MN HOUSE RESEARCH

Bill Summary

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Subject Health and Human Services Omnibus Finance Bill

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Overview

This bill contains appropriation and policy provisions related to health care and human services programs, licensing and background studies, child care and child protection, and health boards.

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Article 1: DHS Health Care Programs

This article contains provisions related to the medical assistance and MinnesotaCare programs.

Section	Description - Article 1: DHS Health Care Programs
1	**Applicability of chapter.** Adds § 62A.002. Provides that any benefit or coverage mandate in this chapter (regulation of health insurers) does not apply to managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees.
2	**Applicability.** Amends § 62C.01, by adding subd. 4. Provides that any benefit or coverage mandate in this chapter (regulation of nonprofit health service plan corporations) does not apply to managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees.
3	**Applicability.** Amends § 62D.01, by adding subd. 3. Provides that any benefit or coverage mandate in this chapter (regulation of HMOs) does not apply to managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees.
4	**Applicability of chapter.** Adds § 62J.011. Provides that any benefit or coverage mandate in this chapter (dealing with health care cost containment, health information technology, administrative simplification, patient protection, and other topics) does not apply to managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees.

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5	**Applicability of chapter.** Amends § 62Q.02. Provides that any benefit or coverage mandate in this chapter (health plan companies) does not apply to managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees.
6	**Other standards; wheelchair securement; protected transport.** Amends § 174.30, subd. 3. Makes a conforming change in a cross-reference to MA nonemergency medical transportation coverage.
7	**Statewide health information exchange.** Amends § 256.01, subd. 28. Gives the commissioner the authority to develop and operate, as part of a statewide health information exchange, an encounter alerting service.
8	**Hospital payment rates.** Amends § 256.969, subd. 2b. Allows the commissioner, when rebasing inpatient hospital payment rates, to combine claims from two consecutive years if claims volume for a single year falls below the threshold needed for a statistically valid sample. Prohibits the use of years in which claims volume is reduced or altered due to a pandemic or public health emergency, if the base year includes more than one year.
9	**Alternate inpatient payment rate.** Amends § 256.969, by adding subd. 2f. Requires the commissioner, effective July 1, 2021, to reduce the disproportionate share hospital (DSH) payment by 99 percent for a hospital with an MA utilization rate at least two and one-half standard deviations above the statewide mean, and compute an alternative inpatient payment rate for that hospital. The alternative payment rate must target total aggregate reimbursement equal to what the hospital would have received for fee-for-service inpatient services had the hospital received the full DSH payment. Specifies a January 1, 2022, effective date.
10	**Disproportionate numbers of low-income patients served.** Amends § 256.969, subd. 9. Modifies the provisions governing disproportionate share hospital (DSH) payments, by: (1) basing the DSH adjustment for providing transplant services on all MA payments including managed care, not just fee-for-service payment; (2) clarifying an existing DSH payment for a hospital (HCMC) with an MA utilization rate at least 2.5 standard deviations above the statewide mean by adding the requirement that this hospital be a level one trauma center; and (3) specifying that the MA utilization rate and discharge thresholds used to determine eligibility for various DSH factors are to be measured using only one year, when a

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two-year base period is used. Provides that these provisions are effective July 1, 2021.

Increases from $1.5 million to $9 million the amount of a payment adjustment for disproportionate share hospitals with high levels of administering high-cost drugs to MA fee-for-service enrollees (the adjustment takes into account as one factor 340B drug payments). Also allows a children's hospital that qualifies for an alternate inpatient payment rate to be eligible for this DSH payment. Provides that these provisions are effective January 1, 2023.

11 **Appeals.**

Amends § 256.9695, subd. 1. Extends from 12 to 18 months the time period, after the last day of the calendar year that is the base year, during which hospitals can appeal base year information used to set inpatient hospital payment rates.

12 **Fraud prevention investigations.**

Amends § 256.983. Includes tribal agencies as recipients of fraud prevention investigation grant funding, and requires tribal agencies to comply with the same requirements that apply to county grant recipients.

13 **Administration of dental services.**

Adds § 256B.0371. (a) Effective January 1, 2023, requires the commissioner to contract with a dental administrator to administer dental services for MA and MinnesotaCare enrollees, including those persons enrolled in managed care as described in § 256B.69.

(b) Requires the administrator to provide administrative services, including but not limited to: provider recruitment, contracting, and assistance; recipient outreach and assistance; utilization management and reviews of medical necessity; claims processing; service coordination; management of fraud and abuse; monitoring access to services; performance measurement; quality improvement and evaluation; and management of third-party liability requirements.

(c) Sets payment rates at the MA rate as established under section 256B.76.

Provides a January 1, 2023, effective date.

14 **Limitation on services.**

Amends § 256B.04, subd. 12. Strikes outdated language related to service delivery and reimbursement for emergency and nonemergency transportation providers, and other providers.

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15 **Competitive bidding.**

Amends § 256B.04, subd. 14. Allows the commissioner to volume purchase through competitive bidding and negotiation allergen-reducing products as described in section 256B.0625, subd. 67, paragraph (c) or (d).

Allows the commissioner to use volume purchase through competitive bidding for nonemergency medical transportation generally (current law limits this to level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursement). Also eliminates the specific prohibition on the use of volume purchase through competitive bidding for special transportation services.

16 **Pregnant women; needy unborn child.**

Amends § 256B.055, subd. 6. Extends MA coverage for pregnant women from 60 days to six months postpartum. States that the section is effective January 1, 2022, or upon federal approval, whichever is later.

17 **Eligibility verification.**

Amends § 256B.056, subd. 10. Makes a conforming change related to the extension of MA coverage for pregnant women to six months postpartum. States that the section is effective January 1, 2022, or upon federal approval, whichever is later.

18 **Qualified Medicare beneficiaries.**

Amends § 256B.057, subd. 3. Sets the asset limit for eligibility for Medicare savings programs (programs that assist low-income Medicare beneficiaries with Medicare premiums and cost-sharing) at the current level -- $10,000 for one and $18,000 for two or more individuals, or at the asset level for the Medicare Part D extra help low income subsidy (LIS), once this indexed asset level exceeds the current asset limits. States that this section is effective the day following final enactment.

19 **Citizenship requirements.**

Amends § 256B.06, subd. 4. Makes a conforming change related to the extension of MA coverage for pregnant women to six months postpartum. States that the section is effective January 1, 2022, or upon federal approval, whichever is later.

20 **Health Services Advisory Council.**

Amends § 256B.0625, subd. 3c. Makes a number of changes related to the Health Services Advisory Council. These include:

- renaming the Health Services Policy Committee the Health Services Advisory Council;

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- requiring the council to advise the commissioner on evidence-based decision-making and health care benefit and coverage policies for Minnesota health care programs;
- eliminating language that requires the chair to be a physician;
- allowing the council to monitor and track practice patterns of health care providers generally (current law allows this for physicians); and
- striking obsolete language and making conforming and related changes.

21 **Health Services Advisory Council members.**

Amends § 256B.0625, subd. 3d. Modifies council membership by:

- reducing the number of physicians from seven to six, and striking the requirement that one physician be actively engaged in treating persons with mental illness;
- adding one member who is a health care or mental health professional actively engaged in treating persons with mental illness; and
- increasing the number of consumer members from one to two.

Also clarifies what constitutes a quorum and renames the committee.

22 **Health Services Advisory Council.**

Amends § 256B.0625, subd. 3e. Renames the Health Services Advisory Committee the Health Services Advisory Council and makes conforming changes.

23 **Dental services.**

Amends § 256B.0625, subd. 9. Requires the commissioner to contract with a dental administrator for the administration of dental services, including the administration of dental services for persons enrolled in managed care as described in § 256B.69. Makes conforming changes. Provides that these provisions are effective January 1, 2023.

Expands MA coverage of dental services for nonpregnant adults, to include coverage of nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures. This expansion of coverage also applies to the MinnesotaCare program, through cross-reference elsewhere in statute. Provides that these provisions are effective July 1, 2021.

24 **Drugs.**

Amends § 256B.0625, subd. 13. Allows a 90-day supply of a prescription drug to be dispensed under MA, if the drug appears on the 90-day supply list published by the commissioner. Requires the list to be published on the DHS website. Allows the

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commissioner to modify the list after providing public notice and a 15-day comment period. Provides that the list may include cost-effective generic drugs, but shall not include controlled substances.

Requires each 340B covered entity and ambulatory pharmacy under common ownership of the covered entity to report to the commissioner, by March 1 of each year, reimbursement for the previous calendar year from each managed care and county-based purchasing plan, or from the PBM under contract with the plan. Requires the aggregate cost of drugs purchased through the 340B program, and other specified information, to be reported. Directs the commissioner to submit a copy of the reports to the legislature, by April 1 of each year. States that 340B drugs acquired and dispensed by a 340B covered entity or ambulatory pharmacy under common ownership are not eligible for coverage if the covered entity fails to submit the required report.

25 **Formulary Committee.**

Amends § 256B.0625, subd. 13c. Removes the June 30, 2022, expiration date for the Formulary Committee, and provides that the committee does not expire.

26 **Drug formulary.**

Amends § 256B.0625, subd. 13d. Allows MA to cover drugs or active pharmaceutical ingredients used for weight loss. Under current law, the MA formulary only covers drugs for weight loss if they are medically necessary lipase inhibitors used by recipients with Type II diabetes.

27 **Transportation costs.**

Amends § 256B.0625, subd. 17. Makes various changes to MA coverage of NEMT services, including changes related to the use of an administrator. These changes include:

- striking references to the Nonemergency Medical Transportation Advisory Committee (this committee is repealed elsewhere in the article);
- striking references to the single administrative structure;
- replacing a reference to “local agency” with a reference to the “administrator” and striking a provision designating the local agency as the single administrative agency; and
- striking the existing language on NEMT reimbursement for the various modes of service.

States that the section is effective January 1, 2023.

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28 **Documentation required.**

Amends § 256B.0625, subd. 17b. Allows funds paid for NEMT transportation that is not documented to be recovered by the NEMT vendor, as well as the department. States that the section is effective January 1, 2023.

29 **Public transit or taxicab transportation.**

Amends § 256B.0625, subd. 18. Allows the commissioner to provide a monthly public transit pass for the nonemergency medical transportation needs of MA recipients who are well-served by public transit. Provides that recipients are eligible for a transit pass if they are eligible for one public transit trip for a covered service during a month, and have not received a transit pass for that month from another program administered by a county or tribe. These recipients are then not eligible for other modes of transportation, unless an unexpected need arises that cannot be accessed through public transit. Prohibits the commissioner from requiring recipients to select a transit pass, if their transportation needs cannot be served by public transit. States that this section is effective January 1, 2022.

