total rate must be calculated as follows:

(1) add the results of paragraph (e), clauses (9) and (10);

(2) add the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(g) The payment methodology for customized living and 24-hour customized living services must be the customized living tool. The commissioner shall revise the customized

living tool to reflect the services and activities unique to disability-related recipient needs and adjust for regional differences in the cost of providing services.

(h) The number of days authorized for all individuals enrolling in residential services must include every day that services start and end.

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

Sec. 24. Minnesota Statutes 2020, section 256B.4914, subdivision 7, is amended to read:

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day services, day treatment and habilitation, day support services, prevocational services, and structured day services, provided in person or remotely, must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (d), clause (1);

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of day program direct staff hours and nursing hours by the appropriate staff wage;

(6) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause (2), for in-person services or subdivision 5, paragraph (e), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause (3), for in-person services or subdivision 5, paragraph (e), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio in subdivision 5, paragraph (d), clause (5), for in-person services or subdivision 5, paragraph (e), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph (d), clause (4), for in-person services or subdivision 5, paragraph (e), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio in subdivision 5, paragraph (d), clause (6), for in-person services or subdivision 5, paragraph (e), clause (6), for remote services;

(11) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs for in-person service only;

(12) for adult day bath services, add $7.01 per 15 minute unit;

(13) this is the subtotal rate;

(14) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(15) divide the result of clause (13) by one minus the result of clause (14). This is the total payment amount;

(16) adjust the result of clause (15) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

(17) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

(18) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

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

Sec. 25. Minnesota Statutes 2020, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including employment exploration services, employment development services, housing access coordination, individualized home supports with family training, individualized home supports with training, in-home family support, independent living skills training, and hourly supported living services provided to an individual outside of any day or residential service plan, provided in person or remotely, must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph ~~(f)~~ (g), clause (1);

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of direct staff hours by the appropriate staff wage;

(6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (2), for in-person services or subdivision 5, paragraph (h), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (3), for in-person services or subdivision 5, paragraph (h), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan supports ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (5), for in-person services or subdivision 5, paragraph (h), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (4), for in-person services or subdivision 5, paragraph (h), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and supports ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (6), for in-person services or subdivision 5, paragraph (h), clause (6), for remote services;

(11) this is the subtotal rate;

(12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for employment exploration services provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed five. For employment support services provided in a shared manner, divide the total payment amount

in clause (13) by the number of service recipients, not to exceed six. For independent living skills training, individualized home supports with training, and individualized home supports with family training provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed two; and

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

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

Sec. 26. Minnesota Statutes 2020, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming, including individualized home supports, night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan, provided in person or remotely, must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph ~~(g)~~ (i), clause (1);

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of direct staff hours by the appropriate staff wage;

(6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (2), for in-person services or subdivision 5, paragraph (j), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(g)~~ (i),

clause (3), for in-person services or subdivision 5, paragraph (j), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (5), for in-person services or subdivision 5, paragraph (j), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (4), for in-person services or subdivision 5, paragraph (j), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (6), for in-person services or subdivision 5, paragraph (j), clause (6), for remote services;

(11) this is the subtotal rate;

(12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for respite services, determine the number of day units of service to meet an individual's needs;

(15) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(16) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (15) by the product of one plus the competitive workforce factor in subdivision 5, paragraph ~~(h)~~ (k), clause (1);

(17) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (16);

(18) multiply the number of direct staff hours by the appropriate staff wage;

(19) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph ~~(h)~~ (k), clause (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(20) combine the results of clauses (18) and (19), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(h)~~ (k), clause (3). This is defined as the direct staffing rate;

(21) for employee-related expenses, multiply the result of clause (20) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(h)~~ (k), clause (4);

(22) this is the subtotal rate;

(23) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(24) divide the result of clause (22) by one minus the result of clause (23). This is the total payment amount;

(25) for individualized home supports provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed two;

(26) for respite care services provided in a shared manner, divide the total payment amount in clause (24) by the number of service recipients, not to exceed three; and

(27) adjust the result of clauses (13), (25), and (26) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

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

Sec. 27. Minnesota Statutes 2020, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the federal Social Security Act; or funding from the medical assistance program under section 256B.0659, for personal care services for residents in the setting; or residing in a setting which receives funding under section 245.73. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section 256B.0659, then the housing support rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service rate exceed $426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of

federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the federal Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

(b) The commissioner is authorized to make cost-neutral transfers from the housing support fund for beds under this section to other funding programs administered by the department after consultation with the ~~county or counties~~ agency in which the affected beds are located. The commissioner may also make cost-neutral transfers from the housing support fund to ~~county human service~~ agencies for beds permanently removed from the housing support census under a plan submitted by the ~~county~~ agency and approved by the commissioner. The commissioner shall report the amount of any transfers under this provision annually to the legislature.

(c) ~~Counties~~ Agencies must not negotiate supplementary service rates with providers of housing support that are licensed as board and lodging with special services and that do not encourage a policy of sobriety on their premises and make referrals to available community services for volunteer and employment opportunities for residents.

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

Sec. 28. Minnesota Statutes 2020, section 256I.05, subdivision 11, is amended to read:

Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a cost-neutral transfer of funding from the housing support fund to ~~county human service agencies~~ the agency for emergency shelter beds removed from the housing support census under a biennial plan submitted by the ~~county~~ agency and approved by the commissioner. The plan must describe: (1) anticipated and actual outcomes for persons experiencing homelessness in emergency shelters; (2) improved efficiencies in administration; (3) requirements for individual eligibility; and (4) plans for quality assurance monitoring and quality assurance outcomes. The commissioner shall review the ~~county~~ agency plan to monitor implementation and outcomes at least biennially, and more frequently if the commissioner deems necessary.

(b) The funding under paragraph (a) may be used for the provision of room and board or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding must be allocated annually, and the room and board portion of the allocation shall be adjusted according to

the percentage change in the housing support room and board rate. The room and board portion of the allocation shall be determined at the time of transfer. The commissioner or ~~county~~ agency may return beds to the housing support fund with 180 days' notice, including financial reconciliation.

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

Sec. 29. **WAIVER REIMAGINE PHASE II.**

(a) The commissioner of human services must implement a two-home and community-based services waiver program structure, as authorized under section 1915(c) of the federal Social Security Act, that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

(b) The commissioner of human services must implement an individualized budget methodology, as authorized under section 1915(c) of the federal Social Security Act, that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

(c) The commissioner of human services may seek all federal authority necessary to implement this section.

EFFECTIVE DATE. This section is effective September 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 30. **DIRECTION TO THE COMMISSIONER; CUSTOMIZED LIVING REPORT.**

(a) By January 15, 2022, the commissioner of human services shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance. The report must include the commissioner's:

(1) assessment of the prevalence of customized living services provided under Minnesota Statutes, section 256B.49, supplanting the provision of residential services and supports licensed under Minnesota Statutes, chapter 245D, and provided in settings licensed under Minnesota Statutes, chapter 245A;

(2) recommendations regarding the continuation of the moratorium on home and community-based services customized living settings under Minnesota Statutes, section 256B.49, subdivision 28;

(3) other policy recommendations to ensure that customized living services are being provided in a manner consistent with the policy objectives of the foster care licensing moratorium under Minnesota Statutes, section 245A.03, subdivision 7; and

(4) recommendations for needed statutory changes to implement the transition from existing four-person or fewer customized living settings to corporate adult foster care or community residential settings.

(b) The commissioner of health shall provide the commissioner of human services with the required data to complete the report in paragraph (a) and implement the moratorium on home and community-based services customized living settings under Minnesota Statutes, section 256B.49, subdivision 28. The data must include, at a minimum, each registered housing with services establishment under Minnesota Statutes, chapter 144D, enrolled as a customized living setting to deliver customized living services as defined under the brain injury or community access for disability inclusion waiver plans under Minnesota Statutes, section 256B.49.

Sec. 31. **RATE INCREASE FOR DIRECT SUPPORT SERVICES WORKFORCE.**

(a) Effective October 1, 2021, or upon federal approval, whichever is later, if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved pursuant to Minnesota Statutes, section 3.855, the commissioner of human services shall increase:

(1) reimbursement rates, individual budgets, grants, or allocations by 4.14 percent for services under paragraph (b) provided on or after October 1, 2021, or upon federal approval, whichever is later, to implement the minimum hourly wage, holiday, and paid time off provisions of that agreement;

(2) reimbursement rates, individual budgets, grants, or allocations by 2.95 percent for services under paragraph (b) provided on or after July 1, 2022, or upon federal approval, whichever is later, to implement the minimum hourly wage, holiday, and paid time off provisions of that agreement;

(3) individual budgets, grants, or allocations by 1.58 percent for services under paragraph (c) provided on or after October 1, 2021, or upon federal approval, whichever is later, to

implement the minimum hourly wage, holiday, and paid time off provisions of that agreement; and

(4) individual budgets, grants, or allocations by .81 percent for services under paragraph (c) provided on or after July 1, 2022, or upon federal approval, whichever is later, to implement the minimum hourly wage, holiday, and paid time off provisions of that agreement.

(b) The rate changes described in paragraph (a), clauses (1) and (2), apply to direct support services provided through a covered program, as defined in Minnesota Statutes, section 256B.0711, subdivision 1, with the exception of consumer-directed community supports available under programs established pursuant to home and community-based service waivers authorized under section 1915(c) of the federal Social Security Act and Minnesota Statutes, including but not limited to chapter 256S and sections 256B.092 and 256B.49, and under the alternative care program under Minnesota Statutes, section 256B.0913.

(c) The funding changes described in paragraph (a), clauses (3) and (4), apply to consumer-directed community supports available under programs established pursuant to home and community-based service waivers authorized under section 1915(c) of the federal Social Security Act, and Minnesota Statutes, including but not limited to chapter 256S and sections 256B.092 and 256B.49, and under the alternative care program under Minnesota Statutes, section 256B.0913.

Sec. 32. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; RATE RECOMMENDATIONS FOR OPIOID TREATMENT PROGRAMS.**

The commissioner of human services shall evaluate the rate structure for opioid treatment programs licensed under Minnesota Statutes, section 245G.22, and report recommendations, including a revised rate structure and proposed draft legislation, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance by October 1, 2021.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 33. **REPEALER.**

(a) Minnesota Statutes 2020, section 256B.0596, is repealed.

(b) Minnesota Statutes 2020, sections 245A.191; and 256B.097, are repealed effective July 1, 2021.

(c) Minnesota Statutes 2020, sections 256B.0916, subdivisions 2, 3, 4, 5, 8, 11, and 12; and 256B.49, subdivisions 26 and 27, are repealed effective January 1, 2023, or upon federal approval, whichever is later.

ARTICLE 3
DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2020, section 246.54, subdivision 1b, is amended to read:

Subd. 1b. **Community behavioral health hospitals.** A county's payment of the cost of care provided at state-operated community-based behavioral health hospitals for adults and children shall be according to the following schedule:

(1) 100 percent for each day during the stay, including the day of admission, when the facility determines that it is clinically appropriate for the client to be discharged; and

(2) the county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

ARTICLE 4
HEALTH CARE

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

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

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

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

Sec. 2. Minnesota Statutes 2020, section 256B.057, subdivision 3, is amended to read:

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

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

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

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

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

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

Sec. 3. Minnesota Statutes 2020, section 256B.0622, subdivision 7a, is amended to read:

Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

(i) shall be a licensed mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role but must obtain full licensure within 24 months of assuming the role of team leader;

(ii) must be an active member of the ACT team and provide some direct services to clients;

(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team, providing clinical oversight of services in conjunction with the psychiatrist or psychiatric care provider, and supervising team members to ensure delivery of best and ethical practices; and

(iv) must be available to provide overall clinical oversight to the ACT team after regular business hours and on weekends and holidays. The team leader may delegate this duty to another qualified member of the ACT team;

(2) the psychiatric care provider:

(i) must be a licensed psychiatrist certified by the American Board of Psychiatry and Neurology or eligible for board certification or certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness;

(ii) shall collaborate with the team leader in sharing overall clinical responsibility for screening and admitting clients; monitoring clients' treatment and team member service delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects, and health-related conditions; actively collaborating with nurses; and helping provide clinical supervision to the team;

(iii) shall fulfill the following functions for assertive community treatment clients: provide assessment and treatment of clients' symptoms and response to medications, including side effects; provide brief therapy to clients; provide diagnostic and medication education to clients, with medication decisions based on shared decision making; monitor clients' nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and community visits;

(iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized for mental health treatment and shall communicate directly with the client's inpatient psychiatric care providers to ensure continuity of care;

(v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per 50 clients. Part-time psychiatric care providers shall have designated hours to work on the team, with sufficient blocks of time on consistent days to carry out the provider's clinical, supervisory, and administrative responsibilities. No more than two psychiatric care providers may share this role;

(vi) may ~~not provide specific roles and responsibilities by telemedicine unless approved by the commissioner~~ provide services by telemedicine when necessary to ensure the continuation of psychiatric and medication services availability for clients and to maintain statutory requirements for psychiatric care provider staffing levels; and

(vii) shall provide psychiatric backup to the program after regular business hours and on weekends and holidays. The psychiatric care provider may delegate this duty to another qualified psychiatric provider;

(3) the nursing staff:

(i) shall consist of one to three registered nurses or advanced practice registered nurses, of whom at least one has a minimum of one-year experience working with adults with serious mental illness and a working knowledge of psychiatric medications. No more than two individuals can share a full-time equivalent position;

(ii) are responsible for managing medication, administering and documenting medication treatment, and managing a secure medication room; and

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

(i) shall be a full-time equivalent co-occurring disorder specialist who has received specific training on co-occurring disorders that is consistent with national evidence-based practices. The training must include practical knowledge of common substances and how they affect mental illnesses, the ability to assess substance use disorders and the client's

stage of treatment, motivational interviewing, and skills necessary to provide counseling to clients at all different stages of change and treatment. The co-occurring disorder specialist may also be an individual who is a licensed alcohol and drug counselor as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience, and other requirements in section 245G.11, subdivision 5. No more than two co-occurring disorder specialists may occupy this role; and

(ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients. The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT team members on co-occurring disorders;

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services to individuals with mental illness. An individual who does not meet these qualifications may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

(ii) shall provide or facilitate the provision of vocational services to clients. The vocational specialist serves as a consultant and educator to fellow ACT team members on these services; and

(iii) should not refer individuals to receive any type of vocational services or linkage by providers outside of the ACT team;

(6) the mental health certified peer specialist:

(i) shall be a full-time equivalent mental health certified peer specialist as defined in section 256B.0615. No more than two individuals can share this position. The mental health certified peer specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of clients. This requirement may be waived due to workforce shortages upon approval of the commissioner;

(ii) must provide coaching, mentoring, and consultation to the clients to promote recovery, self-advocacy, and self-direction, promote wellness management strategies, and assist clients in developing advance directives; and

(iii) must model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience, provide consultation to team members, promote a culture where

the clients' points of view and preferences are recognized, understood, respected, and integrated into treatment, and serve in a manner equivalent to other team members;

(7) the program administrative assistant shall be a full-time office-based program administrative assistant position assigned to solely work with the ACT team, providing a range of supports to the team, clients, and families; and

(8) additional staff:

(i) shall be based on team size. Additional treatment team staff may include licensed mental health professionals as defined in Minnesota Rules, part 9505.0371, subpart 5, item A; mental health practitioners as defined in section 245.462, subdivision 17; a mental health practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C; or mental health rehabilitation workers as defined in section 256B.0623, subdivision 5, paragraph (a), clause (4). These individuals shall have the knowledge, skills, and abilities required by the population served to carry out rehabilitation and support functions; and

(ii) shall be selected based on specific program needs or the population served.

(b) Each ACT team must clearly document schedules for all ACT team members.

(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.

(d) Members of the ACT team must have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of rehabilitation services. Each staff member shall be proficient in their respective discipline and be able to work collaboratively as a member of a multidisciplinary team to deliver the majority of the treatment, rehabilitation, and support services clients require to fully benefit from receiving assertive community treatment.

(e) Each ACT team member must fulfill training requirements established by the commissioner.

Sec. 4. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. ~~Coverage is limited to three telemedicine services per enrollee per calendar week, except as provided in paragraph (f).~~ Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site, including the patient's home, and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6~~,~~; a community paramedic as defined under section 144E.001, subdivision 5f~~, or~~; a mental health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26~~, working under the general supervision of a mental health professional, and~~; a community health worker who meets the criteria under subdivision 49, paragraph (a); a mental health certified peer specialist under section 256B.0615, subdivision 5; a mental health certified family peer specialist under section 256B.0616, subdivision 5; a mental health rehabilitation worker under section 256B.0623, subdivision 5, paragraph (a), clause (4), and paragraph (b); a mental health behavioral aide under section 256B.0943, subdivision 7, paragraph (b), clause (3); an alcohol and drug counselor under section 245G.11, subdivision 5; a treatment coordinator under section 245G.11, subdivision 7; or a recovery peer under section 245G.11, subdivision 8; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

~~(f) The limit on coverage of three telemedicine services per enrollee per calendar week does not apply if:~~

~~(1) the telemedicine services provided by the licensed health care provider are for the treatment and control of tuberculosis; and~~

~~(2) the services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the commissioner of health.~~

(f) Telemedicine visits, as described in this section, can be used to satisfy the face-to-face requirement for consideration of reimbursement under the payment methods that apply to a federally qualified health center, rural health clinic, Indian health service, 638 tribal clinic, and certified community behavioral health clinic, if the service would have otherwise qualified for payment if performed in person.

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 5. Minnesota Statutes 2020, section 256B.0625, subdivision 13, is amended to read:

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

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

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

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

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

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

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the Formulary Committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

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

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

(g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a

licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 16.

Sec. 6. Minnesota Statutes 2020, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be ~~$10.48~~ $9.91 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be ~~$10.48~~ $9.91 per ~~bag~~ claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be ~~$10.48~~ $9.91 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in

the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

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

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

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

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. The commissioner shall discount the payment rate for drugs obtained through the federal

340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

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

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

(h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a

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

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

Sec. 7. Minnesota Statutes 2020, section 256B.0625, subdivision 18, is amended to read:

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

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

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

Sec. 8. Minnesota Statutes 2020, section 256B.0625, subdivision 58, is amended to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** (a) Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). The payment amount for a complete EPSDT screening shall not include charges for health care services and products that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

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

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

Sec. 9. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team must use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) Services must be age-appropriate and meet the specific needs of the client.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every six months or prior to discharge from the service, whichever comes first.

(e) An individual treatment plan must:

(1) be based on the information in the client's diagnostic assessment and baselines;

(2) identify goals and objectives of treatment, a treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;

(3) be developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;

(4) be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessments, and treatment planning;

(5) be reviewed at least once every six months and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment;

(6) be signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;

(7) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan;

(8) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports;

(ii) be reviewed at least once every 90 days and revised, if necessary;

(9) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and

(10) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.

(f) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(g) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the

client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(h) The treatment team shall provide interventions to promote positive interpersonal relationships.

(i) The services and responsibilities of the psychiatric provider may be provided through telemedicine when necessary to prevent disruption in client services or to maintain the required psychiatric staffing level.

Sec. 10. Minnesota Statutes 2020, section 256B.0949, subdivision 13, is amended to read:

Subd. 13. **Covered services.** (a) The services described in paragraphs (b) to (l) are eligible for reimbursement by medical assistance under this section. Services must be provided by a qualified EIDBI provider and supervised by a QSP. An EIDBI service must address the person's medically necessary treatment goals and must be targeted to develop, enhance, or maintain the individual developmental skills of a person with ASD or a related condition to improve functional communication, including nonverbal or social communication, social or interpersonal interaction, restrictive or repetitive behaviors, hyperreactivity or hyporeactivity to sensory input, behavioral challenges and self-regulation, cognition, learning and play, self-care, and safety.

(b) EIDBI treatment must be delivered consistent with the standards of an approved modality, as published by the commissioner. EIDBI modalities include:

(1) applied behavior analysis (ABA);

(2) developmental individual-difference relationship-based model (DIR/Floortime);

(3) early start Denver model (ESDM);

(4) PLAY project;

(5) relationship development intervention (RDI); or

(6) additional modalities not listed in clauses (1) to (5) upon approval by the commissioner.

(c) An EIDBI provider may use one or more of the EIDBI modalities in paragraph (b), clauses (1) to (5), as the primary modality for treatment as a covered service, or several EIDBI modalities in combination as the primary modality of treatment, as approved by the commissioner. An EIDBI provider that identifies and provides assurance of qualifications for a single specific treatment modality must document the required qualifications to meet fidelity to the specific model.

(d) Each qualified EIDBI provider must identify and provide assurance of qualifications for professional licensure certification, or training in evidence-based treatment methods, and must document the required qualifications outlined in subdivision 15 in a manner determined by the commissioner.

(e) CMDE is a comprehensive evaluation of the person's developmental status to determine medical necessity for EIDBI services and meets the requirements of subdivision 5. The services must be provided by a qualified CMDE provider.

(f) EIDBI intervention observation and direction is the clinical direction and oversight of EIDBI services by the QSP, level I treatment provider, or level II treatment provider, including developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for the direct benefit of a person. EIDBI intervention observation and direction informs any modification of the current treatment protocol to support the outcomes outlined in the ITP.

(g) Intervention is medically necessary direct treatment provided to a person with ASD or a related condition as outlined in their ITP. All intervention services must be provided under the direction of a QSP. Intervention may take place across multiple settings. The frequency and intensity of intervention services are provided based on the number of treatment goals, person and family or caregiver preferences, and other factors. Intervention services may be provided individually or in a group. Intervention with a higher provider ratio may occur when deemed medically necessary through the person's ITP.

(1) Individual intervention is treatment by protocol administered by a single qualified EIDBI provider delivered ~~face-to-face~~ to one person.

(2) Group intervention is treatment by protocol provided by one or more qualified EIDBI providers, delivered to at least two people who receive EIDBI services.

(h) ITP development and ITP progress monitoring is development of the initial, annual, and progress monitoring of an ITP. ITP development and ITP progress monitoring documents provide oversight and ongoing evaluation of a person's treatment and progress on targeted goals and objectives and integrate and coordinate the person's and the person's legal representative's information from the CMDE and ITP progress monitoring. This service must be reviewed and completed by the QSP, and may include input from a level I provider or a level II provider.

(i) Family caregiver training and counseling is specialized training and education for a family or primary caregiver to understand the person's developmental status and help with the person's needs and development. This service must be provided by the QSP, level I provider, or level II provider.

(j) A coordinated care conference is a voluntary ~~face-to-face~~ meeting with the person and the person's family to review the CMDE or ITP progress monitoring and to integrate and coordinate services across providers and service-delivery systems to develop the ITP. This service must be provided by the QSP and may include the CMDE provider or a level I provider or a level II provider.

(k) Travel time is allowable billing for traveling to and from the person's home, school, a community setting, or place of service outside of an EIDBI center, clinic, or office from a specified location to provide ~~face-to-face~~ in-person EIDBI intervention, observation and direction, or family caregiver training and counseling. The person's ITP must specify the reasons the provider must travel to the person.

(l) Medical assistance covers medically necessary EIDBI services and consultations delivered by a licensed health care provider via telemedicine, as defined under section 256B.0625, subdivision 3b, in the same manner as if the service or consultation was delivered in person.

Sec. 11. Minnesota Statutes 2020, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on

December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics.

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

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

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

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

Sec. 12. Minnesota Statutes 2020, section 256B.79, subdivision 1, is amended to read:

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

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

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

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

Sec. 13. Minnesota Statutes 2020, section 256B.79, subdivision 3, is amended to read:

Subd. 3. **Grant awards.** The commissioner shall award grants to qualifying applicants to support interdisciplinary, integrated perinatal care. Grant funds must be distributed through a request for proposals process to a designated lead agency within an entity that has been

determined to be a qualified integrated perinatal care collaborative or within an entity in the process of meeting the qualifications to become a qualified integrated perinatal care collaborative~~, and priority shall be given to qualified integrated perinatal care collaboratives that received grants under this section prior to January 1, 2019~~. Grant awards must be used to support interdisciplinary, team-based needs assessments, planning, and implementation of integrated care and enhanced services for targeted populations. In determining grant award amounts, the commissioner shall consider the identified health and social risks linked to adverse outcomes and attributed to enrollees within the identified targeted population.

Sec. 14. Minnesota Statutes 2020, section 256L.01, subdivision 5, is amended to read:

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

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

Sec. 15. Minnesota Statutes 2020, section 256L.04, subdivision 7b, is amended to read:

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

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

Sec. 16. Minnesota Statutes 2020, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Redetermination of eligibility.** (a) An enrollee's eligibility must be redetermined on an annual basis~~, in accordance with Code of Federal Regulations, title 42, section 435.916 (a). The 12-month eligibility period begins the month of application. Beginning July 1, 2017, the commissioner shall adjust the eligibility period for enrollees to implement renewals throughout the year according to guidance from the Centers for Medicare and Medicaid Services~~. The period of eligibility is the entire calendar year following the year in which eligibility is redetermined. Eligibility redeterminations shall occur during the open enrollment period for qualified health plans as specified in Code of Federal Regulations, title 45, section 155.410(e)(3).

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

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

ARTICLE 5
LICENSING AND BACKGROUND STUDIES

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

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

(1) each navigator;

(2) each in-person assister; and

(3) each certified application counselor.

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

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

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

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

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

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

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

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

(2) payment to conduct the background check. The Professional Educator Licensing and Standards Board must deposit payments received under this subdivision in an account in

the special revenue fund. Amounts in the account are annually appropriated to the Professional Educator Licensing and Standards Board to pay for the costs of background checks on applicants for licensure.

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

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

Sec. 3. Minnesota Statutes 2020, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600
125 to 149 persons	$700
150 to 174 persons	$800
175 to 199 persons	$900
200 to 224 persons	$1,000
225 or more persons	$1,100

(b)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee based on revenues derived from the provision of services that would require licensure under chapter 245D during the calendar

year immediately preceding the year in which the license fee is paid, according to the following schedule:

License Holder Annual Revenue	License Fee
less than or equal to $10,000	$200
greater than $10,000 but less than or equal to $25,000	$300
greater than $25,000 but less than or equal to $50,000	$400
greater than $50,000 but less than or equal to $100,000	$500
greater than $100,000 but less than or equal to $150,000	$600
greater than $150,000 but less than or equal to $200,000	$800
greater than $200,000 but less than or equal to $250,000	$1,000
greater than $250,000 but less than or equal to $300,000	$1,200
greater than $300,000 but less than or equal to $350,000	$1,400
greater than $350,000 but less than or equal to $400,000	$1,600
greater than $400,000 but less than or equal to $450,000	$1,800
greater than $450,000 but less than or equal to $500,000	$2,000
greater than $500,000 but less than or equal to $600,000	$2,250
greater than $600,000 but less than or equal to $700,000	$2,500
greater than $700,000 but less than or equal to $800,000	$2,750
greater than $800,000 but less than or equal to $900,000	$3,000
greater than $900,000 but less than or equal to $1,000,000	$3,250
greater than $1,000,000 but less than or equal to $1,250,000	$3,500
greater than $1,250,000 but less than or equal to $1,500,000	$3,750
greater than $1,500,000 but less than or equal to $1,750,000	$4,000
greater than $1,750,000 but less than or equal to $2,000,000	$4,250

greater than $2,000,000 but less than or equal to $2,500,000	$4,500
greater than $2,500,000 but less than or equal to $3,000,000	$4,750
greater than $3,000,000 but less than or equal to $3,500,000	$5,000
greater than $3,500,000 but less than or equal to $4,000,000	$5,500
greater than $4,000,000 but less than or equal to $4,500,000	$6,000
greater than $4,500,000 but less than or equal to $5,000,000	$6,500
greater than $5,000,000 but less than or equal to $7,500,000	$7,000
greater than $7,500,000 but less than or equal to $10,000,000	$8,500
greater than $10,000,000 but less than or equal to $12,500,000	$10,000
greater than $12,500,000 but less than or equal to $15,000,000	$14,000
greater than $15,000,000	$18,000

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(5) Notwithstanding clause (1), a license holder providing services under one or more licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license holder for all licenses held under chapter 245B for calendar year 2013. For calendar year 2017 and thereafter, the license holder shall pay an annual license fee according to clause (1).

(c) A chemical dependency treatment program licensed under chapter 245G, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

(d) A ~~chemical dependency~~ detoxification program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, ~~to provide detoxification services~~ or a withdrawal management program licensed under chapter 245F shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

A detoxification program that also operates a withdrawal management program at the same location shall only pay one fee based upon the licensed capacity of the program with the higher overall capacity.

(e) Except for child foster care, a residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

(f) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

(g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(h) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of $1,500.

(i) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

(j) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900
75 to 99 persons	$1,100
100 or more persons	$1,300

(k) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(l) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of $1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

Sec. 4. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision to read:

Subd. 5b. **Alternative background study.** "Alternative background study" means a review of records conducted by the commissioner pursuant to section 245C.08 in order to forward the background study investigating information to the entity that submitted the alternative background study request under section 245C.031, subdivision 2. The commissioner shall not make any eligibility determinations on background studies conducted under section 245C.031.

Sec. 5. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision to read:

Subd. 11c. **Entity.** "Entity" means any program or organization initiating a background study.

Sec. 6. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision to read:

Subd. 16a. **Results.** "Results" means a determination that a study subject is eligible, disqualified, set aside, granted a variance, or that more time is needed to complete the background study.

Sec. 7. Minnesota Statutes 2020, section 245C.03, is amended to read:

245C.03 BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study on:

(1) the person or persons applying for a license;

(2) an individual age 13 and over living in the household where the licensed program will be provided who is not receiving licensed services from the program;

(3) current or prospective employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program, when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(7) all controlling individuals as defined in section 245A.02, subdivision 5a;

(8) notwithstanding the other requirements in this subdivision, child care background study subjects as defined in section 245C.02, subdivision 6a; and

(9) notwithstanding clause (3), for children's residential facilities and foster residence settings, any adult working in the facility, whether or not the individual will have direct contact with persons served by the facility.

(b) For child foster care when the license holder resides in the home where foster care services are provided, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

Subd. 1a. **Procedure.** (a) Individuals and organizations that are required under this section to have or initiate background studies shall comply with the requirements of this chapter.

(b) All studies conducted under this section shall be conducted according to sections 299C.60 to 299C.64. This requirement does not apply to subdivisions 1, 4, 6a, 9, and 9a.

Subd. 2. **Personal care provider organizations.** The commissioner shall conduct background studies on any individual required under sections 256B.0651 to 256B.0654 and 256B.0659 to have a background study completed under this chapter.

Subd. 3. **Supplemental nursing services agencies.** The commissioner shall conduct all background studies required under this chapter and initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1.

Subd. 3a. **Exception to personal care assistant; requirements.** The personal care assistant for a recipient may be allowed to enroll with a different personal care assistant provider agency upon initiation of a new background study according to this chapter if:

(1) the commissioner determines that a change in enrollment or affiliation of the personal care assistant is needed in order to ensure continuity of services and protect the health and safety of the recipient;

(2) the chosen agency has been continuously enrolled as a personal care assistance provider agency for at least two years;

(3) the recipient chooses to transfer to the personal care assistance provider agency;

(4) the personal care assistant has been continuously enrolled with the former personal care assistance provider agency since the last background study was completed; and

(5) the personal care assistant continues to meet requirements of Minnesota Statutes, section 256B.0659, subdivision 11, notwithstanding paragraph (a), clause (3).

Subd. 3b. **Personal care assistance provider agency; background studies.** Personal care assistance provider agencies enrolled to provide personal care assistance services under the medical assistance program must meet the following requirements:

(1) owners who have a five percent interest or more and all managing employees are subject to a background study as provided in this chapter. This requirement applies to currently enrolled personal care assistance provider agencies and agencies seeking enrollment as a personal care assistance provider agency. "Managing employee" has the same meaning as Code of Federal Regulations, title 42, section 455. An organization is barred from enrollment if:

(i) the organization has not initiated background studies of owners and managing employees; or

(ii) the organization has initiated background studies of owners and managing employees and the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified under section 245C.14, and the owner or managing employee has not received a set aside of the disqualification under section 245C.22; and

(2) a background study must be initiated and completed for all qualified professionals.

Subd. 4. **Personnel agencies; educational programs; professional services agencies.** The commissioner also may conduct studies on individuals specified in subdivision 1, paragraph (a), clauses (3) and (4), when the studies are initiated by:

(1) personnel pool agencies;

(2) temporary personnel agencies;

(3) educational programs that train individuals by providing direct contact services in licensed programs; and

(4) professional services agencies that are not licensed and which contract with licensed programs to provide direct contact services or individuals who provide direct contact services.

Subd. 5. **Other state agencies.** The commissioner shall conduct background studies on applicants and license holders under the jurisdiction of other state agencies who are required in other statutory sections to initiate background studies under this chapter, including the applicant's or license holder's employees, contractors, and volunteers when required under other statutory sections.

Subd. 5a. **Facilities serving children or adults licensed or regulated by the Department of Health.** (a) The commissioner of health shall contract with the commissioner of human services to conduct background studies of:

(1) individuals providing services who have direct contact, as defined under section 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; assisted living facilities and assisted living facilities with dementia care licensed under chapter 144G; and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17;

(2) individuals specified in section 245C.03, subdivision 1, who provide direct contact services in a nursing home or a home care agency licensed under chapter 144A; an assisted living facility or assisted living facility with dementia care licensed under chapter 144G; or a boarding care home licensed under sections 144.50 to 144.58. If the individual understudy resides outside of Minnesota, the study must include a check for substantiated findings of maltreatment of adults and children in the individual's state of residence when the state makes the information available;

(3) all other employees in assisted living facilities or assisted living facilities with dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact with or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as defined in section 245C.02, subdivision 8, when the employee's employment responsibilities do not include providing direct contact services;

(4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

(5) controlling persons of a supplemental nursing services agency, as defined by section 144A.70.

(b) If a facility or program is licensed by the Department of Human Services and the Department of Health and is subject to the background study provisions of this chapter, the Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed program.

Subd. 5b. **Facilities serving children or youth licensed by the Department of Corrections.** (a) The commissioner shall conduct background studies of individuals providing services in secure and nonsecure residential facilities and detention facilities who have direct contact, as defined under section 245C.02, subdivision 11, with persons served in the facilities.

(b) A clerk or administrator of any court, the Bureau of Criminal Apprehension, a prosecuting attorney, a county sheriff, or a chief of a local police department shall assist in conducting background studies by providing the commissioner of human services or the commissioner's representative with all criminal conviction data available from local, state, and national criminal history record repositories, related to applicants, operators, all persons living in a household, and all staff of any facility subject to background studies under this subdivision.

(c) For the purpose of this subdivision, the term "secure and nonsecure residential facility and detention facility" includes programs licensed or certified under section 241.021, subdivision 2.

(d) If an individual is disqualified, the Department of Human Services shall notify the disqualified individual and the facility in which the disqualified individual provides services and shall inform the disqualified individual of the right to request a reconsideration of the disqualification by submitting the request to the Department of Corrections.

(e) The commissioner of corrections shall review and make decisions regarding reconsideration requests, including whether to grant variances, according to the procedures and criteria in this chapter. The commissioner of corrections shall inform the requesting individual and the Department of Human Services of the commissioner's decision. The commissioner's decision to grant or deny a reconsideration of a disqualification is the final administrative agency action.

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** The commissioner shall conduct background studies ~~on~~ of any individual ~~required under section 256B.4912 to have a background study completed under this chapter~~ who provides direct contact, as defined in section 245C.02, subdivision 11, for services specified in the federally approved home and community-based waiver plans under section 256B.4712 and the individual studied must meet the requirements of this chapter prior to providing waiver services and as part of ongoing enrollment. Upon federal approval, this requirement applies to consumer-directed community supports.

Subd. 6a. **Legal nonlicensed and certified child care programs.** The commissioner shall conduct background studies ~~on an individual~~ of the following individuals as required ~~under~~ by sections 119B.125 and 245H.10 ~~to complete a background study under this chapter.~~:

(1) every individual who applies for certification;

(2) every member of a provider's household who is age 13 and older; and

(3) an individual who is at least ten years of age and under 13 years of age and lives in the household where the nonlicensed child care will be provided when the county has reasonable cause as defined under section 245C.02, subdivision 15.

Subd. 7. **Children's therapeutic services and supports providers.** The commissioner shall conduct background studies ~~according to this chapter when initiated by a children's therapeutic services and supports provider~~ of all direct service providers and volunteers for children's therapeutic services and supports providers under section 256B.0943.

Subd. 8. **Self-initiated background studies.** Upon implementation of NETStudy 2.0, the commissioner shall conduct background studies according to this chapter when initiated by an individual who is not on the master roster. A subject under this subdivision who is not disqualified must be placed on the inactive roster.

Subd. 9. **Community first services and supports organizations.** ~~The commissioner shall conduct background studies on any individual required under section 256B.85 to have a background study completed under this chapter.~~ Individuals affiliated with Community First Services and Supports (CFSS) agency-providers and Financial Management Services (FMS) providers enrolled to provide CFSS services under the medical assistance program must meet the following requirements:

(1) owners who have a five percent interest or more and all managing employees are subject to a background study under this chapter. This requirement applies to currently enrolled providers and agencies seeking enrollment. "Managing employee" has the meaning

given in Code of Federal Regulations, title 42, section 455.101. An organization is barred from enrollment if:

(i) the organization has not initiated background studies of owners and managing employees; or

(ii) the organization has initiated background studies of owners and managing employees and the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified under section 245C.14 and the owner or managing employee has not received a set aside of the disqualification under section 245C.22;

(2) a background study must be initiated and completed for all staff who will have direct contact with the participant to provide worker training and development; and

(3) a background study must be initiated and completed for all support workers.

Subd. 9a. **Exception to support worker requirements for continuity of services.** The support worker for a participant may enroll with a different Community First Services and Supports (CFSS) agency-provider or Financial Management Services (FMS) provider upon initiation, rather than completion, of a new background study according to this chapter if:

(1) the commissioner determines that the support worker's change in enrollment or affiliation is necessary to ensure continuity of services and to protect the health and safety of the participant;

(2) the chosen agency-provider or FMS provider has been continuously enrolled as a CFSS agency-provider or FMS provider for at least two years or since the inception of the CFSS program, whichever is shorter;

(3) the participant served by the support worker chooses to transfer to the CFSS agency-provider or the FMS provider to which the support worker is transferring;

(4) the support worker has been continuously enrolled with the former CFSS agency-provider or FMS provider since the support worker's last background study was completed; and

(5) the support worker continues to meet the requirements of section 256B.85, subdivision 16, notwithstanding paragraph (a), clause (1).

Subd. 10. **Providers of group residential housing or supplementary services.** (a) The commissioner shall conduct background studies ~~on any individual required under section 256I.04 to have a background study completed under this chapter.~~ of the following individuals who provide services under section 256I.04:

(1) controlling individuals as defined in section 245A.02;

(2) managerial officials as defined in section 245A.02; and

(3) all employees and volunteers of the establishment who have direct contact with recipients or who have unsupervised access to recipients, recipients' personal property, or recipients' private data.

(b) The provider of housing support must comply with all requirements for entities initiating background studies under this chapter.

(c) A provider of housing support must demonstrate that all individuals who are required to have a background study according to paragraph (a) have a notice stating that:

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

(2) the individual is disqualified and the individual has been issued a set aside of the disqualification for the setting under section 245C.22.

~~Subd. 11. **Child protection workers or social services staff having responsibility for child protective duties.** (a) The commissioner must complete background studies, according to paragraph (b) and section 245C.04, subdivision 10, when initiated by a county social services agency or by a local welfare agency according to section 626.559, subdivision 1b.~~

~~(b) For background studies completed by the commissioner under this subdivision, the commissioner shall not make a disqualification decision, but shall provide the background study information received to the county that initiated the study.~~

Subd. 12. **Providers of special transportation service.** (a) The commissioner shall conduct background studies ~~on any individual required under section 174.30 to have a background study completed under this chapter.~~ of the following individuals who provide special transportation services under section 174.30:

(1) each person with a direct or indirect ownership interest of five percent or higher in a transportation service provider;

(2) each controlling individual as defined under section 245A.02;

(3) a managerial official as defined in section 245A.02;

(4) each driver employed by the transportation service provider;

(5) each individual employed by the transportation service provider to assist a passenger during transport; and

(6) each employee of the transportation service agency who provides administrative support, including an employee who:

(i) may have face-to-face contact with or access to passengers, passengers' personal property, or passengers' private data;

(ii) performs any scheduling or dispatching tasks; or

(iii) performs any billing activities.

(b) When a local or contracted agency is authorizing a ride under section 256B.0625, subdivision 17, by a volunteer driver, and the agency authorizing the ride has a reason to believe that the volunteer driver has a history that would disqualify the volunteer driver or that may pose a risk to the health or safety of passengers, the agency may initiate a background study that shall be completed according to this chapter using the commissioner of human services' online NETStudy system, or by contacting the Department of Human Services background study division for assistance. The agency that initiates the background study under this paragraph shall be responsible for providing the volunteer driver with the privacy notice required by section 245C.05, subdivision 2c, and with the payment for the background study required by section 245C.10 before the background study is completed.

Subd. 13. **Providers of housing support services.** The commissioner shall conduct background studies ~~on~~ of any ~~individual~~ provider of housing support services required ~~under~~ by section 256B.051 to have a background study completed under this chapter.

Subd. 14. **Tribal nursing facilities.** For completed background studies to comply with a tribal organization's licensing requirements for individuals affiliated with a tribally licensed nursing facility, the commissioner shall obtain state and national criminal history data according to section 245C.32.

Sec. 8. **[245C.031] BACKGROUND STUDY; ALTERNATIVE BACKGROUND STUDIES.**

Subdivision 1. **Alternative background studies.** (a) The commissioner shall conduct an alternative background study of individuals listed in this section.

(b) Notwithstanding other sections of this chapter, all alternative background studies except subdivision 9 shall be conducted according to this section and with section 299C.60 to 299C.64.

(c) All terms in this section shall have the definitions provided in section 245C.02.

(d) The entity that submits an alternative background study request under this section shall submit the request to the commissioner according to section 245C.05.

(e) The commissioner shall comply with the destruction requirements in section 245C.051.

(f) Background studies conducted under this section are subject to the provisions of section 245C.32.

(g) The commissioner shall forward all information that the commissioner receives under section 245C.08 to the entity that submitted the alternative background study request under subdivision 2. The commissioner shall not make any eligibility determinations regarding background studies conducted under this section.

Subd. 2. **Access to information.** Each entity that submits an alternative background study request shall enter into an agreement with the commissioner before submitting requests for alternative background studies under this section. As a part of the agreement, the entity must agree to comply with state and federal law.

Subd. 3. **Child protection workers or social services staff having responsibility for child protective duties.** The commissioner shall conduct an alternative background study of any person who has responsibility for child protection duties when the background study is initiated by a county social services agency or by a local welfare agency according to section 260E.36, subdivision 3.

Subd. 4. **Applicants, licensees, and other occupations regulated by the commissioner of health.** The commissioner shall conduct an alternative background study, including a check of state data, and a national criminal history records check of the following individuals. The check must be structured so that any new crimes that an applicant or licensee or certificate holder commits after the initial background check are flagged in the Bureau of Criminal Apprehension's or Federal Bureau of Investigation's database and reported to the commissioner of human services. For studies under this section, the following persons shall complete a consent form:

(1) an applicant for initial licensure, temporary licensure, or relicensure after a lapse in licensure as an audiologist or speech-language pathologist or an applicant for initial certification as a hearing instrument dispenser who must submit to a background study under section 144.0572.

(2) an applicant for a renewal license or certificate as an audiologist, speech-language pathologist, or hearing instrument dispenser who was licensed or obtained a certificate before January 1, 2018.

Subd. 5. **Guardians and conservators.** (a) The commissioner shall conduct an alternative background study of:

(1) every court-appointed guardian and conservator, unless a background study has been completed of the person under this section within the previous five years. The alternative background study shall be completed prior to the appointment of the guardian or conservator, unless a court determines that it would be in the best interests of the ward or protected person to appoint a guardian or conservator before the alternative background study can be completed. If the court appoints the guardian or conservator while the alternative background study is pending, the alternative background study must be completed as soon as reasonably possible after the guardian or conservator's appointment and no later than 30 days after the guardian or conservator's appointment; and

(2) a guardian and a conservator once every five years after the guardian or conservator's appointment if the person continues to serve as a guardian or conservator.

(b) An alternative background study is not required if the guardian or conservator is:

(1) a state agency or county;

(2) a parent or guardian of a proposed ward or protected person who has a developmental disability if the parent or guardian has raised the proposed ward or protected person in the family home until the time that the petition is filed, unless counsel appointed for the proposed ward or protected person under section 524.5-205, paragraph (d); 524.5-304, paragraph (b); 524.5-405, paragraph (a); or 524.5-406, paragraph (b), recommends a background study; or

(3) a bank with trust powers, a bank and trust company, or a trust company, organized under the laws of any state or of the United States and regulated by the commissioner of commerce or a federal regulator.

Subd. 6. **Required checks.** (a) An alternative background study pursuant to subdivision 5 shall include:

(1) criminal history data from the Bureau of Criminal Apprehension and other criminal history data held by the commissioner of human services;

(2) data regarding whether the person has been a perpetrator of substantiated maltreatment of a vulnerable adult under section 626.557 or a minor under chapter 260E. If the subject of the study has been the perpetrator of substantiated maltreatment of a vulnerable adult or a minor, the commissioner must include a copy of the public portion of the investigation memorandum under section 626.557, subdivision 12b, or the public portion of the

investigation memorandum under section 260E.30. The commissioner shall provide the court with information from a review of information according to subdivision 7 if the study subject provided information that the study subject has a current or prior affiliation with a state licensing agency;

(3) criminal history data from a national criminal history record check as defined in section 245C.02, subdivision 13c; and

(4) state licensing agency data if a search of the database or databases of the agencies listed in subdivision 7 shows that the proposed guardian or conservator has held a professional license directly related to the responsibilities of a professional fiduciary from an agency listed in subdivision 7 that was conditioned, suspended, revoked, or canceled.

(b) If the guardian or conservator is not an individual, the background study must be completed of all individuals who are currently employed by the proposed guardian or conservator who are responsible for exercising powers and duties under the guardianship or conservatorship.

Subd. 7. **State licensing data.** (a) Within 25 working days of receiving the request, the commissioner shall provide the court with licensing agency data for licenses directly related to the responsibilities of a professional fiduciary if the study subject has a current or prior affiliation with the:

(1) Lawyers Responsibility Board;

(2) State Board of Accountancy;

(3) Board of Social Work;

(4) Board of Psychology;

(5) Board or Nursing;

(6) Board of Medical Practice;

(7) Department of Education;

(8) Department of Commerce;

(9) Board of Chiropractic Examiners;

(10) Board of Dentistry;

(11) Board of Marriage and Family Therapy;

(12) Department of Human Services;

(13) Peace Officer Standards and Training (POST) Board; and

(14) Professional Educator Licensing and Standards Board.

(b) The commissioner and each of the agencies listed above, except for the Department of Human Services, shall enter into a written agreement to provide the commissioner with electronic access to the relevant licensing data and to provide the commissioner with a quarterly list of new sanctions issued by the agency.

(c) The commissioner shall provide to the court the electronically available data maintained in the agency's database, including whether the proposed guardian or conservator is or has been licensed by the agency, and whether a disciplinary action or a sanction against the individual's license, including a condition, suspension, revocation, or cancellation is in the licensing agency's database.

(d) If the proposed guardian or conservator has resided in a state other than Minnesota during the previous ten years, licensing agency data under this section shall also include licensing agency data from any other state where the proposed guardian or conservator reported to have resided during the previous ten years if the study subject has a current or prior affiliation to the licensing agency. If the proposed guardian or conservator has or has had a professional license in another state that is directly related to the responsibilities of a professional fiduciary from one of the agencies listed under paragraph (a), state licensing agency data shall also include data from the relevant licensing agency of the other state.

(e) The commissioner is not required to repeat a search for Minnesota or out-of-state licensing data on an individual if the commissioner has provided this information to the court within the prior five years.

(f) The commissioner shall review the information in paragraph (c) at least once every four months to determine whether an individual who has been studied within the previous five years:

(1) has any new disciplinary action or sanction against the individual's license; or

(2) did not disclose a prior or current affiliation with a Minnesota licensing agency.

(g) If the commissioner's review in paragraph (f) identifies new information, the commissioner shall provide any new information to the court.

Subd. 8. **Guardians ad litem.** The commissioner shall conduct an alternative background study of:

(1) a guardian ad litem appointed under section 518.165 if a background study of the guardian ad litem has not been completed within the past three years. The background study of the guardian ad litem must be completed before the court appoints the guardian ad litem, unless the court determines that it is in the best interests of the child to appoint the guardian ad litem before a background study is completed by the commissioner.

(2) a guardian ad litem once every three years after the guardian has been appointed, as long as the individual continues to serve as a guardian ad litem.

Subd. 9. **Required checks.** (a) An alternative background study under subdivision 5 must include:

(1) criminal history data from the Bureau of Criminal Apprehension and other criminal history data held by the commissioner of human services;

(2) data regarding whether the person has been a perpetrator of substantiated maltreatment of a minor or a vulnerable adult. If the study subject has been determined by the Department of Human Services or the Department of Health to be the perpetrator of substantiated maltreatment of a minor or a vulnerable adult in a licensed facility, the response must include a copy of the public portion of the investigation memorandum under section 260E.30 or the public portion of the investigation memorandum under section 626.557, subdivision 12b. When the background study shows that the subject has been determined by a county adult protection or child protection agency to have been responsible for maltreatment, the court shall be informed of the county, the date of the finding, and the nature of the maltreatment that was substantiated;

(3) when the information from the Bureau of Criminal Apprehension indicates that the study subject is a multistate offender or that the subject's multistate offender status is undetermined, the court shall require a national criminal history records check, and shall provide the commissioner with a set of classifiable fingerprints of the study subject.

(b) For checks of records under paragraph (a), clauses (1) and (2), the commissioner shall provide the investigating information within 15 working days of receiving the request. The information obtained under sections 245C.05 and 245C.08 from a national criminal history records check shall be provided within three working days of the commissioner's receipt of the data.

(c) Notwithstanding section 260E.30 or 626.557, subdivision 12b, if the commissioner or county lead agency or lead investigative agency has information that a person of whom a background study was previously completed under this section has been determined to

be a perpetrator of maltreatment of a minor or vulnerable adult, the commissioner or the county may provide this information to the court that requested the background study.

Subd. 10. **First-time applicants for educator licenses with the Professional Educator Licensing and Standards Board.** The Professional Educator Licensing and Standards Board shall make all eligibility determinations for alternative background studies conducted under this section for the Professional Educator Licensing and Standards Board. The commissioner may conduct an alternative background study of all first-time applicants for educator licenses pursuant to section 122A.18, subdivision 8. The alternative background study for all first-time applicants for educator licenses must include a review of information from the Bureau of Criminal Apprehension, including criminal history data as defined in section 13.87, and must also include a review of the national criminal records repository.

Subd. 11. **First-time applicants for administrator licenses with the Board of School Administrators.** The Board of School Administrators shall make all eligibility determinations for alternative background studies conducted under this section for the Board of School Administrators. The commissioner may conduct an alternative background study of all first-time applicants for administrator licenses pursuant to section 122A.18, subdivision 8. The alternative background study for all first-time applicants for administrator licenses must include a review of information from the Bureau of Criminal Apprehension, including criminal history data as defined in section 13.87, and must also include a review of the national criminal records repository.

Subd. 12. **MNsure.** The commissioner shall conduct a background study of any individual required under section 62V.05 to have a background study completed under this chapter.

Sec. 9. Minnesota Statutes 2020, section 245C.05, subdivision 1, is amended to read:

Subdivision 1. **Individual studied.** (a) The individual who is the subject of the background study must provide the applicant, license holder, or other entity under section 245C.04 with sufficient information to ensure an accurate study, including:

(1) the individual's first, middle, and last name and all other names by which the individual has been known;

(2) current home address, city, and state of residence;

(3) current zip code;

(4) sex;

(5) date of birth;

(6) driver's license number or state identification number; and

(7) upon implementation of NETStudy 2.0, the home address, city, county, and state of residence for the past five years.

(b) Every subject of a background study conducted or initiated by counties or ~~private agencies~~ commissioner's delegates under this chapter must also provide the home address, city, county, and state of residence for the past five years.

(c) Every subject of a background study related to private agency adoptions or related to child foster care licensed through a private agency, who is 18 years of age or older, shall also provide the commissioner a signed consent for the release of any information received from national crime information databases to the private agency that initiated the background study.

(d) The subject of a background study shall provide fingerprints and a photograph as required in subdivision 5.

(e) The subject of a background study shall submit a completed criminal and maltreatment history records check consent form for applicable national and state level record checks.

Sec. 10. Minnesota Statutes 2020, section 245C.05, subdivision 2, is amended to read:

Subd. 2. **Applicant, license holder, or other entity.** (a) The applicant, license holder, or other ~~entities~~ entity initiating the background study as provided in this chapter shall verify that the information collected under subdivision 1 about an individual who is the subject of the background study is correct and must provide the information on forms or in a format prescribed by the commissioner.

(b) The information collected under subdivision 1 about an individual who is the subject of a completed background study may only be viewable by an entity that initiates a subsequent background study on that individual under NETStudy 2.0 after the entity has paid the applicable fee for the study and has provided the individual with the privacy notice in subdivision 2c.

Sec. 11. Minnesota Statutes 2020, section 245C.05, subdivision 2a, is amended to read:

Subd. 2a. **County or private agency.** For background studies related to child foster care when the applicant or license holder resides in the home where child foster care services are provided, county and private agencies initiating the background study must collect the information under subdivision 1 and forward it to the commissioner.

Sec. 12. Minnesota Statutes 2020, section 245C.05, subdivision 2b, is amended to read:

Subd. 2b. **County agency to collect and forward information to commissioner.** (a) For background studies related to all family adult day services and to adult foster care when the adult foster care license holder resides in the adult foster care residence, the county agency or private agency initiating the background study must collect the information required under subdivision 1 and forward it to the commissioner.

(b) Upon implementation of NETStudy 2.0, for background studies related to family child care and legal nonlicensed child care authorized under chapter 119B, the county agency initiating the background study must collect the information required under subdivision 1 and provide the information to the commissioner.

Sec. 13. Minnesota Statutes 2020, section 245C.05, subdivision 4, is amended to read:

Subd. 4. **Electronic transmission.** (a) For background studies conducted by the Department of Human Services, the commissioner shall implement a secure system for the electronic transmission of:

(1) background study information to the commissioner;

(2) background study results to the license holder;

(3) background study ~~results~~ information obtained under this section and section 245C.08 to counties and private agencies for background studies conducted by the commissioner for child foster care; and

(4) background study results to county agencies for background studies conducted by the commissioner for adult foster care and family adult day services and, upon implementation of NETStudy 2.0, family child care and legal nonlicensed child care authorized under chapter 119B.

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as NETStudy or NETStudy 2.0 to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

(d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under this subdivision.

(e) Information obtained under this section and section 245C.08 applies to state and tribal agencies for alternative studies under section 245C.031.

Sec. 14. Minnesota Statutes 2020, section 245C.08, is amended by adding a subdivision to read:

Subd. 5. **Authorized recipient.** The commissioner of human services shall be the authorized recipient of information and records received under this chapter.

Sec. 15. Minnesota Statutes 2020, section 245C.08, is amended by adding a subdivision to read:

Subd. 6. **Bureau of Criminal Apprehension background check crimes.** When applicable, all background studies conducted under this chapter shall comply with the requirements of sections 299C.60 to 299C.64.

Sec. 16. Minnesota Statutes 2020, section 245C.10, subdivision 15, is amended to read:

Subd. 15. **Guardians and conservators.** The ~~commissioner shall recover the cost of conducting background studies for guardians and conservators under section 524.5-118 through a fee of no more than $110 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.~~ fee for conducting an alternative background study for appointment of a professional guardian or conservator must be paid by the guardian or conservator. In other cases, the fee must be paid as follows:

(1) if the matter is proceeding in forma pauperis, the fee must be paid as an expense for purposes of section 524.5-502, paragraph (a);

(2) if there is an estate of the ward or protected person, the fee must be paid from the estate; or

(3) in the case of a guardianship or conservatorship of a person that is not proceeding in forma pauperis, the fee must be paid by the guardian, conservator, or the court.

Sec. 17. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 18. **Applicants, licensees, and other occupations regulated by commissioner of health.** The applicant or license holder is responsible for paying to the Department of

Human Services all fees associated with the preparation of the fingerprints, the criminal records check consent form, and the criminal background check.

Sec. 18. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 19. **Guardians ad litem.** The Minnesota Supreme Court shall pay the commissioner a fee for conducting an alternative background study.

Sec. 19. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 20. **Occupations regulated by MNsure.** The commissioner shall set fees to recover the cost of background studies and criminal background checks initiated by MNsure under sections 62V.05 and 245C.03. The fee amount shall be established through interagency agreement between the commissioner and the board of MNsure or its designee. The fees collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks.

Sec. 20. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 21. **Professional Educators Licensing Standards Board.** The commissioner shall recover the cost of background studies initiated by the Professional Educators Licensing Standards Board through a fee of no more than $51 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Sec. 21. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 22. **Board of School Administrators.** The commissioner shall recover the cost of background studies initiated by the Board of School Administrators through a fee of no more than $51 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Sec. 22. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 23. **Background studies fee schedule.** (a) By March 1 each year, the commissioner shall publish a schedule of fees sufficient to administer and conduct background studies under this chapter. The published schedule of fees shall be effective on July 1 each year.

(b) Fees shall be based on the actual costs of administering and conducting background studies, including payments to external agencies, department indirect cost payments under section 16A.127, processing fees, and costs related to due process.

(c) The commissioner shall publish notice of fees by posting fee amounts on the department website. The notice shall specify the actual costs that comprise the fees, including the categories described in paragraph (b).

(d) The published schedule of fees shall remain in effect from July 1 to June 30 each year.

(e) The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

EFFECTIVE DATE. This section is effective July 1, 2021. The commissioner of human services shall publish the initial fee schedule on the Department of Human Services' website on July 1, 2021, and the initial fee schedule is effective September 1, 2021

Sec. 23. Minnesota Statutes 2020, section 245C.13, subdivision 2, is amended to read:

Subd. 2. **Activities pending completion of background study.** The subject of a background study may not perform any activity requiring a background study under paragraph (c) until the commissioner has issued one of the notices under paragraph (a).

(a) Notices from the commissioner required prior to activity under paragraph (c) include:

(1) a notice of the study results under section 245C.17 stating that:

(i) the individual is not disqualified; or

(ii) more time is needed to complete the study but the individual is not required to be removed from direct contact or access to people receiving services prior to completion of the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice that more time is needed to complete the study must also indicate whether the individual is required to be under continuous direct supervision prior to completion of the background study. When more time is necessary to complete a background study of an individual affiliated with a Title IV-E eligible children's residential facility or foster residence setting,

the individual may not work in the facility or setting regardless of whether or not the individual is supervised;

(2) a notice that a disqualification has been set aside under section 245C.23; or

(3) a notice that a variance has been granted related to the individual under section 245C.30.

(b) For a background study affiliated with a licensed child care center or certified license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii), must require the individual to be under continuous direct supervision prior to completion of the background study except as permitted in subdivision 3.

(c) Activities prohibited prior to receipt of notice under paragraph (a) include:

(1) being issued a license;

(2) living in the household where the licensed program will be provided;

(3) providing direct contact services to persons served by a program unless the subject is under continuous direct supervision;

(4) having access to persons receiving services if the background study was completed under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2), (5), or (6), unless the subject is under continuous direct supervision;

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

(ii) disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(5) for licensed child care centers and certified license-exempt child care centers, providing direct contact services to persons served by the program; ~~or~~

(6) for children's residential facilities or foster residence settings, working in the facility or setting~~.~~; or

(7) for background studies affiliated with a personal care provider organization, except as provided in section 245C.03, subdivision 3a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study of the personal care assistant under this chapter and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

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

(ii) disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22.

Sec. 24. Minnesota Statutes 2020, section 245C.14, is amended by adding a subdivision to read:

Subd. 4. **Disqualification from working in licensed child care centers or certified license-exempt child care centers.** (a) For a background study affiliated with a licensed child care center or certified license-exempt child care center, if an individual is disqualified from direct contact under subdivision 1, the commissioner must also disqualify the individual from working in any position regardless of whether the individual would have direct contact with or access to children served in the licensed child care center or certified license-exempt child care center and from having access to a person receiving services from the center.

(b) Notwithstanding any other requirement of this chapter, for a background study affiliated with a licensed child care center or a certified license-exempt child care center, if an individual is disqualified, the individual may not work in the child care center until the commissioner has issued a notice stating that:

(1) the individual is not disqualified;

(2) a disqualification has been set aside under section 245C.23; or

(3) a variance has been granted related to the individual under section 245C.30.