30 **Administration of nonemergency medical transportation.**

Amends § 256B.0625, subd. 18b. Requires the commissioner to contract, either statewide or regionally, for the administration of the NEMT program. Specifies that the contract must also include administration of all covered modes of NEMT services for those enrolled in managed care under § 256B.69. Also strikes language that limited the use of a broker or coordinator for NEMT services to establishing the level of service. States that the section is effective January 1, 2023.

31 **Other clinic services.**

Amends § 2567B.0625, subd. 30. For purposes of rebasing encounter rates for federally qualified health centers (FQHCs) and rural health clinics, prohibits the use of years in which costs or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency, when the base year includes more than one year. Allows the commissioner to use Medicare cost reports of a year unaffected by pandemic, disease, or other public health emergency, or the previous two consecutive years, inflated to the base year.

32 **Medical supplies and equipment.**

Amends § 256B.0625, subd. 31. States that allergen-reducing products provided according to subd. 67, paragraph (c) or (d), shall be considered durable medical equipment. States that the section is effective January 1, 2022, or upon federal approval, whichever is later.

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33 **Early and periodic screening, diagnosis, and treatment services.**

Amends § 256B.0625, subd. 58. (a) Requires the commissioner, in administering the EPSDT program, to, at a minimum:

1) provide information to children and families on the benefits of preventative visits, services available, and assistance in finding a provider, transportation, or interpreter services;
2) maintain an up-to-date periodicity schedule in the department policy manual; and
3) maintain up-to-date policies for providers on delivering EPSDT services that are in the provider manual on the department website.

(b) Allows the commissioner to contract for the administration of outreach services as required by the EPSDT program.

(c) Allows the commissioner to contract for required EPSDT outreach services, including but not limited to children enrolled in or attributed to an integrated health partnership (IHP) demonstration project. Requires IHPs that choose to provide EPSDT outreach services to receive compensation from the commissioner on a per-member, per-month basis for each child. Specifies related requirements. Provides that this paragraph is effective January 1, 2022.

34 **Enhanced asthma care services.**

Amends § 256B.0625, by adding subd. 67. (a) States that MA covers enhanced asthma care services and related products provided in children's homes for children with poorly controlled asthma. To be eligible, requires a child:

1) to have poorly controlled asthma, defined as having received asthma care from a hospital emergency department at least once in the past year or having been hospitalized for the treatment of asthma at least once in the past year; and
2) to have received a referral for services and products under this subdivision from a treating health care provider.

(b) States that covered services include home visits provided by a registered environmental health specialist or lead risk assessor credentialed by the Department of Health or a healthy homes specialist credentialed by the Building Performance Institute.

(c) Requires covered products to be identified and recommended for the child by a registered environmental health specialist, healthy homes specialist, lead risk assessor, certified asthma educator, public health nurse, or other health professional

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providing asthma care, and proven to reduce asthma triggers. Lists specific products covered.

(d) Requires the commissioner to determine other products that may be covered, as new best practices for asthma are identified.

(e) Defines a home assessment as a home visit to identify asthma triggers and to provide education on trigger-reducing products. Limits a child to two home assessments, except that an additional home assessment may be provided if the child moves to a new home, a new asthma trigger enters the home, or if the child's health care provider identifies a new allergy for the child. Requires the commissioner to determine the frequency with which a child may receive a product listed in paragraph (c) or (d), based on the reasonable expected lifetime of the product.

States that the section is effective January 1, 2022, or upon federal approval, whichever is later.

35 **Cost-sharing.**

Amends § 256B.0631, subd. 1. Exempts medications when used to prevent or treat HIV from MA copayments. States that the section is effective January 1, 2022, subject to federal approval.

36 **Opioid prescribing work group.**

Amends § 256B.0638, subd. 3. Adds to the opioid prescribing work group two consumer members who are Minnesota residents and who have used or are using opioids to manage chronic pain. Also adds a representative of the Minnesota Department of Health as a nonvoting member.

37 **Program implementation.**

Amends § 256B.0638, subd. 5. Modifies the procedure used to report opioid prescriber data, by requiring the commissioner to report to provider groups data on individual prescribers' prescribing patterns, and requiring provider groups to distribute this data to prescribers. Under current law, the commissioner reports to prescribers.

38 **Data practices.**

Amends § 256B.0638, subd. 6. Allows the commissioner to share with provider groups data on prescribers' prescribing patterns. Under current law, the information shared is limited to information on prescribers who are subject to quality improvement activities.

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39 **Qualified professional; qualifications.**

Amends § 256B.0659, subd. 13. Eliminates a requirement that DHS enroll qualified professionals who work for personal care assistance provider agencies. Requires qualified professionals to meet provider training requirements and strikes outdated language.

40 **Commissioner's duties.**

Amends § 256B.196, subd. 2. Removes Hennepin County from an existing voluntary intergovernmental transfer, under which Hennepin County would transfer to the commissioner $12 million per year. Provides that this section is effective January 1, 2022, or upon federal approval of this section and § 256B.1973, whichever is later.

41 **Directed payment arrangements.**

Adds § 256B.1973.

Subd. 1. Definitions. Defines the following terms: billing professionals, health plan, and high medical assistance utilization.

Subd. 2. Federal approval required. States that each directed payment arrangement under this section is contingent on federal approval and must conform with the requirements for permissible directed managed care organization expenditures.

Subd. 3. Eligible providers. States that eligible providers under this section are nonstate government teaching hospitals with high MA utilization and a level I trauma center, and the hospital's affiliated billing professionals, ambulance services, and clinics.

Subd. 4. Voluntary intergovernmental transfers. Allows a nonstate governmental entity eligible to perform intergovernmental transfers to make voluntary intergovernmental transfers to the commissioner. Requires the commissioner to inform the entity of the transfers necessary to maximize the allowable directed payments.

Subd. 5. Commissioner's duties; state-directed fee schedule requirement. (a) Requires the commissioner, for each federally approved directed payment arrangement that is a state-directed fee schedule requirement, to determine a uniform adjustment factor for each claim submitted to a health plan and to apply this to each claim. Directs the commissioner to ensure that the adjustment factor maximizes the allowable directed payments and does not result in payments exceeding federal limits, and allows the commissioner to use a settle-up process to adjust health plan payments to comply with this requirement.

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(b) Requires the commissioner to develop a plan for initial implementation of the state-directed fee schedule requirement to ensure that eligible providers receive the entire permissible value under each arrangement. If federal approval is retroactive, requires the commissioner to make a onetime pro rata increase in the adjustment factor and initial payments.

Subd. 6. Health plan duties; submission of claims. Requires each health plan to submit to the commissioner payment information for each claim paid to an eligible provider for MA services.

Subd. 7. Health plan duties; directed payments. Requires each health plan to make directed payments to the eligible provider in an amount equal to the payment amounts the plan received from the commissioner.

Subd. 8. State quality goals. Requires the directed payment arrangement and the state-directed fee schedule requirement to align with state quality goals for Hennepin Healthcare MA patients. Specifies related requirements and quality measure domains.

States that this section is effective January 1, 2022, or upon federal approval, whichever is later, and allows for retroactive implementation.

42 **Prescription drugs.**

Amends § 256B.69, subd. 6d. Requires the commissioner to exclude (carve out) outpatient drugs from MA managed care contracts. States that the section is effective January 1, 2023, or upon completion of the Medicaid Management Information System pharmacy module modernization project, whichever is later.

43 **Annual report on provider reimbursement rates.**

Amends § 256B.69, by adding subd. 9f. (a) Requires the commissioner, by December 15 of each year, to report to the legislature on managed care and county-based purchasing plan provider reimbursement rates. Requires compliance with general requirements for reports to the legislature (e.g. transmittal to Legislative Reference Library, statement of cost).

(b) Requires the report to include, for each managed care and county-based purchasing plan, the mean provider reimbursement rates by county for the preceding calendar year, for the five most common billing codes statewide across all plans, for the following categories: (1) physician services – prenatal and preventive; (2) physician services – nonprenatal and nonpreventive; (3) dental services; (4) inpatient hospital services; (5) outpatient hospital services; and (6) mental health services.

(c) Requires the commissioner to also include in the report: (1) the mean and median reimbursement rates by county for the preceding calendar year for the billing codes

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and service categories described in paragraph (b); and (2) the mean and median fee-for-service reimbursement rates by county for the preceding calendar year for the billing codes and service categories described in paragraph (b).

44 **Annual report on prepaid health plan reimbursement to 340B covered entities.**

Amends § 256B.69, by adding subd. 9g. (a) Requires managed care and county-based purchasing plans, by March 1 of each year, to report to the commissioner their reimbursement to 340B covered entities for the previous calendar year. Specifies the information that must be reported.

(b) Requires the commissioner to submit a copy of the reports to the legislature by April 1 of each year.

45 **Direction of managed care organization expenditures.**

Amends § 256B.6928, subd. 5. Allows the commissioner to direct managed care organization expenditures as permitted under the federal rule governing Medicaid directed payments (42 CFR 438.6(c)).

46 **Hospital outpatient reimbursement.**

Amends § 256B.75. Effective for services provided on or after July 1, 2023, requires payments to critical access hospitals for outpatient, emergency, and ambulatory surgery facility fee services to be increased for hospitals providing high levels of high-cost or 340B drugs. Requires the adjustment to be based on each hospital's share of total reimbursement for 340B drugs to all critical access hospitals, but not to exceed three percentage points.

Directs the commissioner, when implementing prospective payment methodologies for outpatient hospital services, to use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for outpatient hospital and ambulatory surgical center settings, unless other payment methodologies are specified in state MA law.

47 **Dental reimbursement.**

Amends § 256B.76, subd. 2. Sunsets existing MA dental payment rates effective January 1, 2023.

A new paragraph (l) sets payments for dental services provided on or after January 1, 2023, at the lower of the submitted charge or the …. percentile of 2018 submitted charges. Requires the commissioner to increase this payment by 20 percent for critical access dental providers under MA and MinnesotaCare, and requires this add-on to be calculated to be specific to each individual clinic location within a larger

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system. States that this paragraph does not apply to FQHCs, rural health centers, state-operated dental clinics, or Indian health centers.

A new paragraph (m) requires dental payment rates to be rebased beginning January 1, 2026, and every four years thereafter, to the first percentile of submitted charges for the applicable base year (the calendar year two years prior to the effective date of rebasing).

48 **Critical access dental providers.**

Amends § 256B.76, subd. 4. Provides that MA critical access dental payments are in effect only through December 31, 2022 (these payments are ongoing under current law).

49 **Reimbursement for basic care services.**

Amends § 256B.766. Makes various changes to reimbursement methods for durable medical equipment, medical supplies, prosthetics, and orthotics.

The amendment to paragraph (i) terminates, after June 30, 2021, individual pricing for certain medical supplies and durable medical equipment and a prohibition on any MA rate reductions to durable medical equipment as a result of Medicare competitive bidding.

The amendment to paragraph (j) terminates, after June 30, 2021, various rate increases for durable medical equipment, prosthetics, orthotics, or supplies.

The amendment to paragraph (k) terminates, after June 30, 2021, certain payment rate provisions for ventilators.

A new paragraph (m) provides that effective July 1, 2021, payment rates for all durable medical equipment, prosthetics, orthotics, or supplies, except pressure support ventilators, shall be at the lesser of submitted charges or the Medicare fee schedule amount, without any increases or decreases in paragraphs (a) to (k) applied. Requires pressure support ventilators to be paid at the Medicare rate plus 47 percent.

A new paragraph (n) sets payment rates, effective July 1, 2021, for items for which Medicare has not established a payment amount at the lesser of submitted charges or an alternate payment methodology rate, without any increases or decreases in paragraphs (a) to (k) applied. Specifies criteria for the alternate payment methodology rate.

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A new paragraph (o) sets the payment at the provider's actual acquisition cost plus 20 percent, until sufficient data is available to calculate the alternate payment methodology.

A new paragraph (p) provides that notwithstanding paragraph (n), durable medical equipment and supplies billed using miscellaneous codes, for which no Medicare rate is available, shall be paid at the provider's acquisition cost plus ten percent.

50 **Medicare payment limit.**

Amends § 256B.767. Strikes the exemption of durable medical equipment, prosthetics, orthotics, and supplies from a general provision providing that the MA payment rate not exceed the Medicare payment rate.

51 **Definitions.**

Amends § 256B.79, subd. 1. Modifies the definition of "targeted populations" for the integrated care for high-risk pregnant women grant program, to refer to pregnant MA enrollees residing in "communities" rather than "geographic areas."

52 **Grant awards.**

Amends § 256B.79, subd. 3. Strikes language that requires integrated perinatal care collaboratives that received grants prior to January 1, 2019, to be given priority when determining subsequent grants.

53 **Income.**

Amends § 256L.01, subd. 5. Defines "income" under MinnesotaCare as projected annual income for the applicable tax year, and strikes references to current income and income during the 12-month eligibility period. Provides that the section is effective the day following final enactment. (The changes in this section and the sections related to income limit adjustments and eligibility redetermination that follow reflect the failure of the Centers for Medicare and Medicaid Services to approve Minnesota eligibility determination changes passed in 2016 and reflected in current law.)

54 **Cost-sharing.**

Amends § 256L.03, subd. 5. Exempts from MinnesotaCare co-payments pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of HIV. States that the section is effective January 1, 2022, subject to federal approval.

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55	**Annual income limits adjustment.** Amends § 256L.04, subd. 7b. Requires the commissioner to adjust MinnesotaCare income limits annually on January 1, rather than each July 1. Provides that the section is effective the day following final enactment.
56	**Redetermination of eligibility.** Amends § 256L.05, subd. 3a. Specifies that the period of MinnesotaCare eligibility is the calendar year, and that eligibility redeterminations shall occur during the open enrollment period for qualified health plans. Strikes language that defined the period of eligibility as the 12-month period beginning the month of application, with renewals being implemented throughout the year. Provides that the section is effective the day following final enactment.
57	**Dental providers.** Amends § 256L.11, subd. 6a. Provides that the MinnesotaCare dental payment rate increase of 54 percent is in effect only through December 31, 2022 (these payments are ongoing under current law).
58	**Critical access dental providers.** Amends § 256L.11, subd. 7. Provides that MinnesotaCare critical access dental payments are in effect only through December 31, 2022 (these payments are ongoing under current law).
59	**Exclusions and exemptions.** Amends § 295.53, subd. 1. Excludes from the MinnesotaCare provider tax directed payments authorized under § 256B.1973. States that this section is effective for taxable years beginning after December 31, 2021.
60	**Court ruling on Affordable Care Act.** In the event the U.S. Supreme Court reverses the Affordable Care Act (ACA), requires the commissioner of human services to take all actions necessary to maintain current MA and MinnesotaCare policies, including pursuing federal funds or, if federal funds are not available, using state funds for at least a year following the Supreme Court decision or until the conclusion of the next regular legislative session, whichever is later.
61	**Delivery reform analysis report.** Requires the commissioner of human services to present to the legislature, by January 15, 2023, a report comparing service delivery and payment models for MinnesotaCare and certain MA enrollees. Specifies report requirements.

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62 **Dental home demonstration project.**

Requires the Dental Services Advisory Committee, in collaboration with specified stakeholders, to design a dental home demonstration project and present recommendations by February 1, 2022, to the commissioner and legislature. Specifies requirements for the demonstration projects.

63 **Direction to commissioner; income and asset exclusion for St. Paul guaranteed income demonstration project.**

Subd. 1. Definitions. Defines the terms "commissioner" and "guaranteed income demonstration project."

Subd. 2. Commissioner; income and asset exclusion. Paragraph (a) prohibits the commissioner from counting payments made to families by the guaranteed income demonstration project as income or assets for purposes of determining or redetermining eligibility for child care assistance programs and MFIP, the work benefit program, or DWP.

Paragraph (b) prohibits the commissioner from counting payments made to families by the guaranteed income demonstration project as income or assets for purposes of determining or redetermining eligibility for MA or MinnesotaCare.

Subd. 3. Report. Requires the city of St. Paul to provide a report to the legislative committees with jurisdiction over human services policy and finance by February 15, 2023, with information on the progress and outcomes of the guaranteed income demonstration project.

Subd. 4. Expiration. Makes this section expire June 30, 2023.

Provides a July 1, 2021, effective date, except for subdivision 2, paragraph (b), which is effective July 1, 2021, or upon federal approval, whichever is later.

64 **Expansion of outpatient drug carve out; prescription drug purchasing program.**

Requires the commissioner of human services, in consultation with the commissioners of commerce and health, to assess and develop recommendations related to: (1) expanding the managed care drug carve out to include MinnesotaCare; and (2) establishing a prescription drug purchasing program to serve persons with private sector insurance coverage. Specifies criteria for the recommendations and requires a report to the legislature by December 15, 2023.

65 **Federal approval; extension of postpartum coverage.**

Requires the commissioner of human services to seek all federal waivers and approvals necessary to extend MA coverage for pregnant women to six months postpartum. States that the section is effective the day following final enactment.

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66	**Proposal for a public option.** Requires the commissioner of human services, in consultation with other entities, to develop a proposal for a public option program. Specifies requirements for the public option and public option proposals. Requires the commissioner to report to the legislature by December 15, 2021.
67	**Response to COVID-19 public health emergency.** (a) Prohibits the commissioner from collecting any unpaid premium under MA employer persons with disabilities or MinnesotaCare, for a coverage month that occurred during the federal COVID-19 public health emergency. (b) Allows the commissioner to suspend periodic data matching for up to six months following the last day of the federal COVID-19 public health emergency. (c) Suspends the requirement that the commissioner issue an annual report on periodic data matching, for one year following the last day of the federal COVID-19 public health emergency. Provides that this section is effective the day following final enactment, except that paragraph (a) as it relates to MinnesotaCare premiums is effective upon federal approval.
68	**Revisor instruction.** Directs the revisor to change the term “Health Services Policy Committee” to “Health Services Advisory Council” wherever it appears in law, and make conforming changes.
69	**Repealer.** (a) Repeals rules related to the EPSDT program, effective July 1, 2021. (b) Repeals § 256B.0625, subd. 18c (nonemergency medical transportation advisory committee), 18d (advisory committee members), 18e (single administrative structure and delivery system for NEMT), and 18h (NEMT provisions applicable to managed care and county-based purchasing plans). Provides a January 1, 2023, effective date.

Article 2: DHS Licensing and Background Studies

This article includes modifications to human services licensing statutes related to withdrawal management, detoxification programs, family foster settings, and family child care providers. It also establishes new standards for family foster setting licensure applicant background studies, adds professions and individuals to undergo DHS background studies, establishes alternative

background studies standards, and moves DHS background studies to a fee schedule. This article also directs DHS to develop programs to assist family child care providers and establishes a family child care training advisory committee.

Section	Description – Article 2: DHS Licensing and Background Studies
1	**Background study required.** Amends § 62V.05 by adding subd. 4a. Requires the Board of Directors of MNsure to initiate human services background studies of navigators, in-person assisters, and certified application counselors; prohibits any individual from providing services until the board receives notice that the individual is not disqualified, or if a disqualification was set aside. Requires the board or a delegate to review reconsideration requests.
2	**Background studies.** Amends § 122A.18, subd. 8. Modifies terminology for the Professional Educator Licensing and Standards Board (PELSB) and the Board of School Administrators background studies.
3	**Ombudsperson for family child care providers.** Creates § 245.975. Requires the governor to appoint an ombudsperson in the classified service to assist family child care providers with licensing, compliance, and other issues. Lists the duties of the ombudsperson and requires the ombudsperson to report annually to DHS and the legislature on the ombudsperson's activities. Specifies the ombudsperson's access to state data and requires certain state agencies to provide the ombudsperson with copies of specified data and reports related to family child care. Allows the ombudsperson to act independently of DHS to provide testimony to the legislature, make periodic reports to the legislature, and address areas of concern to family child care providers.
4	**Change of ownership process.** Amends § 245A.043, subd. 3. Removes reference to rule relating to the assessment of need for substance use disorder treatment programs.
5	**Denial of application.** Amends § 245A.05. Specifies that the commissioner of human services may deny an applicant for a family foster setting license if the applicant has non-disqualifying background study information that reflects on the applicant's ability to safely care for foster children. Makes this section effective July 1, 2022.

Section	Description – Article 2: DHS Licensing and Background Studies

6 **Sanctions; appeals; license.**

Amends § 245A.07, subd. 1. Allows the commissioner of human services to take adverse licensing action if a license holder has non-disqualifying background study information that reflects on the applicant's ability to safely care for foster children.

Makes this section effective July 1, 2022.

7 **License or certification fee for certain programs.**

Amends § 245A.10, subd. 4. Modifies terminology to clarify detoxification and withdrawal management program licensure fees.

8 **Special family child care homes.**

Amends § 245A.14, subd. 4. Paragraph (g) allows the commissioner to issue up to four licenses to certain types of license holders and each license must have its own primary provider of care and must operate as a distinct and separate program.

Paragraph (h) allows the commissioner to approve up to four licenses of specified types of license holders at the same location if all the license holders demonstrate compliance with applicable rules and laws.

Paragraph (i) provides that for specified types of licenses, the license holder must designate a primary provider of care at the licensed location.

Paragraph (j) provides that for all licenses issued under this section, the license holder must ensure that any caregiver, substitute, or helper who assists in the care of children meets applicable training requirements and background study requirements.

9 **Licensed family foster settings.**

Amends § 245A.16 by adding subd. 9. Requires a county agency or private agency to review specified information relating to non-disqualifying background study results before recommending to grant, deny, or revoke a family foster setting license. Lists information that must be reviewed; lists what constitutes "evidence of rehabilitation."