Sec. 25. Minnesota Statutes 2020, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people receiving services.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

(1) the recency of the disqualifying characteristic;

(2) the recency of discharge from probation for the crimes;

(3) the number of disqualifying characteristics;

(4) the intrusiveness or violence of the disqualifying characteristic;

(5) the vulnerability of the victim involved in the disqualifying characteristic;

(6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact;

(7) whether the individual has a disqualification from a previous background study that has not been set aside; ~~and~~

(8) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 1, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense in the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with, or access to, persons receiving services from the program and from working in a children's residential facility or foster residence setting~~.~~; and

(9) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 2, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense during the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with or access to persons receiving services from the center and from working in a licensed child care center or certified license-exempt child care center.

(c) This section does not apply when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the subject is determined to be responsible for substantiated maltreatment under section 626.557 or chapter 260E.

(d) This section does not apply to a background study related to an initial application for a child foster family setting license.

(e) Except for paragraph (f), this section does not apply to a background study that is also subject to the requirements under section 256B.0659, subdivisions 11 and 13, for a personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1.

(f) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

Sec. 26. Minnesota Statutes 2020, section 245C.16, subdivision 2, is amended to read:

Subd. 2. **Findings.** (a) After evaluating the information immediately available under subdivision 1, the commissioner may have reason to believe one of the following:

(1) the individual poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact or access to persons served by the program or where the individual studied will work;

(2) the individual poses a risk of harm requiring continuous, direct supervision while providing direct contact services during the period in which the subject may request a reconsideration; or

(3) the individual does not pose an imminent risk of harm or a risk of harm requiring continuous, direct supervision while providing direct contact services during the period in which the subject may request a reconsideration.

(b) After determining an individual's risk of harm under this section, the commissioner must notify the subject of the background study and the applicant or license holder as required under section 245C.17.

(c) For Title IV-E eligible children's residential facilities and foster residence settings, the commissioner is prohibited from making the findings in paragraph (a), clause (2) or (3).

(d) For licensed child care centers or certified license-exempt child care centers, the commissioner is prohibited from making the findings in paragraph (a), clause (2) or (3).

Sec. 27. Minnesota Statutes 2020, section 245C.17, subdivision 1, is amended to read:

Subdivision 1. **Time frame for notice of study results and auditing system access.** (a) Within three working days after the commissioner's receipt of a request for a background study submitted through the commissioner's NETStudy or NETStudy 2.0 system, the commissioner shall notify the background study subject and the license holder or other entity as provided in this chapter in writing or by electronic transmission of the results of the study or that more time is needed to complete the study. The notice to the individual shall include the identity of the entity that initiated the background study.

(b) Before being provided access to NETStudy 2.0, the license holder or other entity under section 245C.04 shall sign an acknowledgment of responsibilities form developed by the commissioner that includes identifying the sensitive background study information person, who must be an employee of the license holder or entity. All queries to NETStudy 2.0 are electronically recorded and subject to audit by the commissioner. The electronic

record shall identify the specific user. A background study subject may request in writing to the commissioner a report listing the entities that initiated a background study on the individual.

(c) When the commissioner has completed a prior background study on an individual that resulted in an order for immediate removal and more time is necessary to complete a subsequent study, the notice that more time is needed that is issued under paragraph (a) shall include an order for immediate removal of the individual from any position allowing direct contact with or access to people receiving services and from working in a children's residential facility ~~or~~, foster residence setting, child care center, or certified license-exempt child care center pending completion of the background study.

Sec. 28. Minnesota Statutes 2020, section 245C.17, is amended by adding a subdivision to read:

Subd. 8. **Disqualification notice to child care centers and certified license-exempt child care centers.** (a) For child care centers and certified license-exempt child care centers, all notices under this section that order the license holder to immediately remove the individual studied from any position allowing direct contact with, or access to a person served by the center, must also order the license holder to immediately remove the individual studied from working in any position regardless of whether the individual would have direct contact with or access to children served in the center.

(b) For child care centers and certified license-exempt child care centers, notices under this section must not allow an individual to work in the center.

Sec. 29. Minnesota Statutes 2020, section 245C.18, is amended to read:

245C.18 OBLIGATION TO REMOVE DISQUALIFIED INDIVIDUAL FROM DIRECT CONTACT AND FROM WORKING IN A PROGRAM, FACILITY, ~~OR~~ SETTING, OR CENTER.

(a) Upon receipt of notice from the commissioner, the license holder must remove a disqualified individual from direct contact with persons served by the licensed program if:

(1) the individual does not request reconsideration under section 245C.21 within the prescribed time;

(2) the individual submits a timely request for reconsideration, the commissioner does not set aside the disqualification under section 245C.22, subdivision 4, and the individual

does not submit a timely request for a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14; or

(3) the individual submits a timely request for a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14, and the commissioner does not set aside or rescind the disqualification under section 245A.08, subdivision 5, or 256.045.

(b) For children's residential facility and foster residence setting license holders, upon receipt of notice from the commissioner under paragraph (a), the license holder must also remove the disqualified individual from working in the program, facility, or setting and from access to persons served by the licensed program.

(c) For Title IV-E eligible children's residential facility and foster residence setting license holders, upon receipt of notice from the commissioner under paragraph (a), the license holder must also remove the disqualified individual from working in the program and from access to persons served by the program and must not allow the individual to work in the facility or setting until the commissioner has issued a notice stating that:

(1) the individual is not disqualified;

(2) a disqualification has been set aside under section 245C.23; or

(3) a variance has been granted related to the individual under section 245C.30.

(d) For licensed child care center and certified license-exempt child care center license holders, upon receipt of notice from the commissioner under paragraph (a), the license holder must remove the disqualified individual from working in any position regardless of whether the individual would have direct contact with or access to children served in the center and from having access to persons served by the center and must not allow the individual to work in the center until the commissioner has issued a notice stating that:

(1) the individual is not disqualified;

(2) a disqualification has been set aside under section 245C.23; or

(3) a variance has been granted related to the individual under section 245C.30.

Sec. 30. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 245C.02, so that the subdivisions are alphabetical. The revisor shall correct any cross-references that arise as a result of the renumbering.

Sec. 31. **REPEALER.**

Minnesota Statutes 2020, section 245C.10, subdivisions 2, 2a, 3, 4, 5, 6, 7, 8, 9, 9a, 10, 11, 12, 13, 14, and 16, are repealed.

ARTICLE 6
BLUE RIBBON COMMISSION

Section 1. Minnesota Statutes 2020, section 174.30, subdivision 3, is amended to read:

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

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

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

Sec. 2. Minnesota Statutes 2020, section 256.983, is amended to read:

256.983 FRAUD PREVENTION INVESTIGATIONS.

Subdivision 1. **Programs established.** Within the limits of available appropriations, the commissioner of human services shall require the maintenance of budget neutral fraud prevention investigation programs in the counties or tribal agencies participating in the fraud prevention investigation project established under this section. If funds are sufficient, the commissioner may also extend fraud prevention investigation programs to other counties or tribal agencies provided the expansion is budget neutral to the state. Under any expansion,

the commissioner has the final authority in decisions regarding the creation and realignment of individual county, tribal agency, or regional operations.

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

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

Subd. 4. **Funding.** (a) County and tribal agency reimbursement shall be made through the settlement provisions applicable to the Supplemental Nutrition Assistance Program (SNAP), MFIP, child care assistance programs, the medical assistance program, and other federal and state-funded programs.

(b) The commissioner will maintain program compliance if for any three consecutive month period, a county or tribal agency fails to comply with fraud prevention investigation program guidelines, or fails to meet the cost-effectiveness standards developed by the commissioner. This result is contingent on the commissioner providing written notice, including an offer of technical assistance, within 30 days of the end of the third or subsequent month of noncompliance. The county or tribal agency shall be required to submit a corrective action plan to the commissioner within 30 days of receipt of a notice of noncompliance. Failure to submit a corrective action plan or, continued deviation from standards of more than ten percent after submission of a corrective action plan, will result in denial of funding for each subsequent month, or billing the county or tribal agency for fraud prevention investigation (FPI) service provided by the commissioner, or reallocation of program grant

funds, or investigative resources, or both, to other counties or tribal agencies. The denial of funding shall apply to the general settlement received by the county or tribal agency on a quarterly basis and shall not reduce the grant amount applicable to the FPI project.

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

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

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

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

Sec. 3. **[256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

(a) Effective January 1, 2023, the commissioner shall contract with up to two dental administrators to administer dental services for all recipients of medical assistance and

MinnesotaCare, including the administration of dental services for those enrolled in managed care under section 256B.69.

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

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

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

(4) dental claims processing;

(5) coordination with other services;

(6) management of fraud and abuse;

(7) monitoring of access to dental services;

(8) performance measurement;

(9) quality improvement and evaluation requirements; and

(10) management of third-party liability requirements.

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

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

Sec. 4. Minnesota Statutes 2020, section 256B.04, subdivision 12, is amended to read:

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

~~The rules shall provide:~~

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

~~(2) reimbursement of public and private nonprofit providers serving the population with a disability generally at reasonable maximum rates that reflect the cost of providing the~~

~~service regardless of the fare that might be charged by the provider for similar services to individuals other than those receiving medical assistance or medical care under this chapter.~~

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

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

Sec. 5. Minnesota Statutes 2020, section 256B.04, subdivision 14, is amended to read:

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

(1) eyeglasses;

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

(3) hearing aids and supplies; and

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

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

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

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

(6) drugs.

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

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

Sec. 6. Minnesota Statutes 2020, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services. The commissioner shall contract with a dental administrator for the administration of dental services. The contract shall include the administration of dental services for those enrolled in managed care under section 256B.69.

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

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

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

(3) limited exams;

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

(5) periapical x-rays;

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

(7) prophylaxis, limited to one per year;

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

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

(10) anterior fillings;

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

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

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

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

(15) full-mouth debridement, limited to one every five years.

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

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

(2) general anesthesia; and

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 7. Minnesota Statutes 2020, section 256B.0625, subdivision 17, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety

locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

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

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

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

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

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

(3) investigate all complaints and appeals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 8. Minnesota Statutes 2020, section 256B.0625, subdivision 17b, is amended to read:

Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency medical transportation providers must document each occurrence of a service provided to a recipient according to this subdivision. Providers must maintain odometer and other records sufficient to distinguish individual trips with specific vehicles and drivers. The documentation may be collected and maintained using electronic systems or software or in paper form but must be made available and produced upon request. Program funds paid for transportation that is not documented according to this subdivision shall be recovered by the nonemergency medical transportation vendor or department.

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

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

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

(3) each entry in the record must document:

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

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

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

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

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

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

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

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

(ix) whether the service was ambulatory or nonambulatory;

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

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

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

Sec. 9. Minnesota Statutes 2020, section 256B.0625, subdivision 18b, is amended to read:

Subd. 18b. **~~Broker dispatching prohibition~~ Administration of nonemergency medical transportation.** ~~Except for establishing level of service process, the commissioner shall not use a broker or coordinator for any purpose related to nonemergency medical transportation services under subdivision 18.~~ The commissioner shall contract either statewide or regionally for the administration of the nonemergency medical transportation program

in compliance with the provisions of this chapter. The contract shall include the administration of all covered modes under the nonemergency medical transportation benefit for those enrolled in managed care as described in section 256B.69.

Sec. 10. Minnesota Statutes 2020, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC code 31-1014); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for adult day services, 70 percent of the median wage for nursing assistant (SOC code 31-1014); and 30 percent of the median wage for personal care aide (SOC code 39-9021);

(3) for day services, day support services, and prevocational services, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(4) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota for large employers~~, except in a family foster care setting, the wage is 36 percent of the minimum wage in Minnesota for large employers~~;

(5) for positive supports analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(6) for positive supports professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(7) for positive supports specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(8) for supportive living services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(9) for housing access coordination staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099);

(10) for in-home family support and individualized home supports with family training staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for individualized home supports with training services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(12) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(13) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(14) for employment exploration services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(15) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(16) for individualized home support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(17) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(18) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(19) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(20) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(21) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of positive supports professional, positive supports analyst, and positive supports specialists, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(22) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

(23) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for corporate foster care services, corporate supportive living services daily, community residential services, and integrated community support services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

~~(c) Component values for family foster care are:~~

~~(1) competitive workforce factor: 4.7 percent;~~

~~(2) supervisory span of control ratio: 11 percent;~~

~~(3) employee vacation, sick, and training allowance ratio: 8.71 percent;~~

~~(4) employee-related cost ratio: 23.6 percent;~~

~~(5) general administrative support ratio: 3.3 percent;~~

~~(6) program-related expense ratio: 1.3 percent; and~~

~~(7) absence factor: 1.7 percent.~~

~~(d)~~ (c) Component values for day training and habilitation, day support services, and prevocational services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: ten percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

~~(e)~~ (d) Component values for adult day services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 7.4 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

~~(f)~~ (e) Component values for unit-based services with programming are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan supports ratio: 15.5 percent;

(6) client programming and supports ratio: 4.7 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 6.1 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

~~(g)~~ (f) Component values for unit-based services without programming except respite are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 7.0 percent;

(6) client programming and support ratio: 2.3 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

~~(h)~~ (g) Component values for unit-based services without programming for respite are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 2.9 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

~~(i)~~ (h) On July 1, 2022, and every two years thereafter, the commissioner shall update the base wage index in paragraph (a) based on wage data by SOC from the Bureau of Labor Statistics available 30 months and one day prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

~~(j)~~ (i) Beginning February 1, 2021, and every two years thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance an analysis of the competitive workforce factor. The report must include recommendations to update the competitive workforce factor using:

(1) the most recently available wage data by SOC code for the weighted average wage for direct care staff for residential services and direct care staff for day services;

(2) the most recently available wage data by SOC code of the weighted average wage of comparable occupations; and

(3) workforce data as required under subdivision 10a, paragraph (g).

The commissioner shall not recommend an increase or decrease of the competitive workforce factor from the current value by more than two percentage points. If, after a biennial analysis for the next report, the competitive workforce factor is less than or equal to zero, the commissioner shall recommend a competitive workforce factor of zero.

~~(k)~~ (j) On July 1, 2022, and every two years thereafter, the commissioner shall update the framework components in paragraph ~~(d)~~ (c), clause (6); paragraph ~~(e)~~ (d), clause (6); paragraph ~~(f)~~ (e), clause (6); and paragraph ~~(g)~~ (f), clause (6); subdivision 6, paragraphs (b), clauses (9) and (10), and (e), clause (10); and subdivision 7, clauses (11), (17), and (18)~~,~~; and subdivision 18, for changes in the Consumer Price Index. The commissioner shall

adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the data available 30 months and one day prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

~~(l)~~ (k) Upon the implementation of the updates under paragraphs ~~(i)~~ (h) and ~~(k)~~ (j), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013, chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall be removed from service rates calculated under this section.

~~(m)~~ (l) Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section shall be removed from rate calculations upon implementation of the updates under paragraphs ~~(i)~~ (h) and ~~(k)~~ (j).

~~(n)~~ (m) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later.

Sec. 11. Minnesota Statutes 2020, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Payments for residential support services.** (a) For purposes of this subdivision, residential support services includes 24-hour customized living services, community residential services, customized living services, ~~family residential services, foster care services,~~ and integrated community supports~~, and supportive living services daily~~.

(b) Payments for community residential services~~, corporate foster care services, corporate supportive living services daily, family residential services, and family foster care services~~ must be calculated as follows:

(1) determine the number of shared staffing and individual direct staff hours to meet a recipient's needs provided on site or through monitoring technology;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (b), clause (1);

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages;

(6) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (3). This is defined as the direct staffing cost;

(8) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (4);

(9) for client programming and supports, the commissioner shall add $2,179; and

(10) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport, based on the resident with the highest assessed need.

(c) The total rate must be calculated using the following steps:

(1) subtotal paragraph (b), clauses (8) to (10), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause (8);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(d) The payment methodology for customized living, 24-hour customized living, and residential care services must be the customized living tool. Revisions to the customized living tool must be made to reflect the services and activities unique to disability-related recipient needs. Customized living and 24-hour customized living rates determined under this section shall not include more than 24 hours of support in a daily unit.

(e) Payments for integrated community support services must be calculated as follows:

(1) the base shared staffing shall be eight hours divided by the number of people receiving support in the integrated community support setting;

(2) the individual staffing hours shall be the average number of direct support hours provided directly to the service recipient;

(3) the personnel hourly wage rate must be based on the most recent Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(4) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (3) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (b), clause (1);

(5) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (4);

(6) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the appropriate staff wages;

(7) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the product of the supervisory span of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervisory wage in subdivision 5, paragraph (a), clause (21);

(8) combine the results of clauses (6) and (7) and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (3). This is defined as the direct staffing cost;

(9) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (4); and

(10) for client programming and supports, the commissioner shall add $2,260.21 divided by 365.

(f) The total rate must be calculated as follows:

(1) add the results of paragraph (e), clauses (9) and (10);

(2) add the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(g) The payment methodology for customized living and 24-hour customized living services must be the customized living tool. The commissioner shall revise the customized living tool to reflect the services and activities unique to disability-related recipient needs and adjust for regional differences in the cost of providing services.

(h) The number of days authorized for all individuals enrolling in residential services must include every day that services start and end.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later.

Sec. 12. Minnesota Statutes 2020, section 256B.4914, is amended by adding a subdivision to read:

Subd. 18. **Payments for family residential services.** The commissioner shall establish rates for family residential services based on a person's assessed needs as described in the federally approved waiver plans.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later.

Sec. 13. Minnesota Statutes 2020, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude ~~or modify~~ coverage for outpatient prescription drugs dispensed by a pharmacy to a member eligible for medical assistance under this chapter from the prepaid managed care contracts entered into under this section ~~in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize~~

~~the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates~~. The commissioner may include, exclude, or modify coverage for outpatient prescription drugs dispensed by a pharmacy to a member eligible for MinnesotaCare under chapter 256L and prescription drugs administered to a medical assistance member or MinnesotaCare member from the prepaid managed care contracts entered into under this section.

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

Sec. 14. Minnesota Statutes 2020, section 256B.76, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph

(f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

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

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

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

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

(l) Effective for services provided on or after January 1, 2017, through December 31, 2022, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care

plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

(m) Effective for services provided on or after July 1, 2017, through December 31, 2022, the commissioner shall increase payment rates by 23.8 percent for dental services provided to enrollees under the age of 21. This rate increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers. This rate increase does not apply to managed care plans and county-based purchasing plans.

(n) Effective for dental services provided on or after January 1, 2023, the commissioner shall increase payment rates by 54 percent. This rate increase must not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers.

Sec. 15. Minnesota Statutes 2020, section 256B.76, subdivision 4, is amended to read:

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

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

(c) Critical access dental payments made under paragraph (a) or (b) for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid

according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

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

(1) nonprofit community clinics that:

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

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

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

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

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

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

(vii) have free care available as needed;

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

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

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

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

(6) private practicing dentists if:

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

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

Sec. 16. Minnesota Statutes 2020, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(f) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates as determined under paragraphs (i) and (j).

(g) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

(i) Effective for services provided on or after July 1, 2015, through June 30, 2021, the following categories of medical supplies and durable medical equipment shall be individually priced items: enteral nutrition and supplies, customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service. This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item. The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding through June 30, 2021.

(j) Effective for services provided on or after July 1, 2015, through June 30, 2021, medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased as follows:

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid

that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, items provided to dually eligible recipients when Medicare is the primary payer for the item, and individually priced items identified in paragraph (i). Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the rate increases in this paragraph.

(k) Effective for nonpressure support ventilators provided on or after January 1, 2016, through June 30, 2021, the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective for pressure support ventilators provided on or after January 1, 2016, through June 30, 2021, the rate shall be the lower of the submitted charge or 47 percent above the Medicare fee schedule rate. For payments made in accordance with this paragraph, if, and to the extent that, the commissioner identifies that the state has received federal financial participation for ventilators in excess of the amount allowed effective January 1, 2018, under United States Code, title 42, section 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state funds and maintain the full payment rate under this paragraph.

(l) Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall not be applied to the items listed in this paragraph.

(m) Effective July 1, 2021, the payment rates for all durable medical equipment, prosthetics, orthotics, or supplies shall be the lesser of the provider's submitted charges or the Medicare fee schedule amount, with no increases or decreases described in paragraphs (a) to (k) applied.

(n) Effective July 1, 2021, the payment rates for durable medical equipment, prosthetics, orthotics, or supplies for which Medicare has not established a payment amount shall be the lesser of the provider's submitted charges, or the alternative payment methodology rate described in clauses (1) to (4) with no increases or decreases described in paragraphs (a) to (k) applied.

(1) The alternate payment methodology rate is calculated from either:

(i) at least 100 paid claim lines, as priced under paragraph (o), submitted by at least ten different providers within one calendar month; or

(ii) at least 20 paid claim lines, as priced under paragraph (o), submitted by at least five different providers within two consecutive quarters for services that are not paid 100 times in a calendar month.

(2) The alternate payment methodology rate is the mean of the payment per unit of the claim lines, with the top and bottom ten percent of claim lines, by payment per unit, excluded from the calculation of the mean.

(3) The alternate payment methodology rate for the rate period will be added to the fee schedule on the first day of a calendar month or the first day of a calendar quarter if claims from more than one month were used to determine the rate. The alternate payment methodology rates will be subject to Medicare's inflation or deflation factor on January 1 of each year unless the rate was calculated and posted to the fee schedule after July 1 of the previous year.

(4) Not more than once every three years, the alternate payment methodology rates must be evaluated by the commissioner for reasonableness by reviewing invoices from at least 20 paid claim lines and five different providers for claims paid during one calendar month or one quarter if necessary to obtain the required sample. If the evaluation identifies that the alternate payment methodology rate is more than five percent higher or lower than the provider's actual acquisition cost plus 20 percent, then the commissioner shall recalculate and update the fee schedule according to clauses (1) to (3). If the evaluation does not show that the alternate payment methodology fee schedule rate is five percent higher or lower than the provider's actual acquisition cost plus 20 percent or a sufficient sample cannot be collected due to low utilization as defined in clause (1), then the commissioner shall maintain the previously calculated alternate payment methodology rate on the fee schedule.

(o) Until sufficient data is available to calculate the alternative payment methodology, the payment shall be based on the provider's actual acquisition cost plus 20 percent as documented on an invoice submitted by the provider. The payment may be based on a quote the provider received from a vendor showing the provider's actual acquisition cost only if the durable medical equipment, prosthetic, orthotic, or supply requires authorization and the rate is required to complete the authorization.

(p) Notwithstanding paragraph (n), durable medical equipment and supplies billed using miscellaneous codes, and for which no Medicare rate is available, shall be paid the provider's actual acquisition cost plus ten percent.

Sec. 17. Minnesota Statutes 2020, section 256B.767, is amended to read:

256B.767 MEDICARE PAYMENT LIMIT.

(a) Effective for services rendered on or after July 1, 2010, fee-for-service payment rates for physician and professional services under section 256B.76, subdivision 1, and basic care services subject to the rate reduction specified in section 256B.766, shall not exceed the Medicare payment rate for the applicable service, as adjusted for any changes in Medicare payment rates after July 1, 2010. The commissioner shall implement this section after any other rate adjustment that is effective July 1, 2010, and shall reduce rates under this section by first reducing or eliminating provider rate add-ons.

(b) This section does not apply to services provided by advanced practice certified nurse midwives licensed under chapter 148 or traditional midwives licensed under chapter 147D. Notwithstanding this exemption, medical assistance fee-for-service payment rates for advanced practice certified nurse midwives and licensed traditional midwives shall equal and shall not exceed the medical assistance payment rate to physicians for the applicable service.

(c) This section does not apply to mental health services or physician services billed by a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

~~(d) Effective July 1, 2015, this section shall not apply to durable medical equipment, prosthetics, orthotics, or supplies.~~

~~(e)~~ (d) This section does not apply to physical therapy, occupational therapy, speech pathology and related services, and basic care services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4).

Sec. 18. Minnesota Statutes 2020, section 256L.11, subdivision 7, is amended to read:

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

Sec. 19. **REPEALER.**

Minnesota Statutes 2020, sections 256B.0625, subdivisions 18c, 18d, 18e, and 18h; and 256L.11, subdivision 6a, are repealed.

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

ARTICLE 7
MENTAL HEALTH UNIFORM SERVICE STANDARDS: CORE

Section 1. **[245I.01] PURPOSE AND CITATION.**

Subdivision 1. **Citation.** This chapter may be cited as the "Mental Health Uniform Service Standards Act."

Subd. 2. **Purpose.** In accordance with sections 245.461 and 245.487, the purpose of this chapter is to create a system of mental health care that is unified, accountable, and comprehensive, and to promote the recovery and resiliency of Minnesotans who have mental illnesses. The state's public policy is to support Minnesotans' access to quality outpatient and residential mental health services. Further, the state's public policy is to protect the health and safety, rights, and well-being of Minnesotans receiving mental health services.

Sec. 2. **[245I.011] APPLICABILITY.**

Subdivision 1. **License requirements.** A license holder under this chapter must comply with the requirements in chapters 245A, 245C, and 260E; section 626.557; and Minnesota Rules, chapter 9544.

Subd. 2. **Variances.** (a) The commissioner may grant a variance to an applicant, license holder, or certification holder as long as the variance does not affect the health or safety of any person in a licensed or certified program and the applicant, license holder, or certification holder meets the following conditions:

(1) an applicant, license holder, or certification holder must request the variance on a form approved by the commissioner and in a manner prescribed by the commissioner;

(2) the request for a variance must include the:

(i) reasons that the applicant, license holder, or certification holder cannot comply with a requirement as stated in the law; and

(ii) alternative equivalent measures that the applicant, license holder, or certification holder will follow to comply with the intent of the law; and

(3) the request for a variance must state the period of time when the variance is requested.

(b) The commissioner may grant a permanent variance when the conditions under which the applicant, license holder, or certification holder requested the variance do not affect the health or safety of any person whom the licensed or certified program serves, and when the conditions of the variance do not compromise the qualifications of staff who provide services to clients. A permanent variance expires when the conditions that warranted the variance change in any way. Any applicant, license holder, or certification holder must inform the commissioner of any changes to the conditions that warranted the permanent variance. If an applicant, license holder, or certification holder fails to advise the commissioner of changes to the conditions that warranted the variance, the commissioner must revoke the permanent variance and may impose other sanctions under sections 245A.06 and 245A.07.

(c) The commissioner's decision to grant or deny a variance request is final and not subject to appeal under the provisions of chapter 14.

Subd. 3. **Certification required.** (a) An individual, organization, or government entity that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause (19), and chooses to be identified as a certified mental health clinic must:

(1) be a mental health clinic that is certified under section 245I.20;

(2) comply with all of the responsibilities assigned to a license holder by this chapter except subdivision 1; and

(3) comply with all of the responsibilities assigned to a certification holder by chapter 245A.

(b) An individual, organization, or government entity described by this subdivision must obtain a criminal background study for each staff person or volunteer who provides direct contact services to clients.

Subd. 4. **License required.** An individual, organization, or government entity providing intensive residential treatment services or residential crisis stabilization to adults must be licensed under section 245I.23.

Subd. 5. **Programs certified under chapter 256B.** (a) An individual, organization, or government entity certified under the following sections must comply with all of the responsibilities assigned to a license holder under this chapter except subdivision 1:

(1) an assertive community treatment provider under section 256B.0622, subdivision 3a;

(2) an adult rehabilitative mental health services provider under section 256B.0623;

(3) a mobile crisis team under section 256B.0624;

(4) a children's therapeutic services and supports provider under section 256B.0943;

(5) an intensive treatment in foster care provider under section 256B.0946; and

(6) an intensive nonresidential rehabilitative mental health services provider under section 256B.0947.

(b) An individual, organization, or government entity certified under the sections listed in paragraph (a), clauses (1) to (6), must obtain a criminal background study for each staff person and volunteer providing direct contact services to a client.

EFFECTIVE DATE. This section is effective upon federal approval or July 1, 2022, whichever is later.

Sec. 3. **[245I.02] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of this chapter, the terms in this section have the meanings given.

Subd. 2. **Approval.** "Approval" means the documented review of, opportunity to request changes to, and agreement with a treatment document. An individual may demonstrate approval with a written signature, secure electronic signature, or documented oral approval.

Subd. 3. **Behavioral sciences or related fields.** "Behavioral sciences or related fields" means an education from an accredited college or university in social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, nursing, and other similar fields approved by the commissioner.

Subd. 4. **Business day.** "Business day" means a weekday on which government offices are open for business. Business day does not include state or federal holidays, Saturdays, or Sundays.

Subd. 5. **Case manager.** "Case manager" means a client's case manager according to section 256B.0596; 256B.0621; 256B.0625, subdivision 20; 256B.092, subdivision 1a; 256B.0924; 256B.093, subdivision 3a; 256B.094; or 256B.49.

Subd. 6. **Certified rehabilitation specialist.** "Certified rehabilitation specialist" means a staff person who meets the qualifications of section 245I.04, subdivision 8.

Subd. 7. **Child.** "Child" means a client under the age of 18.

Subd. 8. **Client.** "Client" means a person who is seeking or receiving services regulated by this chapter. For the purpose of a client's consent to services, client includes a parent, guardian, or other individual legally authorized to consent on behalf of a client to services.

Subd. 9. **Clinical trainee.** "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

Subd. 10. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designee.

Subd. 11. **Co-occurring substance use disorder treatment.** "Co-occurring substance use disorder treatment" means the treatment of a person who has a co-occurring mental illness and substance use disorder. Co-occurring substance use disorder treatment is characterized by stage-wise comprehensive treatment, treatment goal setting, and flexibility for clients at each stage of treatment. Co-occurring substance use disorder treatment includes assessing and tracking each client's stage of change readiness and treatment using a treatment approach based on a client's stage of change, such as motivational interviewing when working with a client at an earlier stage of change readiness and a cognitive behavioral approach and relapse prevention to work with a client at a later stage of change; and facilitating a client's access to community supports.

Subd. 12. **Crisis plan.** "Crisis plan" means a plan to prevent and de-escalate a client's future crisis situation, with the goal of preventing future crises for the client and the client's family and other natural supports. Crisis plan includes a crisis plan developed according to section 245.4871, subdivision 9a.

Subd. 13. **Critical incident.** "Critical incident" means an occurrence involving a client that requires a license holder to respond in a manner that is not part of the license holder's ordinary daily routine. Critical incident includes a client's suicide, attempted suicide, or homicide; a client's death; an injury to a client or other person that is life-threatening or requires medical treatment; a fire that requires a fire department's response; alleged maltreatment of a client; an assault of a client; an assault by a client; or other situation that requires a response by law enforcement, the fire department, an ambulance, or another emergency response provider.

Subd. 14. **Diagnostic assessment.** "Diagnostic assessment" means the evaluation and report of a client's potential diagnoses that a mental health professional or clinical trainee completes under section 245I.10, subdivisions 4 to 6.

Subd. 15. **Direct contact.** "Direct contact" has the meaning given in section 245C.02, subdivision 11.

Subd. 16. **Family and other natural supports.** "Family and other natural supports" means the people whom a client identifies as having a high degree of importance to the client. Family and other natural supports also means people that the client identifies as being important to the client's mental health treatment, regardless of whether the person is related to the client or lives in the same household as the client.

Subd. 17. **Functional assessment.** "Functional assessment" means the assessment of a client's current level of functioning relative to functioning that is appropriate for someone the client's age. For a client five years of age or younger, a functional assessment is the Early Childhood Service Intensity Instrument (ESCII). For a client six to 17 years of age, a functional assessment is the Child and Adolescent Service Intensity Instrument (CASII). For a client 18 years of age or older, a functional assessment is the functional assessment described in section 245I.10, subdivision 9.

Subd. 18. **Individual abuse prevention plan.** "Individual abuse prevention plan" means a plan according to section 245A.65, subdivision 2, paragraph (b), and section 626.557, subdivision 14.

Subd. 19. **Level of care assessment.** "Level of care assessment" means the level of care decision support tool appropriate to the client's age. For a client five years of age or younger, a level of care assessment is the Early Childhood Service Intensity Instrument (ESCII). For a client six to 17 years of age, a level of care assessment is the Child and Adolescent Service Intensity Instrument (CASII). For a client 18 years of age or older, a level of care assessment is the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS).

Subd. 20. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

Subd. 21. **License holder.** "License holder" has the meaning given in section 245A.02, subdivision 9.

Subd. 22. **Licensed prescriber.** "Licensed prescriber" means an individual who is authorized to prescribe legend drugs under section 151.37.

Subd. 23. **Mental health behavioral aide.** "Mental health behavioral aide" means a staff person who is qualified under section 245I.04, subdivision 16.

Subd. 24. **Mental health certified family peer specialist.** "Mental health certified family peer specialist" means a staff person who is qualified under section 245I.04, subdivision 12.

Subd. 25. **Mental health certified peer specialist.** "Mental health certified peer specialist" means a staff person who is qualified under section 245I.04, subdivision 10.

Subd. 26. **Mental health practitioner.** "Mental health practitioner" means a staff person who is qualified under section 245I.04, subdivision 4.

Subd. 27. **Mental health professional.** "Mental health professional" means a staff person who is qualified under section 245I.04, subdivision 2.

Subd. 28. **Mental health rehabilitation worker.** "Mental health rehabilitation worker" means a staff person who is qualified under section 245I.04, subdivision 14.

Subd. 29. **Mental illness.** "Mental illness" means any of the conditions included in the most recent editions of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three or the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Subd. 30. **Organization.** "Organization" has the meaning given in section 245A.02, subdivision 10c.

Subd. 31. **Personnel file.** "Personnel file" means a set of records under section 245I.07, paragraph (a). Personnel files excludes information related to a person's employment that is not included in section 245I.07.

Subd. 32. **Registered nurse.** "Registered nurse" means a staff person who is qualified under section 148.171, subdivision 20.

Subd. 33. **Rehabilitative mental health services.** "Rehabilitative mental health services" means mental health services provided to an adult client that enable the client to develop and achieve psychiatric stability, social competencies, personal and emotional adjustment, independent living skills, family roles, and community skills when symptoms of mental illness has impaired any of the client's abilities in these areas.

Subd. 34. **Residential program.** "Residential program" has the meaning given in section 245A.02, subdivision 14.

Subd. 35. **Signature.** "Signature" means a written signature or an electronic signature defined in section 325L.02, paragraph (h).

Subd. 36. **Staff person.** "Staff person" means an individual who works under a license holder's direction or under a contract with a license holder. Staff person includes an intern, consultant, contractor, individual who works part-time, and an individual who does not provide direct contact services to clients. Staff person includes a volunteer who provides treatment services to a client or a volunteer whom the license holder regards as a staff person

for the purpose of meeting staffing or service delivery requirements. A staff person must be 18 years of age or older.

Subd. 37. **Strengths.** "Strengths" means a person's inner characteristics, virtues, external relationships, activities, and connections to resources that contribute to a client's resilience and core competencies. A person can build on strengths to support recovery.

Subd. 38. **Trauma.** "Trauma" means an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma includes group traumatic experiences. Group traumatic experiences are emotional or psychological harm that a group experiences. Group traumatic experiences can be transmitted across generations within a community and are often associated with racial and ethnic population groups who suffer major intergenerational losses.

Subd. 39. **Treatment plan.** "Treatment plan" means services that a license holder formulates to respond to a client's needs and goals. A treatment plan includes individual treatment plans under section 245I.10, subdivisions 7 and 8; initial treatment plans under section 245I.23, subdivision 7; and crisis treatment plans under sections 245I.23, subdivision 8, and 256B.0624, subdivision 11.

Subd. 40. **Treatment supervision.** "Treatment supervision" means a mental health professional's or certified rehabilitation specialist's oversight, direction, and evaluation of a staff person providing services to a client according to section 245I.06.

Subd. 41. **Volunteer.** "Volunteer" means an individual who, under the direction of the license holder, provides services to or facilitates an activity for a client without compensation.

Sec. 4. **[245I.03] REQUIRED POLICIES AND PROCEDURES.**

Subdivision 1. **Generally.** A license holder must establish, enforce, and maintain policies and procedures to comply with the requirements of this chapter and chapters 245A, 245C, and 260E; sections 626.557 and 626.5572; and Minnesota Rules, chapter 9544. The license holder must make all policies and procedures available in writing to each staff person. The license holder must complete and document a review of policies and procedures every two years and update policies and procedures as necessary. Each policy and procedure must identify the date that it was initiated and the dates of all revisions. The license holder must clearly communicate any policy and procedural change to each staff person and provide necessary training to each staff person to implement any policy and procedural change.

Subd. 2. **Health and safety.** A license holder must have policies and procedures to ensure the health and safety of each staff person and client during the provision of services, including policies and procedures for services based in community settings.

Subd. 3. **Client rights.** A license holder must have policies and procedures to ensure that each staff person complies with the client rights and protections requirements in section 245I.12.

Subd. 4. **Behavioral emergencies.** (a) A license holder must have procedures that each staff person follows when responding to a client who exhibits behavior that threatens the immediate safety of the client or others. A license holder's behavioral emergency procedures must incorporate person-centered planning and trauma-informed care.

(b) A license holder's behavioral emergency procedures must include:

(1) a plan designed to prevent the client from inflicting self-harm and harming others;

(2) contact information for emergency resources that a staff person must use when the license holder's behavioral emergency procedures are unsuccessful in controlling a client's behavior;

(3) the types of behavioral emergency procedures that a staff person may use;

(4) the specific circumstances under which the program may use behavioral emergency procedures; and

(5) the staff persons whom the license holder authorizes to implement behavioral emergency procedures.

(c) The license holder's behavioral emergency procedures must not include secluding or restraining a client except as allowed under section 245.8261.

(d) Staff persons must not use behavioral emergency procedures to enforce program rules or for the convenience of staff persons. Behavioral emergency procedures must not be part of any client's treatment plan. A staff person may not use behavioral emergency procedures except in response to a client's current behavior that threatens the immediate safety of the client or others.

Subd. 5. **Health services and medications.** If a license holder is licensed as a residential program, stores or administers client medications, or observes clients self-administer medications, the license holder must ensure that a staff person who is a registered nurse or licensed prescriber reviews and approves of the license holder's policies and procedures to comply with the health services and medications requirements in section 245I.11, the training

requirements in section 245I.05, subdivision 6, and the documentation requirements in section 245I.08, subdivision 5.

Subd. 6. **Reporting unethical acts or maltreatment.** (a) A license holder must have policies and procedures for reporting and investigating a staff person's alleged unethical, illegal, or grossly negligent acts, and a staff person's serious violations of policies and procedures. A staff person's serious violation of policies and procedures means: (1) a violation that threatens the health, safety, or rights of a client or other staff person; or (2) repeated nonadherence to the license holder's policies and procedures. The license holder must document that a supervisor reviewed the staff person's reported behavior. If the behavior is substantiated, the license holder must document that the license holder took appropriate disciplinary or corrective action.

(b) A license holder must have policies and procedures for reporting a staff person's suspected maltreatment, abuse, or neglect of a client according to chapter 260E and section 626.557.

Subd. 7. **Critical incidents.** If a license holder is licensed as a residential program, the license holder must have policies and procedures for reporting and maintaining records of critical incidents according to section 245I.13.

Subd. 8. **Personnel.** A license holder must have personnel policies and procedures that:

(1) include a chart or description of the organizational structure of the program that indicates positions and lines of authority;

(2) ensure that it will not adversely affect a staff person's retention, promotion, job assignment, or pay when a staff person communicates in good faith with the Department of Human Services, the Office of Ombudsman for Mental Health and Developmental Disabilities, the Department of Health, a health-related licensing board, a law enforcement agency, or a local agency investigating a complaint regarding a client's rights, health, or safety;

(3) prohibit a staff person from having sexual contact with a client in violation of chapter 604, sections 609.344 or 609.345;

(4) prohibit a staff person from neglecting, abusing, or maltreating a client as described in chapter 260E and sections 626.557 and 626.5572;

(5) include the drug and alcohol policy described in section 245A.04, subdivision 1, paragraph (c);

(6) describe the process for disciplinary action, suspension, or dismissal of a staff person for violating a policy provision described in clauses (3) to (5);

(7) describe the license holder's response to a staff person who violates other program policies or who has a behavioral problem that interferes with providing treatment services to clients; and

(8) describe each staff person's position that includes the staff person's responsibilities, authority to execute the responsibilities, and qualifications for the position.

Subd. 9. **Volunteers.** A license holder must have policies and procedures for using volunteers, including when a license holder must submit a background study for a volunteer, and the specific tasks that a volunteer may perform.

Subd. 10. **Data privacy.** (a) A license holder must have policies and procedures that comply with the Minnesota Government Data Practices Act, chapter 13; the privacy provisions of the Minnesota health care programs provider agreement; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191; and the Minnesota Health Records Act, sections 144.291 to 144.298. A license holder's use of electronic record keeping or electronic signatures does not alter a license holder's obligations to comply with applicable state and federal law.

(b) A license holder must have policies and procedures for a staff person to promptly document a client's revocation of consent to disclose the client's health record. The license holder must verify that the license holder has permission to disclose a client's health record before releasing any client data.

Sec. 5. **[245I.04] PROVIDER QUALIFICATIONS AND SCOPE OF PRACTICE.**

Subdivision 1. **Tribal providers.** For purposes of this section, a tribal entity may credential an individual according to section 256B.02, subdivision 7, paragraphs (b) and (c).

Subd. 2. **Mental health professional qualifications.** The following individuals may provide services to a client as a mental health professional:

(1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a: (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and mental health nursing by a national certification organization; or (ii) nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization;

(2) a licensed independent clinical social worker as defined in section 148E.050, subdivision 5;

(3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;

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

(5) a marriage and family therapist licensed under sections 148B.29 to 148B.392; or

(6) a licensed professional clinical counselor licensed under section 148B.5301.

Subd. 3. **Mental health professional scope of practice.** A mental health professional must maintain a valid license with the mental health professional's governing health-related licensing board and must only provide services to a client within the scope of practice determined by the applicable health-related licensing board.

Subd. 4. **Mental health practitioner qualifications.** (a) An individual who is qualified in at least one of the ways described in paragraph (b) to (d) may serve as a mental health practitioner.

(b) An individual is qualified as a mental health practitioner through relevant coursework if the individual completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:

(1) has at least 2,000 hours of experience providing services to individuals with:

(i) a mental illness or a substance use disorder; or

(ii) a traumatic brain injury or a developmental disability, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to a client;

(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the individual's clients belong, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to a client;

(3) is working in a day treatment program under section 256B.0671, subdivision 3, or 256B.0943; or

(4) has completed a practicum or internship that (i) required direct interaction with adult clients or child clients, and (ii) was focused on behavioral sciences or related fields.

(c) An individual is qualified as a mental health practitioner through work experience providing services to clients if the individual:

(1) has at least 4,000 hours of experience in the delivery of services to individuals with:

(i) a mental illness or a substance use disorder; or

(ii) a traumatic brain injury or a developmental disability, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to clients; or

(2) receives treatment supervision at least once per week until meeting the requirement in clause (1) of 4,000 hours of experience and has at least 2,000 hours of experience providing services to individuals with:

(i) a mental illness or a substance use disorder; or

(ii) a traumatic brain injury or a developmental disability, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to clients.

(d) An individual is qualified as a mental health practitioner if the individual has a master's or other graduate degree in behavioral sciences or related fields.

Subd. 5. **Mental health practitioner scope of practice.** (a) A mental health practitioner under the treatment supervision of a mental health professional or certified rehabilitation specialist may provide an adult client with client education, rehabilitative mental health services, functional assessments, level of care assessments, and treatment plans. A mental health practitioner under the treatment supervision of a mental health professional may provide skill-building services to a child client and complete treatment plans for a child client.

(b) A mental health practitioner must not provide treatment supervision to other staff persons. A mental health practitioner may provide direction to mental health rehabilitation workers and mental health behavioral aides.

(c) A mental health practitioner who provides services to clients according to section 256B.0624 may perform crisis assessments and interventions for a client.

Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who: (1) is enrolled in an accredited graduate program of study to prepare the staff person for independent licensure as a mental health professional and who is participating in a practicum or internship with the license holder through the individual's graduate program; or (2) has

completed an accredited graduate program of study to prepare the staff person for independent licensure as a mental health professional and who is in compliance with the requirements of the applicable health-related licensing board, including requirements for supervised practice.

(b) A clinical trainee is responsible for notifying and applying to a health-related licensing board to ensure that the trainee meets the requirements of the health-related licensing board. As permitted by a health-related licensing board, treatment supervision under this chapter may be integrated into a plan to meet the supervisory requirements of the health-related licensing board but does not supersede those requirements.

Subd. 7. **Clinical trainee scope of practice.** (a) A clinical trainee under the treatment supervision of a mental health professional may provide a client with psychotherapy, client education, rehabilitative mental health services, diagnostic assessments, functional assessments, level of care assessments, and treatment plans.

(b) A clinical trainee must not provide treatment supervision to other staff persons. A clinical trainee may provide direction to mental health behavioral aides and mental health rehabilitation workers.

(c) A psychological clinical trainee under the treatment supervision of a psychologist may perform psychological testing of clients.

(d) A clinical trainee must not provide services to clients that violate any practice act of a health-related licensing board, including failure to obtain licensure if licensure is required.

Subd. 8. **Certified rehabilitation specialist qualifications.** A certified rehabilitation specialist must have:

(1) a master's degree from an accredited college or university in behavioral sciences or related fields;

(2) at least 4,000 hours of post-master's supervised experience providing mental health services to clients; and

(3) a valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner.

Subd. 9. **Certified rehabilitation specialist scope of practice.** (a) A certified rehabilitation specialist may provide an adult client with client education, rehabilitative mental health services, functional assessments, level of care assessments, and treatment plans.

(b) A certified rehabilitation specialist may provide treatment supervision to a mental health certified peer specialist, mental health practitioner, and mental health rehabilitation worker.

Subd. 10. **Mental health certified peer specialist qualifications.** A mental health certified peer specialist must:

(1) have been diagnosed with a mental illness;

(2) be a current or former mental health services client; and

(3) have a valid certification as a mental health certified peer specialist under section 256B.0615.

Subd. 11. **Mental health certified peer specialist scope of practice.** A mental health certified peer specialist under the treatment supervision of a mental health professional or certified rehabilitation specialist must:

(1) provide individualized peer support to each client;

(2) promote a client's recovery goals, self-sufficiency, self-advocacy, and development of natural supports; and

(3) support a client's maintenance of skills that the client has learned from other services.

Subd. 12. **Mental health certified family peer specialist qualifications.** A mental health certified family peer specialist must:

(1) have raised or be currently raising a child with a mental illness;

(2) have experience navigating the children's mental health system; and

(3) have a valid certification as a mental health certified family peer specialist under section 256B.0616.

Subd. 13. **Mental health certified family peer specialist scope of practice.** A mental health certified family peer specialist under the treatment supervision of a mental health professional must provide services to increase the child's ability to function in the child's home, school, and community. The mental health certified family peer specialist must:

(1) provide family peer support to build on a client's family's strengths and help the family achieve desired outcomes;

(2) provide nonadversarial advocacy to a child client and the child's family that encourages partnership and promotes the child's positive change and growth;

(3) support families in advocating for culturally appropriate services for a child in each treatment setting;

(4) promote resiliency, self-advocacy, and development of natural supports;

(5) support maintenance of skills learned from other services;

(6) establish and lead parent support groups;

(7) assist parents in developing coping and problem-solving skills; and

(8) educate parents about mental illnesses and community resources, including resources that connect parents with similar experiences to one another.

Subd. 14. **Mental health rehabilitation worker qualifications.** (a) A mental health rehabilitation worker must:

(1) have a high school diploma or equivalent; and

(2) meet one of the following qualification requirements:

(i) be fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

(ii) have an associate of arts degree;

(iii) have two years of full-time postsecondary education or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields;

(iv) be a registered nurse;

(v) have, within the previous ten years, three years of personal life experience with mental illness;

(vi) have, within the previous ten years, three years of life experience as a primary caregiver to an adult with a mental illness, traumatic brain injury, substance use disorder, or developmental disability; or

(vii) have, within the previous ten years, 2,000 hours of work experience providing health and human services to individuals.

(b) A mental health rehabilitation worker who is scheduled as an overnight staff person and works alone is exempt from the additional qualification requirements in paragraph (a), clause (2).

Subd. 15. **Mental health rehabilitation worker scope of practice.** A mental health rehabilitation worker under the treatment supervision of a mental health professional or

certified rehabilitation specialist may provide rehabilitative mental health services to an adult client according to the client's treatment plan.

Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health behavioral aide must have: (1) a high school diploma or equivalent; or (2) two years of experience as a primary caregiver to a child with mental illness within the previous ten years.

(b) A level 2 mental health behavioral aide must: (1) have an associate or bachelor's degree; or (2) be certified by a program under section 256B.0943, subdivision 8a.

Subd. 17. **Mental health behavioral aide scope of practice.** While under the treatment supervision of a mental health professional, a mental health behavioral aide may practice psychosocial skills with a child client according to the child's treatment plan and individual behavior plan that a mental health professional, clinical trainee, or mental health practitioner has previously taught to the child.

Sec. 6. **[245I.05] TRAINING REQUIRED.**

Subdivision 1. **Training plan.** A license holder must develop a training plan to ensure that staff persons receive ongoing training according to this section. The training plan must include:

(1) a formal process to evaluate the training needs of each staff person. An annual performance evaluation of a staff person satisfies this requirement;

(2) a description of how the license holder conducts ongoing training of each staff person, including whether ongoing training is based on a staff person's hire date or a specified annual cycle determined by the program;

(3) a description of how the license holder verifies and documents each staff person's previous training experience. A license holder may consider a staff person to have met a training requirement in subdivision 3, paragraph (d) or (e), if the staff person has received equivalent postsecondary education in the previous four years or training experience in the previous two years; and

(4) a description of how the license holder determines when a staff person needs additional training, including when the license holder will provide additional training.

Subd. 2. **Documentation of training.** (a) The license holder must provide training to each staff person according to the training plan and must document that the license holder

provided the training to each staff person. The license holder must document the following information for each staff person's training:

(1) the topics of the training;

(2) the name of the trainee;

(3) the name and credentials of the trainer;

(4) the license holder's method of evaluating the trainee's competency upon completion of training;

(5) the date of the training; and

(6) the length of training in hours and minutes.

(b) Documentation of a staff person's continuing education credit accepted by the governing health-related licensing board is sufficient to document training for purposes of this subdivision.

Subd. 3. **Initial training.** (a) A staff person must receive training about:

(1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and

(2) the maltreatment of minor reporting requirements and definitions in chapter 260E within 72 hours of first providing direct contact services to a client.

(b) Before providing direct contact services to a client, a staff person must receive training about:

(1) client rights and protections under section 245I.12;

(2) the Minnesota Health Records Act, including client confidentiality, family engagement under section 144.294, and client privacy;

(3) emergency procedures that the staff person must follow when responding to a fire, inclement weather, a report of a missing person, and a behavioral or medical emergency;

(4) specific activities and job functions for which the staff person is responsible, including the license holder's program policies and procedures applicable to the staff person's position;

(5) professional boundaries that the staff person must maintain; and

(6) specific needs of each client to whom the staff person will be providing direct contact services, including each client's developmental status, cognitive functioning, physical and mental abilities.

(c) Before providing direct contact services to a client, a mental health rehabilitation worker, mental health behavioral aide, or mental health practitioner qualified under section 245I.04, subdivision 4, must receive 30 hours of training about:

(1) mental illnesses;

(2) client recovery and resiliency;

(3) mental health de-escalation techniques;

(4) co-occurring mental illness and substance use disorders; and

(5) psychotropic medications and medication side effects.

(d) Within 90 days of first providing direct contact services to an adult client, a clinical trainee, mental health practitioner, mental health certified peer specialist, or mental health rehabilitation worker must receive training about:

(1) trauma-informed care and secondary trauma;

(2) person-centered individual treatment plans, including seeking partnerships with family and other natural supports;

(3) co-occurring substance use disorders; and

(4) culturally responsive treatment practices.

(e) Within 90 days of first providing direct contact services to a child client, a clinical trainee, mental health practitioner, mental health certified family peer specialist, mental health certified peer specialist, or mental health behavioral aide must receive training about the topics in clauses (1) to (5). This training must address the developmental characteristics of each child served by the license holder and address the needs of each child in the context of the child's family, support system, and culture. Training topics must include:

(1) trauma-informed care and secondary trauma, including adverse childhood experiences (ACEs);

(2) family-centered treatment plan development, including seeking partnership with a child client's family and other natural supports;

(3) mental illness and co-occurring substance use disorders in family systems;

(4) culturally responsive treatment practices; and

(5) child development, including cognitive functioning, and physical and mental abilities.

(f) For a mental health behavioral aide, the training under paragraph (e) must include parent team training using a curriculum approved by the commissioner.

Subd. 4. **Ongoing training.** (a) A license holder must ensure that staff persons who provide direct contact services to clients receive annual training about the topics in subdivision 3, paragraphs (a) and (b), clauses (1) to (3).

(b) A license holder must ensure that each staff person who is qualified under section 245I.04 who is not a mental health professional receives 30 hours of training every two years. The training topics must be based on the program's needs and the staff person's areas of competency.

Subd. 5. **Additional training for medication administration.** (a) Prior to administering medications to a client under delegated authority or observing a client self-administer medications, a staff person who is not a licensed prescriber, registered nurse, or licensed practical nurse qualified under section 148.171, subdivision 8, must receive training about psychotropic medications, side effects, and safe medication management.

(b) Prior to administering medications to a client under delegated authority, a staff person must successfully complete a:

(1) medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution with completion of the course documented in writing and placed in the staff person's personnel file; or

(2) formalized training program taught by a registered nurse or licensed prescriber that is offered by the license holder. A staff person's successful completion of the formalized training program must include direct observation of the staff person to determine the staff person's areas of competency.

Sec. 7. **[245I.06] TREATMENT SUPERVISION.**

Subdivision 1. **Generally.** (a) A license holder must ensure that a mental health professional or certified rehabilitation specialist provides treatment supervision to each staff person who provides services to a client and who is not a mental health professional or certified rehabilitation specialist. When providing treatment supervision, a treatment supervisor must follow a staff person's written treatment supervision plan.

(b) Treatment supervision must focus on each client's treatment needs and the ability of the staff person under treatment supervision to provide services to each client, including the following topics related to the staff person's current caseload:

(1) a review and evaluation of the interventions that the staff person delivers to each client;

(2) instruction on alternative strategies if a client is not achieving treatment goals;

(3) a review and evaluation of each client's assessments, treatment plans, and progress notes for accuracy and appropriateness;

(4) instruction on the cultural norms or values of the clients and communities that the license holder serves and the impact that a client's culture has on providing treatment;

(5) evaluation of and feedback regarding a direct service staff person's areas of competency; and

(6) coaching, teaching, and practicing skills with a staff person.

(c) A treatment supervisor's responsibility for a staff person receiving treatment supervision is limited to the services provided by the associated license holder. If a staff person receiving treatment supervision is employed by multiple license holders, each license holder is responsible for providing treatment supervision related to the treatment of the license holder's clients.

Subd. 2. **Types of treatment supervision.** (a) A treatment supervisor must provide treatment supervision to a staff person using methods that allow for immediate feedback, including in-person, telephone, and interactive video supervision.

(b) Treatment supervisors may provide treatment supervision to a staff person individually, or in a group. "Individual supervision" means that one or more treatment supervisors are providing one staff person with treatment supervision. "Group supervision" means one or more treatment supervisors are providing two to ten staff persons with treatment supervision.

Subd. 3. **Treatment supervision planning.** (a) A treatment supervisor and the staff person supervised by the treatment supervisor must develop a written treatment supervision plan. The license holder must ensure that a new staff person's treatment supervision plan is completed and implemented by a treatment supervisor and the new staff person within 30 days of the new staff person's first day of employment. The license holder must review and update each staff person's treatment supervision plan annually.

(b) Each staff person's treatment supervision plan must include:

(1) the name and qualifications of the staff person receiving treatment supervision;

(2) the name of the license holder from whom the staff person is receiving treatment supervision;

(3) the names and licensures of the treatment supervisors who are supervising the staff person;

(4) how frequently the treatment supervisors must provide treatment supervision to the staff person;

(5) the location of the staff person's treatment supervision record if the license holder does not keep the record in the staff person's personnel file;

(6) procedures that the staff person must use to respond to client emergencies; and

(7) the staff person's authorized scope of practice, including a description of the staff person's job responsibilities with the license holder, a description of the client population that the staff person serves, and a description of the treatment methods and modalities that the staff person may use to provide services to clients.

Subd. 4. **Treatment supervision record.** (a) A license holder must ensure that treatment supervision of each staff person is documented in each staff person's treatment supervision record.

(b) Each staff person's treatment supervision record must include:

(1) the dates and duration of the staff person's treatment supervision;

(2) whether the staff person was under treatment supervision individually or in a group;

(3) subsequent actions that the staff person receiving treatment supervision must take; and

(4) the name, title, and dated signature of the person who provided treatment supervision.

Subd. 5. **Treatment supervision and direct observation of mental health rehabilitation workers and mental health behavioral aides.** (a) A mental health behavioral aide or a mental health rehabilitation worker must receive direct observation from a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner while the mental health behavioral aide or mental health rehabilitation worker provides treatment services to clients, no less than twice per month for the first six months of employment and once per month thereafter. The staff person performing the direct observation must approve of the progress note for the observed treatment service.

(b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work must at a minimum consist of:

(1) monthly individual supervision; and

(2) direct observation twice per month.

Sec. 8. **[245I.07] PERSONNEL FILES.**

(a) For each staff person, a license holder must maintain a personnel file that includes:

(1) verification of the staff person's qualifications required for the position including training, education, practicum or internship agreement, licensure, and any other required qualifications;

(2) documentation related to the staff person's background study;

(3) the hiring date of the staff person;

(4) the date that the staff person's specific duties and responsibilities became effective, including the date that the staff person began having direct contact with clients;

(5) documentation of the staff person's training as required by section 245I.05, subdivision 2;

(6) documentation of license renewals that the staff person completed during the staff person's employment;

(7) annual job performance evaluations;

(8) if applicable, the staff person's alleged and substantiated violations of the license holder's policies under section 245I.03, subdivision 8, clauses (3) to (7), and the license holder's response; and

(9) the staff person's treatment supervision record under section 245I.06, subdivision 4, if applicable.

(b) The license holder must ensure that all personnel files are readily accessible for the commissioner's review. The license holder is not required to keep personnel files in a single location.

Sec. 9. **[245I.08] DOCUMENTATION STANDARDS.**

Subdivision 1. **Generally.** A license holder must ensure that all documentation required by this chapter complies with this section.

Subd. 2. **Documentation standards.** A license holder must ensure that all documentation required by this chapter:

(1) is legible;

(2) identifies the applicable client and staff person on each page; and

(3) is signed and dated by the staff persons who provided services to the client or completed the documentation, including the staff persons' credentials.

Subd. 3. **Documenting approval.** A license holder must ensure that all diagnostic assessments, functional assessments, level of care assessments, and treatment plans completed by a clinical trainee or mental health practitioner contain documentation of approval by a treatment supervisor within five business days of initial completion by the staff person under treatment supervision.

Subd. 4. **Progress notes.** A license holder must use a progress note to promptly document each occurrence of a mental health service that a staff person provides to a client. A progress note must include the following:

(1) the type of service;

(2) the date of service;

(3) the start and stop time of the service unless the license holder is licensed as a residential program;

(4) the location of the service;

(5) the scope of the service, including: (i) the targeted goal and objective; (ii) the intervention that the staff person provided to the client and the methods that the staff person used; (iii) the client's response to the intervention; (iv) the staff person's plan to take future actions, including changes in treatment that the staff person will implement if the intervention was ineffective; and (v) the service modality;

(6) the signature, printed name, and credentials of the staff person who provided the service to the client;

(7) the mental health provider travel documentation required by section 256B.0625, if applicable; and

(8) significant observations by the staff person, if applicable, including: (i) the client's current risk factors; (ii) emergency interventions by staff persons; (iii) consultations with or referrals to other professionals, family, or significant others; and (iv) changes in the client's mental or physical symptoms.

Subd. 5. **Medication administration record.** If a license holder administers or observes a client self-administer medications, the license holder must maintain a medication administration record for each client that contains the following, as applicable:

(1) the client's date of birth;

(2) the client's allergies;

(3) all medication orders for the client, including client-specific orders for over-the-counter medications and approved condition-specific protocols;

(4) the name of each ordered medication, date of each medication's expiration, each medication's dosage frequency, method of administration, and time;

(5) the licensed prescriber's name and telephone number;

(6) the date of initiation;

(7) the signature, printed name, and credentials of the staff person who administered the medication or observed the client self-administer the medication; and

(8) the reason that the license holder did not administer the client's prescribed medication or observe the client self-administer the client's prescribed medication.

Sec. 10. **[245I.09] CLIENT FILES.**

Subdivision 1. **Generally.** (a) A license holder must maintain a file for each client that contains the client's current and accurate records. The license holder must store each client file on the premises where the license holder provides or coordinates services for the client. The license holder must ensure that all client files are readily accessible for the commissioner's review. The license holder is not required to keep client files in a single location.

(b) The license holder must protect client records against loss, tampering, or unauthorized disclosure of confidential client data according to the Minnesota Government Data Practices Act, chapter 13; the privacy provisions of the Minnesota health care programs provider agreement; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191; and the Minnesota Health Records Act, sections 144.291 to 144.298.