Requires the commissioner to consider relative relationships as a significant factor in determining a licensing decision; requires the county or private licensing agency to send a summary of the completed review to the commissioner and to include a recommendation for licensing action.

Makes this section effective July 1, 2022.

Section	Description – Article 2: DHS Licensing and Background Studies

10 **Training requirements for family and group family child care.**

Amends § 245A.50, subd. 7. Allows a family child care provider to count up to two hours of training instruction toward the provider's annual 16-hour training requirement.

11 **Supervising for safety; training requirement.**

Amends § 245A.50, subd. 9. Adds training courses that meet family child care provider's active supervision training requirement.

12 **Authorized fingerprint collection vendor.**

Amends § 245C.02, subd. 4a. Allows the commissioner to retain more than one authorized fingerprint collection vendor.

13 **Background study.**

Amends § 245C.02, subd. 5. Adds collection and processing of fingerprints and photograph to definition of background study.

14 **Alternative background study.**

Amends § 245C.02 by adding subd. 5b. Adds definition of "alternative background study" to the human services background studies chapter.

15 **Entity.**

Amends § 245C.02 by adding subd. 11c. Adds definition of "entity" to the human services background studies chapter.

16 **Results.**

Amends § 245C.02 by adding subd. 16a. Adds definition of "results" to the human services background studies chapter.

17 **Background study; individuals to be studied.**

Amends § 245C.03. Adds and modifies the subdivisions below.

Subd. 1. Licensed programs. Adds list of licensed programs to which the subdivision applies.

Subd. 1a. Procedure. Clarifies procedural requirements for background studies.

Subd. 3a. Personal care assistance provider agency; background studies. Establishes background study requirements for personal care assistance provider agencies enrolled to provide personal care assistance services under medical assistance; requires some owners, all managing employees, and all qualified professionals to undergo a background study.

Section	Description – Article 2: DHS Licensing and Background Studies

Subd. 3b. Exception to personal care assistant; requirements. Allows a personal care assistant for a recipient to enroll with a different provider agency upon initiation of a new background study, under specified circumstances.

Subd. 5a. Facilities serving children or adults licensed or regulated by the Department of Health. Requires the commissioner of health to contract with DHS to conduct background studies for individuals providing direct contact services in a range of entities licensed by the Department of Health, and other employees in certain types of licensed entities facilities. Specifies that if a program is jointly licensed, DHS is solely responsible for the background studies.

Subd. 5b. Facilities serving children or youth licensed by the Department of Corrections. Requires DHS to conduct background studies of individuals providing direct contact services in residential and detention facilities, and requires specified individuals and entities to provide DHS with all available criminal conviction data related to individuals to be studied under this subdivision. Requires DHS to notify an individual and the facility of a disqualification, and of the right to request reconsideration through the Department of Corrections. Specifies reconsideration procedures.

Subd. 6. Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities. Specifies that individuals who provide direct contact services specified in federally approved home and community-based waiver plans under section 256B.4712 consumer-directed community supports, upon federal approval, must meet background study requirements.

Subd. 6a. Legal nonlicensed and certified child care programs. Makes clarifying changes; specifies that DHS background studies are required for each individual who applies for child care program certification, each member of a provider's household age 13 or older, and a member of a provider's household who is aged 10 to 13, if reasonable cause exists.

Subd. 7. Children's therapeutic services and supports providers. Clarifies that all direct service providers and volunteers for children's therapeutic services and supports providers are subject to background studies.

Subd. 9. Community first services and supports organizations. Establishes background study requirements for individuals affiliated with Community First Services and Supports (CFSS) agency-providers and Financial Management Services (FMS) providers enrolled to provide CFSS services under medical assistance.

Subd. 9a. Exception to support worker requirements for continuity of services. Allows a support worker for a participant to enroll with a different CFSS agency-

Section **Description – Article 2: DHS Licensing and Background Studies**

provider or FMS provider upon initiation, rather than completion, of a new background study under specified circumstances.

Subd. 10. Providers of group residential housing or supplementary services. Clarifies who must undergo a background study related to providers of group residential housing or supplementary services; requires compliance with all background study requirements.

Subd. 11. Strikes subdivision relating to child protection workers.

Subd. 12. Providers of special transportation service. Clarifies which individuals providing special transportation services must undergo a background study. Allows a local or contracted agency authorizing a nonemergency medical transportation service ride by a volunteer driver to initiate a background study under certain circumstances.

Subd. 13. Providers of housing support services. Makes clarifying changes.

Subd. 14. Tribal nursing facilities. Requires the commissioner to obtain state and national criminal history data for individuals affiliated with a tribally licensed nursing facility.

Subd. 15. Early intensive developmental and behavioral intervention providers. Requires the commissioner to conduct a background study when initiated by an early intensive developmental and behavioral intervention provider.

18 **Background study; alternative background studies.**

Proposes coding for § 245C.031.

Subd. 1. Alternative background studies. Requires the commissioner to conduct an alternative background study of individuals listed in this section; establishes required procedures for studies and data destruction.

Subd. 2. Access to information. Requires each entity that submits an alternative background study to enter into an agreement with the commissioner to comply with state and federal law.

Subd. 3. Child protection workers or social services staff having responsibility for child protective duties. Requires an alternative background study for these individuals.

Subd. 4. Applicants, licensees, and other occupations regulated by the commissioner of health. Requires alternative background studies for applicants for audiologist or speech-language pathologist licenses or renewals or applicants for hearing instrument dispenser initial certification or certification before

Section **Description – Article 2: DHS Licensing and Background Studies**

January 1, 2018. Establishes alternative background study requirements for these individuals.

Subd. 5. Guardians and conservators. Requires alternative background studies for court-appointed guardians and conservators, with certain exceptions, to be completed prior to the appointment of the guardian or conservator, unless the best interests of the ward or protected person requires appointment before the study is completed.

Subd. 6. Guardians and conservators; required checks. Specifies data to be checked for guardian and conservator alternative background studies.

Subd. 7. Guardians and conservators; state licensing data. Requires the commissioner to provide the court with licensing agency data, within 25 working days, for licenses directly related to the responsibilities of a professional fiduciary, if the study subject is or has been affiliated with a listed professional licensing entity. Requires an agreement by each entity to provide the commissioner with electronic access to relevant licensing data and quarterly lists of new sanctions. Establishes additional procedures for providing licensing data to the court for guardian and conservator background studies.

Subd. 8. Guardians ad litem. Requires alternative background studies for guardians ad litem once every three years.

Subd. 9. Guardians ad litem; required checks. Specifies data to be checked and required procedures for alternative background studies for guardians ad litem.

Subd. 10. First-time applicants for educator licenses with the Professional Educator Licensing and Standards Board. Requires PELSB to make eligibility determinations for alternative background studies. Permits alternative background studies for all first-time applicants for educator licenses; specifies what the studies must include.

Subd. 11. First-time applicants for administrator licenses with the Board of School Administrators. Requires the Board of School Administrators to make eligibility determinations for alternative background studies. Permits alternative background studies for all first-time applicants for administrator licenses; specifies what the studies must include.

Subd. 12. Occupations regulated by MNsure. Requires the commissioner to conduct a background study of any individual required to have a background study under section 62V.05.

Section	Description – Article 2: DHS Licensing and Background Studies
19	**Individual studied.** Amends § 245C.05, subd. 1. Clarifies language; requires a background study subject to submit a completed criminal and maltreatment history records check consent form for applicable record checks.
20	**Applicant, license holder, or other entity.** Amends § 245C.05, subd. 2. Makes clarifying change.
21	**County or private agency.** Amends § 245C.05, subd. 2a. Makes clarifying change.
22	**County agency to collect and forward information to commissioner.** Amends § 245C.05, subd. 2b. Makes clarifying changes.
23	**Privacy notice to background study subject.** Amends § 245C.05, subd. 2c. Removes provision stating that the FBI will only keep fingerprints from national criminal history background checks if the subject has a criminal history; states that the FBI will not retain fingerprints; makes clarifying change related to fingerprint vendors.
24	**Fingerprint data notification.** Amends § 245C.05, subd. 2d. Removes provision stating that the FBI will only keep fingerprints from national criminal history background checks if the subject has a criminal history; states that the FBI will not retain fingerprints.
25	**Electronic transmission.** Amends § 245C.05, subd. 4. Adds a summary of nondisqualifying background study results and relevant underlying investigative information to the information that DHS must transmit electronically to county and private agencies for child foster care; makes clarifying changes. Makes this section effective July 1, 2022.
26	**Arrest and investigative information.** Amends § 245C.08, subd. 3. Removes language prohibiting the sharing of national criminal history check information with county and private agencies. Makes this section effective July 1, 2021.

Section	Description – Article 2: DHS Licensing and Background Studies
27	**Authorization.** Amends § 245C.08 by adding subd. 5. Specifies that the commissioner is authorized to receive background study information.
28	**Background study fees.** Amends § 245C.10 by adding subd. 1b. Specifies that the commissioner shall recover background study costs, and that fees collected are appropriated to the commissioner for the purpose of conducting background studies. Lists what background study fees may include and how they may be paid.
29	**Fingerprint and photograph processing fees.** Amends § 245C.10 by adding subd. 1c. Requires the commissioner to enter into a contract with a qualified vendor or vendors to obtain and process fingerprints and photographs for background study purposes. Outlines payment and reimbursement provisions.
30	**Background studies fee schedule.** Amends § 245C.10 by adding subd. 1d. Requires the commissioner to publish a background study fee schedule by March 1 of each year, to be effective from July 1 to June 30 each year. Specifies that fees will be based on actual costs of background study administration; specifies how the fees must be published and how fees are appropriated. Makes this section effective July 1, 2021; requires the commissioner to publish the initial fee schedule on July 1, 2021, which will be effective September 1, 2021.
31	**Guardians and conservators.** Amends § 245C.10, subd. 15. Modifies requirements for fees to be paid for conducting an alternative background study for appointment of a guardian or conservator.
32	**Early intensive developmental and behavioral intervention providers.** Amends § 245C.10 by adding subd. 17. Establishes fee of no more than $20 for a background study for the purposes of early intensive developmental and behavioral intervention. Makes this section effective the day following final enactment.
33	**Applicants, licensees, and other occupations regulated by commissioner of health.** Amends § 245C.10 by adding subd. 18. Specifies that the applicant or license holder is responsible for paying all fees associated with background studies.

Section	Description – Article 2: DHS Licensing and Background Studies
34	**Occupations regulated by MNsure.** Amends § 245C.10 by adding subd. 20. Requires the commissioner to set fees to recover background study costs for MNsure-related studies, through an interagency agreement; specifies that fees will be deposited in the special revenue fund for the purpose of conducting background studies.
35	**Activities pending completion of background study.** Amends § 245C.13, subd. 2. Adds personal care assistant services to list of activities prohibited prior to receipt of background study notices.
36	**Disqualification from direct contact.** Amends § 245C.14, subd. 1. Specifies that the commissioner must disqualify an individual applying for family foster setting licensure from any position allowing direct contact with persons served, if the background study contains disqualifying information, as listed in section 245C.15, subdivision 4a (new subdivision). Makes this section effective July 1, 2022.
37	**Disqualification from working in licensed child care centers or certified license-exempt child care centers.** Amends § 245C.14 by adding subd. 4. Specifies that a disqualified individual must be disqualified from working in any position in a licensed child care center or certified license-exempt child care center, until the commissioner issues a notice that: (1) the individual is not disqualified; (2) a disqualification has been set aside; or (3) a variance has been granted.
38	**Licensed family foster setting disqualifications.** Amends § 245C.15, by adding subd. 4a. Paragraph (a) lists felony-level convictions that permanently disqualify an individual applying for a family foster setting license. Paragraph (b) lists additional crimes or conduct that permanently disqualify an individual applying for a family foster setting license. Paragraph (c) specifies that an individual whose parental rights have been terminated is disqualified from family foster setting licensure for 20 years. Paragraph (d) lists felony-level convictions that disqualify an individual applying for a family foster setting license for five years. Paragraph (e) lists additional crimes or conduct that disqualify an individual applying for a family foster setting license for five years.

Section	Description – Article 2: DHS Licensing and Background Studies

Paragraph (f) specifies that for purposes of this subdivision, a disqualification begins from: (1) the date of the alleged violation, if the individual was not convicted; (2) the date of the conviction, if the individual was convicted but not committed to the custody of the commissioner of corrections; or (3) the date of release from prison. Adds clause regarding reincarceration.

Paragraph (g) contains language regarding disqualifications for aiding and abetting, attempt, or conspiracy to commit listed offenses.

Paragraph (h) contains language regarding disqualifications for offenses in other states or countries.

Makes this section effective July 1, 2022.

39 **Determining immediate risk of harm.**

Amends § 245C.16, subd. 1. Allows the commissioner to order immediate removal of an individual from any position allowing direct contact with or access to persons receiving services, or from any position in a licensed child care center or certified license-exempt child care center, if the individual has a disqualification that is a permanent bar or the individual is a child care background study subject with a felony drug-related offense in the past five years.

40 **Findings.**

Amends § 245C.16, subd. 2. Prohibits the commissioner from making a finding that an individual requires direct, continuous supervision while providing direct contact services during the disqualification reconsideration request period, for a licensed child care center or certified license-exempt child care center.

41 **Time frame for notice of study results and auditing system access.**

Amends § 245C.17, subd. 1. Adds a child care center or certified license-exempt child care center to the list of facilities in which an individual must be immediately removed from direct contact or access, when notice is issued that more time is needed to complete a study.

42 **Disqualification notice to child care centers or certified license-exempt child care centers.**

Amends § 245C.17 by adding subd. 8. Requires an immediate removal notice to also include an order for a license holder to immediately remove the individual from working in any position in a child care center or certified license-exempt child care center.

Section	Description – Article 2: DHS Licensing and Background Studies
43	**Obligation to remove disqualified individual from direct contact and from working in a program, facility, setting, or center.** Amends § 245C.18. Requires a child care center or certified license-exempt child care center license holder to remove a disqualified individual from working in any position in a licensed child care center or certified license-exempt child care center, until the commissioner issues a notice that: (1) the individual is not disqualified; (2) a disqualification has been set aside; or (3) a variance has been granted.
44	**Permanent bar to set aside a disqualification.** Amends § 245C.24, subd. 2. Prohibits the commissioner from setting aside or granting a variance for a disqualification under section 245C.15, subdivision 4a, paragraphs (a) and (b), for an individual 18 years of age or older. Allows a variance to a disqualification for an individual who is under 18 years of age when the background study is submitted. Makes this section effective July 1, 2022.
45	**Ten-year bar to set aside disqualification.** Amends § 245C.24, subd. 3. Removes family foster setting providers from subdivision prohibiting set asides of disqualifications for ten years. Makes this section effective July 1, 2022.
46	**Seven-year bar to set aside disqualification.** Amends § 245C.24, subd. 4. Removes family foster setting providers from subdivision prohibiting set asides of disqualifications for seven years. Makes this section effective July 1, 2022.
47	**Five-year bar to set aside disqualification; family foster setting.** Amends § 245C.24 by adding subd. 6. Specifies that that the commissioner must not set aside a disqualification for any of the crimes or actions listed in section 245C.15, subdivision 4a, paragraph (d), committed within the past five years, for anyone 18 or older in connection with a family foster setting license. Allows the commissioner to set aside or grant a variance to a disqualification if the individual is under 18 years of age at the time the background study is submitted. Makes this section effective July 1, 2022.
48	**NETStudy 2.0 system.** Amends § 245C.32, subd. 1a. Makes clarifying changes related to fingerprint collection vendors.

Section	Description – Article 2: DHS Licensing and Background Studies

49 **Contents of application.**

Amends § 245F.04, subd. 2. Removes reference to rule relating to the assessment of need for substance use disorder treatment programs.

50 **Application.**

Amends § 245G.03, subd. 2. Adds requirement for an applicant for SUD treatment program licensure to notify the county human services director in writing of the applicant's intent to open a new treatment program. Specifies what the notification must include. Allows the county human services director to submit a written statement, with documented rationale, to the commissioner of human services regarding the county's support of or opposition to the new treatment program opening. Requires the commissioner to consider the county's written statement when deciding whether to issue a license.

51 **Background studies.**

Amends § 256B.0949 by adding subd. 16a. Specifies that early intensive developmental and behavioral intervention background study requirements must be met through a background study under specified sections of chapter 245C.

Makes this section effective the day following final enactment.

52 **Duties of commissioner.**

Amends § 260C.215, subd. 4. Adds paragraph requiring the commissioner of human services to establish family foster setting licensing guidelines for county and private licensing agencies; specifies that the guidelines are directives of the commissioner.

Makes this section effective July 1, 2023.

53 **Waivers and modifications; extension for 180 days.**

Amends Laws 2020, First Special Session chapter 7, section 1, as amended by Laws 2020, Third Special Session chapter 1, section 3, by adding subd. 5.

Extends the DHS waiver modifying background study requirements for 180 days after the peacetime emergency declared by the governor expires, is terminated, or is rescinded by the proper authority.

Makes this section effective the day following final enactment, or retroactively from the date the peacetime emergency ends, whichever is earlier.

54 **Child care center regulation modernization.**

Requires DHS to contract with an organization or consultant to: (1) develop a proposal for a risk-based model for monitoring compliance with child care center licensing standards; (2) develop and implement a stakeholder engagement process

Section	Description – Article 2: DHS Licensing and Background Studies

that solicits input about licensing standards, tiers for violations of the standards, and licensing sanctions for each tier; and (3) solicit input about which child care centers should be eligible for abbreviated inspections. Directs DHS to submit a report and proposed legislation for implementing the new licensing model and the new standards to the legislature no later than February 1, 2024.

55 **Child foster care licensing guidelines.**

Directs the commissioner of human services, in consultation with specified stakeholders, to develop family foster setting licensing guidelines for county and private licensing agencies, by July 1, 2023.

56 **Direction to commissioner of human services; family child care one-stop assistance network.**

Requires DHS to develop a proposal for a one-stop regional assistance network to assist individuals with matters relating to starting or sustaining a licensed family child care program. DHS must develop the proposal by January 1, 2022.

57 **Direction to the commissioner of human services; recommended family child care orientation training.**

Requires DHS to develop recommended, but not required, orientation training for newly licensed family child care providers by July 1, 2022.

58 **Family child care regulation modernization.**

Requires DHS to contract with an organization or consultant to: (1) develop a proposal for a risk-based model for monitoring compliance with family child care licensing standards; (2) develop a proposal for updated family child care licensing standards; (3) develop and implement a stakeholder engagement process that solicits input about licensing standards, tiers for violations of the standards, and licensing sanctions for each tier; and (4) solicit input about which family child care providers should be eligible for abbreviated inspections. Directs DHS to submit a report and proposed legislation for implementing the new licensing model and the new standards to the legislature no later than February 1, 2024.

59 **Family child care training advisory committee.**

Establishes a Family Child Care Training Advisory Committee to advise DHS on the training requirements for licensed family child care providers. DHS must report annually to the legislature on any recommendations from the advisory committee. The committee expires December 1, 2025.

Section	Description – Article 2: DHS Licensing and Background Studies
60	**Revisor instruction.** Instructs the revisor of statutes to renumber subdivisions in the background study definitions section alphabetically and correct any cross-references.
61	**Repealer.** Repeals subdivisions of 245C.10 relating to specific background study fees. Repeals rules requiring the statement of need for licensing a new SUD treatment program, effective the day following final enactment.

Article 3: Health Department

This article establishes or modifies Health Department programs and activities.

Section	Description - Article 3: Health Department
1	**Implementation.** Amends § 62J.495, subd. 1. Eliminates language requiring the commissioner of health to provide an update to the legislature on the development of uniform standards for interoperable electronic health records systems, as part of an annual report to the legislature.
2	**E-Health Advisory Committee.** Amends § 62J.495, subd. 2. Eliminates a requirement for the commissioner of health to issue an annual report outlining progress in implementing a statewide health information infrastructure and providing recommendations to promote adoption and effective use of health information technology. Also extends the subdivision to June 30, 2031 (under current law this subdivision, which establishes the e-Health Advisory Committee, expires June 30, 2021). This section is effective the day following final enactment.
3	**Interoperable electronic health record requirements.** Amends § 62J.495, subd. 3. Strikes a requirement that a health data intermediary to which an electronic health record system must be connected, must be state-certified. (State certification of health data intermediaries is being eliminated in another section.)
4	**Coordination with national HIT activities.** Amends § 62J.495, subd. 4. Eliminates a reference to a specific federal HIT strategic plan with which the statewide interoperable health information infrastructure plan must be consistent and instead requires the plan to be consistent with updated

Section **Description - Article 3: Health Department**

federal plans. Eliminates duties of the commissioner to help develop and support health information technology regional extension centers, to provide supplemental information on best practices gathered by regional centers, and to monitor and respond to development of quality measures. Also strikes a reference to a report to the legislature being eliminated in another subdivision.

5 **Definitions.**

Amends § 62J.497, subd. 1. In a subdivision defining terms for the electronic prescription drug program, deletes a definition of backward compatible. Amends the definition of NCPFP Formulary and Benefits Standard by removing a reference to the 2005 implementation guide version and instead referring to the most recent version of the standard or to the most recent version adopted by CMS for e-prescribing under Medicare Part D. Also amends the definition of NCPDP SCRIPT Standard by removing a reference to the 2005 implementation guide version.

6 **Standards for electronic prescribing.**

Amends § 62J.497, subd. 3. In a subdivision providing standards for electronic prescribing, strikes a list of specific transactions that must be conducted using the NCPDP SCRIPT Standard.