Subd. 2. **Record retention.** A license holder must retain client records of a discharged client for a minimum of seven years from the date of the client's discharge. A license holder who ceases to provide treatment services to a client must retain the client's records for a minimum of seven years from the date that the license holder stopped providing services

to the client and must notify the commissioner of the location of the client records and the name of the individual responsible for storing and maintaining the client records.

Subd. 3. **Contents.** A license holder must retain a clear and complete record of the information that the license holder receives regarding a client, and of the services that the license holder provides to the client. If applicable, each client's file must include the following information:

(1) the client's screenings, assessments, and testing;

(2) the client's treatment plans and reviews of the client's treatment plan;

(3) the client's individual abuse prevention plans;

(4) the client's health care directive under section 145C.01, subdivision 5a, and the client's emergency contacts;

(5) the client's crisis plans;

(6) the client's consents for releases of information and documentation of the client's releases of information;

(7) the client's significant medical and health-related information;

(8) a record of each communication that a staff person has with the client's other mental health providers and persons interested in the client, including the client's case manager, family members, primary caregiver, legal representatives, court representatives, representatives from the correctional system, or school administration;

(9) written information by the client that the client requests to include in the client's file; and

(10) the date of the client's discharge from the license holder's program, the reason that the license holder discontinued services for the client, and the client's discharge summaries.

Sec. 11. **[245I.10] ASSESSMENT AND TREATMENT PLANNING.**

Subdivision 1. **Definitions.** (a) "Diagnostic formulation" means a written analysis and explanation of a client's clinical assessment to develop a hypothesis about the cause and nature of a client's presenting problems and to identify the most suitable approach for treating the client.

(b) "Responsivity factors" means the factors other than the diagnostic formulation that may modify a client's treatment needs. This includes a client's learning style, abilities, cognitive functioning, cultural background, and personal circumstances. When documenting

a client's responsivity factors a mental health professional or clinical trainee must include an analysis of how a client's strengths are reflected in the license holder's plan to deliver services to the client.

Subd. 2. **Generally.** (a) A license holder must use a client's diagnostic assessment or crisis assessment to determine a client's eligibility for mental health services, except as provided in this section.

(b) Prior to completing a client's initial diagnostic assessment, a license holder may provide a client with the following services:

(1) an explanation of the license holder's findings;

(2) neuropsychological testing, neuropsychological assessment, and psychological testing;

(3) any combination of psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed three sessions;

(4) crisis assessment services according to section 256B.0624; and

(5) ten days of intensive residential treatment services according to the assessment and treatment planning standards in section 245.23, subdivision 7.

(c) Based on the client's needs that a crisis assessment identifies under section 256B.0624, a license holder may provide a client with the following services:

(1) crisis intervention and stabilization services under section 245I.23 or 256B.0624; and

(2) any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization.

(d) Based on the client's needs in the client's brief diagnostic assessment, a license holder may provide a client with any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization for any new client or for an existing client who the license holder projects will need fewer than ten sessions during the next 12 months.

(e) Based on the client's needs that a hospital's medical history and presentation examination identifies, a license holder may provide a client with:

(1) any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization for any new client or for an existing client who the license holder projects will need fewer than ten sessions during the next 12 months; and

(2) up to five days of day treatment services or partial hospitalization.

(f) A license holder must complete a new standard diagnostic assessment of a client:

(1) when the client requires services of a greater number or intensity than the services that paragraphs (b) to (e) describe;

(2) at least annually following the client's initial diagnostic assessment if the client needs additional mental health services and the client does not meet the criteria for a brief assessment;

(3) when the client's mental health condition has changed markedly since the client's most recent diagnostic assessment; or

(4) when the client's current mental health condition does not meet the criteria of the client's current diagnosis.

(g) For an existing client, the license holder must ensure that a new standard diagnostic assessment includes a written update containing all significant new or changed information about the client, and an update regarding what information has not significantly changed, including a discussion with the client about changes in the client's life situation, functioning, presenting problems, and progress with achieving treatment goals since the client's last diagnostic assessment was completed.

Subd. 3. **Continuity of services.** (a) For any client with a diagnostic assessment completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before the effective date of this section, the diagnostic assessment is valid for authorizing the client's treatment and billing for one calendar year after the date that the assessment was completed.

(b) For any client with an individual treatment plan completed under section 256B.0622, 256B.0623, 256B.0943, 256B.0946, or 256B.0947 or Minnesota Rules, parts 9505.0370 to 9505.0372, the client's treatment plan is valid for authorizing treatment and billing until the treatment plan's expiration date.

(c) This subdivision expires July 1, 2023.

Subd. 4. **Diagnostic assessment.** A client's diagnostic assessment must: (1) identify at least one mental health diagnosis for which the client meets the diagnostic criteria and recommend mental health services to develop the client's mental health services and treatment plan; or (2) include a finding that the client does not meet the criteria for a mental health disorder.

Subd. 5. **Brief diagnostic assessment; required elements.** (a) Only a mental health professional or clinical trainee may complete a brief diagnostic assessment of a client. A license holder may only use a brief diagnostic assessment for a client who is six years of age or older.

(b) When conducting a brief diagnostic assessment of a client, the assessor must complete a face-to-face interview with the client and a written evaluation of the client. The assessor must gather and document initial components of the client's standard diagnostic assessment, including the client's:

(1) age;

(2) description of symptoms, including the reason for the client's referral;

(3) history of mental health treatment;

(4) cultural influences on the client; and

(5) mental status examination.

(c) Based on the initial components of the assessment, the assessor must develop a provisional diagnostic formulation about the client. The assessor may use the client's provisional diagnostic formulation to address the client's immediate needs and presenting problems.

(d) A mental health professional or clinical trainee may use treatment sessions with the client authorized by a brief diagnostic assessment to gather additional information about the client to complete the client's standard diagnostic assessment if the number of sessions will exceed the coverage limits in subdivision 2.

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a client and a written evaluation of the client. The assessor must complete a client's standard diagnostic assessment within the client's cultural context.

(b) When completing a standard diagnostic assessment of a client, the assessor must gather and document information about the client's current life situation, including the following information:

(1) the client's age;

(2) the client's current living situation, including the client's housing status and household members;

(3) the status of the client's basic needs;

(4) the client's education level and employment status;

(5) the client's current medications;

(6) any immediate risks to the client's health and safety;

(7) the client's perceptions of the client's condition;

(8) the client's description of the client's symptoms, including the reason for the client's referral;

(9) the client's history of mental health treatment; and

(10) cultural influences on the client.

(c) If the assessor cannot obtain the information that this subdivision requires without retraumatizing the client or harming the client's willingness to engage in treatment, the assessor must identify which topics will require further assessment during the course of the client's treatment. The assessor must gather and document information related to the following topics:

(1) the client's relationship with the client's family and other significant personal relationships, including the client's evaluation of the quality of each relationship;

(2) the client's strengths and resources, including the extent and quality of the client's social networks;

(3) important developmental incidents in the client's life;

(4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

(5) the client's history of or exposure to alcohol and drug usage and treatment; and

(6) the client's health history and the client's family health history, including the client's physical, chemical, and mental health history.

(d) When completing a standard diagnostic assessment of a client, an assessor must use a recognized diagnostic framework.

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

(2) When completing a standard diagnostic assessment of a client who is six years of age or older, the assessor must use the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(3) When completing a standard diagnostic assessment of a client who is five years of age or younger, an assessor must administer the Early Childhood Service Intensity Instrument (ECSII) to the client and include the results in the client's assessment.

(4) When completing a standard diagnostic assessment of a client who is six to 17 years of age, an assessor must administer the Child and Adolescent Service Intensity Instrument (CASII) to the client and include the results in the client's assessment.

(5) When completing a standard diagnostic assessment of a client who is 18 years of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association to screen and assess the client for a substance use disorder.

(e) When completing a standard diagnostic assessment of a client, the assessor must include and document the following components of the assessment:

(1) the client's mental status examination;

(2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client information that supports the assessor's findings after applying a recognized diagnostic framework from paragraph (d); and any differential diagnosis of the client;

(3) an explanation of: (i) how the assessor diagnosed the client using the information from the client's interview, assessment, psychological testing, and collateral information about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths; and (v) the client's responsivity factors.

(f) When completing a standard diagnostic assessment of a client, the assessor must consult the client and the client's family about which services that the client and the family

prefer to treat the client. The assessor must make referrals for the client as to services required by law.

Subd. 7. **Individual treatment plan.** A license holder must follow each client's written individual treatment plan when providing services to the client with the following exceptions:

(1) services that do not require that a license holder completes a standard diagnostic assessment of a client before providing services to the client;

(2) when developing a service plan; and

(3) when a client re-engages in services under subdivision 8, clause (8).

Subd. 8. **Individual treatment plan; required elements.** After completing a client's diagnostic assessment and before providing services to the client, the license holder must complete the client's individual treatment plan. The license holder must:

(1) base the client's individual treatment plan on the client's diagnostic assessment and baseline measurements;

(2) for a child client, use a child-centered, family-driven, and culturally appropriate planning process that allows the child's parents and guardians to observe and participate in the child's individual and family treatment services, assessments, and treatment planning;

(3) for an adult client, use a person-centered, culturally appropriate planning process that allows the client's family and other natural supports to observe and participate in the client's treatment services, assessments, and treatment planning;

(4) identify the client's treatment goals, measureable treatment objectives, a schedule for accomplishing the client's treatment goals and objectives, a treatment strategy, and the individuals responsible for providing treatment services and supports to the client. The license holder must have a treatment strategy to engage the client in treatment if the client:

(i) has a history of not engaging in treatment; and

(ii) is ordered by a court to participate in treatment services or to take neuroleptic medications;

(5) identify the participants involved in the client's treatment planning. The client must be a participant in the client's treatment planning. If applicable, the license holder must document the reasons that the license holder did not involve the client's family or other natural supports in the client's treatment planning;

(6) review the client's individual treatment plan every 180 days and update the client's individual treatment plan with the client's treatment progress, new treatment objectives and

goals or, if the client has not made treatment progress, changes in the license holder's approach to treatment; and

(7) ensure that the client approves of the client's individual treatment plan unless a court orders the client's treatment plan under chapter 253B.

If the client disagrees with the client's treatment plan, the license holder must document the client file with the reasons why the client does not agree with the treatment plan. If the license holder cannot obtain the client's approval of the treatment plan, a mental health professional must make efforts to obtain approval from a person who is authorized to consent on the client's behalf within 30 days after the client's previous individual treatment plan expired. A license holder may not deny a client service during this time period solely because the license holder could not obtain the client's approval of the client's individual treatment plan. A license holder may continue to bill for the client's otherwise eligible services when the client re-engages in services.

Subd. 9. **Functional assessment; required elements.** When a license holder is completing a functional assessment for an adult client, the license holder must:

(1) complete a functional assessment of the client after completing the client's diagnostic assessment;

(2) use a collaborative process that allows the client and the client's family and other natural supports, the client's referral sources, and the client's providers to provide information about how the client's symptoms of mental illness impact the client's functioning;

(3) if applicable, document the reasons that the license holder did not contact the client's family and other natural supports;

(4) assess and document how the client's symptoms of mental illness impact the client's functioning in the following areas:

(i) the client's mental health symptoms;

(ii) the client's mental health service needs;

(iii) the client's substance use;

(iv) the client's vocational and educational functioning;

(v) the client's social functioning, including the use of leisure time;

(vi) the client's interpersonal functioning, including relationships with the client's family and other natural supports;

(vii) the client's ability to provide self-care and live independently;

(viii) the client's medical and dental health;

(ix) the client's financial assistance needs; and

(x) the client's housing and transportation needs;

(5) include a narrative summarizing the client's strengths, resources, and all areas of functional impairment;

(6) complete the client's functional assessment before the client's initial individual treatment plan unless a service specifies otherwise; and

(7) update the client's functional assessment with the client's current functioning whenever there is a significant change in the client's functioning or at least every 180 days, unless a service specifies otherwise.

Sec. 12. **[245I.11] HEALTH SERVICES AND MEDICATIONS.**

Subdivision 1. **Generally.** If a license holder is licensed as a residential program, stores or administers client medications, or observes clients self-administer medications, the license holder must ensure that a staff person who is a registered nurse or licensed prescriber is responsible for overseeing storage and administration of client medications and observing as a client self-administers medications, including training according to section 245I.05, subdivision 6, and documenting the occurrence according to section 245I.08, subdivision 5.

Subd. 2. **Health services.** If a license holder is licensed as a residential program, the license holder must:

(1) ensure that a client is screened for health issues within 72 hours of the client's admission;

(2) monitor the physical health needs of each client on an ongoing basis;

(3) offer referrals to clients and coordinate each client's care with psychiatric and medical services;

(4) identify circumstances in which a staff person must notify a registered nurse or licensed prescriber of any of a client's health concerns and the process for providing notification of client health concerns; and

(5) identify the circumstances in which the license holder must obtain medical care for a client and the process for obtaining medical care for a client.

Subd. 3. **Storing and accounting for medications.** (a) If a license holder stores client medications, the license holder must:

(1) store client medications in original containers in a locked location;

(2) store refrigerated client medications in special trays or containers that are separate from food;

(3) store client medications marked "for external use only" in a compartment that is separate from other client medications;

(4) store Schedule II to IV drugs listed in section 152.02, subdivisions 3 to 5, in a compartment that is locked separately from other medications;

(5) ensure that only authorized staff persons have access to stored client medications;

(6) follow a documentation procedure on each shift to account for all scheduled drugs; and

(7) record each incident when a staff person accepts a supply of client medications and destroy discontinued, outdated, or deteriorated client medications.

(b) If a license holder is licensed as a residential program, the license holder must allow clients who self-administer medications to keep a private medication supply. The license holder must ensure that the client stores all private medication in a locked container in the client's private living area, unless the private medication supply poses a health and safety risk to any clients. A client must not maintain a private medication supply of a prescription medication without a written medication order from a licensed prescriber and a prescription label that includes the client's name.

Subd. 4. **Medication orders.** (a) If a license holder stores, prescribes, or administers medications or observes a client self-administer medications, the license holder must:

(1) ensure that a licensed prescriber writes all orders to accept, administer, or discontinue client medications;

(2) accept nonwritten orders to administer client medications in emergency circumstances only;

(3) establish a timeline and process for obtaining a written order with the licensed prescriber's signature when the license holder accepts a nonwritten order to administer client medications;

(4) obtain prescription medication renewals from a licensed prescriber for each client every 90 days for psychotropic medications and annually for all other medications; and

(5) maintain the client's right to privacy and dignity.

(b) If a license holder employs a licensed prescriber, the license holder must inform the client about potential medication effects and side effects and obtain and document the client's informed consent before the licensed prescriber prescribes a medication.

Subd. 5. **Medication administration.** If a license holder is licensed as a residential program, the license holder must:

(1) assess and document each client's ability to self-administer medication. In the assessment, the license holder must evaluate the client's ability to: (i) comply with prescribed medication regimens; and (ii) store the client's medications safely and in a manner that protects other individuals in the facility. Through the assessment process, the license holder must assist the client in developing the skills necessary to safely self-administer medication;

(2) monitor the effectiveness of medications, side effects of medications, and adverse reactions to medications for each client. The license holder must promptly address and document any concerns about a client's medications;

(3) ensure that no staff person or client gives a legend drug supply for one client to another client;

(4) have policies and procedures for: (i) keeping a record of each client's medication orders; (ii) keeping a record of any incident of deferring a client's medications; (iii) documenting any incident when a client's medication is omitted; and (iv) documenting when a client refuses to take medications as prescribed; and

(5) document and track medication errors, document whether the license holder notified anyone about the medication error, determine if the license holder must take any follow-up actions, and identify the staff persons who are responsible for taking follow-up actions.

Sec. 13. **[245I.12] CLIENT RIGHTS AND PROTECTIONS.**

Subdivision 1. **Client rights.** A license holder must ensure that all clients have the following rights:

(1) the rights listed in the health care bill of rights in section 144.651;

(2) the right to be free from discrimination based on age, race, color, creed, religion, national origin, gender, marital status, disability, sexual orientation, and status with regard to public assistance. The license holder must follow all applicable state and federal laws including the Minnesota Human Rights Act, chapter 363A; and

(3) the right to be informed prior to a photograph or audio or video recording being made of the client. The client has the right to refuse to allow any recording or photograph of the client that is not for the purposes of identification or supervision by the license holder.

Subd. 2. **Restrictions to client rights.** If the license holder restricts a client's right, the license holder must document in the client file a mental health professional's approval of the restriction and the reasons for the restriction.

Subd. 3. **Notice of rights.** The license holder must give a copy of the client's rights according to this section to each client on the day of the client's admission. The license holder must document that the license holder gave a copy of the client's rights to each client on the day of the client's admission according to this section. The license holder must post a copy of the client rights in an area visible or accessible to all clients. The license holder must include the client rights in Minnesota Rules, chapter 9544, for applicable clients.

Subd. 4. **Client property.** (a) The license holder must meet the requirements of section 245A.04, subdivision 13.

(b) If the license holder is unable to obtain a client's signature acknowledging the receipt of the client's funds or property required by section 245A.04, subdivision 13, paragraph (c), clause (1), two staff persons must sign documentation acknowledging that the staff persons witnessed the client's receipt of the client's funds or property.

(c) The license holder must return all of the client's funds and other property to the client except for the following items:

(1) illicit drugs, drug paraphernalia, and drug containers that are subject to forfeiture under section 609.5316. The license holder must give illicit drugs, drug paraphernalia, and drug containers to a local law enforcement agency or destroy the items; and

(2) weapons, explosives, and other property that may cause serious harm to the client or others. The license holder may give a client's weapons and explosives to a local law enforcement agency. The license holder must notify the client that a local law enforcement agency has the client's property and that the client has the right to reclaim the property if the client has a legal right to possess the item.

(d) If a client leaves the license holder's program but abandons the client's funds or property, the license holder must retain and store the client's funds or property, including medications, for a minimum of 30 days after the client's discharge from the program.

Subd. 5. **Client grievances.** (a) The license holder must have a grievance procedure that:

(1) describes to clients how the license holder will meet the requirements in this subdivision; and

(2) contains the current telephone numbers, e-mail addresses, and mailing addresses of the Department of Human Services, Licensing Division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Department of Health, Office of Health Facilities Complaints; and all applicable health-related licensing boards.

(b) On the day of each client's admission, the license holder must explain the grievance procedure to the client.

(c) The license holder must:

(1) post the grievance procedure in a place visible to clients and provide a copy of the grievance procedure upon request;

(2) allow clients, former clients, and their authorized representatives to submit a grievance to the license holder;

(3) within three business days of receiving a client's grievance, acknowledge in writing that the license holder received the client's grievance and provide the client with the date by which the license holder will respond to the client's grievance. If applicable, the license holder must include a notice of the client's separate appeal rights for a managed care organization's reduction, termination, or denial of a covered service;

(4) within 15 business days of receiving a client's grievance, provide a written final response to the client's grievance containing the license holder's official response to the grievance; and

(5) allow the client to bring a grievance to the person with the highest level of authority in the program.

Sec. 14. **[245I.13] CRITICAL INCIDENTS.**

If a license holder is licensed as a residential program, the license holder must report all critical incidents to the commissioner within ten days of learning of the incident on a form approved by the commissioner. The license holder must keep a record of critical incidents in a central location that is readily accessible to the commissioner for review upon the commissioner's request for a minimum of two licensing periods.

Sec. 15. **[245I.20] MENTAL HEALTH CLINIC.**

Subdivision 1. **Purpose.** Certified mental health clinics provide clinical services for the treatment of mental illnesses with a treatment team that reflects multiple disciplines and areas of expertise.

Subd. 2. **Definitions.** (a) "Clinical services" means services provided to a client to diagnose, describe, predict, and explain the client's status relative to a condition or problem as described in the: (1) current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or (2) current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three. Where necessary, clinical services includes services to treat a client to reduce the client's impairment due to the client's condition. Clinical services also includes individual treatment planning, case review, record-keeping required for a client's treatment, and treatment supervision. For the purposes of this section, clinical services excludes services delivered to a client under a separate license and services certified by the commissioner.

(b) "Competent" means having professional education, training, continuing education, consultation, supervision, experience, or a combination thereof necessary to demonstrate sufficient knowledge of and proficiency in a specific clinical service.

(c) "Discipline" means a branch of professional knowledge or skill acquired through a specific course of study, training, and supervised practice. Discipline is usually documented by a specific educational degree, licensure, or certification of proficiency. Examples of the mental health disciplines include but are not limited to psychiatry, psychology, clinical social work, marriage and family therapy, clinical counseling, and psychiatric nursing.

(d) "Treatment team" means the mental health professionals, mental health practitioners, and clinical trainees who provide clinical services to clients.

Subd. 3. **Organizational structure.** (a) A mental health clinic location must be an entire facility or a clearly identified unit within a facility that is administratively and clinically separate from the rest of the facility. The mental health clinic location may provide services other than clinical services to clients, including medical services, substance use disorder services, social services, training, and education.

(b) The certification holder must notify the commissioner of all mental health clinic locations. If there is more than one mental health clinic location, the certification holder must designate one location as the main location and all of the other locations as satellite

locations. The main location as a unit and the clinic as a whole must comply with the minimum staffing standards in subdivision 4.

(c) The certification holder must ensure that each satellite location:

(1) adheres to the same policies and procedures as the main location;

(2) provides clients with face-to-face or telephone access to a mental health professional whenever the satellite location is open. The certification holder must maintain a schedule of the mental health professionals who will be available and the contact information for each available mental health professional. The schedule must be current and readily available to treatment team members; and

(3) enables clients to access all of the mental health clinic's clinical services and treatment team members, as needed.

Subd. 4. **Minimum staffing standards.** (a) A certification holder's treatment team must consist of at least four mental health professionals. At least two of the mental health professionals must be employed by or under contract with the mental health clinic for a minimum of 35 hours per week. Each of the two mental health professionals must specialize in a different mental health discipline.

(b) The treatment team must include:

(1) a physician qualified as a mental health professional according to section 245I.04, subdivision 2, clause (4), or a nurse qualified as a mental health professional according to section 245I.04, subdivision 2, clause (1); and

(2) a psychologist qualified as a mental health professional according to section 245I.04, subdivision 2, clause (3).

(c) The staff persons fulfilling the requirement in paragraph (b) must provide clinical services at least:

(1) eight hours every two weeks if the mental health clinic has over 25.0 full-time equivalent treatment team members;

(2) eight hours each month if the mental health clinic has 15.1 to 25.0 full-time equivalent treatment team members;

(3) four hours each month if the mental health clinic has 5.1 to 15.0 full-time equivalent treatment team members; or

(4) two hours each month if the mental health clinic has 2.0 to 5.0 full-time equivalent treatment team members or only provides in-home services to clients.

(d) A certification holder may have additional mental health professional staff persons, provided that no more than 60 percent of the full-time equivalent mental health professional staff specializes in a single mental health discipline. This provision does not apply to a certification holder with fewer than six full-time equivalent mental health professional staff.

(e) The certification holder must maintain a record that demonstrates compliance with this subdivision.

Subd. 5. **Treatment supervision specified.** (a) A mental health professional must remain responsible for each client's case. The certification holder must document the name of the mental health professional responsible for each case and the dates that the mental health professional is responsible for the client's case from beginning date to end date. The certification holder must assign each client's case for assessment, diagnosis, and treatment services to a treatment team member who is competent in the assigned clinical service, the recommended treatment strategy, and in treating the client's characteristics.

(b) Treatment supervision of mental health practitioners and clinical trainees required by section 245I.06 must include case reviews as described in this paragraph. Every two months, a mental health professional must complete a case review of each client assigned to the mental health professional when the client is receiving clinical services from a mental health practitioner or clinical trainee. The case review must include a consultation process that thoroughly examines the client's condition and treatment, including: (1) a review of the client's reason for seeking treatment, diagnoses and assessments, and the individual treatment plan; (2) a review of the appropriateness, duration, and outcome of treatment provided to the client; and (3) treatment recommendations.

Subd. 6. **Additional policy and procedure requirements.** (a) In addition to the policies and procedures required by section 245I.03, the certification holder must establish, enforce, and maintain the policies and procedures required by this subdivision.

(b) The certification holder must have a clinical evaluation procedure to identify and document each treatment team member's areas of competence.

(c) The certification holder must have policies and procedures for client intake and case assignment that:

(1) outline the client intake process;

(2) describe how the mental health clinic determines the appropriateness of accepting a client into treatment by reviewing the client's condition and need for treatment, the clinical services that the mental health clinic offers to clients, and other available resources; and

(3) contain a process for assigning a client's case to a mental health professional who is responsible for the client's case and other treatment team members.

Subd. 7. **Referrals.** If necessary treatment for a client or treatment desired by a client is not available at the mental health clinic, the certification holder must facilitate appropriate referrals for the client. When making a referral for a client, the treatment team member must document a discussion with the client that includes: (1) the reason for the client's referral; (2) potential treatment resources for the client; and (3) the client's response to receiving a referral.

Subd. 8. **Emergency service.** For the certification holder's telephone numbers that clients regularly access, the certification holder must include the contact information for the area's mental health crisis services as part of the certification holder's message when a live operator is not available to answer clients' calls.

Subd. 9. **Quality assurance and improvement plan.** (a) At a minimum, a certification holder must develop a written quality assurance and improvement plan that includes a plan for:

(1) encouraging ongoing consultation among members of the treatment team;

(2) obtaining and evaluating feedback about services from clients, family and other natural supports, referral sources, and staff persons;

(3) measuring and evaluating client outcomes;

(4) reviewing client suicide deaths and suicide attempts;

(5) examining the quality of clinical service delivery to clients;

(6) examining the efficiency of resource usage; and

(7) self-monitoring of compliance with this chapter.

(b) At least annually, the certification holder must review, evaluate, and update the quality assurance and improvement plan. The review must: (1) include documentation of the actions that the certification holder will take as a result of information obtained from monitoring activities in the plan; and (2) establish goals for improved service delivery to clients for the next year.

Subd. 10. **Application procedures.** (a) The applicant for certification must submit any documents that the commissioner requires on forms approved by the commissioner.

(b) Upon submitting an application for certification, an applicant must pay the application fee required by section 245A.10, subdivision 3.

(c) The commissioner must respond to an application within 90 working days of receiving a completed application.

(d) When the commissioner receives an application for initial certification that is incomplete because the applicant failed to submit required documents or is deficient because the submitted documents do not meet certification requirements, the commissioner must provide the applicant with written notice that the application is incomplete or deficient. In the notice, the commissioner must identify the particular documents that are missing or deficient and give the applicant 45 days to submit a second application that is complete. An applicant's failure to submit a complete application within 45 days after receiving notice from the commissioner is a basis for certification denial.

(e) The commissioner must give notice of a denial to an applicant when the commissioner has made the decision to deny the certification application. In the notice of denial, the commissioner must state the reasons for the denial in plain language. The commissioner must send or deliver the notice of denial to an applicant by certified mail or personal service. In the notice of denial, the commissioner must state the reasons that the commissioner denied the application and must inform the applicant of the applicant's right to request a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an applicant delivers an appeal by personal service, the commissioner must receive the appeal within 20 calendar days after the applicant received the notice of denial.

Subd. 11. **Commissioner's right of access.** (a) When the commissioner is exercising the powers conferred to the commissioner by this chapter, if the mental health clinic is in operation and the information is relevant to the commissioner's inspection or investigation, the mental health clinic must provide the commissioner access to:

(1) the physical facility and grounds where the program is located;

(2) documentation and records, including electronically maintained records;

(3) clients served by the mental health clinic;

(4) staff persons of the mental health clinic; and

(5) personnel records of current and former staff employed by the mental health clinic.

(b) The mental health clinic must provide the commissioner with access to the facility, records, clients, and staff without prior notice and as often as the commissioner considers

necessary if the commissioner is investigating alleged maltreatment or a violation of a law or rule, or conducting an inspection. When conducting an inspection, the commissioner may request and must receive assistance from other state, county, and municipal governmental agencies and departments. The applicant or certification holder must allow the commissioner, at the commissioner's expense, to photocopy, photograph, and make audio and video recordings during an inspection.

Subd. 12. **Monitoring and inspections.** (a) The commissioner may conduct a certification review of the certified mental health clinic every two years to determine the clinic's compliance with applicable rules and statutes.

(b) The commissioner must make the results of certification reviews and investigations publicly available on the department's website.

Subd. 13. **Correction orders.** (a) If the applicant or certification holder fails to comply with a law or rule, the commissioner may issue a correction order. The correction order must state:

(1) the condition that constitutes a violation of the law or rule;

(2) the specific law or rule that the applicant or certification holder has violated; and

(3) the time that the applicant or certification holder is allowed to correct each violation.

(b) If the applicant or certification holder believes that the commissioner's correction order is erroneous, the applicant or certification holder may ask the commissioner to reconsider the part of the correction order that is allegedly erroneous. An applicant or certification holder must make a request for reconsideration in writing. The request must be postmarked and sent to the commissioner within 20 calendar days after the applicant or certification holder received the correction order; and the request must:

(1) specify the part of the correction order that is allegedly erroneous;

(2) explain why the specified part is erroneous; and

(3) include documentation to support the allegation of error.

(c) A request for reconsideration does not stay any provision or requirement of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal.

(d) If the commissioner finds that the applicant or certification holder failed to correct the violation specified in the correction order, the commissioner may decertify the certified mental health clinic according to subdivision 14.

(e) Nothing in this subdivision prohibits the commissioner from decertifying a mental health clinic according to subdivision 14.

Subd. 14. **Decertification.** (a) The commissioner may decertify a mental health clinic if a certification holder:

(1) failed to comply with an applicable law or rule; or

(2) knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for certification, during an investigation, or regarding compliance with applicable laws or rules.

(b) When considering decertification of a mental health clinic, the commissioner must consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of clients.

(c) If the commissioner decertifies a mental health clinic, the order of decertification must inform the certification holder of the right to have a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The certification holder may appeal the decertification. The certification holder must appeal a decertification in writing and send or deliver the appeal to the commissioner by certified mail or personal service. If the certification holder mails the appeal, the appeal must be postmarked and sent to the commissioner within ten calendar days after the certification holder receives the order of decertification. If the certification holder delivers an appeal by personal service, the commissioner must receive the appeal within ten calendar days after the certification holder received the order. If a certification holder submits a timely appeal of an order of decertification, the certification holder may continue to operate the program until the commissioner issues a final order on the decertification.

(d) If the commissioner decertifies a mental health clinic pursuant to paragraph (a), clause (1), based on a determination that the mental health clinic was responsible for maltreatment, and if the mental health clinic requests reconsideration of the decertification according to paragraph (c), and appeals the maltreatment determination under section 260E.33, the final decertification determination is stayed until the commissioner issues a final decision regarding the maltreatment appeal.

Sec. 16. **[245I.23] INTENSIVE RESIDENTIAL TREATMENT SERVICES AND RESIDENTIAL CRISIS STABILIZATION.**

Subdivision 1. **Purpose.** (a) Intensive residential treatment services is a community-based medically monitored level of care for an adult client that uses established rehabilitative

principles to promote a client's recovery and to develop and achieve psychiatric stability, personal and emotional adjustment, self-sufficiency, and other skills that help a client transition to a more independent setting.

(b) Residential crisis stabilization provides structure and support to an adult client in a community living environment when a client has experienced a mental health crisis and needs short-term services to ensure that the client can safely return to the client's home or precrisis living environment with additional services and supports identified in the client's crisis assessment.

Subd. 2. **Definitions.** (a) "Program location" means a set of rooms that are each physically self-contained and have defining walls extending from floor to ceiling. Program location includes bedrooms, living rooms or lounge areas, bathrooms, and connecting areas.

(b) "Treatment team" means a group of staff persons who provide intensive residential treatment services or residential crisis stabilization to clients. The treatment team includes mental health professionals, mental health practitioners, clinical trainees, certified rehabilitation specialists, mental health rehabilitation workers, and mental health certified peer specialists.

Subd. 3. **Treatment services description.** The license holder must describe in writing all treatment services that the license holder provides. The license holder must have the description readily available for the commissioner upon the commissioner's request.

Subd. 4. **Required intensive residential treatment services.** (a) On a daily basis, the license holder must follow a client's treatment plan to provide intensive residential treatment services to the client to improve the client's functioning.

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

(1) rehabilitative mental health services;

(2) crisis prevention planning to assist a client with:

(i) identifying and addressing patterns in the client's history and experience of the client's mental illness; and

(ii) developing crisis prevention strategies that include de-escalation strategies that have been effective for the client in the past;

(3) health services and administering medication;

(4) co-occurring substance use disorder treatment;

(5) engaging the client's family and other natural supports in the client's treatment and educating the client's family and other natural supports to strengthen the client's social and family relationships; and

(6) making referrals for the client to other service providers in the community and supporting the client's transition from intensive residential treatment services to another setting.

(c) The license holder must include Illness Management and Recovery (IMR), Enhanced Illness Management and Recovery (E-IMR), or other similar interventions in the license holder's programming as approved by the commissioner.

Subd. 5. **Required residential crisis stabilization services.** (a) On a daily basis, the license holder must follow a client's individual crisis treatment plan to provide services to the client in residential crisis stabilization to improve the client's functioning.

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

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

(2) rehabilitative mental health services;

(3) health services and administering the client's medications; and

(4) making referrals for the client to other service providers in the community and supporting the client's transition from residential crisis stabilization to another setting.

Subd. 6. **Optional treatment services.** (a) If the license holder offers additional treatment services to a client, the treatment service must be:

(1) approved by the commissioner; and

(2)(i) a mental health evidence-based practice that the federal Department of Health and Human Services Substance Abuse and Mental Health Service Administration has adopted;

(ii) a nationally recognized mental health service that substantial research has validated as effective in helping individuals with serious mental illness achieve treatment goals; or

(iii) developed under state-sponsored research of publicly funded mental health programs and validated to be effective for individuals, families, and communities.

(b) Before providing an optional treatment service to a client, the license holder must provide adequate training to a staff person about providing the optional treatment service to a client.

Subd. 7. **Intensive residential treatment services assessment and treatment planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate and document the client's immediate needs, including the client's:

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

(2) responsibilities for children, family and other natural supports, and employers; and

(3) housing and legal issues.

(b) Within 24 hours of the client's admission, the license holder must complete an initial treatment plan for the client. The license holder must:

(1) base the client's initial treatment plan on the client's referral information and an assessment of the client's immediate needs;

(2) consider crisis assistance strategies that have been effective for the client in the past;

(3) identify the client's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the client engage in treatment;

(4) identify the participants involved in the client's treatment planning. The client must be a participant; and

(5) ensure that a treatment supervisor approves of the client's initial treatment plan if a mental health practitioner or clinical trainee completes the client's treatment plan, notwithstanding section 245I.08, subdivision 3.

(c) According to section 245A.65, subdivision 2, paragraph (b), the license holder must complete an individual abuse prevention plan as part of a client's initial treatment plan.

(d) Within five days of the client's admission and again within 60 days after the client's admission, the license holder must complete a level of care assessment of the client. If the license holder determines that a client does not need a medically monitored level of service, a treatment supervisor must document how the client's admission to and continued services in intensive residential treatment services are medically necessary for the client.

(e) Within ten days of a client's admission, the license holder must complete or review and update the client's standard diagnostic assessment.

(f) Within ten days of a client's admission, the license holder must complete the client's individual treatment plan, notwithstanding section 245I.10, subdivision 8. Within 40 days after the client's admission and again within 70 days after the client's admission, the license holder must update the client's individual treatment plan. The license holder must focus the client's treatment planning on preparing the client for a successful transition from intensive

residential treatment services to another setting. In addition to the required elements of an individual treatment plan under section 245I.10, subdivision 8, the license holder must identify the following information in the client's individual treatment plan: (1) the client's referrals and resources for the client's health and safety; and (2) the staff persons who are responsible for following up with the client's referrals and resources. If the client does not receive a referral or resource that the client needs, the license holder must document the reason that the license holder did not make the referral or did not connect the client to a particular resource. The license holder is responsible for determining whether additional follow-up is required on behalf of the client.

(g) Within 30 days of the client's admission, the license holder must complete a functional assessment of the client. Within 60 days after the client's admission, the license holder must update the client's functional assessment to include any changes in the client's functioning and symptoms.

(h) For a client with a current substance use disorder diagnosis and for a client whose substance use disorder screening in the client's standard diagnostic assessment indicates the possibility that the client has a substance use disorder, the license holder must complete a written assessment of the client's substance use within 30 days of the client's admission. In the substance use assessment, the license holder must: (1) evaluate the client's history of substance use, relapses, and hospitalizations related to substance use; (2) assess the effects of the client's substance use on the client's relationships including with family member and others; (3) identify financial problems, health issues, housing instability, and unemployment; (4) assess the client's legal problems, past and pending incarceration, violence, and victimization; and (5) evaluate the client's suicide attempts, noncompliance with taking prescribed medications, and noncompliance with psychosocial treatment.

(i) On a weekly basis, the license holder must review each client's treatment plan and individual abuse prevention plan. The license holder must document in the client's file each weekly review of the client's treatment plan and individual abuse prevention plan.

Subd. 8. **Residential crisis stabilization assessment and treatment planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate the client and document the client's immediate needs, including the client's:

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

(2) responsibilities for children, family and other natural supports, and employers; and

(3) housing and legal issues.

(b) Within 24 hours of a client's admission, the license holder must complete a crisis treatment plan for the client under section 256B.0624, subdivision 11. The license holder must base the client's crisis treatment plan on the client's referral information and an assessment of the client's immediate needs.

(c) Section 245A.65, subdivision 2, paragraph (b), requires the license holder to complete an individual abuse prevention plan for a client as part of the client's crisis treatment plan.

Subd. 9. **Key staff positions.** (a) The license holder must have a staff person assigned to each of the following key staff positions at all times:

(1) a program director who qualifies as a mental health practitioner. The license holder must designate the program director as responsible for all aspects of the operation of the program and the program's compliance with all applicable requirements. The program director must know and understand the implications of this chapter; chapters 245A, 245C, and 260E; sections 626.557 and 626.5572; Minnesota Rules, chapter 9544; and all other applicable requirements. The license holder must document in the program director's personnel file how the program director demonstrates knowledge of these requirements. The program director may also serve as the treatment director of the program, if qualified;

(2) a treatment director who qualifies as a mental health professional. The treatment director must be responsible for overseeing treatment services for clients and the treatment supervision of all staff persons; and

(3) a registered nurse who qualifies as a mental health practitioner. The registered nurse must:

(i) work at the program location a minimum of eight hours per week;

(ii) provide monitoring and supervision of staff persons as defined in section 148.171, subdivisions 8a and 23;

(iii) be responsible for the review and approval of health service and medication policies and procedures under section 245I.03, subdivision 5; and

(iv) oversee the license holder's provision of health services to clients, medication storage, and medication administration to clients.

(b) Within five business days of a change in a key staff position, the license holder must notify the commissioner of the staffing change. The license holder must notify the commissioner of the staffing change on a form approved by the commissioner and include the name of the staff person now assigned to the key staff position and the staff person's qualifications.

Subd. 10. **Minimum treatment team staffing levels and ratios.** (a) The license holder must maintain a treatment team staffing level sufficient to:

(1) provide continuous daily coverage of all shifts;

(2) follow each client's treatment plan and meet each client's needs as identified in the client's treatment plan;

(3) implement program requirements; and

(4) safely monitor and guide the activities of each client, taking into account the client's level of behavioral and psychiatric stability, cultural needs, and vulnerabilities.

(b) The license holder must ensure that treatment team members:

(1) remain awake during all work hours; and

(2) are available to monitor and guide the activities of each client whenever clients are present in the program.

(c) On each shift, the license holder must maintain a treatment team staffing ratio of at least one treatment team member to nine clients. If the license holder is serving nine or fewer clients, at least one treatment team member on the day shift must be a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner. If the license holder is serving more than nine clients, at least one of the treatment team members working during both the day and evening shifts must be a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.

(d) If the license holder provides residential crisis stabilization to clients and is serving at least one client in residential crisis stabilization and more than four clients in residential crisis stabilization and intensive residential treatment services, the license holder must maintain a treatment team staffing ratio on each shift of at least two treatment team members during the client's first 48 hours in residential crisis stabilization.

Subd. 11. **Shift exchange.** A license holder must ensure that treatment team members working on different shifts exchange information about a client as necessary to effectively care for the client and to follow and update a client's treatment plan and individual abuse prevention plan.

Subd. 12. **Daily documentation.** (a) For each day that a client is present in the program, the license holder must provide a daily summary in the client's file that includes observations about the client's behavior and symptoms, including any critical incidents in which the client was involved.

(b) For each day that a client is not present in the program, the license holder must document the reason for a client's absence in the client's file.

Subd. 13. **Access to a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.** Treatment team members must have access in person or by telephone to a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner within 30 minutes. The license holder must maintain a schedule of mental health professionals, clinical trainees, certified rehabilitation specialists, or mental health practitioners who will be available and contact information to reach them. The license holder must keep the schedule current and make the schedule readily available to treatment team members.

Subd. 14. **Treatment supervision.** (a) Treatment supervision under section 245I.06 includes the use of team supervision. "Team supervision" means:

(1) one or more treatment supervisors providing treatment supervision to any number of treatment team members; or

(2) weekly team meetings and ancillary meetings according to paragraph (b).

(b) If the license holder holds weekly team meetings and ancillary meetings to provide team supervision to team members:

(1) the treatment director must hold at least one team meeting each calendar week and be physically present at each team meeting. All treatment team members, including treatment team members who work on a part-time or intermittent basis, must participate in a minimum of one team meeting during each calendar week when the treatment team member is working for the license holder. The license holder must document all weekly team meetings, including the names of meeting attendees; and

(2) if a treatment team member cannot participate in a weekly team meeting, the treatment team member must participate in an ancillary meeting. A mental health professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner who participated in the most recent weekly team meeting may lead the ancillary meeting. During the ancillary meeting, the treatment team member leading the ancillary meeting must review the information that was shared at the most recent weekly team meeting, including revisions to client treatment plans and other information that the treatment supervisors exchanged with treatment team members. The license holder must document all ancillary meetings, including the names of meeting attendees.

Subd. 15. **Intensive residential treatment services admission criteria.** (a) An eligible client for intensive residential treatment services is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a mental illness;

(3) because of a mental illness, has a substantial disability and functional impairment in three or more areas listed in section 245I.10, subdivision 9, clause (4), that markedly reduce the individual's self-sufficiency;

(4) has one or more of the following: a history of recurring or prolonged inpatient hospitalizations during the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services with poor outcomes for the individual; and

(5) in the written opinion of a mental health professional, needs mental health services that available community-based services cannot provide, or is likely to experience a mental health crisis or require a more restrictive setting if the individual does not receive intensive rehabilitative mental health services.

(b) The license holder must not limit or restrict intensive residential treatment services to a client based solely on:

(1) the client's substance use;

(2) the county in which the client resides; or

(3) whether the client elects to receive other services for which the client may be eligible, including case management services.

(c) This subdivision does not prohibit the license holder from restricting admissions of individuals who present an imminent risk of harm or danger to themselves or others.

Subd. 16. **Residential crisis stabilization services admission criteria.** An eligible client for residential crisis stabilization is an individual who is age 18 or older and meets the eligibility criteria in section 256B.0624, subdivision 3.

Subd. 17. **Admissions referrals and determinations.** (a) The license holder must identify the information that the license holder needs to make a determination about a person's admission referral.

(b) The license holder must:

(1) always be available to receive referral information about a person seeking admission to the license holder's program;

(2) respond to the referral source within eight hours of receiving a referral and, within eight hours, communicate with the referral source about what information the license holder needs to make a determination concerning the person's admission;

(3) consider the license holder's staffing ratio and the areas of treatment team members' competency when determining whether the license holder is able to meet the needs of a person seeking admission; and

(4) determine whether to admit a person within 72 hours of receiving all necessary information from the referral source.

Subd. 18. **Discharge standards.** (a) To successfully discharge a client from a program, the license holder must ensure that the following criteria are met:

(1) the client must substantially meet the client's documented treatment plan goals and objectives;

(2) the client must complete discharge planning with the treatment team; and

(3) the client and treatment team must arrange for the client to receive continuing care at a less intensive level of care after discharge.

(b) Prior to successfully discharging a client from a program, the license holder must complete the client's discharge summary and provide the client with a copy of the client's discharge summary in plain language that includes:

(1) a brief review of the client's problems and strengths during the period that the license holder provided services to the client;

(2) the client's response to the client's treatment plan;

(3) the goals and objectives that the license holder recommends that the client addresses during the first three months following the client's discharge from the program;

(4) the recommended actions, supports, and services that will assist the client with a successful transition from the program to another setting;

(5) the client's crisis plan; and

(6) the client's forwarding address and telephone number.

(c) For a non-program-initiated discharge of a client from a program, the following criteria must be met:

(1)(i) the client has withdrawn the client's consent for treatment; (ii) the license holder has determined that the client has the capacity to make an informed decision; and (iii) the client does not meet the criteria for an emergency hold under section 253B.051, subdivision 2;

(2) the client has left the program against staff person advice;

(3) an entity with legal authority to remove the client has decided to remove the client from the program; or

(4) a source of payment for the services is no longer available.

(d) Within ten days of a non-program-initiated discharge of a client from a program, the license holder must complete the client's discharge summary in plain language that includes:

(1) the reasons for the client's discharge;

(2) a description of attempts by staff persons to enable the client to continue treatment or to consent to treatment; and

(3) recommended actions, supports, and services that will assist the client with a successful transition from the program to another setting.

(e) For a program-initiated discharge of a client from a program, the following criteria must be met:

(1) the client is competent but has not participated in treatment or has not followed the program rules and regulations and the client has not participated to such a degree that the program's level of care is ineffective or unsafe for the client, despite multiple, documented attempts that the license holder has made to address the client's lack of participation in treatment;

(2) the client has not made progress toward the client's treatment goals and objectives despite the license holder's persistent efforts to engage the client in treatment, and the license holder has no reasonable expectation that the client will make progress at the program's level of care nor does the client require the program's level of care to maintain the current level of functioning;

(3) a court order or the client's legal status requires the client to participate in the program but the client has left the program against staff person advice; or

(4) the client meets criteria for a more intensive level of care and a more intensive level of care is available to the client.

(f) Prior to a program-initiated discharge of a client from a program, the license holder must consult the client, the client's family and other natural supports, and the client's case manager, if applicable, to review the issues involved in the program's decision to discharge the client from the program. During the discharge review process, which must not exceed five working days, the license holder must determine whether the license holder, treatment team, and any interested persons can develop additional strategies to resolve the issues leading to the client's discharge and to permit the client to have an opportunity to continue receiving services from the license holder. The license holder may temporarily remove a client from the program facility during the five-day discharge review period. The license holder must document the client's discharge review in the client's file.

(g) Prior to a program-initiated discharge of a client from the program, the license holder must complete the client's discharge summary and provide the client with a copy of the discharge summary in plain language that includes:

(1) the reasons for the client's discharge;

(2) the alternatives to discharge that the license holder considered or attempted to implement;

(3) the names of each individual who is involved in the decision to discharge the client and a description of each individual's involvement; and

(4) actions, supports, and services that the license holder recommends for the client to successfully transition from the program to another setting.

Subd. 19. **Program facility.** (a) The license holder must be licensed or certified as a board and lodging facility, supervised living facility, or a boarding care home by the Department of Health.

(b) The license holder must have a capacity of five to 16 beds and the program must not be declared as an institution for mental disease.

(c) The license holder must furnish each program location to meet the psychological, emotional, and developmental needs of clients.

(d) The license holder must provide one living room or lounge area per program location. There must be space available to provide services according to each client's treatment plan, such as an area for learning recreation time skills and areas for learning independent living skills, such as laundering clothes and preparing meals.

(e) The license holder must ensure that each program location allows each client to have privacy. Each client must have privacy during assessment interviews and counseling sessions.

Each client must have a space designated for the client to see outside visitors at the program facility.

Subd. 20. **Physical separation of services.** If the license holder offers services to individuals who are not receiving intensive residential treatment services or residential stabilization at the program location, the license holder must inform the commissioner and submit a plan for approval to the commissioner about how and when the license holder will provide services. The license holder must provide services to clients who are not receiving intensive residential treatment services or residential crisis stabilization at the program location. The license holder must only provide services to clients who are not receiving intensive residential treatment services or residential crisis stabilization in an area that is physically separated from the area in which the license holder provides clients with intensive residential treatment services or residential crisis stabilization.

Subd. 21. **Dividing staff time between locations.** A license holder must obtain approval from the commissioner prior to providing intensive residential treatment services or residential crisis stabilization to clients in more than one program location under one license and dividing one staff person's time between program locations during the same work period.

Subd. 22. **Additional policy and procedure requirements.** (a) In addition to the policies and procedures in section 245I.03, the license holder must establish, enforce, and maintain the policies and procedures in this subdivision.

(b) The license holder must have policies and procedures for receiving referrals and making admissions determinations about referred persons under subdivisions 14 to 16.

(c) The license holder must have policies and procedures for discharging clients under subdivision 17. In the policies and procedures, the license holder must identify the staff persons who are authorized to discharge clients from the program.

Subd. 23. **Quality assurance and improvement plan.** (a) A license holder must develop a written quality assurance and improvement plan that includes a plan to:

(1) encourage ongoing consultation between members of the treatment team;

(2) obtain and evaluate feedback about services from clients, family and other natural supports, referral sources, and staff persons;

(3) measure and evaluate client outcomes in the program;

(4) review critical incidents in the program;

(5) examine the quality of clinical services in the program;

(6) examine how efficiently the license holder uses resources; and

(7) self-monitor the license holder's compliance with this chapter.

(b) At least annually, the license holder must review, evaluate, and update the license holder's quality assurance and improvement plan. The license holder's review must:

(1) document the actions that the license holder will take in response to the information that the license holder obtains from the monitoring activities in the plan; and

(2) establish goals for improving the license holder's services to clients during the next year.

Subd. 24. **Application.** When an applicant requests licensure to provide intensive residential treatment services, residential crisis stabilization, or both to clients, the applicant must submit, on forms that the commissioner provides, any documents that the commissioner requires.

Sec. 17. **[256B.0671] COVERED MENTAL HEALTH SERVICES.**

Subdivision 1. **Definitions.** (a) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(b) "Mental health practitioner" means a staff person who is qualified under section 245I.04, subdivision 4.

(c) "Mental health professional" means a staff person who is qualified under section 245I.04, subdivision 2.

Subd. 2. **Generally.** (a) An individual, organization, or government entity providing mental health services to a client under this section must obtain a criminal background study of each staff person or volunteer who is providing direct contact services to a client.

(b) An individual, organization, or government entity providing mental health services to a client under this section must comply with all responsibilities that chapter 245I assigns to a license holder, except section 245I.011, subdivision 1, unless all of the individual's, organization's, or government entity's treatment staff are qualified as mental health professionals.

(c) An individual, organization, or government entity providing mental health services to a client under this section must comply with the following requirements if all of the license holder's treatment staff are qualified as mental health professionals:

(1) provider qualifications and scopes of practice under section 245I.04;

(2) maintaining and updating personnel files under section 245I.07;

(3) documenting under section 245I.08;

(4) maintaining and updating client files under section 245I.09;

(5) completing client assessments and treatment planning under section 245I.10;

(6) providing clients with health services and medications under section 245I.11; and

(7) respecting and enforcing client rights under section 245I.12.

Subd. 3. **Adult day treatment services.** (a) Subject to federal approval, medical assistance covers adult day treatment (ADT) services that are provided under contract with the county board. Adult day treatment payment is subject to the conditions in paragraphs (b) to (e). The provider must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments, protocols, and forms approved by the commissioner.

(b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve the effects of mental illness on a client to enable the client to benefit from a lower level of care and to live and function more independently in the community. Adult day treatment services must be provided to a client to stabilize the client's mental health and to improve the client's independent living and socialization skills. Adult day treatment must consist of at least one hour of group psychotherapy and must include group time focused on rehabilitative interventions or other therapeutic services that a multidisciplinary team provides to each client. Adult day treatment services are not a part of inpatient or residential treatment services. The following providers may apply to become adult day treatment providers:

(1) a hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 256B.0625, subdivision 5; or

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475.

(c) An adult day treatment (ADT) services provider must:

(1) ensure that the commissioner has approved of the organization as an adult day treatment provider organization;

(2) ensure that a multidisciplinary team provides ADT services to a group of clients. A mental health professional must supervise each multidisciplinary staff person who provides ADT services;

(3) make ADT services available to the client at least two days a week for at least three consecutive hours per day. ADT services may be longer than three hours per day, but medical assistance may not reimburse a provider for more than 15 hours per week;

(4) provide ADT services to each client that includes group psychotherapy by a mental health professional or clinical trainee and daily rehabilitative interventions by a mental health professional, clinical trainee, or mental health practitioner; and

(5) include ADT services in the client's individual treatment plan, when appropriate. The adult day treatment provider must:

(i) complete a functional assessment of each client under section 245I.10, subdivision 9;

(ii) notwithstanding section 245I.07, review the client's progress and update the individual treatment plan at least every 90 days until the client is discharged from the program; and

(iii) include a discharge plan for the client in the client's individual treatment plan.

(d) To be eligible for adult day treatment, a client must:

(1) be 18 years of age or older;

(2) not reside in a nursing facility, hospital, institute of mental disease, or state-operated treatment center unless the client has an active discharge plan that indicates a move to an independent living setting within 180 days;

(3) have the capacity to engage in rehabilitative programming, skills activities, and psychotherapy in the structured, therapeutic setting of an adult day treatment program and demonstrate measurable improvements in functioning resulting from participation in the adult day treatment program;

(4) have a level of care assessment under section 245I.02, subdivision 19, recommending that the client participate in services with the level of intensity and duration of an adult day treatment program; and

(5) have the recommendation of a mental health professional for adult day treatment services. The mental health professional must find that adult day treatment services are medically necessary for the client.

(e) Medical assistance does not cover the following services as adult day treatment services:

(1) services that are primarily recreational or that are provided in a setting that is not under medical supervision, including sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) social or educational services that do not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultations with other providers or service agency staff persons about the care or progress of a client;

(4) prevention or education programs that are provided to the community;

(5) day treatment for clients with a primary diagnosis of a substance use disorder;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours per day; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Subd. 4. **Explanation of findings.** (a) Subject to federal approval, medical assistance covers an explanation of findings that a mental health professional or clinical trainee provides when the provider has obtained the authorization from the client or the client's representative to release the information.

(b) A mental health professional or clinical trainee provides an explanation of findings to assist the client or related parties in understanding the results of the client's testing or diagnostic assessment and the client's mental illness, and provides professional insight that the client or related parties need to carry out a client's treatment plan. Related parties may include the client's family and other natural supports and other service providers working with the client.

(c) An explanation of findings is not paid for separately when a mental health professional or clinical trainee explains the results of psychological testing or a diagnostic assessment to the client or the client's representative as part of the client's psychological testing or a diagnostic assessment.

Subd. 5. **Family psychoeducation services.** (a) Subject to federal approval, medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan

and provided by a mental health professional or a clinical trainee who has determined it medically necessary to involve family members in the child's care.

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

Subd. 6. **Dialectical behavior therapy.** (a) Subject to federal approval, medical assistance covers intensive mental health outpatient treatment for dialectical behavior therapy for adults. A dialectical behavior therapy provider must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments and protocols that are approved by the commissioner.

(b) "Dialectical behavior therapy" means an evidence-based treatment approach that a mental health professional or clinical trainee provides to a client or a group of clients in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program involves: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

(c) To be eligible for dialectical behavior therapy, a client must:

(1) be 18 years of age or older;

(2) have mental health needs that available community-based services cannot meet or that the client must receive concurrently with other community-based services;

(3) have either:

(i) a diagnosis of borderline personality disorder; or

(ii) multiple mental health diagnoses, exhibit behaviors characterized by impulsivity or intentional self-harm, and be at significant risk of death, morbidity, disability, or severe dysfunction in multiple areas of the client's life;

(4) be cognitively capable of participating in dialectical behavior therapy as an intensive therapy program and be able and willing to follow program policies and rules to ensure the safety of the client and others; and

(5) be at significant risk of one or more of the following if the client does not receive dialectical behavior therapy:

(i) having a mental health crisis;

(ii) requiring a more restrictive setting such as hospitalization;

(iii) decompensating; or

(iv) engaging in intentional self-harm behavior.

(d) Individual dialectical behavior therapy combines individualized rehabilitative and psychotherapeutic interventions to treat a client's suicidal and other dysfunctional behaviors and to reinforce a client's use of adaptive skillful behaviors. A mental health professional or clinical trainee must provide individual dialectical behavior therapy to a client. A mental health professional or clinical trainee providing dialectical behavior therapy to a client must:

(1) identify, prioritize, and sequence the client's behavioral targets;

(2) treat the client's behavioral targets;

(3) assist the client in applying dialectical behavior therapy skills to the client's natural environment through telephone coaching outside of treatment sessions;

(4) measure the client's progress toward dialectical behavior therapy targets;

(5) help the client manage mental health crises and life-threatening behaviors; and

(6) help the client learn and apply effective behaviors when working with other treatment providers.

(e) Group skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group setting to reduce the client's suicidal and other dysfunctional coping behaviors and restore function. Group skills training must teach the client adaptive skills in the following areas: (1) mindfulness; (2) interpersonal effectiveness; (3) emotional regulation; and (4) distress tolerance.

(f) Group skills training must be provided by two mental health professionals or by a mental health professional co-facilitating with a clinical trainee or a mental health practitioner. Individual skills training must be provided by a mental health professional, a clinical trainee, or a mental health practitioner.

(g) Before a program provides dialectical behavior therapy to a client, the commissioner must certify the program as a dialectical behavior therapy provider. To qualify for certification as a dialectical behavior therapy provider, a provider must:

(1) allow the commissioner to inspect the provider's program;

(2) provide evidence to the commissioner that the program's policies, procedures, and practices meet the requirements of this subdivision and chapter 245I;

(3) be enrolled as a MHCP provider; and

(4) have a manual that outlines the program's policies, procedures, and practices that meet the requirements of this subdivision.

Subd. 7. **Mental health clinical care consultation.** (a) Subject to federal approval, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a mental health professional or a clinical trainee.

(b) "Clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the treatment supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings and to direct and coordinate clinical service components provided to the client and family.

Subd. 8. **Neuropsychological assessment.** (a) Subject to federal approval, medical assistance covers a client's neuropsychological assessment.

(b) Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist. A neuropsychological assessment must include a face-to-face interview with the client, interpretation of the test results, and preparation and completion of a report.

(c) A client is eligible for a neuropsychological assessment if the client meets at least one of the following criteria:

(1) the client has a known or strongly suspected brain disorder based on the client's medical history or the client's prior neurological evaluation, including a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorder, significant exposure to neurotoxins, central nervous system infection, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformation of the brain; or

(2) the client has cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology or suspected neuropsychological impairment in addition to functional psychopathology. The client's symptoms may include:

(i) having a poor memory or impaired problem solving;

(ii) experiencing change in mental status evidenced by lethargy, confusion, or disorientation;

(iii) experiencing a deteriorating level of functioning;

(iv) displaying a marked change in behavior or personality;

(v) in a child or an adolescent, having significant delays in acquiring academic skill or poor attention relative to peers;

(vi) in a child or an adolescent, having reached a significant plateau in expected development of cognitive, social, emotional, or physical functioning relative to peers; and

(vii) in a child or an adolescent, significant inability to develop expected knowledge, skills, or abilities to adapt to new or changing cognitive, social, emotional, or physical demands.

(d) The neuropsychological assessment must be completed by a neuropsychologist who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program and:

(i) completed an internship or its equivalent in a clinically relevant area of professional psychology;

(ii) completed the equivalent of two full-time years of experience and specialized training, at least one of which is at the postdoctoral level, supervised by a clinical neuropsychologist in the study and practice of clinical neuropsychology and related neurosciences; and

(iii) holds a current license to practice psychology independently according to sections 144.88 to 144.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in clause (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessments prior to December 31, 2010.

Subd. 9. **Neuropsychological testing.** (a) Subject to federal approval, medical assistance covers neuropsychological testing for clients.

(b) "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn, and recall information and use problem solving and judgment.

(c) Medical assistance covers neuropsychological testing of a client when the client:

(1) has a significant mental status change that is not a result of a metabolic disorder and that has failed to respond to treatment;

(2) is a child or adolescent with a significant plateau in expected development of cognitive, social, emotional, or physical function relative to peers;

(3) is a child or adolescent with a significant inability to develop expected knowledge, skills, or abilities to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) has a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(i) traumatic brain injury;

(ii) stroke;

(iii) brain tumor;

(iv) substance use disorder;

(v) cerebral anoxic or hypoxic episode;

(vi) central nervous system infection or other infectious disease;

(vii) neoplasms or vascular injury of the central nervous system;

(viii) neurodegenerative disorders;

(ix) demyelinating disease;

(x) extrapyramidal disease;

(xi) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(xii) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders, including lupus, erythematosus, or celiac disease;

(xiii) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, including phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(xiv) severe or prolonged nutrition or malabsorption syndromes; or

(xv) a condition presenting in a manner difficult for a clinician to distinguish between the neurocognitive effects of a neurogenic syndrome, including dementia or encephalopathy; and a major depressive disorder when adequate treatment for major depressive disorder has not improved the client's neurocognitive functioning; or another disorder, including autism, selective mutism, anxiety disorder, or reactive attachment disorder.