7 **Health information exchange.**

Amends § 62J.498. Eliminates certain definitions and establishes an additional duty for the commissioner of health regarding health information exchange oversight.

Subd. 1. Definitions. Eliminates the following definitions for sections governing health information exchanges, certificates of authority to provide HIE services, and enforcement authority: HITECH Act, meaningful use, meaningful use transaction, and state-certified health data intermediary. Also removes references to health information exchange service providers being state-certified.

Subd. 2. Health information exchange oversight. In a subdivision establishing duties of the commissioner to protect the public interest, adds a duty of requiring health information exchange service providers to provide information to meet statutory requirements.

8 **Certificate of authority to provide health information exchange services.**

Amends § 62J.4981. Eliminates a requirement that health data intermediaries must be certified by the commissioner, and makes conforming changes.

Section	Description - Article 3: Health Department

Subd. 1. Authority to require organizations to apply. Eliminates a requirement for health data intermediaries to apply to the commissioner for certificates of authority.

Subd. 2. Certificate of authority for health data intermediaries. Strikes a subdivision requiring health data intermediaries to be certified by the commissioner in order to operate as a health data intermediary in the state and establishing criteria to obtain a certificate of authority.

Subd. 3. Certificate of authority for health information organizations. Strikes references to state-certified health data intermediaries to conform with subdivision 2.

Subd. 4. Application for certificate of authority for health information organizations. Modifies terms used, eliminates unnecessary language, and modifies cross-references to conform with the elimination of a requirement for health data intermediaries to be certified.

Subd. 5. Reciprocal agreements between health information organizations. Strikes language requiring reciprocal agreements between health information organizations and health data intermediaries to meet the requirements in this subdivision. Strikes a reference to state-certified health data intermediary to conform with elimination of a requirement for health data intermediaries to be certified. Also strikes references to meaningful use and meaningful use transaction.

9 **Enforcement authority; compliance.**

Amends § 62J.4982. In a section governing enforcement and compliance for health information organizations, eliminates a requirement that health data intermediaries must be certified by the commissioner, eliminates the commissioner's authority to impose penalties on health data intermediaries, eliminates application and annual certificate fees for health data intermediaries, and modifies terms used to conform with elimination of the requirement for health data intermediaries to be certified by the commissioner.

10 **Support for state health care purchasing and performance measurement.**

Amends § 62J.63, subd. 1. Eliminates language requiring the commissioner of health to establish and administer a Center for Health Care Purchasing Improvement but retains certain functions of the center and assigns them to the commissioner of health.

Section	Description - Article 3: Health Department
11	**Duties; scope.** Amends § 62J.63, subd. 2. Eliminates language authorizing the commissioner to appoint staff for the Center for Health Care Purchasing Improvement. Also eliminates the following duties: initiating projects to develop plan designs for state health care purchasing; conducting policy audits of state programs; consulting with the Health Economics Unit regarding reports and assessments of the health care marketplace; consulting with the Department of Commerce regarding regulatory issues and legislative initiatives; working with DHS and CMS to address federal requirements for health care purchasing and conformity issues; assisting MCHA in purchasing strategies; and convening agency medical directors for advice and collaboration. Allows the commissioner to evaluate current administrative simplification strategies.
12	**Encounter data.** Amends § 62U.04, subd. 4. Requires health plan companies and third-party administrators to submit encounter data to the all-payer claims database on a monthly basis, rather than every six months as in current law. Notwithstanding the data classification as private data on individuals or nonpublic data, allows provider data held by the all-payer claims database to be released or published as authorized in subdivision 11, which specifies authorized uses of data in the database.
13	**Pricing data.** Amends § 62U.04, subd. 5. Notwithstanding the data classification of pricing data as nonpublic, allows pricing data held by the all-payer claims database to be released or published for the purposes specified in subdivision 11, which specifies authorized uses of data in the database.
14	**Restricted uses of the all-payer claims data.** Amends § 62U.04, subd. 11. Modifies data from the all-payer claims database that is available for use and that may be published, to: (1) allow public use files compiled by the commissioner to identify the rendering or billing hospital, clinic, or medical practice; and (2) allow the commissioner to publish the results of authorized uses under this subdivision in a way that identifies hospitals, clinics, and medical practices, provided no individual health professionals are identified and the commissioner determines the data is accurate, valid, and suitable for publication.
15	**Procedure.** Amends § 103H.201, subd. 1. Modifies a provision authorizing the commissioner of health to adopt health risk limits for substances degrading groundwater. For toxicants that are known or probable carcinogens, requires the commissioner to use a quantitative estimate of a chemical's carcinogenic potency either: (1) published by the federal Environmental Protection Agency; or (2) determined by the commissioner to have undergone thorough scientific review. (Under current law the quantitative

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estimate must be both published by the EPA and determined by the commissioner to have undergone thorough scientific review.)

16 **Distribution of COVID-19 vaccines.**

Adds § 144.066. Directs the commissioner of health to distribute COVID-19 vaccines according to this section.

Subd. 1. Definitions. Defines the following terms for this section and sections 144.0661 to 144.0663: commissioner, COVID-19 vaccine, department, disproportionately impacted community, local health department, and mobile vaccination vehicle.

Subd. 2. Distribution. Requires the commissioner to establish and maintain partnerships or agreements with the listed entities to administer COVID-19 vaccines throughout the state. Also allows COVID-19 vaccines to be administered via mobile vaccination vehicles.

Subd. 3. Second dose or booster. States that a registered vaccine provider should be directed by the department during the registration process to assist vaccine recipients with scheduling an appointment for any required second dose or booster.

Subd. 4. Nondiscrimination. Provides that nothing in section 144.066 to 144.0663 shall be construed to allow or require denial of a benefit or opportunity based on certain characteristics.

This section is effective the day following final enactment.

17 **Equitable COVID-19 vaccine distribution.**

Adds § 144.0661. Requires the commissioner of health to establish positions to continue COVID-19 vaccine equity and outreach activities, establishes education and outreach and community assistance programs, and requires establishment of metrics to measure equitable distribution of COVID-19 vaccines.

Subd. 1. COVID-19 vaccination equity and outreach. Requires the commissioner of health to establish positions to work on COVID-19 vaccine equity and outreach and to address disparities in COVID-19 vaccination rates. Requires this work to be managed by a director who has a leadership role in the department's COVID-19 response.

Subd. 2. Vaccine education and outreach campaign; direct delivery of information. Requires the commissioner to administer a COVID-19 vaccine education and outreach campaign to directly provide information on the listed

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topics to members of disproportionately impacted communities. Specifies how the information must be delivered.

Subd. 3. Vaccine education and outreach campaign; mass media. Requires the commissioner to administer a mass media campaign to provide COVID-19 vaccine education and outreach on the listed topics to members of disproportionately impacted communities.

Subd. 4. Community assistance. Requires the commissioner to administer a community assistance program to help members of disproportionately impacted communities arrange and prepare to obtain COVID-19 vaccines and to help transportation-limited individuals obtain vaccines.

Subd. 5. Equitable distribution of COVID-19 vaccines. Requires the commissioner to establish a set of metrics to measure the equitable distribution of COVID-19 vaccines, and to set and update goals for vaccine distribution that are focused on equity.

Subd. 6. Expiration of programs. Provides that the vaccine education and outreach programs and the community assistance program shall operate until a sufficient percentage of individuals in each county or census tract have received the full series of COVID-19 vaccines to protect individuals from COVID-19.

This section is effective the day following final enactment.

18 **Mobile vaccination program.**

Adds § 144.0662. Requires the commissioner to administer a mobile vaccination program using mobile vaccination vehicles.

Subd. 1. Administration. Directs the commissioner to administer a mobile vaccination program in which mobile vaccination vehicles are deployed to communities around the state to vaccinate individuals. Requires mobile vaccination vehicles to be deployed to communities to improve access to vaccines.

Subd. 2. Eligibility. Provides that all individuals in a community to which a mobile vaccination vehicle is deployed are eligible to receive COVID-19 vaccines from the vehicle.

Subd. 3. Staffing. Requires mobile vaccination vehicles to be staffed according to CDC guidelines and allows them to be staffed with additional personnel based on local needs.

Subd. 4. Second doses. Requires staff of a mobile vaccination vehicle to assist vaccine recipients receiving a first dose to schedule a second dose or booster,

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and requires the commissioner, to the extent possible, to deploy mobile vaccination vehicles in a way that allows vaccine recipients to receive second doses or boosters from the mobile vaccination vehicle.

Subd. 5. Expiration. Directs the commissioner to administer the mobile vaccination vehicle program until a sufficient percentage of individuals in each county or census tract have received the full series of COVID-19 vaccines to protect individuals from the spread of COVID-19.

This section is effective the day following final enactment.

19 **COVID-19 vaccination plan and data; reports.**

Adds § 144.0663. Requires the commissioner of health to publish metrics for equitable COVID-19 vaccine distribution and implementation protocols for equitable COVID-19 vaccine distribution. Also requires weekly publication of data on COVID-19 vaccines and quarterly reports on funding for certain COVID-19 activities.

Subd. 1. COVID-19 vaccination plan; implementation protocols. Requires the commissioner to publish the equity metrics and goals for equitable COVID-19 vaccine distribution and implementation protocols to address disparities in COVID-19 vaccination rates in certain communities.

Subd. 2. Data on COVID-19 vaccines. Requires the commissioner, on a weekly basis, to publish the specified data related to COVID-19 vaccines.

Subd. 3. Quarterly reports. On at least a quarterly basis while funds are available, requires the commissioner to report to certain members of the legislature on funds distributed to local health departments for COVID-19 activities and funds expended to implement sections 144.066 to 144.0663.

This section is effective the day following final enactment.

20 **Resident reimbursement case mix classifications.**

Amends § 144.0724, subd. 1. Modifies a term used in a subdivision requiring the commissioner of health to establish case mix classifications for residents of nursing homes and boarding care homes.

21 **Definitions.**

Amends § 144.0724, subd. 2. In a subdivision defining terms for a section on case mix classifications, makes a technical change to the definition of minimum data set and modifies the definition of activities of daily living.