(d) Neuropsychological testing must be administered or clinically supervised by a qualified neuropsychologist under subdivision 8, paragraph (c).

(e) Medical assistance does not cover neuropsychological testing of a client when the testing is:

(1) primarily for educational purposes;

(2) primarily for vocational counseling or training;

(3) for personnel or employment testing;

(4) a routine battery of psychological tests given to the client at the client's inpatient admission or during a client's continued inpatient stay; or

(5) for legal or forensic purposes.

Subd. 10. **Psychological testing.** (a) Subject to federal approval, medical assistance covers psychological testing of a client.

(b) "Psychological testing" means the use of tests or other psychometric instruments to determine the status of a client's mental, intellectual, and emotional functioning.

(c) The psychological testing must:

(1) be administered or supervised by a licensed psychologist qualified under section 245I.04, subdivision 2, clause (3), who is competent in the area of psychological testing; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a clinical trainee in psychology under the treatment supervision of a licensed psychologist under section 245I.06.

(d) A licensed psychologist must supervise the administration, scoring, and interpretation of a client's psychological tests when a clinical psychology trainee, technician, psychometrist, or psychological assistant or a computer-assisted psychological testing program completes the psychological testing of the client. The report resulting from the psychological testing must be signed by the licensed psychologist who conducts the face-to-face interview with the client. The licensed psychologist or a staff person who is under treatment supervision must place the client's psychological testing report in the client's record and release one copy of the report to the client and additional copies to individuals authorized by the client to receive the report.

Subd. 11. **Psychotherapy.** (a) Subject to federal approval, medical assistance covers psychotherapy for a client.

(b) "Psychotherapy" means treatment of a client with mental illness that applies to the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client. Medical assistance covers psychotherapy if a mental health professional or a clinical trainee provides psychotherapy to a client.

(c) "Individual psychotherapy" means psychotherapy that a mental health professional or clinical trainee designs for a client.

(d) "Family psychotherapy" means psychotherapy that a mental health professional or clinical trainee designs for a client and one or more and the client's family members or primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance for medical assistance to cover family psychotherapy. For purposes of this paragraph, "primary caregiver whose participation is necessary to accomplish the client's treatment goals" excludes shift or facility staff persons who work at the client's residence. Medical assistance payments for family psychotherapy are limited to face-to-face sessions during which the client is present throughout the session, unless the mental health professional or clinical trainee believes that the client's exclusion from the

family psychotherapy session is necessary to meet the goals of the client's individual treatment plan. If the client is excluded from a family psychotherapy session, a mental health professional or clinical trainee must document the reason for the client's exclusion and the length of time that the client is excluded. The mental health professional must also document any reason that a member of the client's family is excluded from a psychotherapy session.

(e) Group psychotherapy is appropriate for a client who, because of the nature of the client's emotional, behavioral, or social dysfunctions, can benefit from treatment in a group setting. For a group of three to eight clients, at least one mental health professional or clinical trainee must provide psychotherapy to the group. For a group of nine to 12 clients, a team of at least two mental health professionals or two clinical trainees or one mental health professional and one clinical trainee must provide psychotherapy to the group. Medical assistance will cover group psychotherapy for a group of no more than 12 persons.

(f) A multiple-family group psychotherapy session is eligible for medical assistance if a mental health professional or clinical trainee designs the psychotherapy session for at least two but not more than five families. A mental health professional or clinical trainee must design multiple-family group psychotherapy sessions to meet the treatment needs of each client. If the client is excluded from a psychotherapy session, the mental health professional or clinical trainee must document the reason for the client's exclusion and the length of time that the client was excluded. The mental health professional or clinical trainee must document any reason that a member of the client's family was excluded from a psychotherapy session.

Subd. 12. **Partial hospitalization.** (a) Subject to federal approval, medical assistance covers a client's partial hospitalization.

(b) "Partial hospitalization" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x(ff), that a multidisciplinary staff person provides in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services to a client.

(c) Partial hospitalization is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness who meets the criteria for an inpatient hospital admission under Minnesota Rules, part 9505.0520, subpart 1, and who has family and community resources that support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services for a client that a multidisciplinary staff person provides to a client to treat the client's mental illness.

Subd. 13. **Diagnostic assessments.** Subject to federal approval, medical assistance covers a client's diagnostic assessments that a mental health professional or clinical trainee completes under section 245I.10.

Sec. 18. **DIRECTION TO COMMISSIONER; SINGLE COMPREHENSIVE LICENSE STRUCTURE.**

The commissioner of human services, in consultation with stakeholders including counties, tribes, managed care organizations, provider organizations, advocacy groups, and clients and clients' families, shall develop recommendations to develop a single comprehensive licensing structure for mental health service programs, including outpatient and residential services for adults and children. The recommendations must prioritize program integrity, the welfare of clients and clients' families, improved integration of mental health and substance use disorder services, and the reduction of administrative burden on providers.

ARTICLE 8
MENTAL HEALTH UNIFORM SERVICE STANDARDS: CRISIS SERVICES

Section 1. Minnesota Statutes 2020, section 245.469, subdivision 1, is amended to read:

Subdivision 1. **Availability of emergency services.** ~~By July 1, 1988,~~ County boards must provide or contract for enough emergency services within the county to meet the needs of adults, children, and families in the county who are experiencing an emotional crisis or mental illness. Clients may be required to pay a fee according to section 245.481. Emergency service providers must not delay the timely provision of emergency services to a client because of delays in determining the fee under section 245.481 or because of the unwillingness or inability of the client to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of ~~adults with mental illness or emotional crises~~ each client;

(2) minimize further deterioration of ~~adults with mental illness or emotional crises~~ each client;

(3) help ~~adults with mental illness or emotional crises~~ each client to obtain ongoing care and treatment; ~~and~~

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs~~.~~; and

(5) provide support, psychoeducation, and referrals to each client's family members, service providers, and other third parties on behalf of the client in need of emergency services.

Sec. 2. Minnesota Statutes 2020, section 245.469, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to adults with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, ~~a~~ a clinical trainee, or mental health practitioner~~, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional~~.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional, clinical trainee, or mental health practitioner ~~after January 1, 1991,~~ if the county documents that:

(1) mental health professionals, clinical trainees, or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives ~~clinical~~ treatment supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services ~~reviewed by the state advisory council on mental health and then~~ approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services ~~reviewed by the state advisory council on mental health and then~~ approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Sec. 3. Minnesota Statutes 2020, section 245.4879, subdivision 1, is amended to read:

Subdivision 1. **Availability of emergency services.** County boards must provide or contract for ~~enough~~ mental health emergency services ~~within the county to meet the needs of children, and children's families when clinically appropriate, in the county who are experiencing an emotional crisis or emotional disturbance. The county board shall ensure that parents, providers, and county residents are informed about when and how to access emergency mental health services for children. A child or the child's parent may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the parent to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:~~ according to section 245.469.

~~(1) promote the safety and emotional stability of children with emotional disturbances or emotional crises;~~

~~(2) minimize further deterioration of the child with emotional disturbance or emotional crisis;~~

~~(3) help each child with an emotional disturbance or emotional crisis to obtain ongoing care and treatment; and~~

~~(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs.~~

Sec. 4. Minnesota Statutes 2020, section 256B.0624, is amended to read:

256B.0624 ~~ADULT~~ CRISIS RESPONSE SERVICES COVERED.

Subdivision 1. **Scope.** ~~Medical assistance covers adult mental health crisis response services as defined in subdivision 2, paragraphs (c) to (e),~~ (a) Subject to federal approval, ~~if provided to a recipient as defined in subdivision 3 and provided by a qualified provider entity as defined in this section and by a qualified individual provider working within the provider's scope of practice and as defined in this subdivision and identified in the recipient's individual crisis treatment plan as defined in subdivision 11 and if determined to be medically necessary~~ medical assistance covers medically necessary crisis response services when the services are provided according to the standards in this section.

(b) Subject to federal approval, medical assistance covers medically necessary residential crisis stabilization when the services are provided by an entity licensed under and meeting the standards in section 245I.23.

(c) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments and protocols approved by the commissioner.

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

~~(a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization.~~

~~(b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with section 62Q.55.~~

~~A mental health crisis or emergency is determined for medical assistance service reimbursement by a physician, a mental health professional, or crisis mental health practitioner with input from the recipient whenever possible.~~

(a) "Certified rehabilitation specialist" means a staff person who is qualified under section 245I.04, subdivision 8.

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

(c) "~~Mental health~~ Crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or ~~mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation. It includes, when feasible, assessing whether the person might be willing to voluntarily accept treatment, determining whether the person has an advance directive, and obtaining information and history from involved family members or caretakers~~ a qualified member of a crisis team, as described in subdivision 6a.

(d) "~~Mental health mobile~~ Crisis intervention ~~services~~" means face-to-face, short-term intensive mental health services initiated during a mental health crisis ~~or mental health emergency~~ to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning. ~~The services, including screening and treatment plan recommendations, must be culturally and linguistically appropriate.~~

~~(1) This service is provided on site by a mobile crisis intervention team outside of an inpatient hospital setting. Mental health mobile crisis intervention services must be available 24 hours a day, seven days a week.~~

~~(2) The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances.~~

~~(3) The mobile crisis intervention team must be available to meet promptly face-to-face with a person in mental health crisis or emergency in a community setting or hospital emergency room.~~

~~(4) The intervention must consist of a mental health crisis assessment and a crisis treatment plan.~~

~~(5) The team must be available to individuals who are experiencing a co-occurring substance use disorder, who do not need the level of care provided in a detoxification facility.~~

~~(6) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient, including engagement in treatment planning and family psychoeducation.~~

(e) "Crisis screening" means a screening of a client's potential mental health crisis situation under subdivision 6.

~~(e)~~ (f) "~~Mental health~~ Crisis stabilization ~~services~~" means individualized mental health services provided to a recipient ~~following crisis intervention services~~ which are designed

to restore the recipient to the recipient's prior functional level. ~~Mental health~~ Crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. ~~Mental health crisis stabilization does not include partial hospitalization or day treatment. Mental health~~ Crisis stabilization services includes family psychoeducation.

(g) "Crisis team" means the staff of a provider entity who are supervised and prepared to provide mobile crisis services to a client in a potential mental health crisis situation.

(h) "Mental health certified family peer specialist" means a staff person who is qualified under section 245I.04, subdivision 12.

(i) "Mental health certified peer specialist" means a staff person who is qualified under section 245I.04, subdivision 10.

(j) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without the provision of crisis response services, would likely result in significantly reducing the recipient's levels of functioning in primary activities of daily living, in an emergency situation under section 62Q.55, or in the placement of the recipient in a more restrictive setting, including but not limited to inpatient hospitalization.

(k) "Mental health practitioner" means a staff person who is qualified under section 245I.04, subdivision 4.

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

(m) "Mental health rehabilitation worker" means a staff person who is qualified under section 245I.04, subdivision 14.

(n) "Mobile crisis services" means screening, assessment, intervention, and community based stabilization, excluding residential crisis stabilization, that is provided to a recipient.

Subd. 3. **Eligibility.** ~~An eligible recipient is an individual who:~~

~~(1) is age 18 or older;~~

~~(2) is screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed; and~~

~~(3) is assessed as experiencing a mental health crisis or emergency, and mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.~~

(a) A recipient is eligible for crisis assessment services when the recipient has screened positive for a potential mental health crisis during a crisis screening.

(b) A recipient is eligible for crisis intervention services and crisis stabilization services when the recipient has been assessed during a crisis assessment to be experiencing a mental health crisis.

Subd. 4. **Provider entity standards.** (a) A ~~provider entity is an entity that meets the standards listed in paragraph (c) and~~ mobile crisis provider must be:

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

(2) an Indian health services facility or facility owned and operated by a tribe or tribal organization operating under United States Code, title 325, section 450f; or

~~(2) is~~ (3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

(b) A mobile crisis provider must meet the following standards:

(1) must ensure that crisis screenings, crisis assessments, and crisis intervention services are available to a recipient 24 hours a day, seven days a week;

(2) must be able to respond to a call for services in a designated service area or according to a written agreement with the local mental health authority for an adjacent area;

(3) must have at least one mental health professional on staff at all times and at least one additional staff member capable of leading a crisis response in the community; and

(4) must provide the commissioner with information about the number of requests for service, the number of people that the provider serves face-to-face, outcomes, and the protocols that the provider uses when deciding when to respond in the community.

~~(b)~~ (c) A provider entity that provides crisis stabilization services in a residential setting under subdivision 7 is not required to meet the requirements of ~~paragraph~~ paragraphs (a)~~,~~ ~~clauses (1) and (2)~~ to (b), but must meet all other requirements of this subdivision.

~~(c) The adult mental health~~ (d) A crisis ~~response~~ services provider ~~entity~~ must have the capacity to meet and carry out the standards in section 245I.011, subdivision 5, and the following standards:

(1) ~~has the capacity to recruit, hire, and manage and train mental health professionals, practitioners, and rehabilitation workers~~ ensures that staff persons provide support for a

recipient's family and natural supports, by enabling the recipient's family and natural supports to observe and participate in the recipient's treatment, assessments, and planning services;

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

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

~~(4)~~ (3) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;

~~(5)~~ (4) is able to ensure that staff are ~~capable of~~ implementing culturally specific treatment identified in the ~~individual~~ crisis treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;

~~(6)~~ (5) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient during the service partnership between the recipient and providers;

~~(7)~~ (6) is able to ensure that ~~mental health professionals and mental health practitioners~~ staff have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;

~~(8)~~ (7) is able to coordinate these services with county emergency services, community hospitals, ambulance, transportation services, social services, law enforcement, and mental health crisis services through regularly scheduled interagency meetings;

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

~~(10)~~ (8) is able to ensure that services are coordinated with other ~~mental~~ behavioral health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the ~~adult~~ recipient. Services must also be coordinated with the recipient's case manager if the ~~adult~~ recipient is receiving case management services;

~~(11)~~ (9) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486 and 245.487 to 245.4879;

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

~~(13) maintains staff training and personnel files;~~

(10) is able to coordinate detoxification services for the recipient according to Minnesota Rules, parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F;

~~(14)~~ (11) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction; and

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

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

~~(17)~~ (12) is an enrolled medical assistance provider~~; and~~.

~~(18) develops and maintains written policies and procedures regarding service provision and administration of the provider entity, including safety of staff and recipients in high-risk situations.~~

Subd. 4a. **Alternative provider standards.** If a county or tribe demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services according to the standards in subdivision 4, paragraph ~~(c), clause (9)~~ (b), the commissioner may approve ~~a crisis response provider based on~~ an alternative plan proposed by a county or ~~group of counties~~ tribe. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of mobile crisis services;

(2) provide mobile crisis services outside of the usual nine-to-five office hours and on weekends and holidays; and

(3) comply with standards for emergency mental health services in section 245.469.

Subd. 5. **~~Mobile~~ Crisis assessment and intervention staff qualifications.** ~~For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two people with at least one member providing on-site crisis intervention services when needed.~~ (a) Qualified individual staff of a qualified provider entity must provide crisis assessment and intervention services to a recipient. A staff member providing crisis assessment and intervention services to a recipient must be qualified as a:

(1) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health certified peer specialist.

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

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

(d) Team members must be experienced in ~~mental health~~ crisis assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources. ~~The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.~~

Subd. 6. **Crisis ~~assessment and mobile intervention treatment planning~~ screening.** (a) ~~Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted.~~ The crisis screening may use the resources of ~~crisis assistance and~~ emergency services as defined in ~~sections 245.462, subdivision 6, and~~ section 245.469, subdivisions 1 and 2. The crisis screening must gather information, determine whether a mental health crisis situation exists, identify parties involved, and determine an appropriate response.

(b) When conducting the crisis screening of a recipient, a provider must:

(1) employ evidence-based practices to reduce the recipient's risk of suicide and self-injurious behavior;

(2) work with the recipient to establish a plan and time frame for responding to the recipient's mental health crisis, including responding to the recipient's immediate need for support by telephone or text message until the provider can respond to the recipient face-to-face;

(3) document significant factors in determining whether the recipient is experiencing a mental health crisis, including prior requests for crisis services, a recipient's recent presentation at an emergency department, known calls to 911 or law enforcement, or information from third parties with knowledge of a recipient's history or current needs;

(4) accept calls from interested third parties and consider the additional needs or potential mental health crises that the third parties may be experiencing;

(5) provide psychoeducation, including means reduction, to relevant third parties including family members or other persons living with the recipient; and

(6) consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(c) For the purposes of this section, the following situations indicate a positive screen for a potential mental health crisis and the provider must prioritize providing a face-to-face crisis assessment of the recipient, unless a provider documents specific evidence to show why this was not possible, including insufficient staffing resources, concerns for staff or recipient safety, or other clinical factors:

(1) the recipient presents at an emergency department or urgent care setting and the health care team at that location requested crisis services; or

(2) a peace officer requested crisis services for a recipient who is potentially subject to transportation under section 253B.051.

(d) A provider is not required to have direct contact with the recipient to determine that the recipient is experiencing a potential mental health crisis. A mobile crisis provider may gather relevant information about the recipient from a third party at the scene to establish the recipient's need for services and potential safety factors.

Subd. 6a. **Crisis assessment.** ~~(b)~~ (a) If a ~~crisis exists~~ recipient screens positive for potential mental health crisis, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which ~~emergency~~ services are needed and, as time permits, the recipient's current life situation, health information, including current medications, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, current functioning, and the recipient's preferences as communicated directly by the recipient, or as communicated in a health care directive as described in chapters 145C and 253B, the crisis treatment plan described under ~~paragraph (d)~~ subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

(b) A provider must conduct a crisis assessment at the recipient's location whenever possible.

(c) Whenever possible, the assessor must attempt to include input from the recipient and the recipient's family and other natural supports to assess whether a crisis exists.

(d) A crisis assessment includes determining: (1) whether the recipient is willing to voluntarily engage in treatment or (2) has an advance directive and (3) gathering the recipient's information and history from involved family or other natural supports.

(e) A crisis assessment must include coordinated response with other health care providers if the assessment indicates that a recipient needs detoxification, withdrawal management, or medical stabilization in addition to crisis response services. If the recipient does not need an acute level of care, a team must serve an otherwise eligible recipient who has a co-occurring substance use disorder.

(f) If, after completing a crisis assessment of a recipient, a provider refers a recipient to an intensive setting, including an emergency department, inpatient hospitalization, or residential crisis stabilization, one of the crisis team members who completed or conferred about the recipient's crisis assessment must immediately contact the referral entity and consult with the triage nurse or other staff responsible for intake at the referral entity. During the consultation, the crisis team member must convey key findings or concerns that led to the recipient's referral. Following the immediate consultation, the provider must also send written documentation upon completion. The provider must document if these releases occurred with authorization by the recipient, the recipient's legal guardian, or as allowed by section 144.293, subdivision 5.

Subd. 6b. **Crisis intervention services.** ~~(c)~~ (a) If the crisis assessment determines mobile crisis intervention services are needed, the crisis intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the crisis assessment, crisis treatment plan, and actions taken and needed. At least one of the team members must be ~~on site~~ providing face-to-face crisis intervention services. If providing ~~on-site~~ crisis intervention services, a clinical trainee or mental health practitioner must seek ~~clinical~~ treatment supervision as required in subdivision 9.

(b) If a provider delivers crisis intervention services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

~~(d)~~ (c) The mobile crisis intervention team must develop ~~an initial, brief~~ a crisis treatment plan ~~as soon as appropriate but no later than 24 hours after the initial face-to-face intervention~~ according to subdivision 11. ~~The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.~~

~~(e)~~ (d) The mobile crisis intervention team must document which ~~short-term goals~~ crisis treatment plan goals and objectives have been met and when no further crisis intervention services are required.

~~(f)~~ (e) If the recipient's mental health crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

~~(g)~~ (f) If the recipient's mental health crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis ~~stabilization~~ treatment plan must be developed ~~which~~ that meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; ~~and~~

(3) crisis stabilization services must be delivered according to the crisis treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis ~~stabilization~~ treatment plan, ~~supportive counseling,~~ skills training, and collaboration with other service providers in the community~~.~~; and

(4) if a provider delivers crisis stabilization services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

~~(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.~~

~~(c)~~ (b) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization ~~services~~, the residential staff must include, for at least eight hours per day, at least one ~~individual who meets the qualifications~~

~~in subdivision 8, paragraph (a), clause (1) or (2)~~ mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.

~~(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.~~

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

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

(2) ~~be a~~ certified rehabilitation specialist;

(3) clinical trainee;

(4) mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional~~;

(5) mental health certified family peer specialist;

~~(3) be a~~ (6) mental health certified peer specialist ~~under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional~~; or

~~(4) be a~~ (7) mental health rehabilitation worker ~~who meets the criteria in section 256B.0623, subdivision 5, paragraph (a), clause (4); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional~~.

(b) ~~Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.~~ The 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to a recipient and include training about evidence-based practices identified by the commissioner of health to reduce a recipient's risk of suicide and self-injurious behavior.

Subd. 9. **Supervision.** Clinical trainees and mental health practitioners may provide crisis assessment and ~~mobile~~ crisis intervention services if the following ~~clinical~~ treatment supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity~~, who is an employee or under contract with the provider entity,~~ must be immediately available by phone or in person for ~~clinical~~ treatment supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a clinical trainee or mental health practitioner provides ~~on-site service~~ crisis assessment or crisis intervention services; and

(4) the mental health professional must:

(i) review and approve, as defined in section 245I.02, subdivision 2, of the tentative crisis assessment and crisis treatment plan within 24 hours of first providing services to the recipient, notwithstanding section 245I.08, subdivision 3; and

(ii) document the consultation required in clause (3).~~; and~~

~~(iii) sign the crisis assessment and treatment plan within the next business day;~~

~~(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and~~

~~(6) the on-site observation must be documented in the recipient's record and signed by the mental health professional.~~

~~Subd. 10. **Recipient file.** Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:~~

~~(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;~~

~~(2) signed release forms;~~

~~(3) recipient health information and current medications;~~

~~(4) emergency contacts for the recipient;~~

~~(5) case records which document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;~~

~~(6) required clinical supervision by mental health professionals;~~

~~(7) summary of the recipient's case reviews by staff;~~

~~(8) any written information by the recipient that the recipient wants in the file; and~~

~~(9) an advance directive, if there is one available.~~

~~Documentation in the file must comply with all requirements of the commissioner.~~

Subd. 11. **Crisis treatment plan.** ~~The individual crisis stabilization treatment plan must include, at a minimum:~~

~~(1) a list of problems identified in the assessment;~~

~~(2) a list of the recipient's strengths and resources;~~

~~(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;~~

~~(4) specific objectives directed toward the achievement of each one of the goals;~~

~~(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;~~

~~(6) planned frequency and type of services initiated;~~

~~(7) a crisis response action plan if a crisis should occur;~~

~~(8) clear progress notes on outcome of goals;~~

~~(9) a written plan must be completed within 24 hours of beginning services with the recipient; and~~

~~(10) a treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.~~

(a) Within 24 hours of the recipient's admission, the provider entity must complete the recipient's crisis treatment plan. The provider entity must:

(1) base the recipient's crisis treatment plan on the recipient's crisis assessment;

(2) consider crisis assistance strategies that have been effective for the recipient in the past;

(3) for a child recipient, use a child-centered, family-driven, and culturally appropriate planning process that allows the recipient's parents and guardians to observe or participate in the recipient's individual and family treatment services, assessment, and treatment planning;

(4) for an adult recipient, use a person-centered, culturally appropriate planning process that allows the recipient's family and other natural supports to observe or participate in treatment services, assessment, and treatment planning;

(5) identify the participants involved in the recipient's treatment planning. The recipient, if possible, must be a participant;

(6) identify the recipient's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the recipient engage in treatment;

(7) include documentation of referral to and scheduling of services, including specific providers where applicable;

(8) ensure that the recipient or the recipient's legal guardian approves under section 245I.02, subdivision 2, of the recipient's crisis treatment plan unless a court orders the recipient's treatment plan under chapter 253B. If the recipient or the recipient's legal guardian disagrees with the crisis treatment plan, the license holder must document in the client file the reasons why the recipient disagrees with the crisis treatment plan; and

(9) ensure that a treatment supervisor approves under section 245I.02, subdivision 2, of the recipient's treatment plan within 24 hours of the recipient's admission if a mental health practitioner or clinical trainee completes the crisis treatment plan, notwithstanding section 245I.08, subdivision 3.

(b) The provider entity must provide the recipient and the recipient's legal guardian with a copy of the recipient's crisis treatment plan.

Subd. 12. **Excluded services.** The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) recipient transportation costs may be covered under other medical assistance provisions, but transportation services are not an adult mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide adult mental health crisis response services;

(5) services performed by volunteers;

(6) direct billing of time spent "on call" when not delivering services to a recipient;

(7) provider service time included in case management reimbursement. When a provider is eligible to provide more than one type of medical assistance service, the recipient must have a choice of provider for each service, unless otherwise provided for by law;

(8) outreach services to potential recipients; ~~and~~

(9) a mental health service that is not medically necessary~~.~~;

(10) services that a residential treatment center licensed under Minnesota Rules, chapter 2960, provides to a client;

(11) partial hospitalization or day treatment; and

(12) a crisis assessment that a residential provider completes when a daily rate is paid for the recipient's crisis stabilization.

ARTICLE 9

MENTAL HEALTH UNIFORM SERVICE STANDARDS: CONFORMING CHANGES

Section 1. Minnesota Statutes 2020, section 62A.152, subdivision 3, is amended to read:

Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber contracts that provide benefits for mental or nervous disorder treatments in a hospital must provide direct reimbursement for those services if performed by a mental health professional~~,~~ ~~as defined in sections 245.462, subdivision 18, clauses (1) to (5); and 245.4871, subdivision 27, clauses (1) to (5)~~ qualified according to section 245I.04, subdivision 2, to the extent that the services and treatment are within the scope of mental health professional licensure.

This subdivision is intended to provide payment of benefits for mental or nervous disorder treatments performed by a licensed mental health professional in a hospital and is not intended to change or add benefits for those services provided in policies or contracts to which this subdivision applies.

Sec. 2. Minnesota Statutes 2020, section 62A.3094, subdivision 1, is amended to read:

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

(b) "Autism spectrum disorders" means the conditions as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(c) "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing and preventative services. Medically necessary care must be consistent with generally accepted practice parameters as determined by physicians and licensed psychologists who typically manage patients who have autism spectrum disorders.

(d) "Mental health professional" means a mental health professional ~~as defined in section 245.4871, subdivision 27~~ qualified according to section 245I.04, subdivision 2, clause (1), (2), (3), (4), or (6), who has training and expertise in autism spectrum disorder and child development.

Sec. 3. Minnesota Statutes 2020, section 62Q.096, is amended to read:

62Q.096 CREDENTIALING OF PROVIDERS.

If a health plan company has initially credentialed, as providers in its provider network, individual providers employed by or under contract with an entity that:

(1) is authorized to bill under section 256B.0625, subdivision 5;

(2) ~~meets the requirements of Minnesota Rules, parts 9520.0750 to 9520.0870~~ is a mental health clinic certified under section 245I.20;

(3) is designated an essential community provider under section 62Q.19; and

(4) is under contract with the health plan company to provide mental health services, the health plan company must continue to credential at least the same number of providers from that entity, as long as those providers meet the health plan company's credentialing standards.

A health plan company shall not refuse to credential these providers on the grounds that their provider network has a sufficient number of providers of that type.

Sec. 4. Minnesota Statutes 2020, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under chapter 245G or 245I, or Minnesota Rules, parts 9530.6510 to 9530.6590.

Sec. 5. Minnesota Statutes 2020, section 144D.01, subdivision 4, is amended to read:

Subd. 4. **Housing with services establishment or establishment.** (a) "Housing with services establishment" or "establishment" means:

(1) an establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment; or

(2) an establishment that registers under section 144D.025.

(b) Housing with services establishment does not include:

(1) a nursing home licensed under chapter 144A;

(2) a hospital, certified boarding care home, or supervised living facility licensed under sections 144.50 to 144.56;

(3) a board and lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D ~~or~~, 245G, or 245I;

(4) a board and lodging establishment which serves as a shelter for battered women or other similar purpose;

(5) a family adult foster care home licensed by the Department of Human Services;

(6) private homes in which the residents are related by kinship, law, or affinity with the providers of services;

(7) residential settings for persons with developmental disabilities in which the services are licensed under chapter 245D;

(8) a home-sharing arrangement such as when an elderly or disabled person or single-parent family makes lodging in a private residence available to another person in exchange for services or rent, or both;

(9) a duly organized condominium, cooperative, common interest community, or owners' association of the foregoing where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(10) services for persons with developmental disabilities that are provided under a license under chapter 245D; or

(11) a temporary family health care dwelling as defined in sections 394.307 and 462.3593.

Sec. 6. Minnesota Statutes 2020, section 144G.08, subdivision 7, as amended by Laws 2020, Seventh Special Session chapter 1, article 6, section 5, is amended to read:

Subd. 7. **Assisted living facility.** "Assisted living facility" means a facility that provides sleeping accommodations and assisted living services to one or more adults. Assisted living facility includes assisted living facility with dementia care, and does not include:

(1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361;

(2) a nursing home licensed under chapter 144A;

(3) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56;

(4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D ~~or~~, 245G, or 245I;

(5) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D;

(6) a private home in which the residents are related by kinship, law, or affinity with the provider of services;

(7) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593;

(9) a setting offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing;

(10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services;

(11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q;

(12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56;

(13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011;

(14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b); or

(15) any establishment that exclusively or primarily serves as a shelter or temporary shelter for victims of domestic or any other form of violence.

Sec. 7. Minnesota Statutes 2020, section 148B.5301, subdivision 2, is amended to read:

Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed 4,000 hours of post-master's degree supervised professional practice in the delivery of

clinical services in the diagnosis and treatment of mental illnesses and disorders in both children and adults. The supervised practice shall be conducted according to the requirements in paragraphs (b) to (e).

(b) The supervision must have been received under a contract that defines clinical practice and supervision from a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~ qualified according to section 245I.04, subdivision 2, or by a board-approved supervisor, who has at least two years of postlicensure experience in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders. All supervisors must meet the supervisor requirements in Minnesota Rules, part 2150.5010.

(c) The supervision must be obtained at the rate of two hours of supervision per 40 hours of professional practice. The supervision must be evenly distributed over the course of the supervised professional practice. At least 75 percent of the required supervision hours must be received in person. The remaining 25 percent of the required hours may be received by telephone or by audio or audiovisual electronic device. At least 50 percent of the required hours of supervision must be received on an individual basis. The remaining 50 percent may be received in a group setting.

(d) The supervised practice must include at least 1,800 hours of clinical client contact.

(e) The supervised practice must be clinical practice. Supervision includes the observation by the supervisor of the successful application of professional counseling knowledge, skills, and values in the differential diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders.

Sec. 8. Minnesota Statutes 2020, section 148E.120, subdivision 2, is amended to read:

Subd. 2. **Alternate supervisors.** (a) The board may approve an alternate supervisor as determined in this subdivision. The board shall approve up to 25 percent of the required supervision hours by a ~~licensed~~ mental health professional who is competent and qualified to provide supervision according to the mental health professional's respective licensing board, as established by section ~~245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

(b) The board shall approve up to 100 percent of the required supervision hours by an alternate supervisor if the board determines that:

(1) there are five or fewer supervisors in the county where the licensee practices social work who meet the applicable licensure requirements in subdivision 1;

(2) the supervisor is an unlicensed social worker who is employed in, and provides the supervision in, a setting exempt from licensure by section 148E.065, and who has qualifications equivalent to the applicable requirements specified in sections 148E.100 to 148E.115;

(3) the supervisor is a social worker engaged in authorized social work practice in Iowa, Manitoba, North Dakota, Ontario, South Dakota, or Wisconsin, and has the qualifications equivalent to the applicable requirements in sections 148E.100 to 148E.115; or

(4) the applicant or licensee is engaged in nonclinical authorized social work practice outside of Minnesota and the supervisor meets the qualifications equivalent to the applicable requirements in sections 148E.100 to 148E.115, or the supervisor is an equivalent mental health professional, as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency; or

(5) the applicant or licensee is engaged in clinical authorized social work practice outside of Minnesota and the supervisor meets qualifications equivalent to the applicable requirements in section 148E.115, or the supervisor is an equivalent mental health professional as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency.

(c) In order for the board to consider an alternate supervisor under this section, the licensee must:

(1) request in the supervision plan and verification submitted according to section 148E.125 that an alternate supervisor conduct the supervision; and

(2) describe the proposed supervision and the name and qualifications of the proposed alternate supervisor. The board may audit the information provided to determine compliance with the requirements of this section.

Sec. 9. Minnesota Statutes 2020, section 148F.11, subdivision 1, is amended to read:

Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes, but is not limited to: licensed physicians; registered nurses; licensed practical nurses; licensed psychologists and licensed psychological practitioners; members of the clergy provided such services are provided within the scope of regular ministries; American Indian medicine men and women; licensed attorneys; probation officers; licensed marriage and family therapists; licensed social workers; social workers employed by city, county, or state agencies; licensed professional counselors; licensed professional

clinical counselors; licensed school counselors; registered occupational therapists or occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders (UMICAD) certified counselors when providing services to Native American people; city, county, or state employees when providing assessments or case management under Minnesota Rules, chapter 9530; and individuals defined in section 256B.0623, subdivision 5, paragraph (a), clauses (1) ~~and (2)~~ to (6), providing ~~integrated dual diagnosis~~ co-occurring substance use disorder treatment in adult mental health rehabilitative programs certified or licensed by the Department of Human Services under section 245I.23, 256B.0622, or 256B.0623.

(b) Nothing in this chapter prohibits technicians and resident managers in programs licensed by the Department of Human Services from discharging their duties as provided in Minnesota Rules, chapter 9530.

(c) Any person who is exempt from licensure under this section must not use a title incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug counselor" or otherwise hold himself or herself out to the public by any title or description stating or implying that he or she is engaged in the practice of alcohol and drug counseling, or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the use of one of the titles in paragraph (a).

Sec. 10. Minnesota Statutes 2020, section 245.462, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** The definitions in this section apply to sections 245.461 to ~~245.486~~ 245.4863.

Sec. 11. Minnesota Statutes 2020, section 245.462, subdivision 6, is amended to read:

Subd. 6. **Community support services program.** "Community support services program" means services, other than inpatient or residential treatment services, provided or coordinated by an identified program and staff under the ~~clinical~~ treatment supervision of a mental health professional designed to help adults with serious and persistent mental illness to function and remain in the community. A community support services program includes:

(1) client outreach,

(2) medication monitoring,

(3) assistance in independent living skills,

(4) development of employability and work-related opportunities,

(5) crisis assistance,

(6) psychosocial rehabilitation,

(7) help in applying for government benefits, and

(8) housing support services.

The community support services program must be coordinated with the case management services specified in section 245.4711.

Sec. 12. Minnesota Statutes 2020, section 245.462, subdivision 8, is amended to read:

Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means ~~a structured program of treatment and care provided to an adult in or by: (1) a hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (2) a community mental health center under section 245.62; or (3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least two days a week by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as part of the treatment process. The services are aimed at stabilizing the adult's mental health status, providing mental health services, and developing and improving the adult's independent living and socialization skills. The goal of day treatment is to reduce or relieve mental illness and to enable the adult to live in the community. Day treatment services are not a part of inpatient or residential treatment services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. The commissioner may limit medical assistance reimbursement for day treatment to 15 hours per week per person~~ the treatment services described under section 256B.0671, subdivision 3.

Sec. 13. Minnesota Statutes 2020, section 245.462, subdivision 9, is amended to read:

Subd. 9. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update~~ section 245I.10, subdivisions 4 to 6.

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~

~~(2) description of symptoms, including reason for referral;~~

~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~

~~(5) mental status examination.~~

~~(c) On the basis of the initial components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

~~(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3), unit (a), a brief diagnostic assessment may be used for a client's family who requires a language interpreter to participate in the assessment.~~

Sec. 14. Minnesota Statutes 2020, section 245.462, subdivision 14, is amended to read:

Subd. 14. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan of intervention, treatment, and services for an adult with mental illness that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. The plan identifies goals and objectives of treatment,~~

~~treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsible for providing treatment to the adult with mental illness~~ the formulation of planned services that are responsive to the needs and goals of a client. An individual treatment plan must be completed according to section 245I.10, subdivisions 7 and 8.

Sec. 15. Minnesota Statutes 2020, section 245.462, subdivision 16, is amended to read:

Subd. 16. **Mental health funds.** "Mental health funds" are funds expended under sections 245.73 and 256E.12, federal mental health block grant funds, and funds expended under section 256D.06 to facilities licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670.

Sec. 16. Minnesota Statutes 2020, section 245.462, subdivision 17, is amended to read:

Subd. 17. **Mental health practitioner.** ~~(a)~~ "Mental health practitioner" means a staff person ~~providing services to adults with mental illness or children with emotional disturbance who is qualified in at least one of the ways described in paragraphs (b) to (g). A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults~~ qualified according to section 245I.04, subdivision 4.

~~(b) For purposes of this subdivision, a practitioner is qualified through relevant coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:~~

~~(1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects;~~

~~(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to adults with mental illness or children with emotional disturbance, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;~~

~~(3) is working in a day treatment program under section 245.4712, subdivision 2; or~~

~~(4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(c) For purposes of this subdivision, a practitioner is qualified through work experience if the person:~~

~~(1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; or~~

~~(2) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, emotional disturbance, or substance use disorder, and receives clinical supervision as required by applicable statutes and rules from a mental health professional at least once a week until the requirement of 4,000 hours of supervised experience is met; or~~

~~(ii) traumatic brain injury or developmental disabilities; completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; and receives clinical supervision as required by applicable statutes and rules at least once a week from a mental health professional until the requirement of 4,000 hours of supervised experience is met.~~

~~(d) For purposes of this subdivision, a practitioner is qualified through a graduate student internship if the practitioner is a graduate student in behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training.~~

~~(e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's degree if the practitioner:~~

~~(1) holds a master's or other graduate degree in behavioral sciences or related fields; or~~

~~(2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical care if the practitioner meets the definition of vendor of medical care in section 256B.02, subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.~~

~~(g) For purposes of medical assistance coverage of diagnostic assessments, explanations of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health practitioner working as a clinical trainee means that the practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of direct practice, treatment team collaboration, continued professional learning, and job management. The practitioner must also:~~

~~(1) comply with requirements for licensure or board certification as a mental health professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or~~

~~(2) be a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.~~

~~(h) For purposes of this subdivision, "behavioral sciences or related fields" has the meaning given in section 256B.0623, subdivision 5, paragraph (d).~~

~~(i) Notwithstanding the licensing requirements established by a health-related licensing board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other statute or rule.~~

Sec. 17. Minnesota Statutes 2020, section 245.462, subdivision 18, is amended to read:

Subd. 18. **Mental health professional.** "Mental health professional" means a staff person ~~providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:~~ qualified according to section 245I.04, subdivision 2.

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

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

~~(ii) who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours~~

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

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

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

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

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

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

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

Sec. 18. Minnesota Statutes 2020, section 245.462, subdivision 21, is amended to read:

Subd. 21. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the ~~clinical~~ treatment supervision of a mental health professional to adults with mental illness who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 19. Minnesota Statutes 2020, section 245.462, subdivision 23, is amended to read:

Subd. 23. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the ~~clinical~~ treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for adults with mental illness under chapter 245I, Minnesota Rules, parts 9520.0500 to 9520.0670, or other rules adopted by the commissioner.

Sec. 20. Minnesota Statutes 2020, section 245.462, is amended by adding a subdivision to read:

Subd. 27. **Treatment supervision.** "Treatment supervision" means the treatment supervision described under section 245I.06.

Sec. 21. Minnesota Statutes 2020, section 245.4661, subdivision 5, is amended to read:

Subd. 5. **Planning for pilot projects.** (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), 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 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.

(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 ~~section 256B.0622, subdivision 2, paragraph (b)~~ chapter 245I.

Sec. 22. Minnesota Statutes 2020, section 245.4662, subdivision 1, is amended to read:

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

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

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

(d) "Intensive residential treatment services" has the meaning given in section 256B.0622~~, subdivision 2~~.

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

Sec. 23. Minnesota Statutes 2020, section 245.467, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~All providers of residential, acute care hospital inpatient, and regional treatment centers must complete a diagnostic assessment for each of their clients within five days of admission. Providers of day treatment services must complete a diagnostic assessment within five days after the adult's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within three years preceding admission, only an adult diagnostic assessment update is necessary. An "adult diagnostic assessment update" means a written summary by a mental health professional of the adult's current mental health status and service needs and includes a face-to-face interview with the adult. If the adult's mental health status has changed markedly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.~~ Providers of services governed by this section must complete a diagnostic assessment according to the standards of section 245I.10, subdivisions 4 to 6.

Sec. 24. Minnesota Statutes 2020, section 245.467, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment services, residential treatment, acute care hospital inpatient treatment, and all regional treatment centers must develop an individual treatment plan for each of their adult clients. The individual treatment plan must be based on a diagnostic assessment. To the extent possible, the adult client shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment and acute care hospital inpatient treatment, and all regional treatment centers must develop the individual treatment plan within ten days of client intake and must review the individual treatment plan every 90 days after intake. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or~~

~~within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Outpatient and day treatment services providers must review the individual treatment plan every 90 days after intake.~~ Providers of services governed by this section must complete an individual treatment plan according to the standards of section 245I.10, subdivisions 7 and 8.

Sec. 25. Minnesota Statutes 2020, section 245.470, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of adults with mental illness residing in the county. Services may be provided directly by the county through county-operated ~~mental health centers or~~ mental health clinics ~~approved by the commissioner under section 245.69, subdivision 2~~ meeting the standards of chapter 245I; by contract with privately operated ~~mental health centers or~~ mental health clinics ~~approved by the commissioner under section 245.69, subdivision 2~~ meeting the standards of chapter 245I; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a ~~licensed~~ mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~. Clients may be required to pay a fee according to section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating an adult's mental health needs through therapy;

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication; and

(7) preventing placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the client can best be served outside the county.

Sec. 26. Minnesota Statutes 2020, section 245.4712, subdivision 2, is amended to read:

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be developed as a part of the community support services available to adults with serious and persistent mental illness residing in the county. Adults may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client need;

(4) coordinate with or be offered in conjunction with a local education agency's special education program; and

(5) operate on a continuous basis throughout the year.

(b) ~~For purposes of complying with medical assistance requirements, an adult day treatment program must comply with the method of clinical supervision specified in Minnesota Rules, part 9505.0371, subpart 4. The clinical supervision must be performed by a qualified supervisor who satisfies the requirements of Minnesota Rules, part 9505.0371, subpart 5.~~ An adult day treatment program must comply with medical assistance requirements in section 256B.0671, subdivision 3.

~~A day treatment program must demonstrate compliance with this clinical supervision requirement by the commissioner's review and approval of the program according to Minnesota Rules, part 9505.0372, subpart 8.~~

(c) County boards may request a waiver from including day treatment services if they can document that:

(1) an alternative plan of care exists through the county's community support services for clients who would otherwise need day treatment services;

(2) day treatment, if included, would be duplicative of other components of the community support services; and

(3) county demographics and geography make the provision of day treatment services cost ineffective and infeasible.

Sec. 27. Minnesota Statutes 2020, section 245.472, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** Providers of residential services must be licensed under chapter 245I or applicable rules adopted by the commissioner ~~and must be clinically supervised by a mental health professional. Persons employed in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, in the capacity of program director as of July 1, 1987, in accordance with Minnesota Rules, parts 9520.0500 to 9520.0670, may be allowed to continue providing clinical supervision within a facility, provided they continue to be employed as a program director in a facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670~~. Residential services must be provided under treatment supervision.

Sec. 28. Minnesota Statutes 2020, section 245.4863, is amended to read:

245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.

(a) The commissioner shall require individuals who perform chemical dependency assessments to screen clients for co-occurring mental health disorders, and staff who perform mental health diagnostic assessments to screen for co-occurring substance use disorders. Screening tools must be approved by the commissioner. If a client screens positive for a co-occurring mental health or substance use disorder, the individual performing the screening must document what actions will be taken in response to the results and whether further assessments must be performed.

(b) Notwithstanding paragraph (a), screening is not required when:

(1) the presence of co-occurring disorders was documented for the client in the past 12 months;

(2) the client is currently receiving co-occurring disorders treatment;

(3) the client is being referred for co-occurring disorders treatment; or

(4) a mental health professional~~, as defined in Minnesota Rules, part 9505.0370, subpart 18,~~ who is competent to perform diagnostic assessments of co-occurring disorders is performing a diagnostic assessment ~~that meets the requirements in Minnesota Rules, part 9533.0090, subpart 5,~~ to identify whether the client may have co-occurring mental health and chemical dependency disorders. If an individual is identified to have co-occurring mental health and substance use disorders, the assessing mental health professional must document what actions will be taken to address the client's co-occurring disorders.

(c) The commissioner shall adopt rules as necessary to implement this section. The commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing

a certification process for integrated dual disorder treatment providers and a system through which individuals receive integrated dual diagnosis treatment if assessed as having both a substance use disorder and either a serious mental illness or emotional disturbance.

(d) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of integrated dual diagnosis treatment to persons with co-occurring disorders.

Sec. 29. Minnesota Statutes 2020, section 245.4871, subdivision 9a, is amended to read:

Subd. 9a. **Crisis ~~assistance~~ planning.** "Crisis ~~assistance~~ planning" means ~~assistance to the child, the child's family, and all providers of services to the child to: recognize factors precipitating a mental health crisis, identify behaviors related to the crisis, and be informed of available resources to resolve the crisis. Crisis assistance requires the development of a plan which addresses prevention and intervention strategies to be used in a potential crisis. Other interventions include: (1) arranging for admission to acute care hospital inpatient treatment~~ the development of a written plan to assist a child's family in preventing and addressing a potential crisis and is distinct from the immediate provision of mental health crisis services as defined in section 256B.0624. The plan must address prevention, deescalation, and intervention strategies to be used in a crisis. The plan identifies factors that might precipitate a crisis, behaviors or symptoms related to the emergence of a crisis, and the resources available to resolve a crisis. The plan must address the following potential needs: (1) acute care; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis. Crisis ~~assistance~~ planning does not include services designed to secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.

Sec. 30. Minnesota Statutes 2020, section 245.4871, subdivision 10, is amended to read:

Subd. 10. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to a child in:

(1) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 245.62;

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475; ~~or~~

(4) an entity that operates a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract with an entity that is under contract with a county board~~.~~; and

(5) a program certified under section 256B.0943.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum two-hour time block by a multidisciplinary staff under the ~~clinical~~ treatment supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as an extension of the treatment process. The services are aimed at stabilizing the child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. Day treatment services are not a part of inpatient hospital or residential treatment services.

A day treatment service must be available to a child up to 15 hours a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

Sec. 31. Minnesota Statutes 2020, section 245.4871, subdivision 11a, is amended to read:

Subd. 11a. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update~~ section 245I.10, subdivisions 4 to 6.

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~

~~(2) description of symptoms, including reason for referral;~~

~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~

~~(5) mental status examination.~~

~~(c) On the basis of the brief components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

Sec. 32. Minnesota Statutes 2020, section 245.4871, subdivision 17, is amended to read:

Subd. 17. **Family community support services.** "Family community support services" means services provided under the ~~clinical~~ treatment supervision of a mental health professional and designed to help each child with severe emotional disturbance to function and remain with the child's family in the community. Family community support services do not include acute care hospital inpatient treatment, residential treatment services, or regional treatment center services. Family community support services include:

(1) client outreach to each child with severe emotional disturbance and the child's family;

(2) medication monitoring where necessary;

(3) assistance in developing independent living skills;

(4) assistance in developing parenting skills necessary to address the needs of the child with severe emotional disturbance;

(5) assistance with leisure and recreational activities;

(6) crisis ~~assistance~~ planning, including crisis placement and respite care;

(7) professional home-based family treatment;

(8) foster care with therapeutic supports;

(9) day treatment;

(10) assistance in locating respite care and special needs day care; and

(11) assistance in obtaining potential financial resources, including those benefits listed in section 245.4884, subdivision 5.

Sec. 33. Minnesota Statutes 2020, section 245.4871, subdivision 21, is amended to read:

Subd. 21. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan of intervention, treatment, and services for a child with an emotional disturbance that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. An individual treatment plan for a child must be developed in conjunction with the family unless clinically inappropriate. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment to the child with an emotional disturbance~~ the formulation of planned services that are responsive to the needs and goals of a client. An individual treatment plan must be completed according to section 245I.10, subdivisions 7 and 8.

Sec. 34. Minnesota Statutes 2020, section 245.4871, subdivision 26, is amended to read:

Subd. 26. **Mental health practitioner.** "Mental health practitioner" ~~has the meaning given in section 245.462, subdivision 17~~ means a staff person who is qualified according to section 245I.04, subdivision 4.

Sec. 35. Minnesota Statutes 2020, section 245.4871, subdivision 27, is amended to read:

Subd. 27. **Mental health professional.** "Mental health professional" means a staff person ~~providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:~~ qualified according to section 245I.04, subdivision 2.

~~(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification~~

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

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

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

~~(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

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

~~(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or~~

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

Sec. 36. Minnesota Statutes 2020, section 245.4871, subdivision 29, is amended to read:

Subd. 29. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the ~~clinical~~ treatment supervision of a mental health professional to children with emotional

disturbances who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 37. Minnesota Statutes 2020, section 245.4871, subdivision 31, is amended to read:

Subd. 31. **Professional home-based family treatment.** "Professional home-based family treatment" means intensive mental health services provided to children because of an emotional disturbance (1) who are at risk of out-of-home placement; (2) who are in out-of-home placement; or (3) who are returning from out-of-home placement. Services are provided to the child and the child's family primarily in the child's home environment. Services may also be provided in the child's school, child care setting, or other community setting appropriate to the child. Services must be provided on an individual family basis, must be child-oriented and family-oriented, and must be designed using information from diagnostic and functional assessments to meet the specific mental health needs of the child and the child's family. Examples of services are: (1) individual therapy; (2) family therapy; (3) client outreach; (4) assistance in developing individual living skills; (5) assistance in developing parenting skills necessary to address the needs of the child; (6) assistance with leisure and recreational services; (7) crisis ~~assistance~~ planning, including crisis respite care and arranging for crisis placement; and (8) assistance in locating respite and child care. Services must be coordinated with other services provided to the child and family.

Sec. 38. Minnesota Statutes 2020, section 245.4871, subdivision 32, is amended to read:

Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the ~~clinical~~ treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for children with emotional disturbances under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted by the commissioner.

Sec. 39. Minnesota Statutes 2020, section 245.4871, subdivision 34, is amended to read:

Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care" means the mental health training and mental health support services and ~~clinical~~ treatment supervision provided by a mental health professional to foster families caring for children with severe emotional disturbance to provide a therapeutic family environment and support for the child's improved functioning. Therapeutic support of foster care includes services provided under section 256B.0946.

Sec. 40. Minnesota Statutes 2020, section 245.4871, is amended by adding a subdivision to read:

Subd. 36. **Treatment supervision.** "Treatment supervision" means the treatment supervision described under section 245I.06.

Sec. 41. Minnesota Statutes 2020, section 245.4876, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~All residential treatment facilities and acute care hospital inpatient treatment facilities that provide mental health services for children must complete a diagnostic assessment for each of their child clients within five working days of admission. Providers of day treatment services for children must complete a diagnostic assessment within five days after the child's second visit or 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within 180 days preceding admission, only updating is necessary. "Updating" means a written summary by a mental health professional of the child's current mental health status and service needs. If the child's mental health status has changed markedly since the child's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.~~ Providers of services governed by this section shall complete a diagnostic assessment according to the standards of section 245I.10, subdivisions 4 to 6.

Sec. 42. Minnesota Statutes 2020, section 245.4876, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment services, professional home-based family treatment, residential treatment, and acute care hospital inpatient treatment, and all regional treatment centers that provide mental health services for children must develop an individual treatment plan for each child client. The individual treatment plan must be based on a diagnostic assessment. To the extent appropriate, the child and the child's family shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment, professional home-based family treatment, and acute care hospital inpatient treatment, and regional treatment centers must develop the individual treatment plan within ten working days of client intake or admission and must review the individual treatment plan every 90 days after intake, except that the administrative review of the treatment plan of a child placed in a residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9. Providers of day treatment services must develop the individual treatment plan before the~~

~~completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Providers of outpatient and day treatment services must review the individual treatment plan every 90 days after intake.~~ Providers of services governed by this section shall complete an individual treatment plan according to the standards of section 245I.10, subdivisions 7 and 8.

Sec. 43. Minnesota Statutes 2020, section 245.488, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of each child with emotional disturbance residing in the county and the child's family. Services may be provided directly by the county through county-operated ~~mental health centers or~~ mental health clinics ~~approved by the commissioner under section 245.69, subdivision 2~~ meeting the standards of chapter 245I; by contract with privately operated ~~mental health centers or~~ mental health clinics ~~approved by the commissioner under section 245.69, subdivision 2~~ meeting the standards of chapter 245I; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a ~~licensed~~ mental health professional ~~as defined in section 245.4871, subdivision 27, clauses (1) to (6)~~. A child or a child's parent may be required to pay a fee based in accordance with section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating the child's mental health needs through therapy; and

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication.

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

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

Sec. 44. Minnesota Statutes 2020, section 245.4901, subdivision 2, is amended to read:

Subd. 2. **Eligible applicants.** An eligible applicant for school-linked mental health grants is an entity that is:

(1) a mental health clinic certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20;

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

(3) an Indian health service facility or a facility owned and operated by a tribe or tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943; or

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals qualified according to section ~~245I.16~~ 245I.04, subdivision 2, or two alcohol and drug counselors licensed or exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families.

Sec. 45. Minnesota Statutes 2020, section 245.62, subdivision 2, is amended to read:

Subd. 2. **Definition.** A community mental health center is a private nonprofit corporation or public agency approved under the ~~rules promulgated by the commissioner pursuant to subdivision 4~~ standards of section 256B.0625, subdivision 5.

Sec. 46. Minnesota Statutes 2020, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification process for certified community behavioral health clinics (CCBHCs). Entities that choose to be CCBHCs must:

(1) comply with the CCBHC criteria published by the United States Department of Health and Human Services;

(2) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors,

and staff who are culturally and linguistically trained to meet the needs of the population the clinic serves;

(3) ensure that clinic services are available and accessible to individuals and families of all ages and genders and that crisis management services are available 24 hours per day;

(4) establish fees for clinic services for individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to an individual's inability to pay for services;

(5) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

(6) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans;

(7) provide coordination of care across settings and providers to ensure seamless transitions for individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be ~~certified as~~ mental health clinics ~~under section 245.69, subdivision 2~~ meeting the standards of chapter 245I;

(9) ~~comply with standards relating to mental health services in Minnesota Rules, parts 9505.0370 to 9505.0372~~ be a co-occurring disorder specialist;

(10) be licensed to provide substance use disorder treatment under chapter 245G;

(11) be certified to provide children's therapeutic services and supports under section 256B.0943;

(12) be certified to provide adult rehabilitative mental health services under section 256B.0623;

(13) be enrolled to provide mental health crisis response services under ~~sections~~ section 256B.0624 ~~and 256B.0944~~;

(14) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

(15) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926;

(16) provide services that comply with the evidence-based practices described in paragraph (e); and

(17) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer services are provided.

(b) If an entity is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has a current contract with another entity that has the required authority to provide that service and that meets federal CCBHC criteria as a designated collaborating organization, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under section 256B.0625, subdivision 5m, for those services without a county contract or county approval. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

(f) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

Sec. 47. Minnesota Statutes 2020, section 245A.04, subdivision 5, is amended to read:

Subd. 5. **Commissioner's right of access.** (a) When the commissioner is exercising the powers conferred by this chapter, ~~sections 245.69 and~~ section 626.557, and chapter 260E, the commissioner must be given access to:

(1) the physical plant and grounds where the program is provided;

(2) documents and records, including records maintained in electronic format;

(3) persons served by the program; and

(4) staff and personnel records of current and former staff whenever the program is in operation and the information is relevant to inspections or investigations conducted by the

commissioner. Upon request, the license holder must provide the commissioner verification of documentation of staff work experience, training, or educational requirements.

The commissioner must be given access without prior notice and as often as the commissioner considers necessary if the commissioner is investigating alleged maltreatment, conducting a licensing inspection, or investigating an alleged violation of applicable laws or rules. In conducting inspections, the commissioner may request and shall receive assistance from other state, county, and municipal governmental agencies and departments. The applicant or license holder shall allow the commissioner to photocopy, photograph, and make audio and video tape recordings during the inspection of the program at the commissioner's expense. The commissioner shall obtain a court order or the consent of the subject of the records or the parents or legal guardian of the subject before photocopying hospital medical records.

(b) Persons served by the program have the right to refuse to consent to be interviewed, photographed, or audio or videotaped. Failure or refusal of an applicant or license holder to fully comply with this subdivision is reasonable cause for the commissioner to deny the application or immediately suspend or revoke the license.

Sec. 48. Minnesota Statutes 2020, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600
125 to 149 persons	$700
150 to 174 persons	$800
175 to 199 persons	$900
200 to 224 persons	$1,000
225 or more persons	$1,100

(b)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee based on revenues derived from

the provision of services that would require licensure under chapter 245D during the calendar year immediately preceding the year in which the license fee is paid, according to the following schedule:

License Holder Annual Revenue	License Fee
less than or equal to $10,000	$200
greater than $10,000 but less than or equal to $25,000	$300
greater than $25,000 but less than or equal to $50,000	$400
greater than $50,000 but less than or equal to $100,000	$500
greater than $100,000 but less than or equal to $150,000	$600
greater than $150,000 but less than or equal to $200,000	$800
greater than $200,000 but less than or equal to $250,000	$1,000
greater than $250,000 but less than or equal to $300,000	$1,200
greater than $300,000 but less than or equal to $350,000	$1,400
greater than $350,000 but less than or equal to $400,000	$1,600
greater than $400,000 but less than or equal to $450,000	$1,800
greater than $450,000 but less than or equal to $500,000	$2,000
greater than $500,000 but less than or equal to $600,000	$2,250
greater than $600,000 but less than or equal to $700,000	$2,500
greater than $700,000 but less than or equal to $800,000	$2,750
greater than $800,000 but less than or equal to $900,000	$3,000
greater than $900,000 but less than or equal to $1,000,000	$3,250
greater than $1,000,000 but less than or equal to $1,250,000	$3,500
greater than $1,250,000 but less than or equal to $1,500,000	$3,750
greater than $1,500,000 but less than or equal to $1,750,000	$4,000

greater than $1,750,000 but less than or equal to $2,000,000	$4,250
greater than $2,000,000 but less than or equal to $2,500,000	$4,500
greater than $2,500,000 but less than or equal to $3,000,000	$4,750
greater than $3,000,000 but less than or equal to $3,500,000	$5,000
greater than $3,500,000 but less than or equal to $4,000,000	$5,500
greater than $4,000,000 but less than or equal to $4,500,000	$6,000
greater than $4,500,000 but less than or equal to $5,000,000	$6,500
greater than $5,000,000 but less than or equal to $7,500,000	$7,000
greater than $7,500,000 but less than or equal to $10,000,000	$8,500
greater than $10,000,000 but less than or equal to $12,500,000	$10,000
greater than $12,500,000 but less than or equal to $15,000,000	$14,000
greater than $15,000,000	$18,000

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(5) Notwithstanding clause (1), a license holder providing services under one or more licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license holder for all licenses held under chapter 245B for calendar year 2013. For calendar year 2017 and thereafter, the license holder shall pay an annual license fee according to clause (1).

(c) A chemical dependency treatment program licensed under chapter 245G, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

(d) A chemical dependency program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

(e) Except for child foster care, a residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

(f) A residential facility licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

(g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(h) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of $1,500.

(i) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

(j) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900
75 to 99 persons	$1,100
100 or more persons	$1,300

(k) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(l) A ~~mental health center or~~ mental health clinic requesting certification ~~for purposes of insurance and subscriber contract reimbursement~~ under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20, shall pay a certification fee of $1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

Sec. 49. Minnesota Statutes 2020, section 245A.65, subdivision 2, is amended to read:

Subd. 2. **Abuse prevention plans.** All license holders shall establish and enforce ongoing written program abuse prevention plans and individual abuse prevention plans as required under section 626.557, subdivision 14.

(a) The scope of the program abuse prevention plan is limited to the population, physical plant, and environment within the control of the license holder and the location where licensed services are provided. In addition to the requirements in section 626.557, subdivision 14, the program abuse prevention plan shall meet the requirements in clauses (1) to (5).

(1) The assessment of the population shall include an evaluation of the following factors: age, gender, mental functioning, physical and emotional health or behavior of the client; the need for specialized programs of care for clients; the need for training of staff to meet identified individual needs; and the knowledge a license holder may have regarding previous abuse that is relevant to minimizing risk of abuse for clients.

(2) The assessment of the physical plant where the licensed services are provided shall include an evaluation of the following factors: the condition and design of the building as it relates to the safety of the clients; and the existence of areas in the building which are difficult to supervise.

(3) The assessment of the environment for each facility and for each site when living arrangements are provided by the agency shall include an evaluation of the following factors: the location of the program in a particular neighborhood or community; the type of grounds and terrain surrounding the building; the type of internal programming; and the program's staffing patterns.

(4) The license holder shall provide an orientation to the program abuse prevention plan for clients receiving services. If applicable, the client's legal representative must be notified of the orientation. The license holder shall provide this orientation for each new person within 24 hours of admission, or for persons who would benefit more from a later orientation, the orientation may take place within 72 hours.

(5) The license holder's governing body or the governing body's delegated representative shall review the plan at least annually using the assessment factors in the plan and any substantiated maltreatment findings that occurred since the last review. The governing body or the governing body's delegated representative shall revise the plan, if necessary, to reflect the review results.

(6) A copy of the program abuse prevention plan shall be posted in a prominent location in the program and be available upon request to mandated reporters, persons receiving services, and legal representatives.

(b) In addition to the requirements in section 626.557, subdivision 14, the individual abuse prevention plan shall meet the requirements in clauses (1) and (2).

(1) The plan shall include a statement of measures that will be taken to minimize the risk of abuse to the vulnerable adult when the individual assessment required in section 626.557, subdivision 14, paragraph (b), indicates the need for measures in addition to the specific measures identified in the program abuse prevention plan. The measures shall include the specific actions the program will take to minimize the risk of abuse within the scope of the licensed services, and will identify referrals made when the vulnerable adult is susceptible to abuse outside the scope or control of the licensed services. When the assessment indicates that the vulnerable adult does not need specific risk reduction measures in addition to those identified in the program abuse prevention plan, the individual abuse prevention plan shall document this determination.

(2) An individual abuse prevention plan shall be developed for each new person as part of the initial individual program plan or service plan required under the applicable licensing rule or statute. The review and evaluation of the individual abuse prevention plan shall be done as part of the review of the program plan ~~or~~, service plan, or treatment plan. The person receiving services shall participate in the development of the individual abuse prevention plan to the full extent of the person's abilities. If applicable, the person's legal representative shall be given the opportunity to participate with or for the person in the development of the plan. The interdisciplinary team shall document the review of all abuse prevention plans at least annually, using the individual assessment and any reports of abuse relating to the person. The plan shall be revised to reflect the results of this review.

Sec. 50. Minnesota Statutes 2020, section 245D.02, subdivision 20, is amended to read:

Subd. 20. **Mental health crisis intervention team.** "Mental health crisis intervention team" means a mental health crisis response provider as identified in section 256B.0624~~, subdivision 2, paragraph (d), for adults, and in section 256B.0944, subdivision 1, paragraph (d), for children~~.

Sec. 51. Minnesota Statutes 2020, section 256B.0615, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist services, as established in subdivision 2, subject to federal approval, if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and are provided by a mental health certified peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 10.

Sec. 52. Minnesota Statutes 2020, section 256B.0615, subdivision 5, is amended to read:

Subd. 5. **Certified peer specialist training and certification.** The commissioner of human services shall develop a training and certification process for certified peer specialists~~,~~ ~~who must be at least 21 years of age~~. The candidates must have had a primary diagnosis of mental illness, be a current or former consumer of mental health services, and must demonstrate leadership and advocacy skills and a strong dedication to recovery. The training curriculum must teach participating consumers specific skills relevant to providing peer support to other consumers. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to peer support counseling.

Sec. 53. Minnesota Statutes 2020, section 256B.0616, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services, as established in subdivision 2, subject to federal approval, if provided to recipients who have an emotional disturbance or severe emotional disturbance under chapter 245, and are provided by a mental health certified family peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 12. A family peer specialist cannot provide services to the peer specialist's family.

Sec. 54. Minnesota Statutes 2020, section 256B.0616, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** Family peer support services may be ~~located in~~ provided to recipients of inpatient hospitalization, partial hospitalization, residential treatment, intensive treatment in foster care, day treatment, children's therapeutic services and supports, or crisis services.

Sec. 55. Minnesota Statutes 2020, section 256B.0616, subdivision 5, is amended to read:

Subd. 5. **Certified family peer specialist training and certification.** The commissioner shall develop a training and certification process for certified family peer specialists ~~who must be at least 21 years of age~~. The candidates must have raised or be currently raising a child with a mental illness, have had experience navigating the children's mental health system, and must demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach participating family peer specialists specific skills relevant to providing peer support to other parents. In addition to initial training and certification, the commissioner shall develop ongoing

continuing educational workshops on pertinent issues related to family peer support counseling.

Sec. 56. Minnesota Statutes 2020, section 256B.0622, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically necessary, assertive community treatment ~~for clients as defined in subdivision 2a and intensive residential treatment services for clients as defined in subdivision 3,~~ when the services are provided by an entity certified under and meeting the standards in this section.

(b) Subject to federal approval, medical assistance covers medically necessary, intensive residential treatment services when the services are provided by an entity licensed under and meeting the standards in section 245I.23.

(c) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Sec. 57. Minnesota Statutes 2020, section 256B.0622, subdivision 2, is amended to read:

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

(b) "ACT team" means the group of interdisciplinary mental health staff who work as a team to provide assertive community treatment.

(c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per day, seven days per week, in a community-based setting.

(d) "Individual treatment plan" means ~~the document that results from a person-centered planning process of determining real-life outcomes with clients and developing strategies to achieve those outcomes~~ a plan described under section 245I.10, subdivisions 7 and 8.

~~(e) "Assertive engagement" means the use of collaborative strategies to engage clients to receive services.~~

~~(f) "Benefits and finance support" means assisting clients in capably managing financial affairs. Services include, but are not limited to, assisting clients in applying for benefits; assisting with redetermination of benefits; providing financial crisis management; teaching~~

~~and supporting budgeting skills and asset development; and coordinating with a client's representative payee, if applicable.~~

~~(g) "Co-occurring disorder treatment" means the treatment of co-occurring mental illness and substance use disorders and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment. Services include, but are not limited to, assessing and tracking clients' stages of change readiness and treatment; applying the appropriate treatment based on stages of change, such as outreach and motivational interviewing techniques to work with clients in earlier stages of change readiness and cognitive behavioral approaches and relapse prevention to work with clients in later stages of change; and facilitating access to community supports.~~

~~(h)~~ (e) "Crisis assessment and intervention" means mental health crisis response services as defined in section 256B.0624, subdivision 2~~, paragraphs (c) to (e)~~.

~~(i) "Employment services" means assisting clients to work at jobs of their choosing. Services must follow the principles of the individual placement and support (IPS) employment model, including focusing on competitive employment; emphasizing individual client preferences and strengths; ensuring employment services are integrated with mental health services; conducting rapid job searches and systematic job development according to client preferences and choices; providing benefits counseling; and offering all services in an individualized and time-unlimited manner. Services shall also include educating clients about opportunities and benefits of work and school and assisting the client in learning job skills, navigating the work place, and managing work relationships.~~

~~(j) "Family psychoeducation and support" means services provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include, but are not limited to, individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent.~~

~~(k) "Housing access support" means assisting clients to find, obtain, retain, and move to safe and adequate housing of their choice. Housing access support includes, but is not limited to, locating housing options with a focus on integrated independent settings; applying for housing subsidies, programs, or resources; assisting the client in developing relationships with local landlords; providing tenancy support and advocacy for the individual's tenancy rights at the client's home; and assisting with relocation.~~

~~(l)~~ (f) "Individual treatment team" means a minimum of three members of the ACT team who are responsible for consistently carrying out most of a client's assertive community treatment services.

~~(m) "Intensive residential treatment services treatment team" means all staff who provide intensive residential treatment services under this section to clients. At a minimum, this includes the clinical supervisor; mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision 5, paragraph (a), clause (4); and mental health certified peer specialists under section 256B.0615.~~

~~(n) "Intensive residential treatment services" means short-term, time-limited services provided in a residential setting to clients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes.~~

~~(o) "Medication assistance and support" means assisting clients in accessing medication, developing the ability to take medications with greater independence, and providing medication setup. This includes the prescription, administration, and order of medication by appropriate medical staff.~~

~~(p) "Medication education" means educating clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications.~~

~~(q) "Overnight staff" means a member of the intensive residential treatment services team who is responsible during hours when clients are typically asleep.~~

~~(r) "Mental health certified peer specialist services" has the meaning given in section 256B.0615.~~

~~(s) "Physical health services" means any service or treatment to meet the physical health needs of the client to support the client's mental health recovery. Services include, but are not limited to, education on primary health issues, including wellness education; medication administration and monitoring; providing and coordinating medical screening and follow-up; scheduling routine and acute medical and dental care visits; tobacco cessation strategies; assisting clients in attending appointments; communicating with other providers; and integrating all physical and mental health treatment.~~

~~(t)~~ (g) "Primary team member" means the person who leads and coordinates the activities of the individual treatment team and is the individual treatment team member who has primary responsibility for establishing and maintaining a therapeutic relationship with the client on a continuing basis.

~~(u) "Rehabilitative mental health services" means mental health services that are rehabilitative and enable the client to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness.~~

~~(v) "Symptom management" means supporting clients in identifying and targeting the symptoms and occurrence patterns of their mental illness and developing strategies to reduce the impact of those symptoms.~~

~~(w) "Therapeutic interventions" means empirically supported techniques to address specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms. Interventions include empirically supported psychotherapies including, but not limited to, cognitive behavioral therapy, exposure therapy, acceptance and commitment therapy, interpersonal therapy, and motivational interviewing.~~

~~(x) "Wellness self-management and prevention" means a combination of approaches to working with the client to build and apply skills related to recovery, and to support the client in participating in leisure and recreational activities, civic participation, and meaningful structure.~~

(h) "Certified rehabilitation specialist" means a staff person who is qualified according to section 245I.04, subdivision 8.

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

(j) "Mental health certified peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 10.

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

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

(m) "Mental health rehabilitation worker" means a staff person who is qualified according to section 245I.04, subdivision 14.

Sec. 58. Minnesota Statutes 2020, section 256B.0622, subdivision 3a, is amended to read:

Subd. 3a. **Provider certification and contract requirements for assertive community treatment.** (a) The assertive community treatment provider must:

(1) have a contract with the host county to provide assertive community treatment services; and

(2) have each ACT team be certified by the state following the certification process and procedures developed by the commissioner. The certification process determines whether the ACT team meets the standards for assertive community treatment under this section ~~as well as~~, the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum program fidelity standards as measured by a nationally recognized fidelity tool approved by the commissioner. Recertification must occur at least every three years.

(b) An ACT team certified under this subdivision must meet the following standards:

(1) have capacity to recruit, hire, manage, and train required ACT team members;

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

~~(3) ensure adequate preservice and ongoing training for staff;~~

~~(4) ensure that staff is capable of implementing culturally specific services that are culturally responsive and appropriate as determined by the client's culture, beliefs, values, and language as identified in the individual treatment plan;~~

~~(5)~~ (3) ensure flexibility in service delivery to respond to the changing and intermittent care needs of a client as identified by the client and the individual treatment plan;

~~(6) develop and maintain client files, individual treatment plans, and contact charting;~~

~~(7) develop and maintain staff training and personnel files;~~

~~(8) submit information as required by the state;~~

~~(9)~~ (4) keep all necessary records required by law;

~~(10) comply with all applicable laws;~~

~~(11)~~ (5) be an enrolled Medicaid provider; and

~~(12)~~ (6) establish and maintain a quality assurance plan to determine specific service outcomes and the client's satisfaction with services~~; and~~.

~~(13) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.~~

(c) The commissioner may intervene at any time and decertify an ACT team with cause. The commissioner shall establish a process for decertification of an ACT team and shall require corrective action, medical assistance repayment, or decertification of an ACT team that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process. The decertification is subject to appeal to the state.

Sec. 59. Minnesota Statutes 2020, section 256B.0622, subdivision 4, is amended to read:

Subd. 4. **Provider entity licensure and contract requirements for intensive residential treatment services.** ~~(a) The intensive residential treatment services provider entity must:~~

~~(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;~~

~~(2) not exceed 16 beds per site; and~~

~~(3) comply with the additional standards in this section.~~

~~(b)~~ (a) The commissioner shall develop procedures for counties and providers to submit other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

~~(c)~~ (b) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

~~(d)~~ (c) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and tribal authority that serves as a local mental health authority in the proposed service area. The statement of need must specify if the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within

60 days of the receipt of the request, the commissioner shall determine the need for the program based on the documentation submitted by the provider entity.

Sec. 60. Minnesota Statutes 2020, section 256B.0622, subdivision 7, is amended to read:

Subd. 7. **Assertive community treatment service standards.** (a) ACT teams must offer and have the capacity to directly provide the following services:

(1) assertive engagement using collaborative strategies to encourage clients to receive services;

(2) benefits and finance support that assists clients to capably manage financial affairs. Services include but are not limited to assisting clients in applying for benefits, assisting with redetermination of benefits, providing financial crisis management, teaching and supporting budgeting skills and asset development, and coordinating with a client's representative payee, if applicable;

(3) co-occurring substance use disorder treatment as defined in section 245I.02, subdivision 11;

(4) crisis assessment and intervention;

(5) employment services that assist clients to work at jobs of the clients' choosing. Services must follow the principles of the individual placement and support employment model, including focusing on competitive employment, emphasizing individual client preferences and strengths, ensuring employment services are integrated with mental health services, conducting rapid job searches and systematic job development according to client preferences and choices, providing benefits counseling, and offering all services in an individualized and time-unlimited manner. Services must also include educating clients about opportunities and benefits of work and school and assisting the client in learning job skills, navigating the workplace, workplace accommodations, and managing work relationships;

(6) family psychoeducation and support provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include but are not limited to individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive

counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent;

(7) housing access support that assists clients to find, obtain, retain, and move to safe and adequate housing of their choice. Housing access support includes but is not limited to locating housing options with a focus on integrated independent settings; applying for housing subsidies, programs, or resources; assisting the client in developing relationships with local landlords; providing tenancy support and advocacy for the individual's tenancy rights at the client's home; and assisting with relocation;

(8) medication assistance and support that assists clients in accessing medication, developing the ability to take medications with greater independence, and providing medication setup. Medication assistance and support includes assisting the client with the prescription, administration, and ordering of medication by appropriate medical staff;

(9) medication education that educates clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications;

(10) mental health certified peer specialists services according to section 256B.0615;

(11) physical health services to meet the physical health needs of the client to support the client's mental health recovery. Services include but are not limited to education on primary health and wellness issues, medication administration and monitoring, providing and coordinating medical screening and follow-up, scheduling routine and acute medical and dental care visits, tobacco cessation strategies, assisting clients in attending appointments, communicating with other providers, and integrating all physical and mental health treatment;

(12) rehabilitative mental health services as defined in section 245I.02, subdivision 33;

(13) symptom management that supports clients in identifying and targeting the symptoms and occurrence patterns of their mental illness and developing strategies to reduce the impact of those symptoms;

(14) therapeutic interventions to address specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms. Interventions include empirically supported psychotherapies including but not limited to cognitive behavioral therapy, exposure therapy, acceptance and commitment therapy, interpersonal therapy, and motivational interviewing;

(15) wellness self-management and prevention that includes a combination of approaches to working with the client to build and apply skills related to recovery, and to support the client in participating in leisure and recreational activities, civic participation, and meaningful structure; and

(16) other services based on client needs as identified in a client's assertive community treatment individual treatment plan.

(b) ACT teams must ensure the provision of all services necessary to meet a client's needs as identified in the client's individual treatment plan.

Sec. 61. Minnesota Statutes 2020, section 256B.0622, subdivision 7a, is amended to read:

Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

(i) shall be a ~~licensed~~ mental health professional ~~who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role but must obtain full licensure within 24 months of assuming the role of team leader;

(ii) must be an active member of the ACT team and provide some direct services to clients;

(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team, providing ~~clinical oversight~~ treatment supervision of services in conjunction with the psychiatrist or psychiatric care provider, and supervising team members to ensure delivery of best and ethical practices; and

(iv) must be available to provide overall ~~clinical oversight~~ treatment supervision to the ACT team after regular business hours and on weekends and holidays. The team leader may delegate this duty to another qualified member of the ACT team;

(2) the psychiatric care provider:

(i) must be a ~~licensed psychiatrist certified by the American Board of Psychiatry and Neurology or eligible for board certification or certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~ mental health professional permitted to prescribe psychiatric medications as part of the mental health

professional's scope of practice. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness;

(ii) shall collaborate with the team leader in sharing overall clinical responsibility for screening and admitting clients; monitoring clients' treatment and team member service delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects, and health-related conditions; actively collaborating with nurses; and helping provide ~~clinical~~ treatment supervision to the team;

(iii) shall fulfill the following functions for assertive community treatment clients: provide assessment and treatment of clients' symptoms and response to medications, including side effects; provide brief therapy to clients; provide diagnostic and medication education to clients, with medication decisions based on shared decision making; monitor clients' nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and community visits;

(iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized for mental health treatment and shall communicate directly with the client's inpatient psychiatric care providers to ensure continuity of care;

(v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per 50 clients. Part-time psychiatric care providers shall have designated hours to work on the team, with sufficient blocks of time on consistent days to carry out the provider's clinical, supervisory, and administrative responsibilities. No more than two psychiatric care providers may share this role;

(vi) may not provide specific roles and responsibilities by telemedicine unless approved by the commissioner; and

(vii) shall provide psychiatric backup to the program after regular business hours and on weekends and holidays. The psychiatric care provider may delegate this duty to another qualified psychiatric provider;

(3) the nursing staff:

(i) shall consist of one to three registered nurses or advanced practice registered nurses, of whom at least one has a minimum of one-year experience working with adults with serious mental illness and a working knowledge of psychiatric medications. No more than two individuals can share a full-time equivalent position;

(ii) are responsible for managing medication, administering and documenting medication treatment, and managing a secure medication room; and

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

(i) shall be a full-time equivalent co-occurring disorder specialist who has received specific training on co-occurring disorders that is consistent with national evidence-based practices. The training must include practical knowledge of common substances and how they affect mental illnesses, the ability to assess substance use disorders and the client's stage of treatment, motivational interviewing, and skills necessary to provide counseling to clients at all different stages of change and treatment. The co-occurring disorder specialist may also be an individual who is a licensed alcohol and drug counselor as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience, and other requirements in section 245G.11, subdivision 5. No more than two co-occurring disorder specialists may occupy this role; and

(ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients. The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT team members on co-occurring disorders;

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services to individuals with mental illness. An individual who does not meet these qualifications may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

(ii) shall provide or facilitate the provision of vocational services to clients. The vocational specialist serves as a consultant and educator to fellow ACT team members on these services; and

(iii) ~~should~~ must not refer individuals to receive any type of vocational services or linkage by providers outside of the ACT team;

(6) the mental health certified peer specialist:

(i) shall be a full-time equivalent ~~mental health certified peer specialist as defined in section 256B.0615~~. No more than two individuals can share this position. The mental health certified peer specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of clients. This requirement may be waived due to workforce shortages upon approval of the commissioner;

(ii) must provide coaching, mentoring, and consultation to the clients to promote recovery, self-advocacy, and self-direction, promote wellness management strategies, and assist clients in developing advance directives; and

(iii) must model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience, provide consultation to team members, promote a culture where the clients' points of view and preferences are recognized, understood, respected, and integrated into treatment, and serve in a manner equivalent to other team members;

(7) the program administrative assistant shall be a full-time office-based program administrative assistant position assigned to solely work with the ACT team, providing a range of supports to the team, clients, and families; and

(8) additional staff:

(i) shall be based on team size. Additional treatment team staff may include ~~licensed~~ mental health professionals ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A~~; clinical trainees; certified rehabilitation specialists; mental health practitioners ~~as defined in section 245.462, subdivision 17; a mental health practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C~~; or mental health rehabilitation workers ~~as defined in section 256B.0623, subdivision 5, paragraph (a), clause (4)~~. These individuals shall have the knowledge, skills, and abilities required by the population served to carry out rehabilitation and support functions; and

(ii) shall be selected based on specific program needs or the population served.

(b) Each ACT team must clearly document schedules for all ACT team members.

(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.

(d) Members of the ACT team must have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of rehabilitation services. Each staff member shall be proficient in their respective discipline and be able to work collaboratively as a member of a multidisciplinary team to deliver the majority of the treatment, rehabilitation, and support services clients require to fully benefit from receiving assertive community treatment.

(e) Each ACT team member must fulfill training requirements established by the commissioner.

Sec. 62. Minnesota Statutes 2020, section 256B.0622, subdivision 7b, is amended to read:

Subd. 7b. **Assertive community treatment program size and opportunities.** (a) Each ACT team shall maintain an annual average caseload that does not exceed 100 clients. Staff-to-client ratios shall be based on team size as follows:

(1) a small ACT team must:

(i) employ at least six but no more than seven full-time treatment team staff, excluding the program assistant and the psychiatric care provider;

(ii) serve an annual average maximum of no more than 50 clients;

(iii) ensure at least one full-time equivalent position for every eight clients served;

(iv) schedule ACT team staff for at least eight-hour shift coverage on weekdays and on-call duty to provide crisis services and deliver services after hours when staff are not working;

(v) provide crisis services during business hours if the small ACT team does not have sufficient staff numbers to operate an after-hours on-call system. During all other hours, the ACT team may arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider;

(vi) adjust schedules and provide staff to carry out the needed service activities in the evenings or on weekend days or holidays, when necessary;

(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team's psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must

be arranged and a mechanism of timely communication and coordination established in writing; and

(viii) be composed of, at minimum, one full-time team leader, at least 16 hours each week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time equivalent nursing, one full-time ~~substance abuse~~ co-occurring disorder specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least one additional full-time ACT team member who has mental health professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner status; and

(2) a midsize ACT team shall:

(i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry time for 51 clients, with an additional two hours for every six clients added to the team, 1.5 to two full-time equivalent nursing staff, one full-time ~~substance abuse~~ co-occurring disorder specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT members, with at least one dedicated full-time staff member with mental health professional status. Remaining team members may have mental health professional, certified rehabilitation specialist, clinical trainee, or mental health practitioner status;

(ii) employ seven or more treatment team full-time equivalents, excluding the program assistant and the psychiatric care provider;

(iii) serve an annual average maximum caseload of 51 to 74 clients;

(iv) ensure at least one full-time equivalent position for every nine clients served;

(v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays and six- to eight-hour shift coverage on weekends and holidays. In addition to these minimum specifications, staff are regularly scheduled to provide the necessary services on a client-by-client basis in the evenings and on weekends and holidays;

(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working;

(vii) have the authority to arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the

on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider; and

(viii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must be arranged and a mechanism of timely communication and coordination established in writing;

(3) a large ACT team must:

(i) be composed of, at minimum, one full-time team leader, at least 32 hours each week per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff, one full-time ~~substance abuse~~ co-occurring disorder specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least two additional full-time equivalent ACT team members, with at least one dedicated full-time staff member with mental health professional status. Remaining team members may have mental health professional or mental health practitioner status;

(ii) employ nine or more treatment team full-time equivalents, excluding the program assistant and psychiatric care provider;

(iii) serve an annual average maximum caseload of 75 to 100 clients;

(iv) ensure at least one full-time equivalent position for every nine individuals served;

(v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the second shift providing services at least 12 hours per day weekdays. For weekends and holidays, the team must operate and schedule ACT team staff to work one eight-hour shift, with a minimum of two staff each weekend day and every holiday;

(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working; and

(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team psychiatric care provider during all hours is not feasible, alternative psychiatric backup must be arranged and a mechanism of timely communication and coordination established in writing.

(b) An ACT team of any size may have a staff-to-client ratio that is lower than the requirements described in paragraph (a) upon approval by the commissioner, but may not exceed a one-to-ten staff-to-client ratio.

Sec. 63. Minnesota Statutes 2020, section 256B.0622, subdivision 7c, is amended to read:

Subd. 7c. **Assertive community treatment program organization and communication requirements.** (a) An ACT team shall provide at least 75 percent of all services in the community in non-office-based or non-facility-based settings.

(b) ACT team members must know all clients receiving services, and interventions must be carried out with consistency and follow empirically supported practice.

(c) Each ACT team client shall be assigned an individual treatment team that is determined by a variety of factors, including team members' expertise and skills, rapport, and other factors specific to the individual's preferences. The majority of clients shall see at least three ACT team members in a given month.

(d) The ACT team shall have the capacity to rapidly increase service intensity to a client when the client's status requires it, regardless of geography, provide flexible service in an individualized manner, and see clients on average three times per week for at least 120 minutes per week. Services must be available at times that meet client needs.

(e) ACT teams shall make deliberate efforts to assertively engage clients in services. Input of family members, natural supports, and previous and subsequent treatment providers is required in developing engagement strategies. ACT teams shall include the client, identified family, and other support persons in the admission, initial assessment, and planning process as primary stakeholders, meet with the client in the client's environment at times of the day and week that honor the client's preferences, and meet clients at home and in jails or prisons, streets, homeless shelters, or hospitals.

(f) ACT teams shall ensure that a process is in place for identifying individuals in need of more or less assertive engagement. Interventions are monitored to determine the success of these techniques and the need to adapt the techniques or approach accordingly.

(g) ACT teams shall conduct daily team meetings to systematically update clinically relevant information, briefly discuss the status of assertive community treatment clients over the past 24 hours, problem solve emerging issues, plan approaches to address and prevent crises, and plan the service contacts for the following 24-hour period or weekend. All team members scheduled to work shall attend this meeting.

(h) ACT teams shall maintain a clinical log that succinctly documents important clinical information and develop a daily team schedule for the day's contacts based on a central file of the clients' weekly or monthly schedules, which are derived from interventions specified

within the individual treatment plan. The team leader must have a record to ensure that all assigned contacts are completed.

(i) The treatment supervision required according to section 245I.06 may include the use of team supervision. "Team supervision" means the daily team meeting required in paragraph (g).

Sec. 64. Minnesota Statutes 2020, section 256B.0622, subdivision 7d, is amended to read:

Subd. 7d. **Assertive community treatment assessment and individual treatment plan.** (a) An initial assessment~~, including a diagnostic assessment that meets the requirements of Minnesota Rules, part 9505.0372, subpart 1, and a 30-day treatment plan~~ shall be completed the day of the client's admission to assertive community treatment by the ACT team leader or the psychiatric care provider, with participation by designated ACT team members and the client. The initial assessment must include obtaining or completing a standard diagnostic assessment according to section 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader, psychiatric care provider, or other mental health professional designated by the team leader or psychiatric care provider, must update the client's diagnostic assessment at least annually.

(b) ~~An initial~~ A functional assessment must be completed ~~within ten days of intake and updated every six months for assertive community treatment, or prior to discharge from the service, whichever comes first~~ according to section 245I.10, subdivision 9.

~~(c) Within 30 days of the client's assertive community treatment admission, the ACT team shall complete an in-depth assessment of the domains listed under section 245.462, subdivision 11a.~~

~~(d)~~ Each part of the ~~in-depth~~ functional assessment areas shall be completed by each respective team specialist or an ACT team member with skill and knowledge in the area being assessed. ~~The assessments are based upon all available information, including that from client interview family and identified natural supports, and written summaries from other agencies, including police, courts, county social service agencies, outpatient facilities, and inpatient facilities, where applicable.~~

~~(e)~~ (c) Between 30 and 45 days after the client's admission to assertive community treatment, the entire ACT team must hold a comprehensive case conference, where all team members, including the psychiatric provider, present information discovered from the completed ~~in-depth~~ assessments and provide treatment recommendations. The conference

must serve as the basis for the first ~~six-month~~ individual treatment plan, which must be written by the primary team member.

~~(f)~~ (d) The client's psychiatric care provider, primary team member, and individual treatment team members shall assume responsibility for preparing the written narrative of the results from the psychiatric and social functioning history timeline and the comprehensive assessment.

~~(g)~~ (e) The primary team member and individual treatment team members shall be assigned by the team leader in collaboration with the psychiatric care provider by the time of the first treatment planning meeting or 30 days after admission, whichever occurs first.

~~(h)~~ (f) Individual treatment plans must be developed through the following treatment planning process:

(1) The individual treatment plan shall be developed in collaboration with the client and the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT team shall evaluate, together with each client, the client's needs, strengths, and preferences and develop the individual treatment plan collaboratively. The ACT team shall make every effort to ensure that the client and the client's family and natural supports, with the client's consent, are in attendance at the treatment planning meeting, are involved in ongoing meetings related to treatment, and have the necessary supports to fully participate. The client's participation in the development of the individual treatment plan shall be documented.

(2) The client and the ACT team shall work together to formulate and prioritize the issues, set goals, research approaches and interventions, and establish the plan. The plan is individually tailored so that the treatment, rehabilitation, and support approaches and interventions achieve optimum symptom reduction, help fulfill the personal needs and aspirations of the client, take into account the cultural beliefs and realities of the individual, and improve all the aspects of psychosocial functioning that are important to the client. The process supports strengths, rehabilitation, and recovery.

(3) Each client's individual treatment plan shall identify service needs, strengths and capacities, and barriers, and set specific and measurable short- and long-term goals for each service need. The individual treatment plan must clearly specify the approaches and interventions necessary for the client to achieve the individual goals, when the interventions shall happen, and identify which ACT team member shall carry out the approaches and interventions.

(4) The primary team member and the individual treatment team, together with the client and the client's family and natural supports with the client's consent, are responsible for

reviewing and rewriting the treatment goals and individual treatment plan whenever there is a major decision point in the client's course of treatment or at least every six months.

(5) The primary team member shall prepare a summary that thoroughly describes in writing the client's and the individual treatment team's evaluation of the client's progress and goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last individual treatment plan. The client's most recent diagnostic assessment must be included with the treatment plan summary.

(6) The individual treatment plan and review must be ~~signed~~ approved or acknowledged by the client, the primary team member, the team leader, the psychiatric care provider, and all individual treatment team members. A copy of the ~~signed~~ approved individual treatment plan ~~is~~ must be made available to the client.

Sec. 65. Minnesota Statutes 2020, section 256B.0623, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers medically necessary adult rehabilitative mental health services ~~as defined in subdivision 2, subject to federal approval, if provided to recipients as defined in subdivision 3 and provided by a qualified provider entity meeting the standards in this section and by a qualified individual provider working within the provider's scope of practice and identified in the recipient's individual treatment plan as defined in section 245.462, subdivision 14, and if determined to be medically necessary according to section 62Q.53~~ when the services are provided by an entity meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Sec. 66. Minnesota Statutes 2020, section 256B.0623, subdivision 2, is amended to read:

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

(a) "Adult rehabilitative mental health services" means ~~mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services~~ the services described in section 245I.02, subdivision 33.

~~(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.~~

~~(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.~~

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program ~~under Minnesota Rules, chapter 9505~~, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Sec. 67. Minnesota Statutes 2020, section 256B.0623, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section ~~245.462, subdivision 11a~~ 245I.10, subdivision 9, clause (4), so that self-sufficiency is markedly reduced; and

(4) has had a recent standard diagnostic assessment ~~or an adult diagnostic assessment update~~ by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

Sec. 68. Minnesota Statutes 2020, section 256B.0623, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the state following the certification process and procedures developed by the commissioner.

(b) The certification process is a determination as to whether the entity meets the standards in this ~~subdivision~~ section and chapter 245I, as required in section 245I.011, subdivision 5. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) A noncounty provider entity must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate its services with the other services available in that county. A county-operated entity must obtain this additional certification from any other county in which it will provide services.

(d) State-level recertification must occur at least every three years.

(e) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(f) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train ~~mental health professionals, mental health practitioners, and mental health rehabilitation workers~~ qualified staff;

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

~~(3) ensure adequate preservice and inservice and ongoing training for staff;~~

~~(4)~~ (3) ensure that ~~mental health professionals, mental health practitioners, and mental health rehabilitation workers~~ staff are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

~~(5) ensure that staff is capable of implementing culturally specific services that are culturally competent and appropriate as determined by the recipient's culture, beliefs, values, and language as identified in the individual treatment plan;~~

~~(6)~~ (4) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

~~(7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan;~~

~~(8)~~ (5) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

~~(9)~~ (6) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

~~(10) develop and maintain recipient files, individual treatment plans, and contact charting;~~

~~(11) develop and maintain staff training and personnel files;~~

~~(12) submit information as required by the state;~~

~~(13) establish and maintain a quality assurance plan to evaluate the outcome of services provided;~~

~~(14)~~ (7) keep all necessary records required by law;

~~(15)~~ (8) deliver services as required by section 245.461;

~~(16) comply with all applicable laws;~~

~~(17)~~ (9) be an enrolled Medicaid provider; and

~~(18)~~ (10) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services~~; and~~.

~~(19) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.~~

Sec. 69. Minnesota Statutes 2020, section 256B.0623, subdivision 5, is amended to read:

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

(1) a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending receipt of adult mental health rehabilitative services, the definition of mental health~~

~~professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (7), and who holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner~~ qualified according to section 245I.04, subdivision 2;

(2) a certified rehabilitation specialist qualified according to section 245I.04, subdivision 8;

(3) a clinical trainee qualified according to section 245I.04, subdivision 6;

(4) a mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional~~ qualified according to section 245I.04, subdivision 4;

~~(3)~~ (5) a mental health certified peer specialist ~~under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional~~ qualified according to section 245I.04, subdivision 10; or

~~(4)~~ (6) a mental health rehabilitation worker qualified according to section 245I.04, subdivision 14. ~~A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who:~~

~~(i) is at least 21 years of age;~~

~~(ii) has a high school diploma or equivalent;~~

~~(iii) has successfully completed 30 hours of training during the two years immediately prior to the date of hire, or before provision of direct services, in all of the following areas: recovery from mental illness, mental health de-escalation techniques, recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and~~

~~(iv) meets the qualifications in paragraph (b).~~

~~(b) In addition to the requirements in paragraph (a), a mental health rehabilitation worker must also meet the qualifications in clause (1), (2), or (3):~~

~~(1) has an associates of arts degree, two years of full-time postsecondary education, or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields; is a registered nurse; or within the previous ten years has:~~

~~(i) three years of personal life experience with serious mental illness;~~

~~(ii) three years of life experience as a primary caregiver to an adult with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability; or~~

~~(iii) 2,000 hours of supervised work experience in the delivery of mental health services to adults with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability;~~

~~(2)(i) is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;~~

~~(ii) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;~~

~~(iii) has 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;~~

~~(iv) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or mental health practitioner; and~~

~~(v) has 15 hours of additional continuing education on mental health topics during the first year of employment and 15 hours during every additional year of employment; or~~

~~(3) for providers of crisis residential services, intensive residential treatment services, partial hospitalization, and day treatment services:~~

~~(i) satisfies clause (2), items (ii) to (iv); and~~

~~(ii) has 40 hours of additional continuing education on mental health topics during the first year of employment.~~

~~(c) A mental health rehabilitation worker who solely acts and is scheduled as overnight staff is not required to comply with paragraph (a), clause (4), item (iv).~~

~~(d) For purposes of this subdivision, "behavioral sciences or related fields" means an education from an accredited college or university and includes but is not limited to social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, and other fields as approved by the commissioner.~~

Sec. 70. Minnesota Statutes 2020, section 256B.0623, subdivision 6, is amended to read:

Subd. 6. **Required ~~training and~~ supervision.** ~~(a) Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d).~~

~~(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).~~

~~(c) Clinical supervision may be provided by a full- or part-time qualified professional employed by or under contract with the provider entity. Clinical supervision may be provided by interactive videoconferencing according to procedures developed by the commissioner. A mental health professional providing clinical supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:~~

~~(1) review the information in the recipient's file;~~

~~(2) review and approve initial and updates of individual treatment plans;~~

(a) A treatment supervisor providing treatment supervision required under section 245I.06 must:

~~(3)~~ (1) meet with ~~mental health rehabilitation workers and practitioners, individually or in small groups,~~ staff receiving treatment supervision at least monthly to discuss treatment topics of interest ~~to the workers and practitioners;~~

~~(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss~~ and treatment plans of recipients~~, and approve by signature and document in the recipient's file any resulting plan updates~~; and

~~(5)~~ (2) meet at least monthly with the directing clinical trainee or mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing clinical trainee or mental health practitioner~~; and~~.

~~(6) be available for urgent consultation as the individual recipient needs or the situation necessitates.~~

~~(d)~~ (b) An adult rehabilitative mental health services provider entity must have a treatment director who is a ~~mental health practitioner or~~ mental health professional clinical trainee, certified rehabilitation specialist, or mental health practitioner. The treatment director must ~~ensure the following~~:

(1) ~~while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by a mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works~~ ensure the direct observation of mental health rehabilitation workers required under section 245I.06, subdivision 5, is provided;

~~(2) the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;~~

~~(3) progress notes are reviewed from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the individual treatment plan and goals;~~

~~(4)~~ (2) ensure immediate availability by phone or in person for consultation by a mental health professional, certified rehabilitation specialist, clinical trainee, or a mental health practitioner to the mental health rehabilitation ~~services~~ worker during service provision;

~~(5) oversee the identification of changes in individual recipient treatment strategies, revise the plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;~~

~~(6)~~ (3) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;

~~(7)~~ (4) ensure that clinical trainees, mental health practitioners, and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers; and

~~(8)~~ (5) oversee the record of the results of ~~on-site~~ direct observation ~~and charting~~, progress note evaluation, and corrective actions taken to modify the work of the clinical trainees, mental health practitioners, and mental health rehabilitation workers.

~~(c)~~ (c) A clinical trainee or mental health practitioner who is providing treatment direction for a provider entity must receive treatment supervision at least monthly ~~from a mental health professional~~ to:

(1) identify and plan for general needs of the recipient population served;

(2) identify and plan to address provider entity program needs and effectiveness;

(3) identify and plan provider entity staff training and personnel needs and issues; and

(4) plan, implement, and evaluate provider entity quality improvement programs.

Sec. 71. Minnesota Statutes 2020, section 256B.0623, subdivision 9, is amended to read:

Subd. 9. **Functional assessment.** (a) Providers of adult rehabilitative mental health services must complete a written functional assessment ~~as defined in section 245.462, subdivision 11a~~ according to section 245I.10, subdivision 9, for each recipient. ~~The functional assessment must be completed within 30 days of intake, and reviewed and updated at least every six months after it is developed, unless there is a significant change in the functioning of the recipient. If there is a significant change in functioning, the assessment must be updated. A single functional assessment can meet case management and adult rehabilitative mental health services requirements if agreed to by the recipient. Unless the recipient refuses, the recipient must have significant participation in the development of the functional assessment.~~

(b) When a provider of adult rehabilitative mental health services completes a written functional assessment, the provider must also complete a level of care assessment as defined in section 245I.02, subdivision 19, for the recipient.

Sec. 72. Minnesota Statutes 2020, section 256B.0623, subdivision 12, is amended to read:

Subd. 12. **Additional requirements.** (a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.

(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community. Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or section 245I.23, or an acute care hospital.

(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and individual treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's individual treatment plan. No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

(d) Adult rehabilitative mental health services are appropriate if provided to enable a recipient to retain stability and functioning, when the recipient is at risk of significant functional decompensation or requiring more restrictive service settings without these services.

(e) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas including: interpersonal communication skills, community resource utilization and integration skills, crisis planning, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.

(f) Community intervention, including consultation with relatives, guardians, friends, employers, treatment providers, and other significant individuals, is appropriate when directed exclusively to the treatment of the client.

Sec. 73. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week, except as provided in paragraph (f). Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or

support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6, a community paramedic as defined under section 144E.001, subdivision 5f, ~~or~~ a clinical trainee qualified according to section 245I.04, subdivision 6, a mental health practitioner ~~defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional~~ qualified according to section 245I.04, subdivision 4, and a community health worker who meets the criteria under subdivision 49, paragraph (a); "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

(f) The limit on coverage of three telemedicine services per enrollee per calendar week does not apply if:

(1) the telemedicine services provided by the licensed health care provider are for the treatment and control of tuberculosis; and

(2) the services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the commissioner of health.

Sec. 74. Minnesota Statutes 2020, section 256B.0625, subdivision 5, is amended to read:

Subd. 5. **Community mental health center services.** Medical assistance covers community mental health center services provided by a community mental health center that meets the requirements in paragraphs (a) to (j).

(a) The provider is ~~licensed under Minnesota Rules, parts 9520.0750 to 9520.0870~~ certified as a mental health clinic under section 245I.20.

(b) ~~The provider provides mental health services under the clinical supervision of a~~ The treatment supervision required by section 245I.06 is provided by a mental health professional who is licensed for independent practice at the doctoral level or by a board-certified psychiatrist or a psychiatrist who is eligible for board certification. ~~Clinical supervision has the meaning given in Minnesota Rules, part 9505.0370, subpart 6.~~

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in section 245.481, and agree to serve within the limits of its capacity all individuals residing in its service delivery area.

(e) At a minimum, the provider must provide the following outpatient mental health services: diagnostic assessment; explanation of findings; family, group, and individual psychotherapy, including crisis intervention psychotherapy services, ~~multiple family group psychotherapy~~, psychological testing, and medication management. In addition, the provider must provide or be capable of providing upon request of the local mental health authority day treatment services, multiple family group psychotherapy, and professional home-based mental health services. The provider must have the capacity to provide such services to specialized populations such as the elderly, families with children, persons who are seriously and persistently mentally ill, and children who are seriously emotionally disturbed.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are ~~diagnosed with both~~ dually diagnosed with mental illness or emotional disturbance, and ~~chemical dependency~~ substance use disorder, and to individuals who are dually diagnosed with a mental illness or emotional disturbance and developmental disability.

(g) The provider must provide 24-hour emergency care services or demonstrate the capacity to assist recipients in need of such services to access such services on a 24-hour basis.

(h) The provider must have a contract with the local mental health authority to provide one or more of the services specified in paragraph (e).

(i) The provider must agree, upon request of the local mental health authority, to enter into a contract with the county to provide mental health services not reimbursable under the medical assistance program.

(j) The provider may not be enrolled with the medical assistance program as both a hospital and a community mental health center. The community mental health center's administrative, organizational, and financial structure must be separate and distinct from that of the hospital.

Sec. 75. Minnesota Statutes 2020, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision

19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~; a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148E.010 and 148E.055, or a qualified designated coordinator under section 245D.081, subdivision 2. The qualified professional shall perform the duties required in section 256B.0659.

Sec. 76. Minnesota Statutes 2020, section 256B.0625, subdivision 28a, is amended to read:

Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers services performed by a licensed physician assistant if the service is otherwise covered under this chapter as a physician service and if the service is within the scope of practice of a licensed physician assistant as defined in section 147A.09.

(b) Licensed physician assistants, who are supervised by a physician certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, may bill for medication management and evaluation and management services provided to medical assistance enrollees in inpatient hospital settings, and in outpatient settings after the licensed physician assistant completes 2,000 hours of clinical experience in the evaluation and treatment of mental health, consistent with their authorized scope of practice, as defined in section 147A.09, with the exception of performing psychotherapy or diagnostic assessments or providing ~~clinical~~ treatment supervision.

Sec. 77. Minnesota Statutes 2020, section 256B.0625, subdivision 42, is amended to read:

Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part 9505.0175, subpart 28, the definition of a mental health professional ~~shall include a person who is~~ qualified ~~as specified in~~ according to section ~~245.462, subdivision 18, clauses (1) to (6); or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2, for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Sec. 78. Minnesota Statutes 2020, section 256B.0625, subdivision 48, is amended to read:

Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance covers consultation provided by a ~~psychiatrist, a psychologist, an advanced practice registered nurse certified in psychiatric mental health, a licensed independent clinical social worker,~~

~~as defined in section 245.462, subdivision 18, clause (2), or a licensed marriage and family therapist, as defined in section 245.462, subdivision 18, clause (5)~~ mental health professional qualified according to section 245I.04, subdivision 2, except a licensed professional clinical counselor licensed under section 148B.5301, via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Sec. 79. Minnesota Statutes 2020, section 256B.0625, subdivision 49, is amended to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has~~:~~

~~(1)~~ received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum~~; or~~.

~~(2) at least five years of supervised experience with an enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.~~

~~Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.~~

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5)~~, or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Sec. 80. Minnesota Statutes 2020, 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 ~~licensed~~ mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~;

(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 ~~as defined in section 245.462, subdivision 17~~ qualified according to section 245I.04, subdivision 4, working under the ~~clinical~~ treatment supervision of a mental health professional according to section 245I.06;

~~(3)~~ (4) a mental health certified peer specialist ~~under section 256B.0615~~ qualified according to section 245I.04, subdivision 10, working under the ~~clinical~~ treatment supervision of a mental health professional according to section 245I.06;

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

(5) 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.

Sec. 81. Minnesota Statutes 2020, section 256B.0757, subdivision 4c, is amended to read:

Subd. 4c. **Behavioral health home services staff qualifications.** (a) A behavioral health home services provider must maintain staff with required professional qualifications appropriate to the setting.

(b) If behavioral health home services are offered in a mental health setting, the integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice Act, sections 148.171 to 148.285.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be a mental health professional ~~as defined in~~ qualified according to section ~~245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

(d) If behavioral health home services are offered in either a primary care setting or mental health setting, the systems navigator must be a mental health practitioner ~~as defined in~~ qualified according to section ~~245.462, subdivision 17~~ 245I.04, subdivision 4, or a community health worker as defined in section 256B.0625, subdivision 49.

(e) If behavioral health home services are offered in either a primary care setting or mental health setting, the qualified health home specialist must be one of the following:

(1) a mental health certified peer ~~support~~ specialist ~~as defined in~~ qualified according to section ~~256B.0615~~ 245I.04, subdivision 10;

(2) a mental health certified family peer ~~support~~ specialist ~~as defined in~~ qualified according to section ~~256B.0616~~ 245I.04, subdivision 12;

(3) a case management associate as defined in section 245.462, subdivision 4, paragraph (g), or 245.4871, subdivision 4, paragraph (j);

(4) a mental health rehabilitation worker ~~as defined in~~ qualified according to section ~~256B.0623, subdivision 5, clause (4)~~ 245I.04, subdivision 14;

(5) a community paramedic as defined in section 144E.28, subdivision 9;

(6) a peer recovery specialist as defined in section 245G.07, subdivision 1, clause (5); or

(7) a community health worker as defined in section 256B.0625, subdivision 49.

Sec. 82. Minnesota Statutes 2020, section 256B.0941, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, services are determined to be medically necessary according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for

one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) was referred for treatment in a psychiatric residential treatment facility by a ~~qualified~~ mental health professional ~~licensed as defined in~~ qualified according to section ~~245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

(b) The commissioner shall provide oversight and review the use of referrals for clients admitted to psychiatric residential treatment facilities to ensure that eligibility criteria, clinical services, and treatment planning reflect clinical, state, and federal standards for psychiatric residential treatment facility level of care. The commissioner shall coordinate the production of a statewide list of children and youth who meet the medical necessity criteria for psychiatric residential treatment facility level of care and who are awaiting admission. The commissioner and any recipient of the list shall not use the statewide list to direct admission of children and youth to specific facilities.

Sec. 83. Minnesota Statutes 2020, section 256B.0943, subdivision 1, is amended to read:

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

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

~~(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility~~

~~for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.~~

~~(c)~~ (b) "Clinical trainee" means a ~~mental health practitioner who meets the qualifications specified in Minnesota Rules, part 9505.0371, subpart 5, item C~~ staff person who is qualified according to section 245I.04, subdivision 6.

~~(d)~~ (c) "Crisis ~~assistance~~ planning" has the meaning given in section 245.4871, subdivision 9a. ~~Crisis assistance entails the development of a written plan to assist a child's family to contend with a potential crisis and is distinct from the immediate provision of crisis intervention services.~~

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

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

~~(g)~~ (f) "Standard diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0372, subpart 1~~ means the assessment described in 245I.10, subdivision 6.

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

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

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

~~(k)~~ (j) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or a clinical trainee or mental health practitioner~~,~~ under the ~~clinical~~ treatment supervision of a mental health professional, to guide the work of the mental health behavioral aide. The individual behavioral plan may be incorporated into the child's individual treatment plan so long as the behavioral plan is separately communicable to the mental health behavioral aide.

~~(l)~~ (k) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part 9505.0371, subpart 7~~ means the plan described under section 245I.10, subdivisions 7 and 8.

~~(m)~~ (l) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a ~~trained paraprofessional qualified as provided in subdivision 7, paragraph (b), clause (3)~~ mental health behavioral aide qualified according to section 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

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

(n) "Mental health practitioner" ~~has the meaning given in section 245.462, subdivision 17, except that a practitioner working in a day treatment setting may qualify as a mental health practitioner if the practitioner holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university, and: (1) has at least 2,000 hours of clinically supervised experience in the delivery of mental health services to clients with mental illness; (2) is fluent in the language, other than English, of the cultural group that makes up at least 50 percent of the practitioner's clients, completes 40 hours of training on the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once per week until meeting the required 2,000 hours of supervised experience; or (3) receives 40 hours of training on the delivery of services to clients with mental illness within six months of employment, and clinical supervision from a mental health professional at least once per week until meeting the~~

~~required 2,000 hours of supervised experience~~ means a staff person who is qualified according to section 245I.04, subdivision 4.

(o) "Mental health professional" means ~~an individual as defined in Minnesota Rules, part 9505.0370, subpart 18~~ a staff person who is qualified according to section 245I.04, subdivision 2.

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

(1) the development, review, and revision of a child's individual treatment plan, ~~as provided in Minnesota Rules, part 9505.0371, subpart 7,~~ including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) administering and reporting the standardized outcome ~~measurement instruments, determined and updated by the commissioner~~ measurements in section 245I.10, subdivision 6, paragraph (d), clauses (3) and (4), and other standardized outcome measurements approved by the commissioner, as periodically needed to evaluate the effectiveness of treatment ~~for children receiving clinical services and reporting outcome measures, as required by the commissioner~~.

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

(r) "Psychotherapy" means the treatment ~~of mental or emotional disorders or maladjustment by psychological means. Psychotherapy may be provided in many modalities in accordance with Minnesota Rules, part 9505.0372, subpart 6, including patient and/or family psychotherapy; family psychotherapy; psychotherapy for crisis; group psychotherapy; or multiple-family psychotherapy. Beginning with the American Medical Association's Current Procedural Terminology, standard edition, 2014, the procedure "individual psychotherapy" is replaced with "patient and/or family psychotherapy," a substantive change that permits the therapist to work with the client's family without the client present to obtain information about the client or to explain the client's treatment plan to the family. Psychotherapy is appropriate for crisis response when a child has become dysregulated or experienced new trauma since the diagnostic assessment was completed and needs psychotherapy to address issues not currently included in the child's individual treatment plan~~ described in section 256B.0671, subdivision 11.

(s) "Rehabilitative services" or "psychiatric rehabilitation services" means ~~a series or multidisciplinary combination of psychiatric and psychosocial~~ interventions to: (1) restore

a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement. ~~Continuing progress toward goals is expected, and rehabilitative potential ceases when successive improvement is not observable over a period of time.~~

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

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

Sec. 84. Minnesota Statutes 2020, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports ~~as defined in this section that~~ when the services are provided by an eligible provider entity certified under ~~subdivision 4 provides to a client eligible under subdivision 3~~ and meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

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

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

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

(3) crisis ~~assistance~~ planning;

(4) mental health behavioral aide services;

(5) direction of a mental health behavioral aide;

(6) mental health service plan development; and

(7) children's day treatment.

Sec. 85. Minnesota Statutes 2020, section 256B.0943, subdivision 3, is amended to read:

Subd. 3. **Determination of client eligibility.** (a) A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a standard diagnostic assessment by a mental health professional or a ~~mental health practitioner who meets the requirements of a clinical trainee as defined in Minnesota Rules, part 9505.0371, subpart 5, item C,~~ clinical trainee that is performed within one year before the initial start of service. The standard diagnostic assessment must ~~meet the requirements for a standard or extended diagnostic assessment as defined in Minnesota Rules, part 9505.0372, subpart 1, items B and C, and~~:

~~(1) include current diagnoses, including any differential diagnosis, in accordance with all criteria for a complete diagnosis and diagnostic profile as specified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, or, for children under age five, as specified in the current edition of the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood;~~

~~(2)~~ (1) determine whether a child under age 18 has a diagnosis of emotional disturbance or, if the person is between the ages of 18 and 21, whether the person has a mental illness;

~~(3)~~ (2) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals; and

~~(4)~~ (3) be used in the development of the ~~individualized~~ individual treatment plan~~; and~~.

~~(5) be completed annually until age 18. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means an adult diagnostic update as defined in Minnesota Rules, part 9505.0371, subpart 2, item E.~~

(b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to five days of day treatment under this section based on a hospital's medical history and presentation examination of the client.

Sec. 86. Minnesota Statutes 2020, section 256B.0943, subdivision 4, is amended to read:

Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial provider entity application and certification process and recertification process to determine whether a provider entity has an administrative and clinical infrastructure that meets the requirements in subdivisions 5 and 6. A provider entity must be certified for the three core rehabilitation services of psychotherapy, skills training, and crisis ~~assistance~~ planning. The commissioner shall recertify a provider entity at least every three years. The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process.

(b) For purposes of this section, a provider entity must meet the standards in this section and chapter 245I, as required in section 245I.011, subdivision 5, and be:

(1) an Indian health services facility or a facility owned and operated by a tribe or tribal organization operating as a 638 facility under Public Law 93-638 certified by the state;

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

(3) a noncounty entity certified by the state.

Sec. 87. Minnesota Statutes 2020, section 256B.0943, subdivision 5, is amended to read:

Subd. 5. **Provider entity administrative infrastructure requirements.** (a) ~~To be an eligible provider entity under this section, a provider entity must have an administrative infrastructure that establishes authority and accountability for decision making and oversight of functions, including finance, personnel, system management, clinical practice, and individual treatment outcomes measurement.~~ An eligible provider entity shall demonstrate the availability, by means of employment or contract, of at least one backup mental health professional in the event of the primary mental health professional's absence. ~~The provider must have written policies and procedures that it reviews and updates every three years and distributes to staff initially and upon each subsequent update.~~

(b) ~~The administrative infrastructure written~~ In addition to the policies and procedures required under section 245I.03, the policies and procedures must include:

~~(1) personnel procedures, including a process for: (i) recruiting, hiring, training, and retention of culturally and linguistically competent providers; (ii) conducting a criminal background check on all direct service providers and volunteers; (iii) investigating, reporting,~~

~~and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting on violations of data privacy policies that are compliant with federal and state laws; (v) utilizing volunteers, including screening applicants, training and supervising volunteers, and providing liability coverage for volunteers; and (vi) documenting that each mental health professional, mental health practitioner, or mental health behavioral aide meets the applicable provider qualification criteria, training criteria under subdivision 8, and clinical supervision or direction of a mental health behavioral aide requirements under subdivision 6;~~

~~(2)~~ (1) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws; and

~~(3)~~ (2) a client-specific treatment outcomes measurement system, including baseline measures, to measure a client's progress toward achieving mental health rehabilitation goals. ~~Effective July 1, 2017, to be eligible for medical assistance payment, a provider entity must report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner; and~~

~~(4) a process to establish and maintain individual client records. The client's records must include:~~

~~(i) the client's personal information;~~

~~(ii) forms applicable to data privacy;~~

~~(iii) the client's diagnostic assessment, updates, results of tests, individual treatment plan, and individual behavior plan, if necessary;~~

~~(iv) documentation of service delivery as specified under subdivision 6;~~

~~(v) telephone contacts;~~

~~(vi) discharge plan; and~~

~~(vii) if applicable, insurance information.~~

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

Sec. 88. Minnesota Statutes 2020, section 256B.0943, subdivision 5a, is amended to read:

Subd. 5a. **Background studies.** The requirements for background studies under ~~this~~ section 245I.011, subdivision 4, paragraph (d), may be met by a children's therapeutic

services and supports services agency through the commissioner's NETStudy system as provided under ~~sections~~ section 245C.03, subdivision 7~~, and 245C.10, subdivision 8~~.

Sec. 89. Minnesota Statutes 2020, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, ~~individualized~~ individual treatment plans, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review, and update as necessary, the clinical policies and procedures every three years, must distribute the policies and procedures to staff initially and upon each subsequent update, and must train staff accordingly.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for meeting the requirements in this subdivision:

(1) providing or obtaining a client's standard diagnostic assessment, including a standard diagnostic assessment ~~performed by an outside or independent clinician, that identifies acute and chronic clinical disorders, co-occurring medical conditions, and sources of psychological and environmental problems, including baselines, and a functional assessment. The functional assessment component must clearly summarize the client's individual strengths and needs.~~ When required components of the standard diagnostic assessment~~, such as baseline measures,~~ are not provided in an outside or independent assessment or ~~when baseline measures~~ cannot be attained ~~in a one-session standard diagnostic assessment~~ immediately, the provider entity must determine the missing information within 30 days and amend the child's standard diagnostic assessment or incorporate the ~~baselines~~ information into the child's individual treatment plan;

(2) developing an individual treatment plan ~~that:~~;

~~(i) is based on the information in the client's diagnostic assessment and baselines;~~

~~(ii) identified goals and objectives of treatment, treatment strategy, schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;~~

~~(iii) is developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;~~

~~(iv) is developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessment, and treatment planning;~~

~~(v) is reviewed at least once every 90 days and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment; and~~

~~(vi) is signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;~~

(3) developing an individual behavior plan that documents ~~treatment strategies~~ and describes interventions to be provided by the mental health behavioral aide. The individual behavior plan must include:

(i) detailed instructions on the ~~treatment strategies to be provided~~ psychosocial skills to be practiced;

(ii) time allocated to each ~~treatment strategy~~ intervention;

(iii) methods of documenting the child's behavior;

(iv) methods of monitoring the child's progress in reaching objectives; and

(v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) providing ~~clinical~~ treatment supervision plans for ~~mental health practitioners and mental health behavioral aides. A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. The clinical supervisor also shall document supervisee-specific supervision in the supervisee's personnel file. Clinical~~ staff according to section 245I.06. Treatment supervision does not include the authority to make or terminate court-ordered placements of the child. A ~~clinical~~ treatment supervisor must be available for urgent consultation as required by the individual client's needs or the situation~~. Clinical supervision may occur individually or in a small group to discuss treatment and review progress toward goals. The focus of clinical supervision must be the client's treatment needs and progress and the mental health practitioner's or behavioral aide's ability to provide services~~;

(4a) meeting day treatment program conditions in items (i) ~~to (iii)~~ and (ii):

(i) the ~~clinical~~ treatment supervisor must be present and available on the premises more than 50 percent of the time in a provider's standard working week during which the supervisee is providing a mental health service; and

~~(ii) the diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan must be made by or reviewed, approved, and signed by the clinical supervisor; and~~

~~(iii)~~ (ii) every 30 days, the ~~clinical~~ treatment supervisor must review and sign the record indicating the supervisor has reviewed the client's care for all activities in the preceding 30-day period;

(4b) meeting the ~~clinical~~ treatment supervision standards in items (i) ~~to (iv)~~ and (ii) for all other services provided under CTSS:

~~(i) medical assistance shall reimburse for services provided by a mental health practitioner who is delivering services that fall within the scope of the practitioner's practice and who is supervised by a mental health professional who accepts full professional responsibility;~~

~~(ii) medical assistance shall reimburse for services provided by a mental health behavioral aide who is delivering services that fall within the scope of the aide's practice and who is supervised by a mental health professional who accepts full professional responsibility and has an approved plan for clinical supervision of the behavioral aide. Plans must be developed in accordance with supervision standards defined in Minnesota Rules, part 9505.0371, subpart 4, items A to D;~~

~~(iii)~~ (i) the mental health professional is required to be present at the site of service delivery for observation as clinically appropriate when the clinical trainee, mental health practitioner, or mental health behavioral aide is providing CTSS services; and

~~(iv)~~ (ii) when conducted, the on-site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the ~~clinical~~ treatment supervisor must be employed by the provider entity or other provider certified to provide mental health behavioral aide services to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The ~~mental health professional or mental health practitioner~~ staff giving direction must begin with the goals on the ~~individualized~~ individual treatment plan, and instruct the mental health behavioral aide on how to implement therapeutic activities and interventions that will lead

to goal attainment. The ~~professional or practitioner~~ staff giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain or demonstrate the activities the aide is doing with the client and the activities' relationship to treatment goals. Direction is more didactic than is supervision and requires the ~~professional or practitioner~~ staff providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the ~~individualized~~ individual treatment plan and the ~~individualized~~ individual behavior plan. When providing direction, the ~~professional or practitioner~~ staff must:

(i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the ~~professional or practitioner~~ staff must approve and sign the progress notes;

(ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(iii) demonstrate family-friendly behaviors that support healthy collaboration among the child, the child's family, and providers as treatment is planned and implemented;

(iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; ~~and~~

(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide; and

(vi) ensure the immediate accessibility of a mental health professional, clinical trainee, or mental health practitioner to the behavioral aide during service delivery;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met each of the goals and objectives in the treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. ~~Revision of the individual treatment plan does not require a new diagnostic assessment unless the~~

~~client's mental health status has changed markedly. The updated treatment plan must be signed by the clinical supervisor and by the client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.~~

Sec. 90. Minnesota Statutes 2020, section 256B.0943, subdivision 7, is amended to read:

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as a:

(1) ~~a~~ mental health professional ~~as defined in subdivision 1, paragraph (o)~~; ~~or~~

(2) ~~a~~ clinical trainee;

(3) mental health practitioner ~~or clinical trainee. The mental health practitioner or clinical trainee must work under the clinical supervision of a mental health professional~~; ~~or~~

(4) mental health certified family peer specialist; or

~~(3) a~~ (5) mental health behavioral aide ~~working under the clinical supervision of a mental health professional to implement the rehabilitative mental health services previously introduced by a mental health professional or practitioner and identified in the client's individual treatment plan and individual behavior plan.~~

~~(A) A level I mental health behavioral aide must:~~

~~(i) be at least 18 years old;~~

~~(ii) have a high school diploma or commissioner of education-selected high school equivalency certification or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and~~

~~(iii) meet preservice and continuing education requirements under subdivision 8.~~

~~(B) A level II mental health behavioral aide must:~~

~~(i) be at least 18 years old;~~

~~(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents or complete a certificate program established under subdivision 8a; and~~

~~(iii) meet preservice and continuing education requirements in subdivision 8.~~

(c) A day treatment ~~multidisciplinary~~ team must include at least one mental health professional or clinical trainee and one mental health practitioner.