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22	**Resident reimbursement case mix classifications beginning January 1, 2012.** Amends § 144.0724, subd. 3a. In a subdivision establishing requirements for case mix classifications, modifies a term used and removes a reference to the Case Mix Classification Manual for Nursing Facilities.
23	**Short stays.** Amends § 144.0724, subd. 5. Provides that a facility is not required to submit an admission assessment for a resident admitted to and discharged from the facility on the same day. Provides that when an admission assessment is not submitted, the case mix classification will be the rate with a case mix index of 1.0.
24	**Notice of resident reimbursement case mix classification.** Amends § 144.0724, subd. 7. In a subdivision governing notice from the commissioner of health to a nursing facility regarding case mix classifications established for residents, makes technical changes and changes in terminology and requires the notice of modified assessment to be provided to the facility within 3 business days after distribution of the classification notice to the resident.
25	**Request for reconsideration of resident classifications.** Amends § 144.0724, subd. 8. In a subdivision governing requests for reconsideration of resident classifications, allows reconsideration of any items changed during the audit process, reorganizes the subdivision for requests initiated by the resident or a representative and for requests submitted by the facility, and makes technical changes. For requests initiated by the resident or a representative, eliminates language specifying what must accompany the reconsideration request, reorganizes language specifying what the facility must submit, and specifies the consequence when a facility fails to provide the required information. For requests initiated by the facility, requires the facility to provide the resident or a representative with notice of the request, requires the request to be submitted within a certain timeframe, and permits rather than requires the commissioner to deny the reconsideration request if the facility fails to provide the required information. Establishes requirements for transmitting the reconsideration classification notice to the nursing facility and to the resident or representative.
26	**Audit authority.** Amends § 144.0724, subd. 9. In a subdivision requiring the commissioner to ensure the accuracy of resident assessments through audits, reviews of records, and interviews, strikes language requiring the commissioner to make the results of the audit available to the facility, requires distribution of the audit classification notice to the facility and the resident or representative within certain timeframes if the audit results in a case mix classification change, and specifies what the notice must include.

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27 **Appeal of nursing facility level of care determination.**

Amends § 144.0724, subd. 12. Strikes language allowing certain residents to request continued services pending appeal of a nursing facility level of care determination. Also strikes language limiting the effect of a paragraph requiring notice to residents of a change in eligibility for long-term care services due to a nursing facility level of care determination.

28 **Initial and annual fee.**

Amends § 144.1205, subd. 2. A new paragraph (a) requires an entity obtaining a license for radioactive material or source or special nuclear material, to pay an initial fee upon issuance of the initial license.

Paragraph (b) consolidates fee categories, establishes additional fee categories for facilities with multiple locations, modifies the names of fee categories, and modifies annual fee amounts for licensure for radioactive material or source or special nuclear material.

29 **Initial and renewal application fee.**

Amends § 144.1205, subd. 4. Specifies that the application fees due under this subdivision are for initial applications for licensure and to renew applications for licensure. Consolidates fee categories, deletes certain fee categories, and modifies application fees for licensure for radioactive material or source or special nuclear material.

30 **Reciprocity fee.**

Amends § 144.1205, subd. 8. Changes the application fee for reciprocal recognition of a radioactive materials license issued by another state or the federal Nuclear Regulatory Commission, from $1,200 to $2,400.

31 **Fees for license amendments.**

Amends § 144.1205, subd. 9. Changes the fee to amend a license for radioactive material, from $300 to $600.

32 **Fees for general license registrations.**

Adds subd. 10 to § 144.1205. Establishes an annual registration fee of $450 for the registration of generally licensed devices (devices that contain radioactive material and that are designed to detect, measure, or control thickness, density, level, interface location, radiation, leakage, or chemical composition, or designed to produce light or an ionizing atmosphere).

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33 **Duty to perform testing.**

Amends § 144.125, subd. 1. Increases the per-specimen fee for testing under the newborn screening program from $135 to $177. (The newborn screening program tests newborns soon after birth for rare disorders of metabolism, hormones, the immune system, blood, breathing, digestion, hearing, or the heart.)

34 **Dignity in pregnancy and childbirth.**

Adds § 144.1461. Requires hospitals that provide obstetric care and birth centers to provide continuing education on anti-racism training and implicit bias.

Subd. 1. Citation. Provides that this section may be cited as the Dignity in Pregnancy and Childbirth Act.

Subd. 2. Continuing education requirement. Paragraph (a) requires hospitals with obstetric care and birth centers to provide continuing education on anti-racism training and implicit bias. Requires the continuing education to be evidence-based and lists criteria that it must include.

Paragraph (b) requires hospitals and birth centers to also provide an annual refresher course that reflects current trends on race, culture, identity, and anti-racism principles and institutional implicit bias.

Paragraph (c) requires hospitals with obstetric care and birth centers to develop continuing education materials on anti-racism training and implicit bias that must be provided to direct care employees and contractors who routinely care for pregnant or postpartum women.

Paragraph (d) requires hospitals with obstetric care and birth centers to coordinate with health-related licensing boards to obtain continuing education credits for the training and materials required by this section. Also requires the commissioner to monitor compliance with this section and requires initial training to be completed by December 31, 2022.

Paragraph (e) requires hospitals with obstetric care and birth centers to provide a certificate of training completion upon request, and allows a facility to accept the training certificate from another facility for a provider who works in more than one facility.

35 **Establishment; membership.**

Amends § 144.1481, subd. 1. Adds a dentist to the membership of the Rural Health Advisory Committee.

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36 **Definitions.**

Amends § 144.1501, subd. 1. Adds a definition of alcohol and drug counselor to the definitions for the health professional education loan forgiveness program.

37 **Creation of account.**

Amends § 144.1501, subd. 2. Makes alcohol and drug counselors who agree to practice in designated rural areas or underserved urban communities eligible for loan forgiveness under the health professional education loan forgiveness program.

38 **Eligibility.**

Amends § 144.1501, subd. 3. Adds persons enrolled in a training or education program to become an alcohol and drug counselor to the list of professions eligible for loan forgiveness under the health professional education loan forgiveness program.

39 **International medical graduate primary care residency grant program and revolving account.**

Amends § 144.1911, subd. 6. Adds general surgery residency programs to the types of primary care residency programs eligible for a grant to support residency positions designated for Minnesota immigrant physicians willing to serve in rural or underserved areas of the state.

40 **Homeless youth.**

Adds subd. 12 to § 144.212. Adds a definition of homeless youth to definitions that apply to vital records sections.

41 **Data about births.**

Amends § 144.225, subd. 2. Under current law, data on the birth of a child born to a woman not married to the child's father when the child was conceived or born is classified as confidential data but may be disclosed to certain persons, including to the child if the child is 16 or older. This section (1) allows this data to be disclosed to the child if the child is homeless youth, and does not require the homeless youth to be 16 or older; and (2) allows an entity administering a children's savings program to access these birth records to open an account in the program for the child as a beneficiary.

42 **Certified birth or death record.**

Amends § 144.225, subd. 7. Adds a cross-reference to section 144.2255, to exempt homeless youth from paying the required fees to obtain a certified birth record. Also makes the following changes to who may obtain an individual's certified birth or death record:

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- removes a requirement that an individual requesting a certified record has a tangible interest in the record and defining tangible interest, and instead just lists individuals who may obtain a certified record;
- removes from the list of individuals who may obtain a certified record, the party responsible for filing the record; and
- provides that for an attorney to obtain a certified record, the attorney must represent the subject of the record or another individual otherwise authorized in clause (1) to obtain a record (under current law any attorney may obtain a certified record).

43 **Certified birth record for homeless youth.**

Adds § 144.2255. Establishes procedures and documentation requirements for a homeless youth to obtain a certified birth record.

Subd. 1. Application; certified birth record. Allows a subject of a birth record who is a homeless youth in this or another state to apply to the state registrar or a local issuance office for a certified birth record. Lists what a homeless youth must submit to the state registrar or local issuance office.

Subd. 2. Statement verifying subject is a homeless youth. If a homeless youth submits a statement from another individual to verify that the youth is a homeless youth, lists information that must be included in the statement, and requires the individual providing the statement to also provide a copy of the individual's employment identification.

Subd. 3. Expiration; reissuance. If a subject of a birth record obtains a birth record in part using a statement from another individual to verify that the subject is a homeless youth, makes the birth record expire 6 months after issuance. Allows the subject of such a birth record to surrender the expired record to the state registrar or local issuance office and obtain another birth record. Provides that all birth records obtained under this subdivision expire 6 months after issuance. If the subject does not surrender the expired birth record, requires the subject to apply for a certified record according to subdivision 1.

Subd. 4. Fees waived. Prohibits the state registrar or local issuance office from charging a fee to a homeless youth for issuing a certified birth record or statement of no vital record found under this section.

Subd. 5. Data practices. Classifies as private data on individuals, a statement from the subject of the birth record that he or she is a homeless youth, and a statement from another individual verifying that the subject of the birth record is a homeless youth.

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Makes this section effective the day following final enactment for applications for and the issuance of certified birth records on or after January 1, 2022.

44 **Transaction fees.**

Adds subd. 7 to § 144.226. Allows the state registrar and agents to charge a convenience fee and a transaction fee for electronic transactions and transactions by the telephone or the Internet for distribution of vital records.

45 **Birth record fees waived for homeless youth.**

Adds subd. 8 to § 144.226. Amends a section governing fees for the issuance of vital records to exempt a homeless youth from payment of fees to obtain a certified birth record or statement of no record found.

This section is effective the day following final enactment for applications for and the issuance of certified birth records on or after January 1, 2022.

46 **Routine inspections; presumption.**

Amends § 144.55, subd. 4. In a subdivision governing the commissioner of health's authority to inspect hospitals, requires the commissioner to conduct hospital inspections as needed to determine whether a hospital or hospital corporate system continues to satisfy the conditions on which a moratorium exception was granted.

47 **Suspension, revocation, and refusal to renew.**

Amends § 144.55, subd. 6. Prohibits the commissioner from renewing licenses for hospital beds issued according to a hospital construction moratorium exception if the commissioner finds the hospital or hospital corporate system is not satisfying the conditions included in the exception.

This section is effective for license renewals occurring on or after July 1, 2021.

48 **Restricted construction or modification.**

Amends § 144.551, subd. 1. Amends an existing exception to the hospital construction moratorium to require hospital beds transferred from a closed hospital to another site or complex in a hospital corporate system to be first used to replace the beds that had been used in the closed hospital for mental health services and substance use disorder services, before transferring remaining beds for any other purpose. Also adds two additional exceptions to the hospital construction moratorium to:

- allow Regions to add 45 licensed beds. This exception is effective contingent on Regions adding the 15 licensed mental health beds authorized in clause (28), designating 5 of the 45 beds in the current

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exception for inpatient mental health, and agreeing to not use revenue recapture; and

- allow the addition of licensed beds to primarily provide mental health services or substance use disorder services. In order to be eligible to add beds, a hospital must have an emergency department, not be a hospital that solely treats adults for mental illness or substance use disorders, and make the beds available to MA and MinnesotaCare enrollees.

49 **Monitoring.**

Adds subd. 5 to § 144.551. Requires the commissioner to monitor the addition of beds and establishment of new hospitals according to exceptions established under this section. Requires hospitals and hospital corporate systems to annually report to the commissioner on how the hospital or system continues to satisfy the conditions included in the exception.

50 **Facility or campus closings, relocating services, or ceasing to offer certain services; patient relocations.**

Amends § 144.555.