Sec. 91. Minnesota Statutes 2020, section 256B.0943, subdivision 9, is amended to read:

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

(1) ~~each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs.~~ the provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

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

(3) a day treatment program is provided to a group of clients by a ~~multidisciplinary~~ team under the ~~clinical~~ treatment supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available year-round at least three to five days per week, two or three hours per day, unless the normal five-day school week is shortened by a holiday, weather-related cancellation, or other districtwide reduction in a school week. A child transitioning into or out of day treatment must receive a minimum treatment of one day a week for a two-hour time block. The two-hour time block must include at least one hour of patient and/or family or group psychotherapy. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group

size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

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

(1) ~~patient and/or family, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0372, subpart 6.~~ psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it. When a provider delivering other services to a child under this section deems it not medically necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider entity must document the medical reasons why psychotherapy is not necessary. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training ~~must be provided by a mental health professional or a mental health practitioner who is delivering services that fall within the scope of the provider's practice and is supervised by a mental health professional who accepts full professional responsibility for the training. Skills training~~ is subject to the following requirements:

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

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

(iii) the mental health professional delivering or supervising the delivery of skills training must document any underlying psychiatric condition and must document how skills training is being used in conjunction with psychotherapy to address the underlying condition;

(iv) skills training delivered to the child's family must teach skills needed by parents to enhance the child's skill development, to help the child utilize daily life skills taught by a

mental health professional, clinical trainee, or mental health practitioner, and to develop or maintain a home environment that supports the child's progressive use of skills;

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

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

(B) any combination of two mental health professionals, ~~two~~ clinical trainees, or mental health practitioners ~~under supervision of a licensed mental health professional, or one mental health professional or clinical trainee and one mental health practitioner~~ must work with a group of nine to 12 clients;

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

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

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

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan and individual behavior plan, ~~which are performed minimally by a paraprofessional qualified according to subdivision 7, paragraph (b), clause (3),~~ and which are designed to improve the functioning of the child in the progressive use of developmentally appropriate psychosocial skills. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice,

repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (t), as previously taught by a mental health professional, clinical trainee, or mental health practitioner including:

(i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions so that the child progressively recognizes and responds to the cues independently;

(ii) performing as a practice partner or role-play partner;

(iii) reinforcing the child's accomplishments;

(iv) generalizing skill-building activities in the child's multiple natural settings;

(v) assigning further practice activities; and

(vi) intervening as necessary to redirect the child's target behavior and to de-escalate behavior that puts the child or other person at risk of injury.

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

~~(5) direction of a mental health behavioral aide must include the following:~~

~~(i) ongoing face-to-face observation of the mental health behavioral aide delivering services to a child by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and~~

~~(ii) immediate accessibility of the mental health professional, clinical trainee, or mental health practitioner to the mental health behavioral aide during service provision;~~

~~(6)~~ (5) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to ~~review, revise, and sign~~ approve the individual treatment

plan. ~~Notwithstanding Minnesota Rules, part 9505.0371, subpart 7,~~ Medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development~~; and~~.

~~(7) to be eligible for payment, a diagnostic assessment must be complete with regard to all required components, including multiple assessment appointments required for an extended diagnostic assessment and the written report. Dates of the multiple assessment appointments must be noted in the client's clinical record.~~

Sec. 92. Minnesota Statutes 2020, section 256B.0943, subdivision 11, is amended to read:

Subd. 11. **Documentation and billing.** ~~(a)~~ A provider entity must document the services it provides under this section. The provider entity must ensure that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. Billing for covered service components under subdivision 2, paragraph (b), must not include anything other than direct service time.

~~(b) An individual mental health provider must promptly document the following in a client's record after providing services to the client:~~

~~(1) each occurrence of the client's mental health service, including the date, type, start and stop times, scope of the service as described in the child's individual treatment plan, and outcome of the service compared to baselines and objectives;~~

~~(2) the name, dated signature, and credentials of the person who delivered the service;~~

~~(3) contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools. The provider must document the name and date of each contact;~~

~~(4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative, if applicable;~~

~~(5) required clinical supervision directly related to the identified client's services and needs, as appropriate, with co-signatures of the supervisor and supervisee; and~~

~~(6) the date when services are discontinued and reasons for discontinuation of services.~~

Sec. 93. Minnesota Statutes 2020, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) ~~Effective May 23, 2013, and~~ Subject to federal approval, medical assistance covers medically necessary intensive treatment services ~~described under paragraph (b) that~~ when the services are provided by a provider entity ~~eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the regulations established by a federally recognized Minnesota tribe~~ certified under and meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) Intensive treatment services to children with mental illness residing in foster family settings that comprise specific required service components provided in clauses (1) to (5) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~;

(2) crisis ~~assistance provided according to standards for children's therapeutic services and supports in section 256B.0943~~ planning;

(3) individual, family, and group psychoeducation services~~, defined in subdivision 1a, paragraph (q),~~ provided by a mental health professional or a clinical trainee;

(4) clinical care consultation~~, as defined in subdivision 1a, and~~ provided by a mental health professional or a clinical trainee; and

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

Sec. 94. Minnesota Statutes 2020, 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) "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) "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.~~

~~(c) "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.~~

~~(d)~~ (b) "Clinical trainee" ~~has the meaning given in Minnesota Rules, part 9505.0371, subpart 5, item C;~~ means a staff person who is qualified according to section 245I.04, subdivision 6.

~~(e)~~ (c) "Crisis ~~assistance~~ planning" has the meaning given in section 245.4871, subdivision 9a~~, including the development of a plan that addresses prevention and intervention strategies to be used in a potential crisis, but does not include actual crisis intervention~~.

~~(f)~~ (d) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences~~, as defined in Minnesota Rules, part 9505.0370, subpart 9,~~ into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

~~(g)~~ (e) "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.

~~(h)~~ (f) "Standard diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 11~~ means the assessment described in section 245I.10, subdivision 6.

~~(i)~~ (g) "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.

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

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

~~(l)~~ (j) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 15~~ means the plan described in section 245I.04, subdivisions 6 and 7.

~~(m) "Mental health practitioner" has the meaning given in section 245.462, subdivision 17, and a mental health practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C.~~

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

~~(n)~~ (l) "Mental health professional" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 18~~ means a staff person who is qualified according to section 245I.04, subdivision 2.

~~(o)~~ (m) "Mental illness" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 20~~ section 245I.02, subdivision 29.

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

~~(q)~~ (o) "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.

~~(r)~~ (p) "Psychotherapy" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 27~~ means the treatment described in section 256B.0671, subdivision 11.

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

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

Sec. 95. Minnesota Statutes 2020, 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, and has received: (1) a standard diagnostic assessment ~~and an evaluation of level of care needed, as defined in paragraphs (a) and (b).~~ within 180 days before the start of service that documents that intensive 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.

~~(a) The diagnostic assessment must:~~

~~(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be conducted by a mental health professional or a clinical trainee;~~

~~(2) determine whether or not a child meets the criteria for mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20;~~

~~(3) document that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments;~~

~~(4) be performed within 180 days before the start of service; and~~

~~(5) be completed as either a standard or extended diagnostic assessment annually to determine continued eligibility for the service.~~

~~(b) The evaluation of level of care must be conducted by the placing county, tribe, or case manager in conjunction with the diagnostic assessment as described by Minnesota Rules, part 9505.0372, subpart 1, item B, using a validated tool approved by the commissioner of human services and not subject to the rulemaking process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates that the child requires intensive intervention without 24-hour medical monitoring. The commissioner shall update the list of approved level of care tools annually and publish on the department's website.~~

Sec. 96. Minnesota Statutes 2020, section 256B.0946, subdivision 3, is amended to read:

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive children's mental 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.

Sec. 97. Minnesota Statutes 2020, 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 intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply with the following requirements in paragraphs (b) to ~~(n)~~ (l).

~~(b) A qualified clinical supervisor, as defined in and performing in compliance with Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and provision of services described in this section.~~

~~(c) Each client receiving treatment services must receive an extended diagnostic assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30 days of enrollment in this service unless the client has a previous extended diagnostic assessment that the client, parent, and mental health professional agree still accurately describes the client's current mental health functioning.~~

~~(d)~~ (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.

~~(e)~~ (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.

~~(f)~~ (e) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and ~~signed~~ approved every 90 days using the team consultation and treatment planning process~~, as defined in subdivision 1a, paragraph (s)~~.

~~(g)~~ (f) Clinical care consultation~~, as defined in subdivision 1a, paragraph (a),~~ must be provided in accordance with the client's individual treatment plan.

~~(h)~~ (g) Each client must have a crisis ~~assistance~~ 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.

~~(i)~~ (h) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week, unless reduced units of service are specified on the treatment plan as part of transition or on a discharge plan to another service or level of care. ~~Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.~~

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

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

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

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

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

Sec. 98. Minnesota Statutes 2020, section 256B.0946, subdivision 6, is amended to read:

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

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

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

(6) crisis response services under section ~~256B.0944~~ 256B.0624; ~~and~~

(7) transportation~~.~~; and

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

(b) Children receiving intensive treatment in foster care services are not eligible for medical assistance reimbursement for the following services while receiving intensive treatment in foster care:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section ~~256B.0625, subdivision 35b~~ 256B.0943;

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

Sec. 99. Minnesota Statutes 2020, section 256B.0947, subdivision 1, is amended to read:

Subdivision 1. **Scope.** ~~Effective November 1, 2011, and~~ Subject to federal approval, medical assistance covers medically necessary, intensive nonresidential rehabilitative mental health services ~~as defined in subdivision 2, for recipients as defined in subdivision 3,~~ when

the services are provided by an entity meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Sec. 100. Minnesota Statutes 2020, section 256B.0947, subdivision 2, is amended to read:

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

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, as adapted for youth, and are directed to recipients ~~ages 16, 17, 18, 19, or 20 with a serious mental illness or co-occurring mental illness and substance abuse addiction~~ who require intensive services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

(b) "Co-occurring mental illness and substance ~~abuse addiction~~ use disorder" means a dual diagnosis of at least one form of mental illness and at least one substance use disorder. Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine use.

(c) "Standard diagnostic assessment" ~~has the meaning given to it in Minnesota Rules, part 9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota Rules, part 9505.0372, subpart 1, and for this section must incorporate a determination of the youth's necessary level of care using a standardized functional assessment instrument approved and periodically updated by the commissioner~~ means the assessment described in section 245I.10, subdivision 6.

~~(d) "Education specialist" means an individual with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities.~~

~~(e) "Housing access support" means an ancillary activity to help an individual find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.~~

~~(f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring mental illness and substance use disorders by a team of cross-trained clinicians within the~~

~~same program, and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment.~~

~~(g)~~ (d) "Medication education services" means services provided individually or in groups, which focus on:

(1) educating the client and client's family or significant nonfamilial supporters about mental illness and symptoms;

(2) the role and effects of medications in treating symptoms of mental illness; and

(3) the side effects of medications.

Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses with certification in psychiatric and mental health care.

~~(h) "Peer specialist" means an employed team member who is a mental health certified peer specialist according to section 256B.0615 and also a former children's mental health consumer who:~~

~~(1) provides direct services to clients including social, emotional, and instrumental support and outreach;~~

~~(2) assists younger peers to identify and achieve specific life goals;~~

~~(3) works directly with clients to promote the client's self-determination, personal responsibility, and empowerment;~~

~~(4) assists youth with mental illness to regain control over their lives and their developmental process in order to move effectively into adulthood;~~

~~(5) provides training and education to other team members, consumer advocacy organizations, and clients on resiliency and peer support; and~~

~~(6) meets the following criteria:~~

~~(i) is at least 22 years of age;~~

~~(ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20, or co-occurring mental illness and substance abuse addiction;~~

~~(iii) is a former consumer of child and adolescent mental health services, or a former or current consumer of adult mental health services for a period of at least two years;~~

~~(iv) has at least a high school diploma or equivalent;~~

~~(v) has successfully completed training requirements determined and periodically updated by the commissioner;~~

~~(vi) is willing to disclose the individual's own mental health history to team members and clients; and~~

~~(vii) must be free of substance use problems for at least one year.~~

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

~~(i)~~ (f) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.

~~(j)~~ (g) "Substance use disorders" means one or more of the disorders defined in the diagnostic and statistical manual of mental disorders, current edition.

~~(k)~~ (h) "Transition services" means:

(1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the client to establish provider relationships;

(2) providing the client with knowledge and skills needed posttransition;

(3) establishing communication between sending and receiving entities;

(4) supporting a client's request for service authorization and enrollment; and

(5) establishing and enforcing procedures and schedules.

A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.

~~(l)~~ (i) "Treatment team" means all staff who provide services to recipients under this section.

~~(m)~~ (j) "Family peer specialist" means a staff person who is qualified under section 256B.0616.

Sec. 101. Minnesota Statutes 2020, section 256B.0947, subdivision 3, is amended to read:

Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

(1) is age 16, 17, 18, 19, or 20; and

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance ~~abuse addiction~~ use disorder, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a ~~level-of-care determination, using an instrument approved by the commissioner~~ level of care assessment as defined in section 245I.02, subdivision 19, that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers;

(4) has received a functional assessment as defined in section 245I.02, subdivision 17, that indicates functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system within the next two years; and

(5) has had a recent standard diagnostic assessment~~, as provided in Minnesota Rules, part 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A,~~ that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

Sec. 102. Minnesota Statutes 2020, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** ~~(a) Subject to federal approval, medical assistance covers all medically necessary intensive nonresidential rehabilitative mental health services and supports, as defined in this section, under a single daily rate per client. Services and supports must be delivered by an eligible provider under subdivision 5 to an eligible client under subdivision 3.~~

~~(b)~~ (a) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities are covered by ~~the~~ a single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

(2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph (t);

(3) crisis ~~assistance~~ planning as defined in section 245.4871, subdivision 9a~~, which includes recognition of factors precipitating a mental health crisis, identification of behaviors~~

~~related to the crisis, and the development of a plan to address prevention, intervention, and follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental health crisis; crisis assistance does not mean crisis response services or crisis intervention services provided in section 256B.0944~~;

(4) medication management provided by a physician or an advanced practice registered nurse with certification in psychiatric and mental health care;

(5) mental health case management as provided in section 256B.0625, subdivision 20;

(6) medication education services as defined in this section;

(7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;

(8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;

(9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

(10) coordination with, or performance of, crisis intervention and stabilization services as defined in section ~~256B.0944~~ 256B.0624;

~~(11) assessment of a client's treatment progress and effectiveness of services using standardized outcome measures published by the commissioner;~~

~~(12)~~ (11) transition services ~~as defined in this section~~;

~~(13) integrated dual disorders treatment as defined in this section~~ (12) co-occurring substance use disorder treatment as defined in section 245I.02, subdivision 11; and

~~(14)~~ (13) housing access support that assists clients to find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

~~(c)~~ (b) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity:

~~(1)~~ client access to crisis intervention services, as defined in section ~~256B.0944~~ 256B.0624, and available 24 hours per day and seven days per week~~;~~.

~~(2) completion of an extended diagnostic assessment, as defined in Minnesota Rules, part 9505.0372, subpart 1, item C; and~~

~~(3) determination of the client's needed level of care using an instrument approved and periodically updated by the commissioner.~~

Sec. 103. Minnesota Statutes 2020, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must ~~be provided by a provider entity as provided in subdivision 4~~ meet the standards in this section and chapter 245I as required in section 245I.011, subdivision 5.

(b) The treatment team for intensive nonresidential rehabilitative mental health services comprises both permanently employed core team members and client-specific team members as follows:

(1) ~~The core treatment team is an entity that operates under the direction of an independently licensed mental health professional, who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility for clients.~~ Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must minimally include~~, but is not limited to~~:

(i) ~~an independently licensed~~ a mental health professional~~, qualified under Minnesota Rules, part 9505.0371, subpart 5, item A,~~ who serves as team leader to provide administrative direction and ~~clinical~~ treatment supervision to the team;

(ii) an advanced-practice registered nurse with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist, either of which must be credentialed to prescribe medications;

(iii) a licensed alcohol and drug counselor who is also trained in mental health interventions; and

(iv) a mental health certified peer specialist ~~as defined in subdivision 2, paragraph (h)~~ who is qualified according to section 245I.04, subdivision 10, and is also a former children's mental health consumer.

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a clinical trainee qualified according to section 245I.04, subdivision 6;

(vi) a mental health practitioner~~, as defined in section 245.4871, subdivision 26~~ qualified according to section 245I.04, subdivision 4;

~~(vi)~~ (vii) a case management service provider, as defined in section 245.4871, subdivision 4;

~~(vii)~~ (viii) a housing access specialist; and

~~(viii)~~ (ix) a family peer specialist as defined in subdivision 2, paragraph (m).

(3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc members not employed by the team who consult on a specific client and who must accept overall clinical direction from the treatment team for the duration of the client's placement with the treatment team and must be paid by the provider agency at the rate for a typical session by that provider with that client or at a rate negotiated with the client-specific member. Client-specific treatment team members may include:

(i) the mental health professional treating the client prior to placement with the treatment team;

(ii) the client's current substance ~~abuse~~ use counselor, if applicable;

(iii) a lead member of the client's individualized education program team or school-based mental health provider, if applicable;

(iv) a representative from the client's health care home or primary care clinic, as needed to ensure integration of medical and behavioral health care;

(v) the client's probation officer or other juvenile justice representative, if applicable; and

(vi) the client's current vocational or employment counselor, if applicable.

(c) The ~~clinical~~ treatment supervisor shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team shall meet with the ~~clinical~~ treatment supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting must include

client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the individual client's treatment record.

(d) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

(e) The treatment team shall serve no more than 80 clients at any one time. Should local demand exceed the team's capacity, an additional team must be established rather than exceed this limit.

(f) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner, clinical trainee, or mental health professional. The provider shall have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(g) The intensive nonresidential rehabilitative mental health services provider shall participate in evaluation of the assertive community treatment for youth (Youth ACT) model as conducted by the commissioner, including the collection and reporting of data and the reporting of performance measures as specified by contract with the commissioner.

(h) A regional treatment team may serve multiple counties.

Sec. 104. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team must use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) Services must be age-appropriate and meet the specific needs of the client.

(d) The ~~initial functional assessment must be completed within ten days of intake and~~ 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 ~~six months~~ 90 days or prior to discharge from the service, whichever comes first.

(e) An individual treatment plan must be completed for each client, according to section 245I.10, subdivisions 7 and 8, and, additionally, must:

~~(1) be based on the information in the client's diagnostic assessment and baselines;~~

~~(2) identify goals and objectives of treatment, a treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;~~

~~(3) be developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;~~

~~(4) be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessments, and treatment planning;~~

~~(5) be reviewed at least once every six months and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment;~~

~~(6) be signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;~~

~~(7)~~ (1) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan;

~~(8)~~ (2) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment;

(ii) develop a schedule for accomplishing substance use disorder treatment goals and objectives; and

(iii) identify the individuals responsible for providing substance use disorder treatment services and supports;

~~(ii) be reviewed at least once every 90 days and revised, if necessary;~~

~~(9) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and~~

~~(10)~~ (3) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services~~.~~; and

(4) notwithstanding section 245I.10, subdivision 8, be reviewed at least every 90 days and revised to document treatment progress or, if progress is not documented, to document changes in treatment.

(f) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(g) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(h) The treatment team shall provide interventions to promote positive interpersonal relationships.

Sec. 105. Minnesota Statutes 2020, section 256B.0947, subdivision 7, is amended to read:

Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this section must be based on one daily encounter rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services, supports, and ancillary activities under this section, staff travel time to provide rehabilitative services under this section, and crisis response services under section ~~256B.0944~~ 256B.0624.

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

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

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

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

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

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

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

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

Sec. 106. Minnesota Statutes 2020, section 256B.0949, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this subdivision.

(b) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide EIDBI services and that has the legal responsibility to ensure that its employees or contractors carry out the responsibilities defined in this section. Agency includes a licensed individual professional who practices independently and acts as an agency.

(c) "Autism spectrum disorder or a related condition" or "ASD or a related condition" means either autism spectrum disorder (ASD) as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found to be closely related to ASD, as identified under the current version of the DSM, and meets all of the following criteria:

(1) is severe and chronic;

(2) results in impairment of adaptive behavior and function similar to that of a person with ASD;

(3) requires treatment or services similar to those required for a person with ASD; and

(4) results in substantial functional limitations in three core developmental deficits of ASD: social or interpersonal interaction; functional communication, including nonverbal or social communication; and restrictive or repetitive behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits or a high level of support in one or more of the following domains:

(i) behavioral challenges and self-regulation;

(ii) cognition;

(iii) learning and play;

(iv) self-care; or

(v) safety.

(d) "Person" means a person under 21 years of age.

(e) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including individual treatment planning, staff supervision, individual treatment plan progress monitoring, and treatment review for each person. Clinical supervision is provided by a qualified supervising professional (QSP) who takes full professional responsibility for the service provided by each supervisee.

(f) "Commissioner" means the commissioner of human services, unless otherwise specified.

(g) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive evaluation of a person to determine medical necessity for EIDBI services based on the requirements in subdivision 5.

(h) "Department" means the Department of Human Services, unless otherwise specified.

(i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI benefit" means a variety of individualized, intensive treatment modalities approved and published by the commissioner that are based in behavioral and developmental science consistent with best practices on effectiveness.

(j) "Generalizable goals" means results or gains that are observed during a variety of activities over time with different people, such as providers, family members, other adults, and people, and in different environments including, but not limited to, clinics, homes, schools, and the community.

(k) "Incident" means when any of the following occur:

(1) an illness, accident, or injury that requires first aid treatment;

(2) a bump or blow to the head; or

(3) an unusual or unexpected event that jeopardizes the safety of a person or staff, including a person leaving the agency unattended.

(l) "Individual treatment plan" or "ITP" means the person-centered, individualized written plan of care that integrates and coordinates person and family information from the CMDE for a person who meets medical necessity for the EIDBI benefit. An individual treatment plan must meet the standards in subdivision 6.

(m) "Legal representative" means the parent of a child who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about service for a person. For the purpose of this subdivision, "other representative with legal authority to make decisions" includes a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(n) "Mental health professional" ~~has the meaning given in~~ means a staff person who is qualified according to section ~~245.4871, subdivision 27, clauses (1) to (6)~~ 245I.04, subdivision 2.

(o) "Person-centered" means a service that both responds to the identified needs, interests, values, preferences, and desired outcomes of the person or the person's legal representative and respects the person's history, dignity, and cultural background and allows inclusion and participation in the person's community.

(p) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or level III treatment provider.

Sec. 107. Minnesota Statutes 2020, section 256B.0949, subdivision 4, is amended to read:

Subd. 4. **Diagnosis.** (a) A diagnosis of ASD or a related condition must:

(1) be based upon current DSM criteria including direct observations of the person and information from the person's legal representative or primary caregivers;

(2) be completed by either (i) a licensed physician or advanced practice registered nurse or (ii) a mental health professional; and

(3) meet the requirements of ~~Minnesota Rules, part 9505.0372, subpart 1, items B and C~~ a standard diagnostic assessment according to section 245I.10, subdivision 6.

(b) Additional assessment information may be considered to complete a diagnostic assessment including specialized tests administered through special education evaluations and licensed school personnel, and from professionals licensed in the fields of medicine, speech and language, psychology, occupational therapy, and physical therapy. A diagnostic assessment may include treatment recommendations.

Sec. 108. Minnesota Statutes 2020, section 256B.0949, subdivision 5a, is amended to read:

Subd. 5a. **Comprehensive multidisciplinary evaluation provider qualification.** A CMDE provider must:

(1) be a licensed physician, advanced practice registered nurse, a mental health professional, or a ~~mental health practitioner who meets the requirements of a~~ clinical trainee ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~ who is qualified according to section 245I.04, subdivision 6;

(2) have at least 2,000 hours of clinical experience in the evaluation and treatment of people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in the following content areas: ASD or a related condition diagnosis, ASD or a related condition treatment strategies, and child development; and

(3) be able to diagnose, evaluate, or provide treatment within the provider's scope of practice and professional license.

Sec. 109. Minnesota Statutes 2020, section 256B.25, subdivision 3, is amended to read:

Subd. 3. **Payment exceptions.** The limitation in subdivision 2 shall not apply to:

(1) payment of Minnesota supplemental assistance funds to recipients who reside in facilities which are involved in litigation contesting their designation as an institution for treatment of mental disease;

(2) payment or grants to a boarding care home or supervised living facility licensed by the Department of Human Services under Minnesota Rules, parts 2960.0130 to 2960.0220 ~~or~~, 2960.0580 to 2960.0700, or 9520.0500 to 9520.0670, or under chapter 245G or 245I, or payment to recipients who reside in these facilities;

(3) payments or grants to a boarding care home or supervised living facility which are ineligible for certification under United States Code, title 42, sections 1396-1396p;

(4) payments or grants otherwise specifically authorized by statute or rule.

Sec. 110. Minnesota Statutes 2020, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

~~(c) The commissioner shall establish three levels of payment for mental health diagnostic assessment, based on three levels of complexity. The aggregate payment under the tiered rates must not exceed the projected aggregate payments for mental health diagnostic assessment under the previous single rate. The new rate structure is effective January 1, 2011, or upon federal approval, whichever is later.~~

~~(d)~~ (c) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

~~(e)~~ (d) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

Sec. 111. Minnesota Statutes 2020, section 256B.763, is amended to read:

256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.

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

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

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

(3) mental health clinics ~~and centers~~ certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ 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) For services defined in paragraph (b) and rendered on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943 and not already included in paragraph (a), payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007.

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

(h) For services described in paragraphs (b), (e), and (g) and rendered on or after July 1, 2017, payment rates for mental health clinics ~~and centers~~ certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20, that are not designated as essential community providers under section 62Q.19 shall be equal to payment rates for mental health clinics ~~and centers~~ certified under ~~Minnesota Rules, parts 9520.0750 to 9520.0870~~ section 245I.20, that are designated as essential community providers under section 62Q.19. In order to receive increased payment rates under this paragraph, a provider must demonstrate a commitment to serve low-income and underserved populations by:

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

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

Sec. 112. Minnesota Statutes 2020, section 256P.01, subdivision 6a, is amended to read:

Subd. 6a. **Qualified professional.** (a) For illness, injury, or incapacity, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse, physical therapist, occupational therapist, or licensed chiropractor, according to their scope of practice.

(b) For developmental disability, learning disability, and intelligence testing, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse, licensed independent clinical social worker, licensed psychologist, certified school psychologist, or certified psychometrist working under the supervision of a licensed psychologist.

(c) For mental health, a "qualified professional" means a licensed physician, advanced practice registered nurse, or qualified mental health professional under section ~~245.462, subdivision 18, clauses (1) to (6)~~ 245I.04, subdivision 2.

(d) For substance use disorder, a "qualified professional" means a licensed physician, a qualified mental health professional under section 245.462, subdivision 18, clauses (1) to (6), or an individual as defined in section 245G.11, subdivision 3, 4, or 5.

Sec. 113. Minnesota Statutes 2020, section 295.50, subdivision 9b, is amended to read:

Subd. 9b. **Patient services.** (a) "Patient services" means inpatient and outpatient services and other goods and services provided by hospitals, surgical centers, or health care providers. They include the following health care goods and services provided to a patient or consumer:

(1) bed and board;

(2) nursing services and other related services;

(3) use of hospitals, surgical centers, or health care provider facilities;

(4) medical social services;

(5) drugs, biologicals, supplies, appliances, and equipment;

(6) other diagnostic or therapeutic items or services;

(7) medical or surgical services;

(8) items and services furnished to ambulatory patients not requiring emergency care; and

(9) emergency services.

(b) "Patient services" does not include:

(1) services provided to nursing homes licensed under chapter 144A;

(2) examinations for purposes of utilization reviews, insurance claims or eligibility, litigation, and employment, including reviews of medical records for those purposes;

(3) services provided to and by community residential mental health facilities licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, and to and by residential treatment programs for children with severe emotional disturbance licensed or certified under chapter 245A;

(4) services provided under the following programs: day treatment services as defined in section 245.462, subdivision 8; assertive community treatment as described in section 256B.0622; adult rehabilitative mental health services as described in section 256B.0623; ~~adult~~ crisis response services as described in section 256B.0624; and children's therapeutic services and supports as described in section 256B.0943; ~~and children's mental health crisis response services as described in section 256B.0944;~~

(5) services provided to and by community mental health centers as defined in section 245.62, subdivision 2;

(6) services provided to and by assisted living programs and congregate housing programs;

(7) hospice care services;

(8) home and community-based waivered services under chapter 256S and sections 256B.49 and 256B.501;

(9) targeted case management services under sections 256B.0621; 256B.0625, subdivisions 20, 20a, 33, and 44; and 256B.094; and

(10) services provided to the following: supervised living facilities for persons with developmental disabilities licensed under Minnesota Rules, parts 4665.0100 to 4665.9900; housing with services establishments required to be registered under chapter 144D; board and lodging establishments providing only custodial services that are licensed under chapter 157 and registered under section 157.17 to provide supportive services or health supervision services; adult foster homes as defined in Minnesota Rules, part 9555.5105; day training and habilitation services for adults with developmental disabilities as defined in section 252.41, subdivision 3; boarding care homes as defined in Minnesota Rules, part 4655.0100; adult day care services as defined in section 245A.02, subdivision 2a; and home health agencies as defined in Minnesota Rules, part 9505.0175, subpart 15, or licensed under chapter 144A.

Sec. 114. Minnesota Statutes 2020, section 325F.721, subdivision 1, is amended to read:

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

(b) "Covered setting" means an unlicensed setting providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, supportive services. For the purposes of this section, covered setting does not mean:

(1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361;

(2) a nursing home licensed under chapter 144A;

(3) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56;

(4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D ~~or~~, 245G, or 245I;

(5) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D;

(6) private homes in which the residents are related by kinship, law, or affinity with the providers of services;

(7) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(8) temporary family health care dwellings as defined in sections 394.307 and 462.3593;

(9) settings offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing;

(10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services;

(11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q;

(12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56;

(13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011; or

(14) an assisted living facility licensed under chapter 144G.

(c) "'I'm okay' check services" means providing a service to, by any means, check on the safety of a resident.

(d) "Resident" means a person entering into written contract for housing and services with a covered setting.

(e) "Supportive services" means:

(1) assistance with laundry, shopping, and household chores;

(2) housekeeping services;

(3) provision of meals or assistance with meals or food preparation;

(4) help with arranging, or arranging transportation to, medical, social, recreational, personal, or social services appointments; or

(5) provision of social or recreational services.

Arranging for services does not include making referrals or contacting a service provider in an emergency.

Sec. 115. **REPEALER.**

(a) Minnesota Statutes 2020, sections 245.462, subdivision 4a; 245.4879, subdivision 2; 245.62, subdivisions 3 and 4; 245.69, subdivision 2; 256B.0615, subdivision 2; 256B.0616, subdivision 2; 256B.0622, subdivisions 3 and 5a; 256B.0623, subdivisions 7, 8, 10, and 11; 256B.0625, subdivisions 5l, 35a, 35b, 61, 62, and 65; 256B.0943, subdivisions 8 and 10; 256B.0944; and 256B.0946, subdivision 5, are repealed.

(b) Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020; 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090; 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160; 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; 9520.0230; 9520.0750; 9520.0760; 9520.0770; 9520.0780; 9520.0790; 9520.0800; 9520.0810; 9520.0820; 9520.0830; 9520.0840; 9520.0850; 9520.0860; and 9520.0870, are repealed.

ARTICLE 10
FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2019, First Special Session chapter 9, article 14, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2021" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2021.

APPROPRIATIONS
Available for the Year

		Ending June 30	
		2021	
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**			
Subdivision 1. **Total Appropriation**		**$**	**(755,322,000)**
Appropriations by Fund			
	2021		
General	(692,529,000)		
Health Care Access	(38,888,000)		
Federal TANF	(23,905,000)		
Subd. 2. **Forecasted Programs**			
(a) **Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP)**			
Appropriations by Fund			
	2021		
General	42,700,000		
Federal TANF	(23,911,000)		
(b) **MFIP Child Care Assistance**			(19,230,000)
(c) **General Assistance**			2,560,000
(d) **Minnesota Supplemental Aid**			3,672,000
(e) **Housing Support**			3,676,000
(f) **Northstar Care for Children**			(8,435,000)
(g) **MinnesotaCare**			(38,888,000)
This appropriation is from the health care access fund.			
(h) **Medical Assistance**			
Appropriations by Fund			
	2021		
General	(667,401,000)		
Health Care Access	-0-		
(i) **Alternative Care**			247,000

(j) **Consolidated Chemical Dependency Treatment Fund (CCDTF) Entitlement**	(50,318,000)	
Subd. 3. **Technical Activities**	6,000	

This appropriation is from the federal TANF fund.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 11

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2022" and "2023" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2022, or June 30, 2023, respectively. "The first year" is fiscal year 2022. "The second year" is fiscal year 2023. "The biennium" is fiscal years 2022 and 2023.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2022	**2023**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ 9,319,214,000**	**$ 9,441,484,000**

Appropriations by Fund

	2022	2023
General	8,160,825,000	8,307,874,000
State Government Special Revenue	4,299,000	4,299,000
Health Care Access	858,608,000	837,211,000
Federal TANF	291,026,000	287,644,000

Lottery Prize	1,896,000	1,896,000
Opiate Epidemic Response	2,560,000	2,560,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **TANF Maintenance of Effort**

(a) **Nonfederal Expenditures.** The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF/MOE requirements, the commissioner may report as TANF/MOE expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) **Nonfederal Expenditures; Reporting.** For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) **Certain Expenditures Required.** The commissioner shall ensure that the MOE used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to zero percent in fiscal year 2022, zero percent in fiscal year 2023, and beginning in fiscal year 2024, at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) **Limitation; Exceptions.** The commissioner must not claim an amount of TANF/MOE in excess of the 75 percent

standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

(e) **Supplemental Expenditures.** For the purposes of paragraph (d), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(f) **Reduction of Appropriations; Exception.** The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(g) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(h) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

(i) **Federal SNAP Education and Training Grants.** Federal funds available during fiscal years 2022 and 2023 for Supplemental Nutrition Assistance Program Education and Training and SNAP Quality Control Performance Bonus grants are appropriated to the commissioner of human services for the

purposes allowable under the terms of the federal award. This paragraph is effective the day following final enactment.

Subd. 3. **Central Office; Operations**

	Appropriations by Fund	
General	159,449,000	162,220,000
State Government Special Revenue	4,174,000	4,174,000
Health Care Access	16,966,000	16,966,000
Federal TANF	100,000	100,000

(a) **Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Base Level Adjustment.** The general fund base is $161,781,000 in fiscal year 2024 and $161,934,000 in fiscal year 2025.

Subd. 4. **Central Office; Children and Families**

	Appropriations by Fund	
General	17,623,000	17,994,000
Federal TANF	2,582,000	2,582,000

(a) **Financial Institution Data Match and Payment of Fees.** The commissioner is authorized to allocate up to $310,000 each year in fiscal year 2022 and fiscal year 2023 from the systems special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

(b) **Base Level Adjustment.** The general fund base is $18,054,000 in fiscal year 2024 and $18,054,000 in fiscal year 2025.

Subd. 5. **Central Office; Health Care**

	Appropriations by Fund	
General	22,385,000	22,593,000
Health Care Access	28,168,000	28,168,000

(a) **Case Management Benefit Study for American Indians.** $200,000 in fiscal year 2022 is for a contract to conduct fiscal analysis and development of standards for a targeted case management benefit for American Indians. The commissioner of human services must consult the Minnesota Indian Affairs Council in the development of any request for proposal and in the evaluation of responses. This is a onetime appropriation. Any unencumbered balance remaining from the first year does not cancel and is available for the second year of the biennium.

(b) **Base Level Adjustment.** The general fund base is $23,453,000 in fiscal year 2024 and $23,512,000 in fiscal year 2025.

Subd. 6. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	17,451,000	17,496,000
State Government Special Revenue	125,000	125,000

(a) **Assisted Living Survey.** $2,593,000 in fiscal year 2022 and $2,593,000 in fiscal year 2023 are for development and administration of a resident experience survey and family survey for all housing with services establishments and assisted living facilities. These appropriations are available in either year of the biennium. This paragraph does not expire.

(b) **Evaluation on Equitable Access to Home and Community-Based Waivers.** $190,000 in fiscal year 2022 and $235,000 in fiscal year 2023 are for an evaluation to identify and address barriers to equitable access to home and community-based services for people with disabilities and older adults. The commissioner shall partner with Black people, Indigenous people, and people of color and lead agencies to better understand institutional biases in the home and community-based service system and make recommendations to eliminate them. This is a onetime appropriation.

(c) **Base Level Adjustment.** The general fund base is $17,311,000 in fiscal year 2024 and $17,381,000 in fiscal year 2025.

Subd. 7. **Central Office; Community Supports**

		Appropriations by Fund	
General		33,934,000	33,619,000
Lottery Prize		163,000	163,000
Opioid Epidemic Response		60,000	60,000

(a) **Study of Self Directed Tiered Wage Structure.** $25,000 in fiscal year 2022 is for a study of the feasibility of a tiered wage structure for individual providers. This appropriation is onetime. This appropriation is available only if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

(b) **Case Management Rate Methodology Analysis.** $300,000 in fiscal year 2022 and $200,000 in fiscal year 2023 is for the fiscal analysis needed to establish federally compliant payment methodologies for all Medical Assistance funded case management services. This is a onetime appropriation.

(c) **Case Management Quality Improvement and Training.** $200,000 in fiscal year 2022 is for the development of reporting measures to determine outcomes for case management services and for the identification of training needs and development of training tools across all case management services. This is a onetime appropriation. Any unencumbered balance remaining from the first year does not cancel and is available for the second year of the biennium.

(d) **Homeless Management Information System.** $500,000 in fiscal year 2022 and $500,000 in fiscal year 2023 are for support of the Homeless Management Information System (HMIS).

(e) **Base Level Adjustment.** The general fund base is $33,667,000 in fiscal year 2024 and $33,704,000 in fiscal year 2025. The opiate epidemic response fund base is $60,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 8. **Forecasted Programs; MFIP/DWP**

Appropriations by Fund		
General	75,674,000	75,262,000
Federal TANF	112,689,000	110,251,000

Subd. 9. **Forecasted Programs; MFIP Child Care Assistance** 103,559,000 110,880,000

Subd. 10. **Forecasted Programs; General Assistance** 52,841,000 52,948,000

(a) **General Assistance Standard.** The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

(b) **Emergency General Assistance Limit.** The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2022 and $6,729,812 in fiscal year 2023. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

Subd. 11. **Forecasted Programs; Minnesota Supplemental Aid** 51,560,000 52,486,000

Subd. 12. **Forecasted Programs; Housing Support** 182,448,000 189,494,000

Subd. 13. **Forecasted Programs; Northstar Care for Children** 116,578,000 121,196,000

Subd. 14. **Forecasted Programs; MinnesotaCare** 198,831,000 176,513,000

Generally. This appropriation is from the health care access fund.

Subd. 15. **Forecasted Programs; Medical Assistance**

Appropriations by Fund		
General	6,347,136,000	6,450,726,000
Health Care Access	611,178,000	612,099,000

Behavioral Health Services. $1,000,000 in fiscal year 2022 and $1,000,000 in fiscal year 2023 are for behavioral health services provided by hospitals identified under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (a), clause (4). The increase in payments shall be made by increasing the adjustment under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (e), clause (2).

Subd. 16. **Forecasted Programs; Alternative Care** 45,683,000 45,662,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 17. **Forecasted Programs; Behavioral Health Fund** 102,629,000 115,956,000

Subd. 18. **Grant Programs; Support Services Grants**

Appropriations by Fund

General	8,715,000	8,715,000
Federal TANF	96,311,000	96,311,000

Subd. 19. **Grant Programs; Basic Sliding Fee Child Care Assistance Grants** 53,599,000 53,593,000

Subd. 20. **Grant Programs; Child Care Development Grants** 1,737,000 1,737,000

Subd. 21. **Grant Programs; Child Support Enforcement Grants** 50,000 50,000

Subd. 22. **Grant Programs; Children's Services Grants**

Appropriations by Fund

General	51,983,000	51,698,000
Federal TANF	140,000	140,000

Title IV-E Adoption Assistance. (1) The commissioner shall allocate funds from the Title IV-E reimbursement to the state from the Fostering Connections to Success and Increasing Adoptions Act for adoptive, foster, and kinship families as required in Minnesota Statutes, section 256N.261.

(2) Additional federal reimbursement to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for title IV-E adoption assistance is for postadoption, foster care, adoption, and kinship services, including a parent-to-parent support network.

Subd. 23. **Grant Programs; Children and Community Service Grants** 60,251,000 60,856,000

Subd. 24. **Grant Programs; Children and Economic Support Grants** 27,040,000 27,040,000

Minnesota Food Assistance Program. Unexpended funds for the Minnesota food assistance program for fiscal year 2022 do not

cancel but are available for this purpose in fiscal year 2023.

Subd. 25. **Grant Programs; Health Care Grants**

	Appropriations by Fund	
General	4,811,000	4,811,000
Health Care Access	3,465,000	3,465,000

Integrated Care for High-Risk Pregnant Women Grant Program. $1,100,000 in fiscal year 2022 and $1,100,000 in fiscal year 2023 are for the integrated care for high-risk pregnant women grant program under Minnesota Statutes, section 256B.79.

Subd. 26. **Grant Programs; Other Long-Term Care Grants**	1,925,000	1,925,000
Subd. 27. **Grant Programs; Aging and Adult Services Grants**	32,495,000	32,495,000
Subd. 28. **Grant Programs; Deaf and Hard-of-Hearing Grants**	2,886,000	2,886,000
Subd. 29. **Grant Programs; Disabilities Grants**	18,651,000	17,263,000

Training Stipends for Direct Support Services Providers. $1,000,000 in fiscal year 2022 is for stipends for individual providers of direct support services as defined in Minnesota Statutes, section 256B.0711, subdivision 1. These stipends are available to individual providers who have completed designated voluntary trainings made available through the State-Provider Cooperation Committee formed by the State of Minnesota and the Service Employees International Union Healthcare Minnesota. Any unspent appropriation in fiscal year 2022 is available in fiscal year 2023. This is a onetime appropriation. This appropriation is available only if the labor agreement between the state

of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

Subd. 30. **Grant Programs; Housing Support Grants** 15,364,000 15,364,000

Subd. 31. **Grant Programs; Adult Mental Health Grants**

	Appropriations by Fund	
General	81,043,000	81,044,000
Opiate Epidemic Response	2,000,000	2,000,000

Base Level Adjustment. The general fund base is $82,324,000 in fiscal year 2024 and $82,324,000 in fiscal year 2025.

The Opiate Epidemic Response base is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 32. **Grant Programs; Child Mental Health Grants** 25,703,000 25,703,000

Base Level Adjustment. The general fund base is $25,726,000 in fiscal year 2024 and $25,726,000 in fiscal year 2025.

Subd. 33. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	2,273,000	2,274,000
Lottery Prize	1,733,000	1,733,000
Opiate Epidemic Response	500,000	500,000

Problem Gambling. (a) $225,000 in fiscal year 2022 and $225,000 in fiscal year 2023 are from the lottery prize fund for a grant to the state affiliate recognized by the National

Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

(b) The general fund base is $2,636,000 in fiscal year 2024 and $2,636,000 in fiscal year 2025. The opiate epidemic response fund base is $500,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 34. **Direct Care and Treatment - Generally**

Transfer Authority. Money appropriated to budget activities under this subdivision and subdivisions 35, 36, 37, and 38, may be transferred between budget activities and between years of the biennium with the approval of the commissioner of management and budget.

Subd. 35. **Direct Care and Treatment - Mental Health and Substance Abuse**	142,940,000	144,103,000

(a) **Transfer Authority.** Money appropriated to support the continued operations of the Community Addiction Recovery Enterprise (C.A.R.E.) program may be transferred to the enterprise fund for C.A.R.E.

(b) **Operating Adjustment.** $2,307,000 in fiscal year 2022 and $2,453,000 in fiscal year 2023 are appropriated for the Community Addiction Recovery Enterprise program. The commissioner may transfer $2,307,000 in fiscal year 2022 and $2,453,000 in fiscal year

2023 to the enterprise fund for Community Addiction Recovery Enterprise.

Subd. 36. **Direct Care and Treatment - Community-Based Services** 18,695,000 19,752,000

(a) **Transfer Authority.** Money appropriated to support the continued operations of the Minnesota State Operated Community Services (MSOCS) program may be transferred to the enterprise fund for MSOCS.

(b) **Operating Adjustment.** $1,519,000 in fiscal year 2022 and $2,541,000 in fiscal year 2023 are appropriated for the Minnesota State Operated Community Services program. The commissioner may transfer $1,519,000 in fiscal year 2022 and $2,541,000 in fiscal year 2023 to the enterprise fund for Minnesota State Operated Community Services.

Subd. 37. **Direct Care and Treatment - Forensic Services** 121,039,000 122,206,000

Subd. 38. **Direct Care and Treatment - Sex Offender Program** 98,833,000 99,917,000

Transfer Authority. Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

Subd. 39. **Direct Care and Treatment - Operations** 61,842,000 65,910,000

Subd. 40. **Technical Activities** 79,204,000 78,260,000

(a) **Generally.** This appropriation is from the federal TANF fund.

(b) **Base Level Adjustment.** The TANF fund base is $71,493,000 in fiscal year 2024 and $71,493,000 in fiscal year 2025.

Sec. 3. Laws 2017, chapter 13, article 1, section 15, as amended by Laws 2017, First Special Session chapter 6, article 5, section 10, and Laws 2019, First Special Session chapter 9, article 8, section 19, is amended to read:

Sec. 15. **MINNESOTA PREMIUM SECURITY PLAN FUNDING.**

(a) The Minnesota Comprehensive Health Association shall fund the operational and administrative costs and reinsurance payments of the Minnesota security plan and association using the following amounts deposited in the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1, in the following order:

(1) any federal funding available;

(2) funds deposited under article 1, sections 12 and 13;

(3) any state funds from the health care access fund; and

(4) any state funds from the general fund.

(b) The association shall transfer from the premium security plan account any remaining state funds not used for the Minnesota premium security plan by June 30, 2023, to the commissioner of commerce. Any amount transferred to the commissioner of commerce shall be deposited in the ~~health care access fund in Minnesota Statutes, section 16A.724~~ general fund for the fiscal year starting on July 1, 2023.

(c) The Minnesota Comprehensive Health Association may not spend more than $271,000,000 for benefit year 2018 and not more than $271,000,000 for benefit year 2019 for the operational and administrative costs of, and reinsurance payments under, the Minnesota premium security plan.

Sec. 4. **APPROPRIATION; MINNESOTA FAMILY INVESTMENT PROGRAM SUPPLEMENTAL PAYMENT.**

$24,235,000 in fiscal year 2021 is appropriated from the TANF fund to the commissioner of human services to provide a onetime cash benefit of up to $750 for each household enrolled in the Minnesota family investment program or diversionary work program under Minnesota Statutes, chapter 256J, at the time that the cash benefit is distributed. The commissioner shall distribute these funds through existing systems and in a manner that minimizes the burden to families. This is a onetime appropriation.

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

Sec. 5. **GAMBLING FUNDS BALANCE TRANSFER.**

The commissioner shall cancel $1,000,000 from the available balance in accounts established under Minnesota Statutes, section 297E.02, subdivision 3, paragraph (c), to the general fund by June 30, 2021.

Sec. 6. **TRANSFERS; HUMAN SERVICES.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2023, within fiscal years among the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid program, group residential housing program, the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Sec. 7. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 8. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2023, unless a different expiration date is explicit.

Sec. 9. **EFFECTIVE DATE.**

This article is effective July 1, 2021, unless a different effective date is specified.

245.462 DEFINITIONS.

Subd. 4a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional cosigning individual treatment plans and by entries in the client's record regarding supervisory activities.

245.4879 EMERGENCY SERVICES.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to the child with an emotional disturbance provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) When emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

245.62 COMMUNITY MENTAL HEALTH CENTER.

Subd. 3. **Clinical supervisor.** All community mental health center services shall be provided under the clinical supervision of a licensed psychologist licensed under sections 148.88 to 148.98, or a physician who is board certified or eligible for board certification in psychiatry, and who is licensed under section 147.02.

Subd. 4. **Rules.** The commissioner shall promulgate rules to establish standards for the designation of an agency as a community mental health center. These standards shall include, but are not limited to:

(1) provision of mental health services in the prevention, identification, treatment and aftercare of emotional disorders, chronic and acute mental illness, developmental disabilities, and alcohol and drug abuse and dependency, including the services listed in section 245.61 except detoxification services;

(2) establishment of a community mental health center board pursuant to section 245.66; and

(3) approval pursuant to section 245.69, subdivision 2.

245.69 ADDITIONAL DUTIES OF COMMISSIONER.

Subd. 2. **Approval of centers and clinics.** The commissioner of human services has the authority to approve or disapprove public and private mental health centers and public and private mental health clinics for the purposes of section 62A.152, subdivision 2. For the purposes of this subdivision the commissioner shall promulgate rules in accordance with sections 14.001 to 14.69. The rules shall require each applicant to pay a fee to cover costs of processing applications and determining compliance with the rules and this subdivision. The commissioner may contract with any state agency, individual, corporation or association to which the commissioner shall delegate all but final approval and disapproval authority to determine compliance or noncompliance.

(a) Each approved mental health center and each approved mental health clinic shall have a multidisciplinary team of professional staff persons as required by rule. A mental health center or mental health clinic may provide the staffing required by rule by means of written contracts with professional persons or with other health care providers. Any personnel qualifications developed by rule shall be consistent with any personnel standards developed pursuant to chapter 214.

(b) Each approved mental health clinic and each approved mental health center shall establish a written treatment plan for each outpatient for whom services are reimbursable through insurance or public assistance. The treatment plan shall be developed in accordance with the rules and shall include a patient history, treatment goals, a statement of diagnosis and a treatment strategy. The clinic or center shall provide access to hospital admission as a bed patient as needed by any outpatient. The clinic or center shall ensure ongoing consultation among and availability of all members of the multidisciplinary team.

(c) As part of the required consultation, members of the multidisciplinary team shall meet at least twice monthly to conduct case reviews, peer consultations, treatment plan development and in-depth case discussion. Written minutes of these meetings shall be kept at the clinic or center for three years.

(d) Each approved center or clinic shall establish mechanisms for quality assurance and submit documentation concerning the mechanisms to the commissioner as required by rule, including:

(1) continuing education of each professional staff person;

(2) an ongoing internal utilization and peer review plan and procedures;

(3) mechanisms of staff supervision; and

(4) procedures for review by the commissioner or a delegate.

(e) The commissioner shall disapprove an applicant, or withdraw approval of a clinic or center, which the commissioner finds does not comply with the requirements of the rules or this subdivision. A clinic or center which is disapproved or whose approval is withdrawn is entitled to a contested case hearing and judicial review pursuant to sections 14.01 to 14.69.

(f) Data on individuals collected by approved clinics and centers, including written minutes of team meetings, is private data on individuals within the welfare system as provided in chapter 13.

(g) Each center or clinic that is approved and in compliance with the commissioner's existing rule on July 1, 1980, is approved for purposes of section 62A.152, subdivision 2, until rules are promulgated to implement this section.

245A.191 PROVIDER ELIGIBILITY FOR PAYMENTS FROM THE CHEMICAL DEPENDENCY CONSOLIDATED TREATMENT FUND.

(a) When a substance use disorder treatment provider licensed under this chapter, and governed by the standards of chapter 245G or Minnesota Rules, parts 2960.0430 to 2960.0490, agrees to meet the applicable requirements under section 254B.05, subdivision 5, to be eligible for enhanced funding from the chemical dependency consolidated treatment fund, the applicable requirements

under section 254B.05 are also licensing requirements that may be monitored for compliance through licensing investigations and licensing inspections.

(b) Noncompliance with the requirements identified under paragraph (a) may result in:

(1) a correction order or a conditional license under section 245A.06, or sanctions under section 245A.07;

(2) nonpayment of claims submitted by the license holder for public program reimbursement;

(3) recovery of payments made for the service;

(4) disenrollment in the public payment program; or

(5) other administrative, civil, or criminal penalties as provided by law.

245C.10 BACKGROUND STUDY; FEES.

Subd. 2. **Supplemental nursing services agencies.** The commissioner shall recover the cost of the background studies initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1, through a fee of no more than $20 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 2a. **Occupations regulated by commissioner of health.** The commissioner shall set fees to recover the cost of combined background studies and criminal background checks initiated by applicants, licensees, and certified practitioners regulated under sections 148.511 to 148.5198 and chapter 153A. The fees collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks.

Subd. 3. **Personal care provider organizations.** The commissioner shall recover the cost of background studies initiated by a personal care provider organization under sections 256B.0651 to 256B.0654 and 256B.0659 through a fee of no more than $20 per study charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 4. **Temporary personnel agencies, educational programs, and professional services agencies.** The commissioner shall recover the cost of the background studies initiated by temporary personnel agencies, educational programs, and professional services agencies that initiate background studies under section 245C.03, subdivision 4, through a fee of no more than $20 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 5. **Adult foster care and family adult day services.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for the purposes of adult foster care and family adult day services licensing, through a fee of no more than $20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** The commissioner shall recover the cost of background studies initiated by unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities under section 256B.4912 through a fee of no more than $20 per study.

Subd. 7. **Private agencies.** The commissioner shall recover the cost of conducting background studies under section 245C.33 for studies initiated by private agencies for the purpose of adoption through a fee of no more than $70 per study charged to the private agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 8. **Children's therapeutic services and supports providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 7, for the purposes of children's therapeutic services and supports under section 256B.0943, through a fee of no more than $20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for all programs that are licensed by the commissioner, except child foster care when the applicant or license holder resides in the

home where child foster care services are provided, family child care, child care centers, certified license-exempt child care centers, and legal nonlicensed child care authorized under chapter 119B, through a fee of no more than $20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 9a. **Child care programs.** The commissioner shall recover the cost of a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care providers authorized under chapter 119B through a fee of no more than $40 per study charged to the license holder. A fee of no more than $20 per study shall be charged for studies conducted under section 245C.05, subdivision 5a, paragraph (a). The fees collected under this subdivision are appropriated to the commissioner to conduct background studies.

Subd. 10. **Community first services and supports organizations.** The commissioner shall recover the cost of background studies initiated by an agency-provider delivering services under section 256B.85, subdivision 11, or a financial management services provider providing service functions under section 256B.85, subdivision 13, through a fee of no more than $20 per study, charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 11. **Providers of housing support.** The commissioner shall recover the cost of background studies initiated by providers of housing support under section 256I.04 through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 12. **Child protection workers or social services staff having responsibility for child protective duties.** The commissioner shall recover the cost of background studies initiated by county social services agencies and local welfare agencies for individuals who are required to have a background study under section 626.559, subdivision 1b, through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 13. **Providers of special transportation service.** The commissioner shall recover the cost of background studies initiated by providers of special transportation service under section 174.30 through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 14. **Children's residential facilities.** The commissioner shall recover the cost of background studies initiated by a licensed children's residential facility through a fee of no more than $51 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Subd. 16. **Providers of housing support services.** The commissioner shall recover the cost of background studies initiated by providers of housing support services under section 256B.051 through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

256B.0596 MENTAL HEALTH CASE MANAGEMENT.

Counties shall contract with eligible providers willing to provide mental health case management services under section 256B.0625, subdivision 20. In order to be eligible, in addition to general provider requirements under this chapter, the provider must:

(1) be willing to provide the mental health case management services; and

(2) have a minimum of at least one contact with the client per week. This section is not intended to limit the ability of a county to provide its own mental health case management services.

256B.0615 MENTAL HEALTH CERTIFIED PEER SPECIALIST.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified peer specialist program model, which:

(1) provides nonclinical peer support counseling by certified peer specialists;

(2) provides a part of a wraparound continuum of services in conjunction with other community mental health services;

(3) is individualized to the consumer; and

(4) promotes socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

256B.0616 MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified family peer specialists program model which:

(1) provides nonclinical family peer support counseling, building on the strengths of families and helping them achieve desired outcomes;

(2) collaborates with others providing care or support to the family;

(3) provides nonadversarial advocacy;

(4) promotes the individual family culture in the treatment milieu;

(5) links parents to other parents in the community;

(6) offers support and encouragement;

(7) assists parents in developing coping mechanisms and problem-solving skills;

(8) promotes resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services;

(9) establishes and provides peer-led parent support groups; and

(10) increases the child's ability to function better within the child's home, school, and community by educating parents on community resources, assisting with problem solving, and educating parents on mental illnesses.

256B.0622 ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL TREATMENT SERVICES.

Subd. 3. **Eligibility for intensive residential treatment services.** An eligible client for intensive residential treatment services is an individual who:

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

(4) because of a mental illness, has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced;

(5) has one or more of the following: a history of recurring or prolonged inpatient hospitalizations in the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services yielding poor outcomes; and

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

Subd. 5a. **Standards for intensive residential rehabilitative mental health services.** (a) The standards in this subdivision apply to intensive residential mental health services.

(b) The provider of intensive residential treatment services must have sufficient staff to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the treatment plan and to safely supervise and direct the activities of clients, given the client's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education, when appropriate.

(c) At a minimum:

(1) staff must provide direction and supervision whenever clients are present in the facility;

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

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

(4) if services are provided to clients who need the services of a medical professional, the provider shall ensure that these services are provided either by the provider's own medical staff or through referral to a medical professional; and

(5) the provider must ensure the timely availability of a licensed registered nurse, either directly employed or under contract, who is responsible for ensuring the effectiveness and safety of medication administration in the facility and assessing clients for medication side effects and drug interactions.

(d) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5, who are trained and supervised according to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, paragraph (a), clause (4), item (iv).

(e) The clinical supervisor must be an active member of the intensive residential services treatment team. The team must meet with the clinical supervisor at least weekly to discuss clients' progress and make rapid adjustments to meet clients' needs. The team meeting shall include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the client's treatment record.

(f) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(g) The initial functional assessment must be completed within ten days of intake and updated at least every 30 days, or prior to discharge from the service, whichever comes first.

(h) The initial individual treatment plan must be completed within 24 hours of admission. Within ten days of admission, the initial treatment plan must be refined and further developed, except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the client and updated at least monthly.

256B.0623 ADULT REHABILITATIVE MENTAL HEALTH SERVICES COVERED.

Subd. 7. **Personnel file.** The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff. Each file must contain:

(1) an annual performance review;

(2) a summary of on-site service observations and charting review;

(3) a criminal background check of all direct service staff;

(4) evidence of academic degree and qualifications;

(5) a copy of professional license;

(6) any job performance recognition and disciplinary actions;

(7) any individual staff written input into own personnel file;

(8) all clinical supervision provided; and

(9) documentation of compliance with continuing education requirements.

Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within three years preceding admission, an adult diagnostic assessment update must be completed. An update shall include a face-to-face interview with the recipient and a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required.

Subd. 10. **Individual treatment plan.** All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient. The provisions in clauses (1) and (2) apply:

(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake. The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

(2) The individual treatment plan must include:

(i) a list of problems identified in the assessment;

(ii) the recipient's strengths and resources;

(iii) concrete, measurable goals to be achieved, including time frames for achievement;

(iv) specific objectives directed toward the achievement of each one of the goals;

(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;

(vi) cultural considerations, resources, and needs of the recipient must be included;

(vii) planned frequency and type of services must be initiated; and

(viii) clear progress notes on outcome of goals.

(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).

Subd. 11. **Recipient file.** Providers of adult rehabilitative mental health services must maintain a file for each recipient that contains the following information:

(1) diagnostic assessment or verification of its location that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;

(2) functional assessments;

(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(4) recipient history;

(5) signed release forms;

(6) recipient health information and current medications;

(7) emergency contacts for the recipient;

(8) case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;

(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;

(10) summary of recipient case reviews by staff; and

(11) written information by the recipient that the recipient requests be included in the file.

256B.0625 COVERED SERVICES.

Subd. 5l. **Intensive mental health outpatient treatment.** Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy. The commissioner shall establish:

(1) certification procedures to ensure that providers of these services are qualified; and

(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

Subd. 18c. **Nonemergency Medical Transportation Advisory Committee.** (a) The Nonemergency Medical Transportation Advisory Committee shall advise the commissioner on the administration of nonemergency medical transportation covered under medical assistance. The advisory committee shall meet at least quarterly the first year following January 1, 2015, and at least biannually thereafter and may meet more frequently as required by the commissioner. The advisory committee shall annually elect a chair from among its members, who shall work with the commissioner or the commissioner's designee to establish the agenda for each meeting. The commissioner, or the commissioner's designee, shall attend all advisory committee meetings.

(b) The Nonemergency Medical Transportation Advisory Committee shall advise and make recommendations to the commissioner on:

(1) updates to the nonemergency medical transportation policy manual;

(2) other aspects of the nonemergency medical transportation system, as requested by the commissioner; and

(3) other aspects of the nonemergency medical transportation system, as requested by:

(i) a committee member, who may request an item to be placed on the agenda for a future meeting. The request may be considered by the committee and voted upon. If the motion carries, the meeting agenda item may be developed for presentation to the committee; and

(ii) a member of the public, who may approach the committee by letter or e-mail requesting that an item be placed on a future meeting agenda. The request may be considered by the committee and voted upon. If the motion carries, the agenda item may be developed for presentation to the committee.

(c) The Nonemergency Medical Transportation Advisory Committee shall coordinate its activities with the Minnesota Council on Transportation Access established under section 174.285. The chair of the advisory committee, or the chair's designee, shall attend all meetings of the Minnesota Council on Transportation Access.

(d) The Nonemergency Medical Transportation Advisory Committee shall expire December 1, 2019.

Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical Transportation Advisory Committee consists of:

(1) four voting members who represent counties, utilizing the rural urban commuting area classification system. As defined in subdivision 17, these members shall be designated as follows:

(i) two counties within the 11-county metropolitan area;

(ii) one county representing the rural area of the state; and

(iii) one county representing the super rural area of the state.

The Association of Minnesota Counties shall appoint one county within the 11-county metropolitan area and one county representing the super rural area of the state. The Minnesota Inter-County Association shall appoint one county within the 11-county metropolitan area and one county representing the rural area of the state;

(2) three voting members who represent medical assistance recipients, including persons with physical and developmental disabilities, persons with mental illness, seniors, children, and low-income individuals;

(3) five voting members who represent providers that deliver nonemergency medical transportation services to medical assistance enrollees, one of whom is a taxicab owner or operator;

(4) two voting members of the house of representatives, one from the majority party and one from the minority party, appointed by the speaker of the house, and two voting members from the senate, one from the majority party and one from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(5) one voting member who represents demonstration providers as defined in section 256B.69, subdivision 2;

(6) one voting member who represents an organization that contracts with state or local governments to coordinate transportation services for medical assistance enrollees;

(7) one voting member who represents the Minnesota State Council on Disability;

(8) the commissioner of transportation or the commissioner's designee, who shall serve as a voting member;

(9) one voting member appointed by the Minnesota Ambulance Association; and

(10) one voting member appointed by the Minnesota Hospital Association.

(b) Members of the advisory committee shall not be employed by the Department of Human Services. Members of the advisory committee shall receive no compensation.

Subd. 18e. **Single administrative structure and delivery system.** The commissioner, in coordination with the commissioner of transportation, shall implement a single administrative structure and delivery system for nonemergency medical transportation, beginning the latter of the date the single administrative assessment tool required in this subdivision is available for use, as determined by the commissioner or by July 1, 2016.

In coordination with the Department of Transportation, the commissioner shall develop and authorize a web-based single administrative structure and assessment tool, which must operate 24 hours a day, seven days a week, to facilitate the enrollee assessment process for nonemergency medical transportation services. The web-based tool shall facilitate the transportation eligibility determination process initiated by clients and client advocates; shall include an accessible automated intake and assessment process and real-time identification of level of service eligibility; and shall authorize an appropriate and auditable mode of transportation authorization. The tool shall provide a single framework for reconciling trip information with claiming and collecting complaints regarding inappropriate level of need determinations, inappropriate transportation modes utilized, and interference with accessing nonemergency medical transportation. The web-based single administrative structure shall operate on a trial basis for one year from implementation and, if approved by the commissioner, shall be permanent thereafter. The commissioner shall seek input from the Nonemergency Medical Transportation Advisory Committee to ensure the software is effective and user-friendly and make recommendations regarding funding of the single administrative system.

Subd. 18h. **Managed care.** (a) The following subdivisions apply to managed care plans and county-based purchasing plans:

(1) subdivision 17, paragraphs (a), (b), (i), and (n);

(2) subdivision 18; and

(3) subdivision 18a.

(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service specified in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

Subd. 35a. **Children's mental health crisis response services.** Medical assistance covers children's mental health crisis response services according to section 256B.0944.

Subd. 35b. **Children's therapeutic services and supports.** Medical assistance covers children's therapeutic services and supports according to section 256B.0943.

Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part

9505.0371, subpart 5, item C, who has determined it medically necessary to involve family members in the child's care. For the purposes of this subdivision, "family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

Subd. 65. **Outpatient mental health services.** Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy according to Minnesota Rules, part 9505.0372, when the mental health services are performed by a mental health practitioner working as a clinical trainee according to section 245.462, subdivision 17, paragraph (g).

256B.0916 EXPANSION OF HOME AND COMMUNITY-BASED SERVICES.

Subd. 2. **Distribution of funds; partnerships.** (a) Beginning with fiscal year 2000, the commissioner shall distribute all funding available for home and community-based waiver services for persons with developmental disabilities to individual counties or to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals. The commissioner shall encourage counties to form partnerships that have a sufficient number of recipients and funding to adequately manage the risk and maximize use of available resources.

(b) Counties must submit a request for funds and a plan for administering the program as required by the commissioner. The plan must identify the number of clients to be served, their ages, and their priority listing based on:

(1) requirements in Minnesota Rules, part 9525.1880; and

(2) statewide priorities identified in section 256B.092, subdivision 12.

The plan must also identify changes made to improve services to eligible persons and to improve program management.

(c) In allocating resources to counties, priority must be given to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals and to counties determined by the commissioner to have sufficient waiver capacity to maximize resource use.

(d) Within 30 days after receiving the county request for funds and plans, the commissioner shall provide a written response to the plan that includes the level of resources available to serve additional persons.

(e) Counties are eligible to receive medical assistance administrative reimbursement for administrative costs under criteria established by the commissioner.

(f) The commissioner shall manage waiver allocations in such a manner as to fully use available state and federal waiver appropriations.

Subd. 3. **Failure to develop partnerships or submit a plan.** (a) By October 1 of each year the commissioner shall notify the county board if any county determined by the commissioner to have insufficient capacity to maximize use of available resources fails to develop a partnership with other counties or fails to submit a plan as required in subdivision 2. The commissioner shall provide needed technical assistance to a county or group of counties that fails to form a partnership or submit a plan. If a county has not joined a county partnership or submitted a plan within 30 days following the notice by the commissioner of its failure, the commissioner shall require and assist that county

to develop a plan or contract with another county or group of counties to plan and administer the waiver services program in that county.

(b) Counties may request technical assistance, management information, and administrative support from the commissioner at any time. The commissioner shall respond to county requests within 30 days. Priority shall be given to activities that support the administrative needs of newly formed county partnerships.

Subd. 4. **Allowed reserve.** Counties or groups of counties participating in partnerships that have submitted a plan under this section may develop an allowed reserve amount to meet crises and other unmet needs of current home and community-based waiver recipients. The amount of the allowed reserve shall be a county specific amount based upon documented past experience and projected need for the coming year described in an allowed reserve plan submitted for approval to the commissioner with the allocation request for the fiscal year.

Subd. 5. **Allocation of new diversions and priorities for reassignment of resources for developmental disabilities.** (a) The commissioner shall monitor county utilization of allocated resources and, as appropriate, reassign resources not utilized.

(b) Effective July 1, 2002, the commissioner shall authorize the spending of new diversion resources beginning January 1 of each year.

(c) Effective July 1, 2002, the commissioner shall manage the reassignment of waiver resources that occur from persons who have left the waiver in a manner that results in the cost reduction equivalent to delaying the reuse of those waiver resources by 180 days.

(d) Priority consideration for reassignment of resources shall be given to counties that form partnerships. In addition to the priorities listed in Minnesota Rules, part 9525.1880, the commissioner shall also give priority consideration to persons whose living situations are unstable due to the age or incapacity of the primary caregiver and to children to avoid out-of-home placement.

Subd. 8. **Financial and wait-list data reporting.** (a) The commissioner shall make available financial and waiting list information on the department's website.

(b) The financial information must include:

(1) the most recent end of session forecast available for the disability home and community-based waiver programs authorized under sections 256B.092 and 256B.49; and

(2) the most current financial information, updated at least monthly for the disability home and community-based waiver program authorized under section 256B.092 and three disability home and community-based waiver programs authorized under section 256B.49 for each county and tribal agency, including:

(i) the amount of resources allocated;

(ii) the amount of resources authorized for participants; and

(iii) the amount of allocated resources not authorized and the amount not used as provided in subdivision 12, and section 256B.49, subdivision 27.

(c) The waiting list information must be provided quarterly beginning August 1, 2016, and must include at least:

(1) the number of persons screened and waiting for services listed by urgency category, the number of months on the wait list, age group, and the type of services requested by those waiting;

(2) the number of persons beginning waiver services who were on the waiting list, and the number of persons beginning waiver services who were not on the waiting list;

(3) the number of persons who left the waiting list but did not begin waiver services; and

(4) the number of persons on the waiting list with approved funding but without a waiver service agreement and the number of days from funding approval until a service agreement is effective for each person.

(d) By December 1 of each year, the commissioner shall compile a report posted on the department's website that includes:

(1) the financial information listed in paragraph (b) for the most recently completed allocation period;

(2) for the previous four quarters, the waiting list information listed in paragraph (c);

(3) for a 12-month period ending October 31, a list of county and tribal agencies required to submit a corrective action plan under subdivisions 11 and 12, and section 256B.49, subdivisions 26 and 27; and

(4) for a 12-month period ending October 31, a list of the county and tribal agencies from which resources were moved as authorized in section 256B.092, subdivision 12, and section 256B.49, subdivision 11a, the amount of resources taken from each agency, the counties that were given increased resources as a result, and the amounts provided.

Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending in excess of the allocation made by the commissioner. In the event a county or tribal agency spends in excess of the allocation made by the commissioner for a given allocation period, they must submit a corrective action plan to the commissioner for approval. The plan must state the actions the agency will take to correct their overspending for the two years following the period when the overspending occurred. The commissioner shall recoup spending in excess of the allocation only in cases where statewide spending exceeds the appropriation designated for the home and community-based services waivers. Nothing in this subdivision shall be construed as reducing the county's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to them for that purpose.

Subd. 12. **Use of waiver allocations.** County and tribal agencies are responsible for spending the annual allocation made by the commissioner. In the event a county or tribal agency spends less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services. If a county or tribe does not submit a plan when required or implement the changes required, the commissioner shall assure access to waiver services within the county's or tribe's available allocation and take other actions needed to assure that all waiver participants in that county or tribe are receiving appropriate waiver services to meet their needs.

256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.

Subd. 8. **Required preservice and continuing education.** (a) A provider entity shall establish a plan to provide preservice and continuing education for staff. The plan must clearly describe the type of training necessary to maintain current skills and obtain new skills and that relates to the provider entity's goals and objectives for services offered.

(b) A provider that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of preservice training. The preservice training must include parent team training. The preservice training must include 15 hours of in-person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Curricula for parent team training must be approved in advance by the commissioner. Components of parent team training include:

(1) partnering with parents;

(2) fundamentals of family support;

(3) fundamentals of policy and decision making;

(4) defining equal partnership;

(5) complexities of the parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses;

(6) sibling impacts;

(7) support networks; and

(8) community resources.

(c) A provider entity that employs a mental health practitioner and a mental health behavioral aide to provide children's therapeutic services and supports under this section must require the mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. The continuing education must be related to serving the needs of a child with emotional disturbance in the child's home environment and the child's family.

(d) The provider entity must document the mental health practitioner's or mental health behavioral aide's annual completion of the required continuing education. The documentation must include the date, subject, and number of hours of the continuing education, and attendance records, as verified by the staff member's signature, job title, and the instructor's name. The provider entity must keep documentation for each employee, including records of attendance at professional workshops and conferences, at a central location and in the employee's personnel file.

Subd. 10. **Service authorization.** Children's therapeutic services and supports are subject to authorization criteria and standards published by the commissioner according to section 256B.0625, subdivision 25.

256B.0944 CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.

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

(a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation that, but for the provision of crisis response services to the child, would likely result in significantly reduced levels of functioning in primary activities of daily living, an emergency situation, or the child's placement in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or crisis mental health practitioner determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests the child may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency. Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Mental health mobile services must be provided on site by a mobile crisis intervention team outside of an inpatient hospital setting.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

Subd. 2. **Medical assistance coverage.** Medical assistance covers medically necessary children's mental health crisis response services, subject to federal approval, if provided to an eligible recipient under subdivision 3, by a qualified provider entity under subdivision 4 or a qualified individual provider working within the provider's scope of practice, and identified in the recipient's individual crisis treatment plan under subdivision 8.

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is eligible for medical assistance;

(2) is under age 18 or between the ages of 18 and 21;

(3) is screened as possibly experiencing a mental health crisis or mental health emergency where a mental health crisis assessment is needed;

(4) is assessed as experiencing a mental health crisis or mental health emergency, and mental health mobile crisis intervention or mental health crisis stabilization services are determined to be medically necessary; and

(5) meets the criteria for emotional disturbance or mental illness.

Subd. 4. **Provider entity standards.** (a) A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:

(1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility;

(2) a county board-operated entity; or

(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.

(b) The children's mental health crisis response services provider entity must:

(1) ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(2) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;

(3) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4889; and

(4) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high-risk situations.

Subd. 4a. **Alternative provider standards.** If a provider entity demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services 24 hours a day, seven days a week, according to the standards in subdivision 4, paragraph (b), clause (1), the commissioner may approve a crisis response provider based on an alternative plan proposed by a provider entity. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of crisis services; and

(2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays.

Subd. 5. **Mobile crisis intervention staff qualifications.** (a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:

(1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph (o); or

(2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.

(b) The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including the county social services agency, mental health service providers, and local law enforcement, if necessary.

Subd. 6. **Initial screening and crisis assessment planning.** (a) Before initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify the parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment must evaluate any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As the opportunity presents itself during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of

the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required under subdivision 9.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The crisis treatment plan must be updated as needed to reflect current goals and services. The team must involve the client and the client's family in developing and implementing the plan.

(e) The team must document in progress notes which short-term goals have been met and when no further crisis intervention services are required.

(f) If the client's crisis is stabilized, but the client needs a referral for mental health crisis stabilization services or to other services, the team must provide a referral to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Subd. 7. **Crisis stabilization services.** Crisis stabilization services must be provided by a mental health professional or a mental health practitioner, as defined in section 245.462, subdivision 17, who works under the clinical supervision of a mental health professional and for a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 8;

(2) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community; and

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

Subd. 8. **Treatment plan.** (a) The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;

(4) specific objectives directed toward the achievement of each goal;

(5) documentation of the participants involved in the service planning;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur; and

(8) clear progress notes on the outcome of goals.

(b) The client, if clinically appropriate, must be a participant in the development of the crisis stabilization treatment plan. The client or the client's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the client and the client's legal guardian. The plan should include services arranged, including specific providers where applicable.

(c) A treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. A written plan must be completed within 24 hours of beginning services with the client.

Subd. 9. **Supervision.** (a) A mental health practitioner may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by telephone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by telephone, during the first three hours when a mental health practitioner provides on-site service; and

(4) the mental health professional must review and approve the tentative crisis assessment and crisis treatment plan, document the consultation, and sign the crisis assessment and treatment plan within the next business day.

(b) If the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan. The on-site observation must be documented in the client's record and signed by the mental health professional.

Subd. 10. **Client record.** The provider must maintain a file for each client that complies with the requirements under section 256B.0943, subdivision 11, and contains the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient for not signing the plan;

(2) signed release of information forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records that document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

Subd. 11. **Excluded services.** The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) transportation services under children's mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide children's mental health crisis response services;

(5) crisis response services provided by a residential treatment center to clients in their facility;

(6) services performed by volunteers;

(7) direct billing of time spent "on call" when not delivering services to a recipient;

(8) provider service time included in case management reimbursement;

(9) outreach services to potential recipients; and

(10) a mental health service that is not medically necessary.

256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.

Subd. 5. **Service authorization.** The commissioner will administer authorizations for services under this section in compliance with section 256B.0625, subdivision 25.

256B.097 STATE QUALITY ASSURANCE, QUALITY IMPROVEMENT, AND LICENSING SYSTEM.

Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a State Quality Assurance, Quality

Improvement, and Licensing System for Minnesotans receiving disability services is enacted. This system is a partnership between the Department of Human Services and the State Quality Council established under subdivision 3.

(b) This system is a result of the recommendations from the Department of Human Services' licensing and alternative quality assurance study mandated under Laws 2005, First Special Session chapter 4, article 7, section 57, and presented to the legislature in February 2007.

(c) The disability services eligible under this section include:

(1) the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, or section 256B.49, including brain injuries and services for those who qualify for nursing facility level of care or hospital facility level of care and any other services licensed under chapter 245D;

(2) home care services under section 256B.0651;

(3) family support grants under section 252.32;

(4) consumer support grants under section 256.476;

(5) semi-independent living services under section 252.275; and

(6) services provided through an intermediate care facility for the developmentally disabled.

(d) For purposes of this section, the following definitions apply:

(1) "commissioner" means the commissioner of human services;

(2) "council" means the State Quality Council under subdivision 3;

(3) "Quality Assurance Commission" means the commission under section 256B.0951; and

(4) "system" means the State Quality Assurance, Quality Improvement and Licensing System under this section.

Subd. 2. **Duties of commissioner of human services.** (a) The commissioner of human services shall establish the State Quality Council under subdivision 3.

(b) The commissioner shall initially delegate authority to perform licensing functions and activities according to section 245A.16 to a host county in Region 10. The commissioner must not license or reimburse a participating facility, program, or service located in Region 10 if the commissioner has received notification from the host county that the facility, program, or service has failed to qualify for licensure.

(c) The commissioner may conduct random licensing inspections based on outcomes adopted under section 256B.0951, subdivision 3, at facilities or programs, and of services eligible under this section. The role of the random inspections is to verify that the system protects the safety and well-being of persons served and maintains the availability of high-quality services for persons with disabilities.

(d) The commissioner shall ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety and health or violated services-related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

(e) The commissioner shall seek a federal waiver by July 1, 2012, to allow intermediate care facilities for persons with developmental disabilities to participate in this system.

Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality Council which must define regional quality councils, and carry out a community-based, person-directed quality review component, and a comprehensive system for effective incident reporting, investigation, analysis, and follow-up.

(b) By August 1, 2011, the commissioner of human services shall appoint the members of the initial State Quality Council. Members shall include representatives from the following groups:

(1) disability service recipients and their family members;

(2) during the first four years of the State Quality Council, there must be at least three members from the Region 10 stakeholders. As regional quality councils are formed under subdivision 4, each regional quality council shall appoint one member;

(3) disability service providers;

(4) disability advocacy groups; and

(5) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(c) Members of the council who do not receive a salary or wages from an employer for time spent on council duties may receive a per diem payment when performing council duties and functions.

(d) The State Quality Council shall:

(1) assist the Department of Human Services in fulfilling federally mandated obligations by monitoring disability service quality and quality assurance and improvement practices in Minnesota;

(2) establish state quality improvement priorities with methods for achieving results and provide an annual report to the legislative committees with jurisdiction over policy and funding of disability services on the outcomes, improvement priorities, and activities undertaken by the commission during the previous state fiscal year;

(3) identify issues pertaining to financial and personal risk that impede Minnesotans with disabilities from optimizing choice of community-based services; and

(4) recommend to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and civil law by January 15, 2014, statutory and rule changes related to the findings under clause (3) that promote individualized service and housing choices balanced with appropriate individualized protection.

(e) The State Quality Council, in partnership with the commissioner, shall:

(1) approve and direct implementation of the community-based, person-directed system established in this section;

(2) recommend an appropriate method of funding this system, and determine the feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

(3) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems;

(4) establish variable licensure periods not to exceed three years based on outcomes achieved; and

(5) in cooperation with the Quality Assurance Commission, design a transition plan for licensed providers from Region 10 into the alternative licensing system.

(f) The State Quality Council shall notify the commissioner of human services that a facility, program, or service has been reviewed by quality assurance team members under subdivision 4, paragraph (b), clause (13), and qualifies for a license.

(g) The State Quality Council, in partnership with the commissioner, shall establish an ongoing review process for the system. The review shall take into account the comprehensive nature of the system which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to persons with disabilities. The review shall address efficiencies and effectiveness of the system.

(h) The State Quality Council may recommend to the commissioner certain variances from the standards governing licensure of programs for persons with disabilities in order to improve the quality of services so long as the recommended variances do not adversely affect the health or safety of persons being served or compromise the qualifications of staff to provide services.

(i) The safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make recommendations to the commissioner or to the legislature in the report required under paragraph (c) regarding alternatives or modifications to the safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c).

(j) The State Quality Council may hire staff to perform the duties assigned in this subdivision.

Subd. 4. **Regional quality councils.** (a) The commissioner shall establish, as selected by the State Quality Council, regional quality councils of key stakeholders, including regional representatives of:

(1) disability service recipients and their family members;

(2) disability service providers;

(3) disability advocacy groups; and

(4) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(b) Each regional quality council shall:

(1) direct and monitor the community-based, person-directed quality assurance system in this section;

(2) approve a training program for quality assurance team members under clause (13);

(3) review summary reports from quality assurance team reviews and make recommendations to the State Quality Council regarding program licensure;

(4) make recommendations to the State Quality Council regarding the system;

(5) resolve complaints between the quality assurance teams, counties, providers, persons receiving services, their families, and legal representatives;

(6) analyze and review quality outcomes and critical incident data reporting incidents of life safety concerns immediately to the Department of Human Services licensing division;

(7) provide information and training programs for persons with disabilities and their families and legal representatives on service options and quality expectations;

(8) disseminate information and resources developed to other regional quality councils;

(9) respond to state-level priorities;

(10) establish regional priorities for quality improvement;

(11) submit an annual report to the State Quality Council on the status, outcomes, improvement priorities, and activities in the region;

(12) choose a representative to participate on the State Quality Council and assume other responsibilities consistent with the priorities of the State Quality Council; and

(13) recruit, train, and assign duties to members of quality assurance teams, taking into account the size of the service provider, the number of services to be reviewed, the skills necessary for the team members to complete the process, and ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with anyone served at the facility, program, or service. Quality assurance teams must be comprised of county staff, persons receiving services or the person's families, legal representatives, members of advocacy organizations, providers, and other involved community members. Team members must complete the training program approved by the regional quality council and must demonstrate performance-based competency. Team members may be paid a per diem and reimbursed for expenses related to their participation in the quality assurance process.

(c) The commissioner shall monitor the safety standards, rights, and procedural protections for the monitoring of psychotropic medications and those identified under sections 245.825; 245.91 to 245.97; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivision 1b, clause (7); and 626.557; and chapter 260E.

(d) The regional quality councils may hire staff to perform the duties assigned in this subdivision.

(e) The regional quality councils may charge fees for their services.

(f) The quality assurance process undertaken by a regional quality council consists of an evaluation by a quality assurance team of the facility, program, or service. The process must include an evaluation of a random sample of persons served. The sample must be representative of each service provided. The sample size must be at least five percent but not less than two persons served. All persons must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.

(g) A facility, program, or service may contest a licensing decision of the regional quality council as permitted under chapter 245A.

Subd. 5. **Annual survey of service recipients.** The commissioner, in consultation with the State Quality Council, shall conduct an annual independent statewide survey of service recipients, randomly selected, to determine the effectiveness and quality of disability services. The survey must be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services (CMS) Quality Framework. The survey must analyze whether desired outcomes for persons with different demographic, diagnostic, health, and functional needs, who are receiving different types of services in different settings and with different costs, have been achieved. Annual statewide and regional reports of the results must be published and used to assist regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 6. **Mandated reporters.** Members of the State Quality Council under subdivision 3, the regional quality councils under subdivision 4, and quality assurance team members under subdivision 4, paragraph (b), clause (13), are mandated reporters as defined in sections 260E.06, subdivision 1, and 626.5572, subdivision 16.

256B.49 HOME AND COMMUNITY-BASED SERVICE WAIVERS FOR PERSONS WITH DISABILITIES.

Subd. 26. **Excess allocations.** Effective July 1, 2018, county and tribal agencies will be responsible for spending in excess of the annual allocation made by the commissioner. In the event a county or tribal agency spends in excess of the allocation made by the commissioner for a given allocation period, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The plan must state the actions the agency will take to correct its overspending for the two years following the period when the overspending occurred. The commissioner shall recoup funds spent in excess of the allocation only in cases when statewide spending exceeds the appropriation designated for the home and community-based services waivers. Nothing in this subdivision shall be construed as reducing the county or tribe's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to it for that purpose.

Subd. 27. **Use of waiver allocations.** (a) Effective until June 30, 2018, county and tribal agencies are responsible for authorizing the annual allocation made by the commissioner. In the event a county or tribal agency authorizes less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services.

(b) Effective July 1, 2018, county and tribal agencies are responsible for spending the annual allocation made by the commissioner. In the event a county or tribal agency spends less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services.

(c) If a county or tribe does not submit a plan when required or implement the changes required, the commissioner shall assure access to waiver services within the county or tribe's available allocation, and take other actions needed to assure that all waiver participants in that county or tribe are receiving appropriate waiver services to meet their needs.

256D.051 SNAP EMPLOYMENT AND TRAINING PROGRAM.

Subdivision 1. **SNAP employment and training program.** The commissioner shall implement a SNAP employment and training program in order to meet the SNAP employment and training participation requirements of the United States Department of Agriculture. Unless exempt under subdivision 3a, each adult recipient in the unit must participate in the SNAP employment and training program each month that the person is eligible for SNAP benefits. The person's participation in SNAP employment and training services must begin no later than the first day of the calendar month following the determination of eligibility for SNAP benefits. With the county agency's consent, and to the extent of available resources, the person may voluntarily continue to participate in SNAP employment and training services for up to three additional consecutive months immediately

following termination of SNAP benefits in order to complete the provisions of the person's employability development plan.

Subd. 1a. **Notices and sanctions.** (a) At the time the county agency notifies the household that it is eligible for SNAP benefits, the county agency must inform all mandatory employment and training services participants as identified in subdivision 1 in the household that they must comply with all SNAP employment and training program requirements each month, including the requirement to attend an initial orientation to the SNAP employment and training program and that SNAP eligibility will end unless the participants comply with the requirements specified in the notice.

(b) A participant who fails without good cause to comply with SNAP employment and training program requirements of this section, including attendance at orientation, will lose SNAP eligibility for the following periods:

(1) for the first occurrence, for one month or until the person complies with the requirements not previously complied with, whichever is longer;

(2) for the second occurrence, for three months or until the person complies with the requirements not previously complied with, whichever is longer; or

(3) for the third and any subsequent occurrence, for six months or until the person complies with the requirements not previously complied with, whichever is longer.

If the participant is not the SNAP head of household, the person shall be considered an ineligible household member for SNAP purposes. If the participant is the SNAP head of household, the entire household is ineligible for SNAP as provided in Code of Federal Regulations, title 7, section 273.7(g). "Good cause" means circumstances beyond the control of the participant, such as illness or injury, illness or injury of another household member requiring the participant's presence, a household emergency, or the inability to obtain child care for children between the ages of six and 12 or to obtain transportation needed in order for the participant to meet the SNAP employment and training program participation requirements.

(c) The county agency shall mail or hand deliver a notice to the participant not later than five days after determining that the participant has failed without good cause to comply with SNAP employment and training program requirements which specifies the requirements that were not complied with, the factual basis for the determination of noncompliance, and the right to reinstate eligibility upon a showing of good cause for failure to meet the requirements. The notice must ask the reason for the noncompliance and identify the participant's appeal rights. The notice must request that the participant inform the county agency if the participant believes that good cause existed for the failure to comply and must state that the county agency intends to terminate eligibility for SNAP benefits due to failure to comply with SNAP employment and training program requirements.

(d) If the county agency determines that the participant did not comply during the month with all SNAP employment and training program requirements that were in effect, and if the county agency determines that good cause was not present, the county must provide a ten-day notice of termination of SNAP benefits. The amount of SNAP benefits that are withheld from the household and determination of the impact of the sanction on other household members is governed by Code of Federal Regulations, title 7, section 273.7.

(e) The participant may appeal the termination of SNAP benefits under the provisions of section 256.045.

Subd. 2. **County agency duties.** (a) The county agency shall provide to SNAP benefit recipients a SNAP employment and training program. The program must include:

(1) orientation to the SNAP employment and training program;

(2) an individualized employability assessment and an individualized employability development plan that includes assessment of literacy, ability to communicate in the English language, educational and employment history, and that estimates the length of time it will take the participant to obtain employment. The employability assessment and development plan must be completed in consultation with the participant, must assess the participant's assets, barriers, and strengths, and must identify steps necessary to overcome barriers to employment. A copy of the employability development plan must be provided to the registrant;

(3) referral to available accredited remedial or skills training programs designed to address participant's barriers to employment;

(4) referral to available programs that provide subsidized or unsubsidized employment as necessary;

(5) a job search program, including job seeking skills training; and

(6) other activities, to the extent of available resources designed by the county agency to prepare the participant for permanent employment.

In order to allow time for job search, the county agency may not require an individual to participate in the SNAP employment and training program for more than 32 hours a week. The county agency shall require an individual to spend at least eight hours a week in job search or other SNAP employment and training program activities.

(b) The county agency shall prepare an annual plan for the operation of its SNAP employment and training program. The plan must be submitted to and approved by the commissioner of employment and economic development. The plan must include:

(1) a description of the services to be offered by the county agency;

(2) a plan to coordinate the activities of all public entities providing employment-related services in order to avoid duplication of effort and to provide services more efficiently;

(3) a description of the factors that will be taken into account when determining a client's employability development plan; and

(4) provisions to ensure that the county agency's employment and training service provider provides each recipient with an orientation, employability assessment, and employability development plan as specified in paragraph (a), clauses (1) and (2), within 30 days of the recipient's eligibility for assistance.

Subd. 2a. **Duties of commissioner.** In addition to any other duties imposed by law, the commissioner shall:

(1) based on this section and section 256D.052 and Code of Federal Regulations, title 7, section 273.7, supervise the administration of SNAP employment and training services to county agencies;

(2) disburse money appropriated for SNAP employment and training services to county agencies based upon the county's costs as specified in section 256D.051, subdivision 6c;

(3) accept and supervise the disbursement of any funds that may be provided by the federal government or from other sources for use in this state for SNAP employment and training services;

(4) cooperate with other agencies including any agency of the United States or of another state in all matters concerning the powers and duties of the commissioner under this section and section 256D.052; and

(5) in cooperation with the commissioner of employment and economic development, ensure that each component of an employment and training program carried out under this section is delivered through a statewide workforce development system, unless the component is not available locally through such a system.

Subd. 3. **Participant duties.** In order to receive SNAP assistance, a registrant shall: (1) cooperate with the county agency in all aspects of the SNAP employment and training program; (2) accept any suitable employment, including employment offered through the Job Training Partnership Act, and other employment and training options; and (3) participate in SNAP employment and training activities assigned by the county agency. The county agency may terminate assistance to a registrant who fails to cooperate in the SNAP employment and training program, as provided in subdivision 1a.

Subd. 3a. **Requirement to register work.** (a) To the extent required under Code of Federal Regulations, title 7, section 273.7(a), each applicant for and recipient of SNAP benefits is required to register for work as a condition of eligibility for SNAP benefits. Applicants and recipients are registered by signing an application or annual reapplication for SNAP benefits, and must be informed that they are registering for work by signing the form.

(b) The commissioner shall determine, within federal requirements, persons required to participate in the SNAP employment and training program.

(c) The following SNAP benefit recipients are exempt from mandatory participation in SNAP employment and training services:

(1) recipients of benefits under the Minnesota family investment program, Minnesota supplemental aid program, or the general assistance program;

(2) a child;

(3) a recipient over age 55;

(4) a recipient who has a mental or physical illness, injury, or incapacity which is expected to continue for at least 30 days and which impairs the recipient's ability to obtain or retain employment as evidenced by professional certification or the receipt of temporary or permanent disability benefits issued by a private or government source;

(5) a parent or other household member responsible for the care of either a dependent child in the household who is under age six or a person in the household who is professionally certified as having a physical or mental illness, injury, or incapacity. Only one parent or other household member may claim exemption under this provision;

(6) a recipient receiving unemployment insurance or who has applied for unemployment insurance and has been required to register for work with the Department of Employment and Economic Development as part of the unemployment insurance application process;

(7) a recipient participating each week in a drug addiction or alcohol abuse treatment and rehabilitation program, provided the operators of the treatment and rehabilitation program, in consultation with the county agency, recommend that the recipient not participate in the SNAP employment and training program;

(8) a recipient employed or self-employed for 30 or more hours per week at employment paying at least minimum wage, or who earns wages from employment equal to or exceeding 30 hours multiplied by the federal minimum wage; or

(9) a student enrolled at least half time in any school, training program, or institution of higher education. When determining if a student meets this criteria, the school's, program's or institution's criteria for being enrolled half time shall be used.

Subd. 3b. **Orientation.** The county agency or its employment and training service provider must provide an orientation to SNAP employment and training services to each nonexempt SNAP benefit recipient within 30 days of the date that SNAP eligibility is determined. The orientation must inform the participant of the requirement to participate in services, the date, time, and address to report to for services, the name and telephone number of the SNAP employment and training service provider, the consequences for failure without good cause to comply, the services and support services available through SNAP employment and training services and other providers of similar services, and must encourage the participant to view the SNAP benefits program as a temporary means of supplementing the family's food needs until the family achieves self-sufficiency through employment. The orientation may be provided through audio-visual methods, but the participant must have the opportunity for face-to-face interaction with county agency staff.

Subd. 6b. **Federal reimbursement.** (a) Federal financial participation from the United States Department of Agriculture for SNAP employment and training expenditures that are eligible for reimbursement through the SNAP employment and training program are dedicated funds and are annually appropriated to the commissioner of human services for the operation of the SNAP employment and training program.

(b) The appropriation must be used for skill attainment through employment, training, and support services for SNAP participants.

(c) Federal financial participation for the nonstate portion of SNAP employment and training costs must be paid to the county agency or service provider that incurred the costs.

Subd. 6c. **Program funding.** Within the limits of available resources, the commissioner shall reimburse the actual costs of county agencies and their employment and training service providers for the provision of SNAP employment and training services, including participant support services, direct program services, and program administrative activities. The cost of services for each county's SNAP employment and training program shall not exceed the annual allocated amount. No more than 15 percent of program funds may be used for administrative activities. The county agency may expend county funds in excess of the limits of this subdivision without state reimbursement.

Program funds shall be allocated based on the county's average number of SNAP eligible cases as compared to the statewide total number of such cases. The average number of cases shall be based on counts of cases as of March 31, June 30, September 30, and December 31 of the previous

calendar year. The commissioner may reallocate unexpended money appropriated under this section to those county agencies that demonstrate a need for additional funds.

Subd. 7. **Registrant status.** A registrant under this section is not an employee for the purposes of workers' compensation, unemployment benefits, retirement, or civil service laws, and shall not perform work ordinarily performed by a regular public employee.

Subd. 8. **Voluntary quit.** A person who is required to participate in SNAP employment and training services is not eligible for SNAP benefits if, without good cause, the person refuses a legitimate offer of, or quits, suitable employment within 60 days before the date of application. A person who is required to participate in SNAP employment and training services and, without good cause, voluntarily quits suitable employment or refuses a legitimate offer of suitable employment while receiving SNAP benefits shall be terminated from the SNAP program as specified in subdivision 1a.

Subd. 9. **Subcontractors.** A county agency may, at its option, subcontract any or all of the duties under this section to a public or private entity approved by the commissioner of employment and economic development.

Subd. 18. **Work experience placements.** (a) To the extent of available resources, each county agency must establish and operate a work experience component in the SNAP employment and training program for recipients who are subject to a federal limit of three months of SNAP eligibility in any 36-month period. The purpose of the work experience component is to enhance the participant's employability, self-sufficiency, and to provide meaningful, productive work activities.

(b) The commissioner shall assist counties in the design and implementation of these components. The commissioner must ensure that job placements under a work experience component comply with section 256J.72. Written or oral concurrence with job duties of persons placed under the community work experience program shall be obtained from the appropriate exclusive bargaining representative.

(c) Worksites developed under this section are limited to projects that serve a useful public service such as health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, community service, services to aged citizens or citizens with a disability, and child care. To the extent possible, the prior training, skills, and experience of a recipient must be used in making appropriate work experience assignments.

(d) Structured, supervised volunteer work with an agency or organization that is monitored by the county service provider may, with the approval of the county agency, be used as a work experience placement.

(e) As a condition of placing a person receiving SNAP benefits in a program under this subdivision, the county agency shall first provide the recipient the opportunity:

(1) for placement in suitable subsidized or unsubsidized employment through participation in job search under section 256D.051; or

(2) for placement in suitable employment through participation in on-the-job training, if such employment is available.

(f) The county agency shall limit the maximum monthly number of hours that any participant may work in a work experience placement to a number equal to the amount of the family's monthly SNAP benefit allotment divided by the greater of the federal minimum wage or the applicable state minimum wage.

After a participant has been assigned to a position for nine months, the participant may not continue in that assignment unless the maximum number of hours a participant works is no greater than the amount of the SNAP benefit divided by the rate of pay for individuals employed in the same or similar occupations by the same employer at the same site.

(g) The participant's employability development plan must include the length of time needed in the work experience program, the need to continue job seeking activities while participating in work experience, and the participant's employment goals.

(h) After each six months of a recipient's participation in a work experience job placement, and at the conclusion of each work experience assignment under this section, the county agency shall reassess and revise, as appropriate, the participant's employability development plan.

(i) A participant has good cause for failure to cooperate with a work experience job placement if, in the judgment of the employment and training service provider, the reason for failure is reasonable and justified. Good cause for purposes of this section is defined in subdivision 1a, paragraph (b).

(j) A recipient who has failed without good cause to participate in or comply with the work experience job placement shall be terminated from participation in work experience job activities. If the recipient is not exempt from mandatory SNAP employment and training program participation under subdivision 3a, the recipient will be assigned to other mandatory program activities. If the recipient is exempt from mandatory participation but is participating as a volunteer, the person shall be terminated from the SNAP employment and training program.

256D.052 LITERACY TRAINING FOR RECIPIENTS.

Subd. 3. **Participant literacy transportation costs.** Within the limits of the state appropriation the county agency must provide transportation to enable Supplemental Nutrition Assistance Program (SNAP) employment and training participants to participate in literacy training under this section. The state shall reimburse county agencies for the costs of providing transportation under this section up to the amount of the state appropriation. Counties must make every effort to ensure that child care is available as needed by recipients who are pursuing literacy training.

256J.08 DEFINITIONS.

Subd. 10. **Budget month.** "Budget month" means the calendar month which the county agency uses to determine the income or circumstances of an assistance unit to calculate the amount of the assistance payment in the payment month.

Subd. 53. **Lump sum.** "Lump sum" means nonrecurring income that is not excluded in section 256J.21.

Subd. 61. **Monthly income test.** "Monthly income test" means the test used to determine ongoing eligibility and the assistance payment amount according to section 256J.21.

Subd. 62. **Nonrecurring income.** "Nonrecurring income" means a form of income which is received:

(1) only one time or is not of a continuous nature; or

(2) in a prospective payment month but is no longer received in the corresponding retrospective payment month.

Subd. 81. **Retrospective budgeting.** "Retrospective budgeting" means a method of determining the amount of the assistance payment in which the payment month is the second month after the budget month.

Subd. 83. **Significant change.** "Significant change" means a decline in gross income of the amount of the disregard as defined in section 256P.03 or more from the income used to determine the grant for the current month.

256J.30 APPLICANT AND PARTICIPANT REQUIREMENTS AND RESPONSIBILITIES.

Subd. 5. **Monthly MFIP household reports.** Each assistance unit with a member who has earned income or a recent work history, and each assistance unit that has income deemed to it from a financially responsible person must complete a monthly MFIP household report form. "Recent work history" means the individual received earned income in the report month or any of the previous three calendar months even if the earnings are excluded. To be complete, the MFIP household report form must be signed and dated by the caregivers no earlier than the last day of the reporting period. All questions required to determine assistance payment eligibility must be answered, and documentation of earned income must be included.

Subd. 7. **Due date of MFIP household report form.** An MFIP household report form must be received by the county agency by the eighth calendar day of the month following the reporting period covered by the form. When the eighth calendar day of the month falls on a weekend or holiday, the MFIP household report form must be received by the county agency the first working day that follows the eighth calendar day.

Subd. 8. **Late MFIP household report forms.** (a) Paragraphs (b) to (e) apply to the reporting requirements in subdivision 7.

(b) When the county agency receives an incomplete MFIP household report form, the county agency must immediately return the incomplete form and clearly state what the caregiver must do for the form to be complete.

(c) The automated eligibility system must send a notice of proposed termination of assistance to the assistance unit if a complete MFIP household report form is not received by a county agency. The automated notice must be mailed to the caregiver by approximately the 16th of the month. When a caregiver submits an incomplete form on or after the date a notice of proposed termination has been sent, the termination is valid unless the caregiver submits a complete form before the end of the month.

(d) An assistance unit required to submit an MFIP household report form is considered to have continued its application for assistance if a complete MFIP household report form is received within a calendar month after the month in which the form was due and assistance shall be paid for the period beginning with the first day of that calendar month.

(e) A county agency must allow good cause exemptions from the reporting requirements under subdivision 5 when any of the following factors cause a caregiver to fail to provide the county agency with a completed MFIP household report form before the end of the month in which the form is due:

(1) an employer delays completion of employment verification;

(2) a county agency does not help a caregiver complete the MFIP household report form when the caregiver asks for help;

(3) a caregiver does not receive an MFIP household report form due to mistake on the part of the department or the county agency or due to a reported change in address;

(4) a caregiver is ill, or physically or mentally incapacitated; or

(5) some other circumstance occurs that a caregiver could not avoid with reasonable care which prevents the caregiver from providing a completed MFIP household report form before the end of the month in which the form is due.

256J.33 PROSPECTIVE AND RETROSPECTIVE MFIP ELIGIBILITY.

Subd. 3. **Retrospective eligibility.** After the first two months of MFIP eligibility, a county agency must continue to determine whether an assistance unit is prospectively eligible for the payment month by looking at all factors other than income and then determine whether the assistance unit is retrospectively income eligible by applying the monthly income test to the income from the budget month. When the monthly income test is not satisfied, the assistance payment must be suspended when ineligibility exists for one month or ended when ineligibility exists for more than one month.

Subd. 4. **Monthly income test.** A county agency must apply the monthly income test retrospectively for each month of MFIP eligibility. An assistance unit is not eligible when the countable income equals or exceeds the MFIP standard of need or the family wage level for the assistance unit. The income applied against the monthly income test must include:

(1) gross earned income from employment, prior to mandatory payroll deductions, voluntary payroll deductions, wage authorizations, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36, unless the employment income is specifically excluded under section 256J.21, subdivision 2;

(2) gross earned income from self-employment less deductions for self-employment expenses in section 256J.37, subdivision 5, but prior to any reductions for personal or business state and federal income taxes, personal FICA, personal health and life insurance, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36;

(3) unearned income after deductions for allowable expenses in section 256J.37, subdivision 9, and allocations in section 256J.36, unless the income has been specifically excluded in section 256J.21, subdivision 2;

(4) gross earned income from employment as determined under clause (1) which is received by a member of an assistance unit who is a minor child or minor caregiver and less than a half-time student;

(5) child support received by an assistance unit, excluded under section 256J.21, subdivision 2, clause (49), or section 256P.06, subdivision 3, clause (2), item (xvi);

(6) spousal support received by an assistance unit;

(7) the income of a parent when that parent is not included in the assistance unit;

(8) the income of an eligible relative and spouse who seek to be included in the assistance unit; and

(9) the unearned income of a minor child included in the assistance unit.

Subd. 5. **When to terminate assistance.** When an assistance unit is ineligible for MFIP assistance for two consecutive months, the county agency must terminate MFIP assistance.

256J.34 CALCULATING ASSISTANCE PAYMENTS.

Subdivision 1. **Prospective budgeting.** A county agency must use prospective budgeting to calculate the assistance payment amount for the first two months for an applicant who has not received assistance in this state for at least one payment month preceding the first month of payment under a current application. Notwithstanding subdivision 3, paragraph (a), clause (2), a county agency must use prospective budgeting for the first two months for a person who applies to be added to an assistance unit. Prospective budgeting is not subject to overpayments or underpayments unless fraud is determined under section 256.98.

(a) The county agency must apply the income received or anticipated in the first month of MFIP eligibility against the need of the first month. The county agency must apply the income received or anticipated in the second month against the need of the second month.

(b) When the assistance payment for any part of the first two months is based on anticipated income, the county agency must base the initial assistance payment amount on the information available at the time the initial assistance payment is made.

(c) The county agency must determine the assistance payment amount for the first two months of MFIP eligibility by budgeting both recurring and nonrecurring income for those two months.

Subd. 2. **Retrospective budgeting.** The county agency must use retrospective budgeting to calculate the monthly assistance payment amount after the payment for the first two months has been made under subdivision 1.

Subd. 3. **Additional uses of retrospective budgeting.** Notwithstanding subdivision 1, the county agency must use retrospective budgeting to calculate the monthly assistance payment amount for the first two months under paragraphs (a) and (b).

(a) The county agency must use retrospective budgeting to determine the amount of the assistance payment in the first two months of MFIP eligibility:

(1) when an assistance unit applies for assistance for the same month for which assistance has been interrupted, the interruption in eligibility is less than one payment month, the assistance payment for the preceding month was issued in this state, and the assistance payment for the immediately preceding month was determined retrospectively; or

(2) when a person applies in order to be added to an assistance unit, that assistance unit has received assistance in this state for at least the two preceding months, and that person has been living with and has been financially responsible for one or more members of that assistance unit for at least the two preceding months.

(b) Except as provided in clauses (1) to (4), the county agency must use retrospective budgeting and apply income received in the budget month by an assistance unit and by a financially responsible household member who is not included in the assistance unit against the MFIP standard of need or family wage level to determine the assistance payment to be issued for the payment month.

(1) When a source of income ends prior to the third payment month, that income is not considered in calculating the assistance payment for that month. When a source of income ends prior to the fourth payment month, that income is not considered when determining the assistance payment for that month.

(2) When a member of an assistance unit or a financially responsible household member leaves the household of the assistance unit, the income of that departed household member is not budgeted retrospectively for any full payment month in which that household member does not live with that household and is not included in the assistance unit.

(3) When an individual is removed from an assistance unit because the individual is no longer a minor child, the income of that individual is not budgeted retrospectively for payment months in

which that individual is not a member of the assistance unit, except that income of an ineligible child in the household must continue to be budgeted retrospectively against the child's needs when the parent or parents of that child request allocation of their income against any unmet needs of that ineligible child.

(4) When a person ceases to have financial responsibility for one or more members of an assistance unit, the income of that person is not budgeted retrospectively for the payment months which follow the month in which financial responsibility ends.

Subd. 4. **Significant change in gross income.** The county agency must recalculate the assistance payment when an assistance unit experiences a significant change, as defined in section 256J.08, resulting in a reduction in the gross income received in the payment month from the gross income received in the budget month. The county agency must issue a supplemental assistance payment based on the county agency's best estimate of the assistance unit's income and circumstances for the payment month. Supplemental assistance payments that result from significant changes are limited to two in a 12-month period regardless of the reason for the change. Notwithstanding any other statute or rule of law, supplementary assistance payments shall not be made when the significant change in income is the result of receipt of a lump sum, receipt of an extra paycheck, business fluctuation in self-employment income, or an assistance unit member's participation in a strike or other labor action.

256J.37 TREATMENT OF INCOME AND LUMP SUMS.

Subd. 10. **Treatment of lump sums.** (a) The agency must treat lump-sum payments as earned or unearned income. If the lump-sum payment is included in the category of income identified in subdivision 9, it must be treated as unearned income. A lump sum is counted as income in the month received and budgeted either prospectively or retrospectively depending on the budget cycle at the time of receipt. When an individual receives a lump-sum payment, that lump sum must be combined with all other earned and unearned income received in the same budget month, and it must be applied according to paragraphs (a) to (c). A lump sum may not be carried over into subsequent months. Any funds that remain in the third month after the month of receipt are counted in the asset limit.

(b) For a lump sum received by an applicant during the first two months, prospective budgeting is used to determine the payment and the lump sum must be combined with other earned or unearned income received and budgeted in that prospective month.

(c) For a lump sum received by a participant after the first two months of MFIP eligibility, the lump sum must be combined with other income received in that budget month, and the combined amount must be applied retrospectively against the applicable payment month.

(d) When a lump sum, combined with other income under paragraphs (b) and (c), is less than the MFIP transitional standard for the appropriate payment month, the assistance payment must be reduced according to the amount of the countable income. When the countable income is greater than the MFIP standard or family wage level, the assistance payment must be suspended for the payment month.

256L.11 PROVIDER PAYMENT.

Subd. 6a. **Dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2018, the commissioner shall increase payment rates to dental providers by 54 percent. Payments made to prepaid health plans under section 256L.12 shall reflect the payment increase described in this subdivision. The prepaid health plans under contract with the commissioner shall provide payments to dental providers that are at least equal to a rate that includes the payment rate specified in this subdivision, and if applicable to the provider, the rates described under subdivision 7.

9505.0370 DEFINITIONS.

Subpart 1. **Scope.** For parts 9505.0370 to 9505.0372, the following terms have the meanings given them.

Subp. 2. **Adult day treatment.** "Adult day treatment" or "adult day treatment program" means a structured program of treatment and care.

Subp. 3. **Child.** "Child" means a person under 18 years of age.

Subp. 4. **Client.** "Client" means an eligible recipient who is determined to have or who is being assessed for a mental illness as specified in part 9505.0371.

Subp. 5. **Clinical summary.** "Clinical summary" means a written description of a clinician's formulation of the cause of the client's mental health symptoms, the client's prognosis, and the likely consequences of the symptoms; how the client meets the criteria for the diagnosis by describing the client's symptoms, the duration of symptoms, and functional impairment; an analysis of the client's other symptoms, strengths, relationships, life situations, cultural influences, and health concerns and their potential interaction with the diagnosis and formulation of the client's mental health condition; and alternative diagnoses that were considered and ruled out.

Subp. 6. **Clinical supervision.** "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

Subp. 7. **Clinical supervisor.** "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

Subp. 8. **Cultural competence or culturally competent.** "Cultural competence" or "culturally competent" means the mental health provider's:

A. awareness of the provider's own cultural background, and the related assumptions, values, biases, and preferences that influence assessment and intervention processes;

B. ability and will to respond to the unique needs of an individual client that arise from the client's culture;

C. ability to utilize the client's culture as a resource and as a means to optimize mental health care; and

D. willingness to seek educational, consultative, and learning experiences to expand knowledge of and increase effectiveness with culturally diverse populations.

Subp. 9. **Cultural influences.** "Cultural influences" means historical, geographical, and familial factors that affect assessment and intervention processes. Cultural influences that are relevant to the client may include the client's:

A. racial or ethnic self-identification;

B. experience of cultural bias as a stressor;

C. immigration history and status;

D. level of acculturation;

E. time orientation;

F. social orientation;

G. verbal communication style;

H. locus of control;

I. spiritual beliefs; and

J. health beliefs and the endorsement of or engagement in culturally specific healing practices.

Subp. 10. **Culture.** "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

Subp. 11. **Diagnostic assessment.** "Diagnostic assessment" means a written assessment that documents a clinical and functional face-to-face evaluation of the client's mental health, including the nature, severity and impact of behavioral difficulties, functional impairment, and subjective distress of the client, and identifies the client's strengths and resources.

Subp. 12. **Dialectical behavior therapy.** "Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program is certified by the commissioner and involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

Subp. 13. **Explanation of findings.** "Explanation of findings" means the explanation of a client's diagnostic assessment, psychological testing, treatment program, and consultation with culturally informed mental health consultants as required under parts 9520.0900 to 9520.0926, or other accumulated data and recommendations to the client, client's family, primary caregiver, or other responsible persons.

Subp. 14. **Family.** "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, or persons who are presently residing together as a family unit.

Subp. 15. **Individual treatment plan.** "Individual treatment plan" means a written plan that outlines and defines the course of treatment. It delineates the goals, measurable objectives, target dates for achieving specific goals, main participants in treatment process, and recommended services that are based on the client's diagnostic assessment and other meaningful data that are needed to aid the client's recovery and enhance resiliency.

Subp. 16. **Medication management.** "Medication management" means a service that determines the need for or effectiveness of the medication prescribed for the treatment of a client's symptoms of a mental illness.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a person who is qualified according to part 9505.0371, subpart 5, items B and C, and provides mental health services to a client with a mental illness under the clinical supervision of a mental health professional.

Subp. 18. **Mental health professional.** "Mental health professional" means a person who is enrolled to provide medical assistance services and is qualified according to part 9505.0371, subpart 5, item A.

Subp. 19. **Mental health telemedicine.** "Mental health telemedicine" has the meaning given in Minnesota Statutes, section 256B.0625, subdivision 46.

Subp. 20. **Mental illness.** "Mental illness" has the meaning given in Minnesota Statutes, section 245.462, subdivision 20. "Mental illness" includes "emotional disturbance" as defined in Minnesota Statutes, section 245.4871, subdivision 15.

Subp. 21. **Multidisciplinary staff.** "Multidisciplinary staff" means a group of individuals from diverse disciplines who come together to provide services to clients under part 9505.0372, subparts 8, 9, and 10.

Subp. 22. **Neuropsychological assessment.** "Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist.

Subp. 23. **Neuropsychological testing.** "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn and recall information; and use problem-solving and judgment.

Subp. 24. **Partial hospitalization program.** "Partial hospitalization program" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x, (ff), that is provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services.

Subp. 25. **Primary caregiver.** "Primary caregiver" means a person, other than the facility staff, who has primary legal responsibility for providing the client with food, clothing, shelter, direction, guidance, and nurturance.

Subp. 26. **Psychological testing.** "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the recipient's mental, intellectual, and emotional functioning.

Subp. 27. **Psychotherapy.** "Psychotherapy" means treatment of a client with mental illness that applies the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client.

Subp. 28. **Supervisee.** "Supervisee" means an individual who requires clinical supervision because the individual does not meet mental health professional standards in part 9505.0371, subpart 5, item A.

9505.0371 MEDICAL ASSISTANCE COVERAGE REQUIREMENTS FOR OUTPATIENT MENTAL HEALTH SERVICES.

Subpart 1. **Purpose.** This part describes the requirements that outpatient mental health services must meet to receive medical assistance reimbursement.

Subp. 2. **Client eligibility for mental health services.** The following requirements apply to mental health services:

A. The provider must use a diagnostic assessment as specified in part 9505.0372 to determine a client's eligibility for mental health services under this part, except:

(1) prior to completion of a client's initial diagnostic assessment, a client is eligible for:

(a) one explanation of findings;

(b) one psychological testing; and

(c) either one individual psychotherapy session, one family psychotherapy session, or one group psychotherapy session; and

(2) for a client who is not currently receiving mental health services covered by medical assistance, a crisis assessment as specified in Minnesota Statutes, section 256B.0624 or 256B.0944, conducted in the past 60 days may be used to allow up to ten sessions of mental health services within a 12-month period.

B. A brief diagnostic assessment must meet the requirements of part 9505.0372, subpart 1, item D, and:

(1) may be used to allow up to ten sessions of mental health services as specified in part 9505.0372 within a 12-month period before a standard or extended diagnostic assessment is required when the client is:

(a) a new client; or

(b) an existing client who has had fewer than ten sessions of psychotherapy in the previous 12 months and is projected to need fewer than ten sessions of psychotherapy in the next 12 months, or who only needs medication management; and

(2) may be used for a subsequent annual assessment, if based upon the client's treatment history and the provider's clinical judgment, the client will need ten or fewer sessions of mental health services in the upcoming 12-month period; and

(3) must not be used for:

(a) a client or client's family who requires a language interpreter to participate in the assessment unless the client meets the requirements of subitem (1), unit (b), or (2); or

(b) more than ten sessions of mental health services in a 12-month period. If, after completion of ten sessions of mental health services, the mental health professional determines the need for additional sessions, a standard assessment or extended assessment must be completed.

C. For a child, a new standard or extended diagnostic assessment must be completed:

(1) when the child does not meet the criteria for a brief diagnostic assessment;

(2) at least annually following the initial diagnostic assessment, if:

(a) additional services are needed; and

(b) the child does not meet criteria for brief assessment;

(3) when the child's mental health condition has changed markedly since the child's most recent diagnostic assessment; or

(4) when the child's current mental health condition does not meet criteria of the child's current diagnosis.

D. For an adult, a new standard diagnostic assessment or extended diagnostic assessment must be completed:

(1) when the adult does not meet the criteria for a brief diagnostic assessment or an adult diagnostic assessment update;

(2) at least every three years following the initial diagnostic assessment for an adult who receives mental health services;

(3) when the adult's mental health condition has changed markedly since the adult's most recent diagnostic assessment; or

(4) when the adult's current mental health condition does not meet criteria of the current diagnosis.

E. An adult diagnostic assessment update must be completed at least annually unless a new standard or extended diagnostic assessment is performed. An adult diagnostic assessment update must include an update of the most recent standard or extended diagnostic assessment and any recent adult diagnostic assessment updates that have occurred since the last standard or extended diagnostic assessment.

Subp. 3. **Authorization for mental health services.** Mental health services under this part are subject to authorization criteria and standards published by the commissioner according to Minnesota Statutes, section 256B.0625, subdivision 25.

Subp. 4. **Clinical supervision.**

A. Clinical supervision must be based on each supervisee's written supervision plan and must:

(1) promote professional knowledge, skills, and values development;

(2) model ethical standards of practice;

(3) promote cultural competency by:

(a) developing the supervisee's knowledge of cultural norms of behavior for individual clients and generally for the clients served by the supervisee regarding the client's cultural influences, age, class, gender, sexual orientation, literacy, and mental or physical disability;

(b) addressing how the supervisor's and supervisee's own cultures and privileges affect service delivery;

(c) developing the supervisee's ability to assess their own cultural competence and to identify when consultation or referral of the client to another provider is needed; and

(d) emphasizing the supervisee's commitment to maintaining cultural competence as an ongoing process;

(4) recognize that the client's family has knowledge about the client and will continue to play a role in the client's life and encourage participation among the client, client's family, and providers as treatment is planned and implemented; and

(5) monitor, evaluate, and document the supervisee's performance of assessment, treatment planning, and service delivery.

B. Clinical supervision must be conducted by a qualified supervisor using individual or group supervision. Individual or group face-to-face supervision may be conducted via electronic communications that utilize interactive telecommunications equipment that includes at a minimum audio and video equipment for two-way, real-time, interactive communication between the supervisor and supervisee, and meet the equipment and connection standards of part 9505.0370, subpart 19.

(1) Individual supervision means one or more designated clinical supervisors and one supervisee.

(2) Group supervision means one clinical supervisor and two to six supervisees in face-to-face supervision.

C. The supervision plan must be developed by the supervisor and the supervisee. The plan must be reviewed and updated at least annually. For new staff the plan must be completed and implemented within 30 days of the new staff person's employment. The supervision plan must include:

(1) the name and qualifications of the supervisee and the name of the agency in which the supervisee is being supervised;

(2) the name, licensure, and qualifications of the supervisor;

(3) the number of hours of individual and group supervision to be completed by the supervisee including whether supervision will be in person or by some other method approved by the commissioner;

(4) the policy and method that the supervisee must use to contact the clinical supervisor during service provision to a supervisee;

(5) procedures that the supervisee must use to respond to client emergencies; and

(6) authorized scope of practices, including:

(a) description of the supervisee's service responsibilities;

(b) description of client population; and

(c) treatment methods and modalities.

D. Clinical supervision must be recorded in the supervisee's supervision record. The documentation must include:

(1) date and duration of supervision;

(2) identification of supervision type as individual or group supervision;

(3) name of the clinical supervisor;

(4) subsequent actions that the supervisee must take; and

(5) date and signature of the clinical supervisor.

E. Clinical supervision pertinent to client treatment changes must be recorded by a case notation in the client record after supervision occurs.

Subp. 5. **Qualified providers.** Medical assistance covers mental health services according to part 9505.0372 when the services are provided by mental health professionals or mental health practitioners qualified under this subpart.

A. A mental health professional must be qualified in one of the following ways:

(1) in clinical social work, a person must be licensed as an independent clinical social worker by the Minnesota Board of Social Work under Minnesota Statutes, chapter 148D until August 1, 2011, and thereafter under Minnesota Statutes, chapter 148E;

(2) in psychology, a person licensed by the Minnesota Board of Psychology under Minnesota Statutes, sections 148.88 to 148.98, who has stated to the board competencies in the diagnosis and treatment of mental illness;

(3) in psychiatry, a physician licensed under Minnesota Statutes, chapter 147, who is certified by the American Board of Psychiatry and Neurology or is eligible for board certification;

(4) in marriage and family therapy, a person licensed as a marriage and family therapist by the Minnesota Board of Marriage and Family Therapy under Minnesota Statutes, sections 148B.29 to 148B.39, and defined in parts 5300.0100 to 5300.0350;

(5) in professional counseling, a person licensed as a professional clinical counselor by the Minnesota Board of Behavioral Health and Therapy under Minnesota Statutes, section 148B.5301;

(6) a tribally approved mental health care professional, who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), and who is serving a federally recognized Indian tribe; or

(7) in psychiatric nursing, a registered nurse who is licensed under Minnesota Statutes, sections 148.171 to 148.285, and meets one of the following criteria:

(a) is certified as a clinical nurse specialist;

(b) for children, is certified as a nurse practitioner in child or adolescent or family psychiatric and mental health nursing by a national nurse certification organization; or

(c) for adults, is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization.

B. A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults. A mental health practitioner must be qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university; and

(a) has at least 2,000 hours of supervised experience in the delivery of mental health services to clients with mental illness; or

(b) is fluent in the non-English language of the cultural group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once a week until the requirements of 2,000 hours of supervised experience are met;

(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to clients with mental illness. Hours worked as a mental health behavioral aide I or II under Minnesota Statutes, section 256B.0943, subdivision 7, may be included in the 6,000 hours of experience for child clients;

(3) is a graduate student in one of the mental health professional disciplines defined in item A and is formally assigned by an accredited college or university to an agency or facility for clinical training;

(4) holds a master's or other graduate degree in one of the mental health professional disciplines defined in item A from an accredited college or university; or

(5) is an individual who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), who is serving a federally recognized Indian tribe.

C. Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy performed by a mental health practitioner working as a clinical trainee when:

(1) the mental health practitioner is:

(a) complying with requirements for licensure or board certification as a mental health professional, as defined in item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or

(b) a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional defined in item A; and

(2) the mental health practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of:

(a) direct practice;

(b) treatment team collaboration;

(c) continued professional learning; and

(d) job management.

D. A clinical supervisor must:

(1) be a mental health professional licensed as specified in item A;

(2) hold a license without restrictions that has been in good standing for at least one year while having performed at least 1,000 hours of clinical practice;

(3) be approved, certified, or in some other manner recognized as a qualified clinical supervisor by the person's professional licensing board, when this is a board requirement;

(4) be competent as demonstrated by experience and graduate-level training in the area of practice and the activities being supervised;

(5) not be the supervisee's blood or legal relative or cohabitant, or someone who has acted as the supervisee's therapist within the past two years;

(6) have experience and skills that are informed by advanced training, years of experience, and mastery of a range of competencies that demonstrate the following:

(a) capacity to provide services that incorporate best practice;

(b) ability to recognize and evaluate competencies in supervisees;

(c) ability to review assessments and treatment plans for accuracy and appropriateness;

(d) ability to give clear direction to mental health staff related to alternative strategies when a client is struggling with moving towards recovery; and

(e) ability to coach, teach, and practice skills with supervisees;

(7) accept full professional liability for a supervisee's direction of a client's mental health services;

(8) instruct a supervisee in the supervisee's work, and oversee the quality and outcome of the supervisee's work with clients;

(9) review, approve, and sign the diagnostic assessment, individual treatment plans, and treatment plan reviews of clients treated by a supervisee;

(10) review and approve the progress notes of clients treated by the supervisee according to the supervisee's supervision plan;

(11) apply evidence-based practices and research-informed models to treat clients;

(12) be employed by or under contract with the same agency as the supervisee;

(13) develop a clinical supervision plan for each supervisee;

(14) ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices;

(15) establish an evaluation process that identifies the performance and competence of each supervisee; and

(16) document clinical supervision of each supervisee and securely maintain the documentation record.

Subp. 6. **Release of information.** Providers who receive a request for client information and providers who request client information must:

A. comply with data practices and medical records standards in Minnesota Statutes, chapter 13, and Code of Federal Regulations, title 45, part 164; and

B. subject to the limitations in item A, promptly provide client information, including a written diagnostic assessment, to other providers who are treating the client to ensure that the client will get services without undue delay.

Subp. 7. **Individual treatment plan.** Except as provided in subpart 2, item A, subitem (1), a medical assistance payment is available only for services provided in accordance with the client's written individual treatment plan (ITP). The client must be involved in the development, review, and revision of the client's ITP. For all mental health services, except

as provided in subpart 2, item A, subitem (1), and medication management, the ITP and subsequent revisions of the ITP must be signed by the client before treatment begins. The mental health professional or practitioner shall request the client, or other person authorized by statute to consent to mental health services for the client, to sign the client's ITP or revision of the ITP. In the case of a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child shall be asked to sign the child's ITP and revisions of the ITP. If the client or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the refusal to sign the plan and the reason or reasons for the refusal. A client's individual treatment plan must be:

A. based on the client's current diagnostic assessment;

B. developed by identifying the client's service needs and considering relevant cultural influences to identify planned interventions that contain specific treatment goals and measurable objectives for the client; and

C. reviewed at least once every 90 days, and revised as necessary. Revisions to the initial individual treatment plan do not require a new diagnostic assessment unless the client's mental health status has changed markedly as provided in subpart 2.

Subp. 8. **Documentation.** To obtain medical assistance payment for an outpatient mental health service, a mental health professional or a mental health practitioner must promptly document:

A. in the client's mental health record:

(1) each occurrence of service to the client including the date, type of service, start and stop time, scope of the mental health service, name and title of the person who gave the service, and date of documentation; and

(2) all diagnostic assessments and other assessments, psychological test results, treatment plans, and treatment plan reviews;

B. the provider's contact with persons interested in the client such as representatives of the courts, corrections systems, or schools, or the client's other mental health providers, case manager, family, primary caregiver, legal representative, including the name and date of the contact or, if applicable, the reason the client's family, primary caregiver, or legal representative was not contacted; and

C. dates that treatment begins and ends and reason for the discontinuation of the mental health service.

Subp. 9. **Service coordination.** The provider must coordinate client services as authorized by the client as follows:

A. When a recipient receives mental health services from more than one mental health provider, each provider must coordinate mental health services they provide to the client with other mental health service providers to ensure services are provided in the most efficient manner to achieve maximum benefit for the client.

B. The mental health provider must coordinate mental health care with the client's physical health provider.

Subp. 10. **Telemedicine services.** Mental health services in part 9505.0372 covered as direct face-to-face services may be provided via two-way interactive video if it is medically appropriate to the client's condition and needs. The interactive video equipment and connection must comply with Medicare standards that are in effect at the time of service. The commissioner may specify parameters within which mental health services can be provided via telemedicine.

9505.0372 COVERED SERVICES.

Subpart 1. **Diagnostic assessment.** Medical assistance covers four types of diagnostic assessments when they are provided in accordance with the requirements in this subpart.

A. To be eligible for medical assistance payment, a diagnostic assessment must:

(1) identify a mental health diagnosis and recommended mental health services, which are the factual basis to develop the recipient's mental health services and treatment plan; or

(2) include a finding that the client does not meet the criteria for a mental health disorder.

B. A standard diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The standard diagnostic assessment must be done within the cultural context of the client and must include relevant information about:

(1) the client's current life situation, including the client's:

(a) age;

(b) current living situation, including household membership and housing status;

(c) basic needs status including economic status;

(d) education level and employment status;

(e) significant personal relationships, including the client's evaluation of relationship quality;

(f) strengths and resources, including the extent and quality of social networks;

(g) belief systems;

(h) contextual nonpersonal factors contributing to the client's presenting concerns;

(i) general physical health and relationship to client's culture; and

(j) current medications;

(2) the reason for the assessment, including the client's:

(a) perceptions of the client's condition;

(b) description of symptoms, including reason for referral;

(c) history of mental health treatment, including review of the client's records;

(d) important developmental incidents;

(e) maltreatment, trauma, or abuse issues;

(f) history of alcohol and drug usage and treatment;

(g) health history and family health history, including physical, chemical, and mental health history; and

(h) cultural influences and their impact on the client;

(3) the client's mental status examination;

(4) the assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(5) the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

(6) assessment methods and use of standardized assessment tools by the provider as determined and periodically updated by the commissioner;

(7) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(8) the client data that is adequate to support the findings on all axes of the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and any differential diagnosis.

C. An extended diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The face-to-face interview is conducted over three or more assessment appointments because the client's complex needs necessitate significant additional assessment time. Complex needs are those caused by acuity of psychotic disorder; cognitive or neurocognitive impairment; need to consider past diagnoses and determine their current applicability; co-occurring substance abuse use disorder; or disruptive or changing environments, communication barriers, or cultural considerations as documented in the assessment. For child clients, the appointments may be conducted outside the diagnostician's office for face-to-face consultation and information gathering with family members, doctors, caregivers, teachers, and other providers, with or without the child present, and may involve directly observing the child in various settings that the child frequents such as home, school, or care settings. To complete the diagnostic assessment with adult clients, the appointments may be conducted outside of the diagnostician's office for face-to-face assessment with the adult client. The appointment may involve directly observing the adult client in various settings that the adult frequents, such as home, school, job, service settings, or community settings. The appointments may include face-to-face meetings with the adult client and the client's family members, doctors, caregivers, teachers, social support network members, recovery support resource representatives, and other providers for consultation and information gathering for the diagnostic assessment. The components of an extended diagnostic assessment include the following relevant information:

(1) for children under age 5:

(a) utilization of the DC:0-3R diagnostic system for young children;

(b) an early childhood mental status exam that assesses the client's developmental, social, and emotional functioning and style both within the family and with the examiner and includes:

i. physical appearance including dysmorphic features;

ii. reaction to new setting and people and adaptation during evaluation;

iii. self-regulation, including sensory regulation, unusual behaviors, activity level, attention span, and frustration tolerance;

iv. physical aspects, including motor function, muscle tone, coordination, tics, abnormal movements, and seizure activity;

v. vocalization and speech production, including expressive and receptive language;

vi. thought, including fears, nightmares, dissociative states, and hallucinations;

vii. affect and mood, including modes of expression, range, responsiveness, duration, and intensity;

viii. play, including structure, content, symbolic functioning, and modulation of aggression;

ix. cognitive functioning; and

x. relatedness to parents, other caregivers, and examiner; and

(c) other assessment tools as determined and periodically revised by the commissioner;

(2) for children ages 5 to 18, completion of other assessment standards for children as determined and periodically revised by the commissioner; and

(3) for adults, completion of other assessment standards for adults as determined and periodically revised by the commissioner.

D. A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The professional or practitioner must gather initial background information using the components of a standard diagnostic assessment in item B, subitems (1), (2), unit (b), (3), and (5), and draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem. Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.

E. Adult diagnostic assessment update includes a face-to-face interview with the client, and contains a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C, who reviews a standard or extended diagnostic assessment. The adult diagnostic assessment update must update the most recent assessment document in writing in the following areas:

(1) review of the client's life situation, including an interview with the client about the client's current life situation, and a written update of those parts where significant new or changed information exists, and documentation where there has not been significant change;

(2) review of the client's presenting problems, including an interview with the client about current presenting problems and a written update of those parts where there is significant new or changed information, and note parts where there has not been significant change;

(3) screenings for substance use, abuse, or dependency and other screenings as determined by the commissioner;

(4) the client's mental health status examination;

(5) assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(6) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary, or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(7) the client's diagnosis on all axes of the current edition of the Diagnostic and Statistical Manual and any differential diagnosis.

Subp. 2. **Neuropsychological assessment.** A neuropsychological assessment must include a face-to-face interview with the client, the interpretation of the test results, and preparation and completion of a report. A client is eligible for a neuropsychological assessment if at least one of the following criteria is met:

A. There is a known or strongly suspected brain disorder based on medical history or neurological evaluation such as a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorders, significant exposure to neurotoxins, central nervous system infections, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformations of the brain; or

B. In the absence of a medically verified brain disorder based on medical history or neurological evaluation, there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology, or suspected neuropsychological impairment in addition to functional psychopathology. Examples include:

(1) poor memory or impaired problem solving;

(2) change in mental status evidenced by lethargy, confusion, or disorientation;

(3) deterioration in level of functioning;

(4) marked behavioral or personality change;

(5) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;

(6) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers; and

(7) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

C. If neither criterion in item A nor B is fulfilled, neuropsychological evaluation is not indicated.

D. The neuropsychological assessment must be conducted by a neuropsychologist with competence in the area of neuropsychological assessment as stated to the Minnesota Board of Psychology who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program:

(a) completed an internship, or its equivalent, in a clinically relevant area of professional psychology;

(b) completed the equivalent of two full-time years of experience and specialized training, at least one which is at the postdoctoral level, in the study and practices of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist; and

(c) holds a current license to practice psychology independently in accordance with Minnesota Statutes, sections 148.88 to 148.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in subitem (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010.

Subp. 3. **Neuropsychological testing.**

A. Medical assistance covers neuropsychological testing when the client has either:

(1) a significant mental status change that is not a result of a metabolic disorder that has failed to respond to treatment;

(2) in children or adolescents, a significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers;

(3) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities, as required to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(a) traumatic brain injury;

(b) stroke;

(c) brain tumor;

(d) substance abuse or dependence;

(e) cerebral anoxic or hypoxic episode;

(f) central nervous system infection or other infectious disease;

(g) neoplasms or vascular injury of the central nervous system;

(h) neurodegenerative disorders;

(i) demyelinating disease;

(j) extrapyramidal disease;

(k) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(l) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders such as lupus, erythematosis, or celiac disease;

(m) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, such as phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(n) severe or prolonged nutrition or malabsorption syndromes; or

(o) a condition presenting in a manner making it difficult for a clinician to distinguish between:

i. the neurocognitive effects of a neurogenic syndrome such as dementia or encephalopathy; and

ii. a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function, or another disorder such as autism, selective mutism, anxiety disorder, or reactive attachment disorder.

B. Neuropsychological testing must be administered or clinically supervised by a neuropsychologist qualified as defined in subpart 2, item D.

C. Neuropsychological testing is not covered when performed:

(1) primarily for educational purposes;

(2) primarily for vocational counseling or training;

(3) for personnel or employment testing;

(4) as a routine battery of psychological tests given at inpatient admission or continued stay; or

(5) for legal or forensic purposes.

Subp. 4. **Psychological testing.** Psychological testing must meet the following requirements:

A. The psychological testing must:

(1) be administered or clinically supervised by a licensed psychologist with competence in the area of psychological testing as stated to the Minnesota Board of Psychology; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a mental health practitioner working as a clinical psychology trainee as required by part 9505.0371, subpart 5, item C, under the clinical supervision of a licensed psychologist according to part 9505.0371, subpart 5, item A, subitem (2).

B. The administration, scoring, and interpretation of the psychological tests must be done under the clinical supervision of a licensed psychologist when performed by a technician, psychometrist, or psychological assistant or as part of a computer-assisted psychological testing program.

C. The report resulting from the psychological testing must be:

(1) signed by the psychologist conducting the face-to-face interview;

(2) placed in the client's record; and

(3) released to each person authorized by the client.

Subp. 5. **Explanations of findings.** To be eligible for medical assistance payment, the mental health professional providing the explanation of findings must obtain the authorization of the client or the client's representative to release the information as required in part 9505.0371, subpart 6. Explanation of findings is provided to the client, client's family, and caregivers, or to other providers to help them understand the results of the testing or diagnostic assessment, better understand the client's illness, and provide professional insight needed to carry out a plan of treatment. An explanation of findings is not paid separately when the results of psychological testing or a diagnostic assessment are explained to the client or the client's representative as part of the psychological testing or a diagnostic assessment.

Subp. 6. **Psychotherapy.** Medical assistance covers psychotherapy as conducted by a mental health professional or a mental health practitioner as defined in part 9505.0371, subpart 5, item C, as provided in this subpart.

A. Individual psychotherapy is psychotherapy designed for one client.

B. Family psychotherapy is designed for the client and one or more family members or the client's primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance. For purposes of this subpart, the phrase "whose participation is necessary to accomplish the client's treatment goals" does not include shift or facility staff members at the client's residence. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes

the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of time of the exclusion. The mental health professional must also document the reason or reasons why a member of the client's family is excluded.

C. Group psychotherapy is appropriate for individuals who because of the nature of their emotional, behavioral, or social dysfunctions can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or practitioner is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two mental health practitioners or one mental health professional and one mental health practitioner is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 persons.

D. A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in client's treatment plan. If the client is excluded, the mental health professional or practitioner must document the reason for and the length of the time of the exclusion. The mental health professional or practitioner must document the reasons why a member of the client's family is excluded.

Subp. 7. **Medication management.** The determination or evaluation of the effectiveness of a client's prescribed drug must be carried out by a physician or by an advanced practice registered nurse, as defined in Minnesota Statutes, sections 148.171 to 148.285, who is qualified in psychiatric nursing.

Subp. 8. **Adult day treatment.** Adult day treatment payment limitations include the following conditions.

A. Adult day treatment must consist of at least one hour of group psychotherapy, and must include group time focused on rehabilitative interventions, or other therapeutic services that are provided by a multidisciplinary staff. Adult day treatment is an intensive psychotherapeutic treatment. The services must stabilize the client's mental health status, and develop and improve the client's independent living and socialization skills. The goal of adult day treatment is to reduce or relieve the effects of mental illness so that an individual is able to benefit from a lower level of care and to enable the client to live and function more independently in the community. Day treatment services are not a part of inpatient or residential treatment services.

B. To be eligible for medical assistance payment, a day treatment program must:

(1) be reviewed by and approved by the commissioner;

(2) be provided to a group of clients by a multidisciplinary staff under the clinical supervision of a mental health professional;

(3) be available to the client at least two days a week for at least three consecutive hours per day. The day treatment may be longer than three hours per day, but medical assistance must not reimburse a provider for more than 15 hours per week;

(4) include group psychotherapy done by a mental health professional, or mental health practitioner qualified according to part 9505.0371, subpart 5, item C, and rehabilitative interventions done by a mental health professional or mental health practitioner daily;

(5) be included in the client's individual treatment plan as necessary and appropriate. The individual treatment plan must include attainable, measurable goals as they relate to services and must be completed before the first day treatment session. The vendor must review the recipient's progress and update the treatment plan at least every 30 days until the client is discharged and include an available discharge plan for the client in the treatment plan; and

(6) document the interventions provided and the client's response daily.

C. To be eligible for adult day treatment, a recipient must:

(1) be 18 years of age or older;

(2) not be residing in a nursing facility, hospital, institute of mental disease, or regional treatment center, unless the recipient has an active discharge plan that indicates a move to an independent living arrangement within 180 days;

(3) have a diagnosis of mental illness as determined by a diagnostic assessment;

(4) have the capacity to engage in the rehabilitative nature, the structured setting, and the therapeutic parts of psychotherapy and skills activities of a day treatment program and demonstrate measurable improvements in the recipient's functioning related to the recipient's mental illness that would result from participating in the day treatment program;

(5) have at least three areas of functional impairment as determined by a functional assessment with the domains prescribed by Minnesota Statutes, section 245.462, subdivision 11a;

(6) have a level of care determination that supports the need for the level of intensity and duration of a day treatment program; and

(7) be determined to need day treatment by a mental health professional who must deem the day treatment services medically necessary.

D. The following services are not covered by medical assistance if they are provided by a day treatment program:

(1) a service that is primarily recreation-oriented or that is provided in a setting that is not medically supervised. This includes: sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultation with other providers or service agency staff about the care or progress of a client;

(4) prevention or education programs provided to the community;

(5) day treatment for recipients with primary diagnoses of alcohol or other drug abuse;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours daily; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Subp. 9. **Partial hospitalization.** Partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission as specified in part 9505.0520, subpart 1, and who has the family and community resources necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services provided by a multidisciplinary staff to treat the client's mental illness.

Subp. 10. **Dialectical behavior therapy (DBT).** Dialectical behavior therapy (DBT) treatment services must meet the following criteria:

A. DBT must be provided according to this subpart and Minnesota Statutes, section 256B.0625, subdivision 5l.

B. DBT is an outpatient service that is determined to be medically necessary by either: (1) a mental health professional qualified according to part 9505.0371, subpart 5, or (2) a mental health practitioner working as a clinical trainee according to part 9505.0371, subpart 5, item C, who is under the clinical supervision of a mental health professional according to part 9505.0371, subpart 5, item D, with specialized skill in dialectical behavior therapy. The treatment recommendation must be based upon a comprehensive evaluation that includes a diagnostic assessment and functional assessment of the client, and review of the client's prior treatment history. Treatment services must be provided pursuant to the client's individual treatment plan and provided to a client who satisfies the criteria in item C.

C. To be eligible for DBT, a client must:

(1) be 18 years of age or older;

(2) have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services;

(3) meet one of the following criteria:

(a) have a diagnosis of borderline personality disorder; or

(b) have multiple mental health diagnoses and exhibit behaviors characterized by impulsivity, intentional self-harm behavior, and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas;

(4) understand and be cognitively capable of participating in DBT as an intensive therapy program and be able and willing to follow program policies and rules assuring safety of self and others; and

(5) be at significant risk of one or more of the following if DBT is not provided:

(a) mental health crisis;

(b) requiring a more restrictive setting such as hospitalization;

(c) decompensation; or

(d) engaging in intentional self-harm behavior.

D. The treatment components of DBT are individual therapy and group skills as follows:

(1) Individual DBT combines individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and reinforce the use of adaptive skillful behaviors. The therapist must:

(a) identify, prioritize, and sequence behavioral targets;

(b) treat behavioral targets;

(c) generalize DBT skills to the client's natural environment through telephone coaching outside of the treatment session;

(d) measure the client's progress toward DBT targets;

(e) help the client manage crisis and life-threatening behaviors; and

(f) help the client learn and apply effective behaviors when working with other treatment providers.

(2) Individual DBT therapy is provided by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

(3) Group DBT skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce the client's suicidal and other dysfunctional coping behaviors and restore function by teaching the client adaptive skills in the following areas:

(a) mindfulness;

(b) interpersonal effectiveness;

(c) emotional regulation; and

(d) distress tolerance.

(4) Group DBT skills training is provided by two mental health professionals, or by a mental health professional cofacilitating with a mental health practitioner.

(5) The need for individual DBT skills training must be determined by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

E. A program must be certified by the commissioner as a DBT provider. To qualify for certification, a provider must:

(1) hold current accreditation as a DBT program from a nationally recognized certification body approved by the commissioner or submit to the commissioner's inspection and provide evidence that the DBT program's policies, procedures, and practices will continuously meet the requirements of this subpart;

(2) be enrolled as a MHCP provider;

(3) collect and report client outcomes as specified by the commissioner; and

(4) have a manual that outlines the DBT program's policies, procedures, and practices which meet the requirements of this subpart.

F. The DBT treatment team must consist of persons who are trained in DBT treatment. The DBT treatment team may include persons from more than one agency. Professional and clinical affiliations with the DBT team must be delineated:

(1) A DBT team leader must:

(a) be a mental health professional employed by, affiliated with, or contracted by a DBT program certified by the commissioner;

(b) have appropriate competencies and working knowledge of the DBT principles and practices; and

(c) have knowledge of and ability to apply the principles and DBT practices that are consistent with evidence-based practices.

(2) DBT team members who provide individual DBT or group skills training must:

(a) be a mental health professional or be a mental health practitioner, who is employed by, affiliated with, or contracted with a DBT program certified by the commissioner;

(b) have or obtain appropriate competencies and working knowledge of DBT principles and practices within the first six months of becoming a part of the DBT program;

(c) have or obtain knowledge of and ability to apply the principles and practices of DBT consistently with evidence-based practices within the first six months of working at the DBT program;

(d) participate in DBT consultation team meetings; and

(e) require mental health practitioners to have ongoing clinical supervision by a mental health professional who has appropriate competencies and working knowledge of DBT principles and practices.

Subp. 11. **Noncovered services.** The mental health services in items A to J are not eligible for medical assistance payment under this part:

A. a mental health service that is not medically necessary;

B. a neuropsychological assessment carried out by a person other than a neuropsychologist who is qualified according to part 9505.0372, subpart 2, item D;

C. a service ordered by a court that is solely for legal purposes and not related to the recipient's diagnosis or treatment for mental illness;

D. services dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health;

E. a service that is only for a vocational purpose or an educational purpose that is not mental health related;

F. staff training that is not related to a client's individual treatment plan or plan of care;

G. child and adult protection services;

H. fund-raising activities;

I. community planning; and

J. client transportation.

9520.0010 STATUTORY AUTHORITY AND PURPOSE.

Parts 9520.0010 to 9520.0230 provide methods and procedures relating to the establishment and operation of area-wide, comprehensive, community-based mental health, developmental disability, and chemical dependency programs under state grant-in-aid as provided under Minnesota Statutes, sections 245.61 to 245.69. Minnesota Statutes, sections 245.61 to 245.69 are entitled The Community Mental Health Services Act. For purposes of these parts, "community mental health services" includes services to persons who have mental or emotional disorders or other psychiatric disabilities, developmental disabilities, and chemical dependency, including drug abuse and alcoholism.

9520.0020 BOARD DUTIES.

The community mental health board has the responsibility for ensuring the planning, development, implementation, coordination, and evaluation of the community comprehensive mental health program for the mentally ill/behaviorally disabled, developmentally disabled, and chemically dependent populations in the geographic area it serves. It also has the responsibility for ensuring delivery of services designated by statute.

9520.0030 DEFINITIONS.

Parts 9520.0040 and 9520.0050 also set forth definitions of community mental health centers and community mental health clinics.

9520.0040 COMMUNITY MENTAL HEALTH CENTER.

A community mental health center means an agency which includes all of the following:

A. Established under the provision of Minnesota Statutes, sections 245.61 to 245.69.

B. Provides as a minimum the following services for individuals with mental or emotional disorders, developmental disabilities, alcoholism, drug abuse, and other psychiatric conditions. The extent of each service to be provided by the center shall be indicated in the program plan, which is to reflect the problems, needs, and resources of the community served:

(1) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, developmental disability, alcoholism, drug abuse, and other psychiatric disorders;

(2) informational and educational services to schools, courts, health and welfare agencies, both public and private;

(3) informational and educational services to the general public, lay, and professional groups;

(4) consultative services to schools, courts, and health and welfare agencies, both public and private;

(5) outpatient diagnostic and treatment services; and

(6) rehabilitative services, particularly for those who have received prior treatment in an inpatient facility.

C. Provides or contracts for detoxification, evaluation, and referral for chemical dependency services (Minnesota Statutes, section 254A.08).

D. Provides specific coordination for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. (Minnesota Statutes, sections 254A.07 and 245.61).

E. Has a competent multidisciplinary mental health/developmental disability/chemical dependency professional team whose members meet the professional standards in their respective fields.

F. The professional mental health team is qualified by specific mental health training and experience and shall include as a minimum the services of each of the following:

(1) a licensed physician, who has completed an approved residency program in psychiatry; and

(2) a doctoral clinical, counseling, or health care psychologist, who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

(3) a clinical social worker with a master's degree in social work from an accredited college or university; and/or

(4) a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health nursing with mental health major, maternal and child health with mental health major, etc.

G. The multidisciplinary staff shall be sufficient in number to implement and operate the described program of the center. In addition to the above, this team should include other professionals, paraprofessionals, and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner. If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the center, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts

to acquire such staff and show evidence of how the specialized functions of the required professionals are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0050 COMMUNITY MENTAL HEALTH CLINIC.

Subpart 1. **Definitions.** A community mental health clinic is an agency which devotes, as its major service, at least two-thirds of its resources for outpatient mental health diagnosis, treatment, and consultation by a multidisciplinary professional mental health team. The multidisciplinary professional mental health team is qualified by special mental health training and experience and shall include as a minimum the services of each of the following:

A. a licensed physician, who has completed an approved residency program in psychiatry; and

B. a doctoral clinical, or counseling or health care psychologist who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

C. a clinical social worker with a master's degree in social work from an accredited college or university; and/or

D. a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health with a mental health major, maternal and child health with a mental health major.

Subp. 2. **Other members of multidisciplinary team.** The multidisciplinary team shall be sufficient in number to implement and operate the described program of the clinic. In addition to the above, this team should include other professionals, paraprofessionals and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner.

Subp. 3. **Efforts to acquire staff.** If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the clinic, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts to acquire such staff and evidence of how the specialized functions of the required professional positions are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0060 ANNUAL PLAN AND BUDGET.

On or before the date designated by the commissioner, each year the chair of the community mental health board or director of the community mental health program, provided for in Minnesota Statutes, section 245.62, shall submit an annual plan identifying program priorities in accordance with state grant-in-aid guidelines, and a budget on prescribed report forms for the next state fiscal year, together with the recommendations of the community mental health board, to the commissioner of human services for approval as provided under Minnesota Statutes, section 245.63.

9520.0070 FISCAL AFFILIATES.

Other providers of community mental health services may affiliate with the community mental health center and may be approved and eligible for state grant-in-aid funds. The state funding for other community mental health services shall be contingent upon appropriate inclusion in the center's community mental health plan for the continuum of community mental health services and conformity with the state's appropriate disability plan for mental health, developmental disability, or chemical dependency. Fiscal affiliates (funded contracting agencies) providing specialized services under contract must meet all rules and standards that apply to the services they are providing.

9520.0080 OTHER REQUIRED REPORTS.

The program director of the community mental health program shall provide the commissioner of human services with such reports of program activities as the commissioner may require.

9520.0090 FUNDING.

All state community mental health funding shall go directly to the community mental health board or to a human service board established pursuant to Laws of Minnesota 1975, chapter 402, which itself provides or contracts with another agency to provide the community mental health program. Such programs must meet the standards and rules for community mental health programs as enunciated in parts 9520.0010 to 9520.0230 in accordance with Laws of Minnesota 1975, chapter 402.

9520.0100 OPERATION OF OTHER PROGRAMS.

When the governing authority of the community mental health program operates other programs, services, or activities, only the community mental health center program shall be subject to these parts.

9520.0110 APPLICATIONS AND AGREEMENTS BY LOCAL COUNTIES.

New applications for state assistance or applications for renewal of support must be accompanied by an agreement executed by designated signatories on behalf of the participating counties that specifies the involved counties, the amount and source of local funds in each case, and the period of support. The local funds to be used to match state grant-in-aid must be assured in writing on Department of Human Services forms by the local funding authority(ies).

9520.0120 USE OF MATCHING FUNDS.

Funds utilized by the director as authorized by the community mental health board to match a state grant-in-aid must be available to that director for expenditures for the same general purpose as the state grant-in-aid funds.

9520.0130 QUARTERLY REPORTS.

The director of the community mental health program shall, within 20 days after the end of the quarter, submit quarterly prescribed reports to the commissioner of human services (controller's office), containing all receipts, expenditures, and cash balance, subject to an annual audit by the commissioner or his/her designee.

9520.0140 PAYMENTS.

Payments on approved grants will be made subsequent to the department's receipt of the program's quarterly reporting forms, unless the commissioner of human services has determined that funds allocated to a program are not needed for that program. Payments shall be in an amount of at least equal to the quarterly allocation minus any unexpended balance from the previous quarter providing this payment does not exceed the program grant award. In the event the program does not report within the prescribed time, the department will withhold the process of the program's payment until the next quarterly cycle.

9520.0150 FEES.

No fees shall be charged until the director with approval of the community mental health board has established fee schedules for the services rendered and they have been submitted to the commissioner of human services at least two months prior to the effective date thereof and have been approved by him/her. All fees shall conform to the approved schedules, which are accessible to the public.

9520.0160 SUPPLEMENTAL AWARDS.

The commissioner of human services may make supplemental awards to the community mental health boards.

9520.0170 WITHDRAWAL OF FUNDS.

The commissioner of human services may withdraw funds from any program that is not administered in accordance with its approved plan and budget. Written notice of such intended action will be provided to the director and community mental health board. Opportunity for hearing before the commissioner or his/her designee shall be provided.

9520.0180 BUDGET TRANSFERS.

Community mental health boards may make budget transfers within specified limits during any fiscal year without prior approval of the department. The specified limit which can be transferred in any fiscal year between program activity budgets shall be up to ten percent or up to $5,000 whichever is less. Transfers within an activity can be made into or out of line items with a specified limit of up to ten percent or up to $5,000 whichever is less. No line item can be increased or decreased by more than $5,000 or ten percent in a fiscal year without prior approval of the commissioner. Transfers above the specified limits can be made with prior approval from the commissioner. All transfers within and into program budget activities and/or line items must have prior approval by the community mental health board and this approval must be reflected in the minutes of its meeting, it must be reported to the commissioner with the reasons therefor, including a statement of how the transfer will affect program objectives.

9520.0190 BUDGET ADJUSTMENTS.

Budget adjustments made necessary by funding limitations shall be made by the commissioner and provided in writing to the director and board of the community mental health center.

9520.0200 CENTER DIRECTOR.

Every community mental health board receiving state funds for a community mental health program shall have a center director, who is the full-time qualified professional staff member who serves as the executive officer. To be considered qualified, the individual must have professional training to at least the level of graduate degree in his/her clinical and/or administrative discipline, which is relevant to MH-DD-CD and a minimum of two years experience in community mental health programs. The center director is responsible for the planning/design, development, coordination, and evaluation of a comprehensive, area-wide program and for the overall administration of services operated by the board.

The center director shall be appointed by the community mental health board and shall be approved by the commissioner of human services.

9520.0210 DEADLINE FOR APPROVAL OR DENIAL OF REQUEST FOR APPROVAL STATUS.

The commissioner shall approve or deny, in whole or in part, an application for state financial assistance within 90 days of receipt of the grant-in-aid application or by the beginning of the state fiscal year, whichever is the later.

9520.0230 ADVISORY COMMITTEE.

Subpart 1. **Purpose.** To assist the community mental health board in meeting its responsibilities as described in Minnesota Statutes, section 245.68 and to provide opportunity for broad community representation necessary for effective comprehensive mental health, developmental disability, and chemical dependency program planning, each community

mental health board shall appoint a separate advisory committee in at least the three disability areas of mental health, developmental disability, and chemical dependency.

Subp. 2. **Membership.** The advisory committees shall consist of residents of the geographic area served who are interested and knowledgeable in the area governed by such committee.

Subp. 3. **Nominations for membership.** Nominations for appointments as members of the advisory committees are to be made to the community mental health board from agencies, organizations, groups, and individuals within the area served by the community mental health center. Appointments to the advisory committees are made by the community mental health board.

Subp. 4. **Board member on committee.** One community mental health board member shall serve on each advisory committee.

Subp. 5. **Nonprovider members.** Each advisory committee shall have at least one-half of its membership composed of individuals who are not providers of services to the three disability groups.

Subp. 6. **Representative membership.** Membership of each advisory committee shall generally reflect the population distribution of the service delivery area of the community mental health center.

Subp. 7. **Chairperson appointed.** The community mental health board shall appoint a chairperson for each advisory committee. The chairperson shall not be a community mental health board member nor a staff member. The power to appoint the chairperson may be delegated by the community mental health board to the individual advisory committee.

Subp. 8. **Committee responsibility to board.** Each advisory committee shall be directly responsible to the community mental health board. Direct communication shall be effected and maintained through contact between the chairperson of the particular advisory committee, or his/her designee, and the chairperson of the community mental health board, or his/her designee.

Subp. 9. **Staff.** Staff shall be assigned by the director to serve the staffing needs of each advisory committee.

Subp. 10. **Study groups and task forces.** Each advisory committee may appoint study groups and task forces upon consultation with the community mental health board. It is strongly recommended that specific attention be given to the aging and children and youth populations.

Subp. 11. **Quarterly meetings required.** Each advisory committee shall meet at least quarterly.

Subp. 12. **Annual report required.** Each advisory committee must make a formal written and oral report on its work to the community mental health board at least annually.

Subp. 13. **Minutes.** Each advisory committee shall submit copies of minutes of their meetings to the community mental health board and to the Department of Human Services (respective disability group program divisions).

Subp. 14. **Duties of advisory committee.** The advisory committees shall be charged by the community mental health board with assisting in the identification of the community's needs for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. The advisory committee also assists the community mental health board in determining priorities for the community programs. Based on the priorities, each advisory committee shall recommend to the community mental health board ways in which the limited available community resources (work force, facilities, and finances) can be put to maximum and optimal use.

Subp. 15. **Recommendations.** The advisory committee recommendations made to the community mental health board shall be included as a separate section in the grant-in-aid request submitted to the Department of Human Services by the community mental health board.

Subp. 16. **Assessment of programs.** The advisory committees shall assist the community mental health board in assessing the programs carried on by the community mental health board, and make recommendations regarding the reordering of priorities and modifying of programs where necessary.

9520.0750 PURPOSE.

Parts 9520.0750 to 9520.0870 establish standards for approval of mental health centers and mental health clinics for purposes of insurance and subscriber contract reimbursement under Minnesota Statutes, section 62A.152.

9520.0760 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9520.0760 to 9520.0870, the following terms have the meanings given them.

Subp. 2. **Application.** "Application" means the formal statement by a center to the commissioner, on the forms created for this purpose, requesting recognition as meeting the requirements of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 3. **Approval.** "Approval" means the determination by the commissioner that the applicant center has met the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870, and is therefore eligible to claim reimbursement for outpatient clinical services under the terms of Minnesota Statutes, section 62A.152. Approval of a center under these parts does not mean approval of a multidisciplinary staff person of such center to claim reimbursement from medical assistance or other third-party payors when practicing privately. Approval of a center under these parts does not mean approval of such center to claim reimbursement from medical assistance.

Subp. 4. **Case review.** "Case review" means a consultation process thoroughly examining a client's condition and treatment. It includes review of the client's reason for seeking treatment, diagnosis and assessment, and the individual treatment plan; review of the appropriateness, duration, and outcome of treatment provided; and treatment recommendations.

Subp. 5. **Center.** "Center" means a public or private health and human services facility which provides clinical services in the treatment of mental illness. It is an abbreviated term used in place of "mental health center" or "mental health clinic" throughout parts 9520.0750 to 9520.0870.

Subp. 6. **Client.** "Client" means a person accepted by the center to receive clinical services in the diagnosis and treatment of mental illness.

Subp. 7. **Clinical services.** "Clinical services" means services provided to a client to diagnose, describe, predict, and explain that client's status relative to a disabling condition or problem, and where necessary, to treat the client to reduce impairment due to that condition. Clinical services also include individual treatment planning, case review, record keeping required for treatment, peer review, and supervision.

Subp. 8. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or a designated representative.

Subp. 9. **Competent.** "Competent" means having sufficient knowledge of and proficiency in a specific mental illness assessment or treatment service, technique, method, or procedure, documented by experience, education, training, and certification, to be able to provide it to a client with little or no supervision.

Subp. 10. **Consultation.** "Consultation" means the process of deliberating or conferring between multidisciplinary staff regarding a client and the client's treatment.

Subp. 11. **Deferral.** "Deferral" means the determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 and is not approved, but is granted a period of time to comply with these standards and receive a second review without reapplication.

Subp. 12. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 13. **Disapproval or withdrawal of approval.** "Disapproval" or "withdrawal of approval" means a determination by the commissioner that the applicant center does not meet the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 14. **Discipline.** "Discipline" means a branch of professional knowledge or skill acquired through a specific course of study and training and usually documented by a specific educational degree or certification of proficiency. Examples of the mental health disciplines include but are not limited to psychiatry, psychology, clinical social work, and psychiatric nursing.

Subp. 15. **Documentation.** "Documentation" means the automatically or manually produced and maintained evidence that can be read by person or machine, and that will attest to the compliance with requirements of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 16. **Individual treatment plan.** "Individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results for a specific client, and updated as necessary. The plan specifies the goals and objectives in measurable terms, states the treatment strategy, and identifies responsibilities of multidisciplinary staff.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a staff person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

A. by having a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and 2,000 hours of supervised experience in the delivery of clinical services in the treatment of mental illness;

B. by having 6,000 hours of supervised experience in the delivery of clinical services in the treatment of mental illness;

C. by being a graduate student in one of the behavioral sciences or related fields formally assigned to the center for clinical training by an accredited college or university; or

D. by having a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university.

Documentation of compliance with part 9520.0800, subpart 4, item B is required for designation of work as supervised experience in the delivery of clinical services. Documentation of the accreditation of a college or university shall be a listing in Accredited Institutions of Postsecondary Education Programs, Candidates for the year the degree was issued. The master's degree in behavioral sciences or related fields shall include a minimum of 28 semester hours of graduate course credit in mental health theory and supervised clinical training, as documented by an official transcript.

Subp. 18. **Mental health professional.** "Mental health professional" has the meaning given in Minnesota Statutes, section 245.462, subdivision 18.

Subp. 19. **Mental illness.** "Mental illness" means a condition which results in an inability to interpret the environment realistically and in impaired functioning in primary

aspects of daily living such as personal relations, living arrangements, work, and recreation, and which is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), Ninth Revision (1980), code range 290.0-302.99 or 306.0-316, or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III), Third Edition (1980), Axes I, II or III. These publications are available from the State Law Library.

Subp. 20. **Multidisciplinary staff.** "Multidisciplinary staff" means the mental health professionals and mental health practitioners employed by or under contract to the center to provide outpatient clinical services in the treatment of mental illness.

Subp. 21. **Serious violations of policies and procedures.** "Serious violations of policies and procedures" means a violation which threatens the health, safety, or rights of clients or center staff; the repeated nonadherence to center policies and procedures; and the nonadherence to center policies and procedures which result in noncompliance with Minnesota Statutes, section 245.69, subdivision 2 and parts 9520.0760 to 9520.0870.

Subp. 22. **Treatment strategy.** "Treatment strategy" means the particular form of service delivery or intervention which specifically addresses the client's characteristics and mental illness, and describes the process for achievement of individual treatment plan goals.

9520.0770 ORGANIZATIONAL STRUCTURE OF CENTER.

Subpart 1. **Basic unit.** The center or the facility of which it is a unit shall be legally constituted as a partnership, corporation, or government agency. The center shall be either the entire facility or a clearly identified unit within the facility which is administratively and clinically separate from the rest of the facility. All business shall be conducted in the name of the center or facility, except medical assistance billing by individually enrolled providers when the center is not enrolled.

Subp. 2. **Purpose, services.** The center shall document that the prevention, diagnosis, and treatment of mental illness are the main purposes of the center. If the center is a unit within a facility, the rest of the facility shall not provide clinical services in the outpatient treatment of mental illness. The facility may provide services other than clinical services in the treatment of mental illness, including medical services, chemical dependency services, social services, training, and education. The provision of these additional services is not reviewed in granting approval to the center under parts 9520.0760 to 9520.0870.

Subp. 3. **Governing body.** The center shall have a governing body. The governing body shall provide written documentation of its source of authority. The governing body shall be legally responsible for the implementation of the standards set forth in Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 through the establishment of written policy and procedures.

Subp. 4. **Chart or statement of organization.** The center shall have an organizational chart or statement which specifies the relationships among the governing body, any administrative and support staff, mental health professional staff, and mental health practitioner staff; their respective areas of responsibility; the lines of authority involved; the formal liaison between administrative and clinical staff; and the relationship of the center to the rest of the facility and any additional services provided.

9520.0780 SECONDARY LOCATIONS.

Subpart 1. **Main and satellite offices.** The center shall notify the commissioner of all center locations. If there is more than one center location, the center shall designate one as the main office and all secondary locations as satellite offices. The main office as a unit and the center as a whole shall be in compliance with part 9520.0810. The main office shall function as the center records and documentation storage area and house most administrative functions for the center. Each satellite office shall:

A. be included as a part of the legally constituted entity;

B. adhere to the same clinical and administrative policies and procedures as the main office;

C. operate under the authority of the center's governing body;

D. store all center records and the client records of terminated clients at the main office;

E. ensure that a mental health professional is at the satellite office and competent to supervise and intervene in the clinical services provided there, whenever the satellite office is open;

F. ensure that its multidisciplinary staff have access to and interact with main center staff for consultation, supervision, and peer review; and

G. ensure that clients have access to all clinical services provided in the treatment of mental illness and the multidisciplinary staff of the center.

Subp. 2. **Noncompliance.** If the commissioner determines that a secondary location is not in compliance with subpart 1, it is not a satellite office. Outpatient clinical services in the treatment of mental illness delivered by the center or facility of which it is a unit shall cease at that location, or the application shall be disapproved.

9520.0790 MINIMUM TREATMENT STANDARDS.

Subpart 1. **Multidisciplinary approach.** The center shall document that services are provided in a multidisciplinary manner. That documentation shall include evidence that staff interact in providing clinical services, that the services provided to a client involve all needed disciplines represented on the center staff, and that staff participate in case review and consultation procedures as described in subpart 6.

Subp. 2. **Intake and case assignment.** The center shall establish an intake or admission procedure which outlines the intake process, including the determination of the appropriateness of accepting a person as a client by reviewing the client's condition and need for treatment, the clinical services offered by the center, and other available resources. The center shall document that case assignment for assessment, diagnosis, and treatment is made to a multidisciplinary staff person who is competent in the service, in the recommended treatment strategy and in treating the individual client characteristics. Responsibility for each case shall remain with a mental health professional.

Subp. 3. **Assessment and diagnostic process.** The center shall establish an assessment and diagnostic process that determines the client's condition and need for clinical services. The assessment of each client shall include clinical consideration of the client's general physical, medical, developmental, family, social, psychiatric, and psychological history and current condition. The diagnostic statement shall include the diagnosis based on the codes in the International Classification of Diseases or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and refer to the pertinent assessment data. The diagnosis shall be by or under the supervision of and signed by a psychiatrist or licensed psychologist. The diagnostic assessment, as defined by Minnesota Statutes, sections 245.462, subdivision 9, for adults, and 245.4871, subdivision 11, for children, must be provided by a licensed mental health professional in accordance with Minnesota Statutes, section 245.467, subdivision 2.

Subp. 4. **Treatment planning.** The individual treatment plan, based upon a diagnostic assessment of mental illness, shall be jointly developed by the client and the mental health professional. This planning procedure shall ensure that the client has been informed in the following areas: assessment of the client condition; treatment alternatives; possible outcomes and side effects of treatment; treatment recommendations; approximate length, cost, and hoped-for outcome of treatment; the client's rights and responsibilities in implementation of the individual treatment plan; staff rights and responsibilities in the treatment process; the Government Data Practices Act; and procedures for reporting grievances and alleged violation of client rights. If the client is considering chemotherapy, hospitalization, or other

medical treatment, the appropriate medical staff person shall inform the client of the treatment alternatives, the effects of the medical procedures, and possible side effects. Clinical services shall be appropriate to the condition, age, sex, socioeconomic, and ethnic background of the client, and provided in the least restrictive manner. Clinical services shall be provided according to the individual treatment plan and existing professional codes of ethics.

Subp. 5. **Client record.** The center shall maintain a client record for each client. The record must document the assessment process, the development and updating of the treatment plan, the treatment provided and observed client behaviors and response to treatment, and serve as data for the review and evaluation of the treatment provided to a client. The record shall include:

A. a statement of the client's reason for seeking treatment;

B. a record of the assessment process and assessment data;

C. the initial diagnosis based upon the assessment data;

D. the individual treatment plan;

E. a record of all medication prescribed or administered by multidisciplinary staff;

F. documentation of services received by the client, including consultation and progress notes;

G. when necessary, the client's authorization to release private information, and client information obtained from outside sources;

H. at the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome; and

I. correspondence and other necessary information.

Subp. 6. **Consultation; case review.** The center shall establish standards for case review and encourage the ongoing consultation among multidisciplinary staff. The multidisciplinary staff shall attend staff meetings at least twice monthly for a minimum of four hours per month, or a minimum of two hours per month if the multidisciplinary staff person provides clinical services in the treatment of mental illness less than 15 hours per week. The purpose of these meetings shall be case review and consultation. Written minutes of the meeting shall be maintained at the center for at least three years after the meeting.

Subp. 7. **Referrals.** If the necessary treatment or the treatment desired by the client is not available at the center, the center shall facilitate appropriate referrals. The multidisciplinary staff person shall discuss with the client the reason for the referral, potential treatment resources, and what the process will involve. The staff person shall assist in the process to ensure continuity of the planned treatment.

Subp. 8. **Emergency service.** The center shall ensure that clinical services to treat mental illness are available to clients on an emergency basis.

Subp. 9. **Access to hospital.** The center shall document that it has access to hospital admission for psychiatric inpatient care, and shall provide that access when needed by a client. This requirement for access does not require direct hospital admission privileges on the part of qualified multidisciplinary staff.

9520.0800 MINIMUM QUALITY ASSURANCE STANDARDS.

Subpart 1. **Policies and procedures.** The center shall develop written policies and procedures and shall document the implementation of these policies and procedures for each treatment standard and each quality assurance standard in subparts 2 to 7. The policies shall be approved by the governing body. The procedures shall indicate what actions or accomplishments are to be performed, who is responsible for each action, and any documentation or required forms. Multidisciplinary staff shall have access to a copy of the policies and procedures at all times.

Subp. 2. **Peer review.** The center shall have a multidisciplinary peer review system to assess the manner in which multidisciplinary staff provide clinical services in the treatment of mental illness. Peer review shall include the examination of clinical services to determine if the treatment provided was effective, necessary, and sufficient and of client records to determine if the recorded information is necessary and sufficient. The system shall ensure review of a randomly selected sample of five percent or six cases, whichever is less, of the annual caseload of each mental health professional by other mental health professional staff. Peer review findings shall be discussed with staff involved in the case and followed up by any necessary corrective action. Peer review records shall be maintained at the center.

Subp. 3. **Internal utilization review.** The center shall have a system of internal utilization review to examine the quality and efficiency of resource usage and clinical service delivery. The center shall develop and carry out a review procedure consistent with its size and organization which includes collection or review of information, analysis or interpretation of information, and application of findings to center operations. The review procedure shall minimally include, within any three year period of time, review of the appropriateness of intake, the provision of certain patterns of services, and the duration of treatment. Criteria may be established for treatment length and the provision of services for certain client conditions. Utilization review records shall be maintained, with an annual report to the governing body for applicability of findings to center operations.

Subp. 4. **Staff supervision.** Staff supervision:

A. The center shall have a clinical evaluation and supervision procedure which identifies each multidisciplinary staff person's areas of competence and documents that each multidisciplinary staff person receives the guidance and support needed to provide clinical services for the treatment of mental illness in the areas they are permitted to practice.

B. A mental health professional shall be responsible for the supervision of the mental health practitioner, including approval of the individual treatment plan and bimonthly case review of every client receiving clinical services from the practitioner. This supervision shall include a minimum of one hour of face-to-face, client-specific supervisory contact for each 40 hours of clinical services in the treatment of mental illness provided by the practitioner.

Subp. 5. **Continuing education.** The center shall require that each multidisciplinary staff person attend a minimum of 36 clock hours every two years of academic or practical course work and training. This education shall augment job-related knowledge, understanding, and skills to update or enhance staff competencies in the delivery of clinical services to treat mental illness. Continued licensure as a mental health professional may be substituted for the continuing education requirement of this subpart.

Subp. 6. **Violations of standards.** The center shall have procedures for the reporting and investigating of alleged unethical, illegal, or grossly negligent acts, and of the serious violation of written policies and procedures. The center shall document that the reported behaviors have been reviewed and that responsible disciplinary or corrective action has been taken if the behavior was substantiated. The procedures shall address both client and staff reporting of complaints or grievances regarding center procedures, staff, and services. Clients and staff shall be informed they may file the complaint with the department if it was not resolved to mutual satisfaction. The center shall have procedures for the reporting of suspected abuse or neglect of clients, in accordance with Minnesota Statutes, sections 611A.32, subdivision 5; 626.556; and 626.557.

Subp. 7. **Data classification.** Client information compiled by the center, including client records and minutes of case review and consultation meetings, shall be protected as private data under the Minnesota Government Data Practices Act.

9520.0810 MINIMUM STAFFING STANDARDS.

Subpart 1. **Required staff.** Required staff:

A. The multidisciplinary staff of a center shall consist of at least four mental health professionals. At least two of the mental health professionals shall each be employed or under contract for a minimum of 35 hours a week by the center. Those two mental health professionals shall be of different disciplines.

B. The mental health professional staff shall include a psychiatrist and a licensed psychologist.

C. The mental health professional employed or under contract to the center to meet the requirement of item B shall be at the main office of the center and providing clinical services in the treatment of mental illness at least eight hours every two weeks.

Subp. 2. **Additional staff; staffing balance.** Additional mental health professional staff may be employed by or under contract to the center provided that no single mental health discipline or combination of allied fields shall comprise more than 60 percent of the full-time equivalent mental health professional staff. This provision does not apply to a center with fewer than six full-time equivalent mental health professional staff. Mental health practitioners may also be employed by or under contract to a center to provide clinical services for the treatment of mental illness in their documented area of competence. Mental health practitioners shall not comprise more than 25 percent of the full-time equivalent multidisciplinary staff. In determination of full-time equivalence, only time spent in clinical services for the treatment of mental illness shall be considered.

Subp. 3. **Multidisciplinary staff records.** The center shall maintain records sufficient to document that the center has determined and verified the clinical service qualifications of each multidisciplinary staff person, and sufficient to document each multidisciplinary staff person's terms of employment.

Subp. 4. **Credentialed occupations.** The center shall adhere to the qualifications and standards specified by rule for any human service occupation credentialed under Minnesota Statutes, section 214.13 and employed by or under contract to the center.

9520.0820 APPLICATION PROCEDURES.

Subpart 1. **Form.** A facility seeking approval as a center for insurance reimbursement of its outpatient clinical services in treatment of mental illness must make formal application to the commissioner for such approval. The application form for this purpose may be obtained from the Mental Illness Program Division of the department. The application form shall require only information which is required by statute or rule, and shall require the applicant center to explain and provide documentation of compliance with the minimum standards in Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 2. **Fee.** Each application shall be accompanied by payment of the nonrefundable application fee. The fee shall be established and adjusted in accordance with Minnesota Statutes, section 16A.128 to cover the costs to the department in implementing Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 3. **Completed application.** The application is considered complete on the date the application fee and all information required in the application form are received by the department.

Subp. 4. **Coordinator.** The center shall designate in the application a mental health professional as the coordinator for issues surrounding compliance with parts 9520.0760 to 9520.0870.

9520.0830 REVIEW OF APPLICANT CENTERS.

Subpart 1. **Site visit.** The formal review shall begin after the completed application has been received, and shall include an examination of the written application and a visit to the center. The applicant center shall be offered a choice of site visit dates, with at least one date falling within 60 days of the date on which the department receives the complete application. The site visit shall include interviews with multidisciplinary staff and examination

of a random sample of client records, consultation minutes, quality assurance reports, and multidisciplinary staff records.

Subp. 2. **Documentation.** If implementation of a procedure is too recent to be reliably documented, a written statement of the planned implementation shall be accepted as documentation on the initial application. The evidence of licensure or accreditation through another regulating body shall be accepted as documentation of a specific procedure when the required minimum standard of that body is the same or higher than a specific provision of parts 9520.0760 to 9520.0870.

9520.0840 DECISION ON APPLICATION.

Subpart 1. **Written report.** Upon completion of the site visit, a report shall be written. The report shall include a statement of findings, a recommendation to approve, defer, or disapprove the application, and the reasons for the recommendation.

Subp. 2. **Written notice to center.** The applicant center shall be sent written notice of approval, deferral, or disapproval within 30 days of the completion of the site visit. If the decision is a deferral or a disapproval, the notice shall indicate the specific areas of noncompliance.

Subp. 3. **Noncompliance with statutes and rules.** An application shall be disapproved or deferred if it is the initial application of a center, when the applicant center is not in compliance with Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.

Subp. 4. **Deferral of application.** If an application is deferred, the length of deferral shall not exceed 180 days. If the areas of noncompliance stated in the deferral notice are not satisfactorily corrected by the end of the deferral period, the application shall be disapproved. The applicant center shall allow the commissioner to inspect the center at any time during the deferral period, whether or not the site visit has been announced in advance. A site visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center. At any time during the deferral period, the applicant center may submit documentation indicating correction of noncompliance. The application shall then be approved or disapproved. At any time during the deferral period, the applicant center may submit a written request to the commissioner to change the application status to disapproval. The request shall be complied with within 14 days of receiving this written request. The applicant center is not an approved center for purposes of Minnesota Statutes, section 62A.152 during a deferral period.

Subp. 5. **Effective date of decision.** The effective date of a decision is the date the commissioner signs a letter notifying the applicant center of that decision.

9520.0850 APPEALS.

If an application is disapproved or approval is withdrawn, a contested case hearing and judicial review as provided in Minnesota Statutes, sections 14.48 to 14.69, may be requested by the center within 30 days of the commissioner's decision.

9520.0860 POSTAPPROVAL REQUIREMENTS.

Subpart 1. **Duration of approval.** Initial approval of an application is valid for 12 months from the effective date, subsequent approvals for 24 months, except when approval is withdrawn according to the criteria in subpart 4.

Subp. 2. **Reapplication.** The center shall contact the department for reapplication forms, and submit the completed application at least 90 days prior to the expected expiration date. If an approved center has met the conditions of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870, including reapplication when required, its status as an approved center shall remain in effect pending department processing of the reapplication.

Subp. 3. **Restrictions.** The approval is issued only for the center named in the application and is not transferable or assignable to another center. The approval is issued only for the center location named in the application and is not transferable or assignable to another location. If the commissioner is notified in writing at least 30 days in advance of a change in center location and can determine that compliance with all provisions of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 are maintained, the commissioner shall continue the approval of the center at the new location.

Subp. 4. **Noncompliance.** Changes in center organization, staffing, treatment, or quality assurance procedures that affect the ability of the center to comply with the minimum standards of Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870 shall be reported in writing by the center to the commissioner within 15 days of occurrence. Review of the change shall be conducted by the commissioner. A center with changes resulting in noncompliance in minimum standards shall receive written notice and may have up to 180 days to correct the areas of noncompliance before losing approval status. Interim procedures to resolve the noncompliance on a temporary basis shall be developed and submitted in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. Nonreporting within 15 days of occurrence of a change that results in noncompliance, failure to develop an approved interim procedure within 30 days of the determination of the noncompliance, or nonresolution of the noncompliance within 180 days shall result in the immediate withdrawal of approval status.

Serious violation of policies or procedures, professional association or board sanctioning or loss of licensure for unethical practices, or the conviction of violating a state or federal statute shall be reported in writing by the center to the commissioner within ten days of the substantiation of such behavior. Review of this report and the action taken by the center shall be conducted by the commissioner. Approval shall be withdrawn immediately unless the commissioner determines that: the center acted with all proper haste and thoroughness in investigating the behavior, the center acted with all proper haste and thoroughness in taking appropriate disciplinary and corrective action, and that no member of the governing body was a party to the behavior. Failure to report such behavior within ten days of its substantiation shall result in immediate withdrawal of approval.

Subp. 5. **Compliance reports.** The center may be required to submit written information to the department during the approval period to document that the center has maintained compliance with the rule and center procedures. The center shall allow the commissioner to inspect the center at any time during the approval period, whether or not the site visit has been announced in advance. A site visit shall occur only during normal working hours of the center and shall not disrupt the normal functioning of the center.

9520.0870 VARIANCES.

Subpart 1. **When allowed.** The standards and procedures established by parts 9520.0760 to 9520.0860 may be varied by the commissioner. Standards and procedures established by statute shall not be varied.

Subp. 2. **Request procedure.** A request for a variance must be submitted in writing to the commissioner, accompanying or following the submission of a completed application for approval under Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870. The request shall state:

A. the standard or procedure to be varied;

B. the specific reasons why the standard or procedure cannot be or should not be complied with; and

C. the equivalent standard or procedure the center will establish to achieve the intent of the standard or procedure to be varied.

Subp. 3. **Decision procedure.** Upon receiving the variance request, the commissioner shall consult with a panel of experts in the mental health disciplines regarding the request. Criteria for granting a variance shall be the commissioner's determination that subpart 2, items A to C are met. Hardship shall not be a sufficient reason to grant a variance. No variance shall be granted that would threaten the health, safety, or rights of clients. Variances granted by the commissioner shall specify in writing the alternative standards or procedures to be implemented and any specific conditions or limitations imposed on the variance by the commissioner. Variances denied by the commissioner shall specify in writing the reason for the denial.

Subp. 4. **Notification.** The commissioner shall send the center a written notice granting or not granting the variance within 90 days of receiving the written variance request. This notice shall not be construed as approval or disapproval of the center under Minnesota Statutes, section 245.69, subdivision 2, and parts 9520.0760 to 9520.0870.