Subd. 1. Notice of closing or curtailing operations; facilities other than hospitals. Provides that the existing law requiring notice to the commissioner of health when a facility voluntarily plans to cease or curtail operations applies to facilities other than hospitals. (Notice requirements for hospitals are moved from this subdivision to the new subdivision 1a.)

Subd. 1a. Notice of closing, curtailing operations, relocating services, or ceasing to offer certain services; hospitals. Requires the controlling persons of a hospital or hospital campus to notify the commissioner of health at least nine months before the hospital or hospital campus ceases or curtails operations, relocates the provision of health services to another hospital or hospital campus, or ceases to offer maternity and newborn care services, ICU services, inpatient mental health services, or inpatient substance use disorder services. Requires controlling persons of a hospital or campus to comply with the right of first refusal provisions in section 144.556.

Subd. 1b. Public hearing. Upon receiving notice under subdivision 1a, requires the commissioner to conduct a public hearing on the cessation of operations, curtailment of operations, or relocation or cessation of services. Requires the public hearing to be held in the community where the facility or campus is located at least six months before the scheduled change, and lists what must be addressed at the public hearing.

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Subd. 2. Penalty. Provides that failure to notify the commissioner according to subdivision 1a or to participate in a public hearing according to subdivision 1b may result in the commissioner of health issuing a correction order against the facility.

51 **Right of first refusal for hospital or hospital campus.**

Adds § 144.556. Provides a local unit of government with a right of first refusal to purchase a hospital or hospital campus before the hospital or campus is sold or conveyed to another party, or is closed.

Subd. 1. Prerequisite before sale, conveyance, or ceasing operations of hospital or hospital campus. Before the controlling persons of a hospital sell, convey, or offer to sell or convey a hospital or hospital campus or cease operations of the hospital or campus, requires the controlling persons to first make a good faith offer to sell or convey the hospital or campus to a local unit of government where the hospital or campus is located.

Subd. 2. Offer. Prohibits the offer to sell or convey the hospital or campus from being at a price that exceeds the hospital's or campus's current fair market value, requires the offer to be accepted or declined within 60 days after receipt, and provides that if the party to whom the offer is made does not respond within 60 days, the offer is deemed declined.

52 **Lead hazard reduction.**

Amends § 144.9501, subd. 17. Amends a definition of lead hazard reduction to allow it to take place at any location where lead hazards are identified (current law allows it to take place at a residence, child care facility, school, or playground).

53 **Reports of blood lead analysis required.**

Amends § 144.9502, subd. 3. Amends a subdivision establishing requirements for medical clinics, laboratories, and facilities to report results of blood lead analyses to the commissioner, to specify that the commissioner may prescribe the manner in which a clinic, laboratory, or facility must report the results.

54 **Lead risk assessment.**

Amends § 144.9504, subd. 2. Makes the following changes to a subdivision governing lead risk assessments conducted by assessing agencies:

- expands the locations where an assessing agency must conduct a lead risk assessment to include child care facilities, playgrounds, schools, and other locations where lead hazards are suspected (under current law assessing agencies must conduct lead risk assessments of residences);

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- requires a lead risk assessment to be conducted within ten working days if a child has a venous blood lead level of ten micrograms of lead per deciliter of blood, rather than 15 micrograms as in current law;
- requires a lead risk assessment to be conducted within 20 working days if a child or pregnant female at a location where lead hazards are suspected has a venous blood lead level of five micrograms of lead per deciliter of blood; and
- provides that lead risk assessments must be conducted if a child under 18 has one of the listed blood lead levels, rather than if a child age 6 or under has one of the listed blood lead levels.

Allows an assessing agency to refer investigations at sites other than residences to the commissioner.

55 **Lead orders.**

Amends § 144.9504, subd. 5. Expands an assessing agency's authority to order lead hazard reduction. If an assessing agency finds a lead hazard at a property originated from another source location, allows the assessing agency to order the responsible person of the source location to: (1) perform lead hazard reduction at the lead risk assessment site; and (2) remediate conditions at the source location that allowed the lead to migrate from the source location.

56 **Assisted living facility.**

Amends § 144G.08, subd. 7, as further amended. Amends the definition of assisted living facility for the chapter governing assisted living facility licensure to mean an establishment where an operating person or legal entity, either directly or through one of the specified arrangements, provides accommodations and services to one or more adults in the facility. Also strikes language that covered settings are not included in the definition of assisted living facility.

This section is effective August 1, 2021.

57 **Services for residents with dementia.**

Amends § 144G.84. Amends requirements for access to outdoor space for residents of assisted living facilities with dementia care, to require existing housing with services establishments that obtain an assisted living facility license to provide residents with regular access to outdoor space and to require a licensee with new construction or a new licensee to provide regular access to secured outdoor space on the premises of the facility.

This section is effective August 1, 2021.

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58 **Home visiting for pregnant women and families with young children.**

Adds §145.87.

Subd. 1. Definitions. Defines the following terms for this section: evidence-based home visiting program, evidence-informed home visiting program, health equity, and promising practice home visiting program.

Subd. 2. Grants for home visiting programs. Directs the commissioner of health to award grants to community health boards, nonprofit organizations, and tribal nations to start up or expand voluntary home visiting programs. Grant money must be used to establish evidence-based, evidence-informed, or promising practice home visiting programs that address health equity, use community-driven strategies, and serve families with young children or pregnant women who are high risk or have high needs.

Subd. 3. Grant prioritization. Directs the commissioner to prioritize grants to programs seeking to expand home visiting services with community or regional partnerships. Requires that at least 75% of the grant money awarded each grant cycle supports evidence-based programs and up to 25% supports evidence-informed or promising practice programs.

Subd. 4. Administrative costs. Allows the commissioner to use up to 7% of the annual appropriation for training and technical assistance and to administer and evaluate the program, and allows the commissioner to contract for training, capacity-building, technical assistance, and evaluation support.

Subd. 5. Use of state general fund appropriations. Provides that appropriations dedicated to starting up or expanding evidence-based home visiting programs must be awarded according to this section beginning July 1, 2021. Provides that this section does not govern grant awards of federal funds for home visiting programs or grant awards of state funds dedicated to nurse-family partnership home visiting programs.

59 **Food benefits.**

Amends § 145.893, subd. 1. Changes a term used, from vouchers to food benefits, in a subdivision authorizing eligible individuals to receive benefits to purchase nutritional supplements under WIC.

60 **State commissioner of health; duties, responsibilities.**

Amends § 145.894. Allows local health agencies to issue WIC food benefits three times per month, instead of twice per month as permitted under current law. Strikes obsolete language.

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61 **Food benefits.**

Amends § 145.897. In a section governing foods eligible for purchase under WIC, provides that the federal Department of Agriculture, not the commissioner, determines allowable foods; changes a term; and strikes language listing examples of allowable foods.

62 **Food benefits for organics.**

Amends § 145.899. In a section allowing WIC food benefits to be used to buy cost-neutral organic allowable foods, changes a term used.

63 **Access to data.**

Amends § 145.901, subd. 2. Amends a subdivision governing access to data for maternal death studies to specify that the commissioner has access to the names of providers, clinics, or other health services where care was received before, during, or related to the pregnancy or death. Also allows the commissioner to access records maintained by medical examiners, coroners, and hospitals and hospital discharge data; allows the commissioner to request from a coroner or medical examiner the names of health care providers that provided prenatal, postpartum, or other health services; and allows the commissioner to access DHS data to evaluate welfare systems, and to request and receive law enforcement reports or incident reports.

64 **Classification of data.**

Amends § 145.901, subd. 4. Amends a subdivision classifying data held by the commissioner for purposes of maternal death studies to state that data provided by the commissioner of human services to the commissioner of health under this section retains the same classification as when held by the commissioner of human services.

65 **Severe maternal morbidity studies.**

Adds § 145.9013. Authorizes the commissioner of health to conduct maternal morbidity studies to help with planning for and evaluation of existing systems and to reduce preventable adverse maternal outcomes in the state.

Subd. 1. Purpose. Allows the commissioner of health to conduct maternal morbidity studies for the specified purposes. Defines maternal morbidity as severe maternal morbidity as defined by the CDC and specifies it includes an unexpected outcome of labor or delivery that results in significant short- or long-term consequences to a woman's health. (The CDC uses International Classification of Diseases diagnosis and procedure codes to identify delivery hospitalizations that have severe maternal morbidity indicators. Some severe maternal morbidity indicators include acute myocardial infarction, aneurysm, acute renal failure, eclampsia, and blood products transfusion.)

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Subd. 2. Access to data. Paragraph (a) allows the commissioner to access the medical data and health records of a woman who experienced one or more maternal morbidities during pregnancy or within 12 months of the end of a pregnancy and occurring on or after January 1, 2015. Allows the commissioner to access the names of providers and clinics where care was received before, during, or related to the pregnancy, and allows the commissioner to access the records of certain programs and services to obtain the name and location of services received by the data subject.

Paragraph (b) requires the entity with the data listed in paragraph (a) to provide the commissioner with the information requested by the commissioner in a time and manner designated by the commissioner. Allows the entity to charge a fee for providing the data.

Paragraph (c) requires the commissioner to inform the data subject about collection of the subject's data under this section, once the commissioner determines the data subject meets the criteria for a maternal morbidity review. At any time during the review process, allows the data subject to request that the commissioner remove the data subject's personal identifying information from data the commissioner obtains, and requires the commissioner to comply with such requests.

Paragraph (d) allows the data subject to voluntarily participate in an informant interview and allows the commissioner to compensate the data subject for time and other interview expenses.

Paragraph (e) allows the commissioner to access DHS data to assist with the evaluation of welfare systems to reduce preventable maternal morbidities.

Subd. 3. Management of records. After the commissioner collects all data about a maternal morbidity subject needed to perform the study, requires the commissioner to transfer certain data from the source records to separate records, and to then destroy the source records.

Subd. 4. Classification of data. Classifies data provided to the commissioner to carry out maternal morbidity studies as confidential data on individuals or confidential data on decedents. States that this information shall not be subject to discovery or introduction into evidence, but provides the information otherwise available from an original source is not immune from discovery or barred from introduction into evidence. Makes summary data on maternal morbidity studies public, and states that data provided by the commissioner of human services to the commissioner of health under this section retains the same classification as when held by the commissioner of human services.

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66	**Analog.** Amends § 152.01, subd. 23. Amends the definition of analog in the chapter governing drugs and controlled substances, to specify that analog does not include marijuana or nonsynthetic tetrahydrocannabinols. This section is effective August 1, 2021, and applicable to crimes committed on or after that date.
67	**Schedule I.** Amends § 152.02, subd. 2. Removes marijuana and nonsynthetic tetrahydrocannabinols from Schedule I of controlled substances. (Substances in Schedule I are those with no currently accepted medical use, a lack of accepted safety for use under medical supervision, and a high potential for abuse.) This section is effective August 1, 2021, and applicable to crimes committed on or after that date.
68	**Schedule II.** Amends § 152.02, subd. 3. Adds marijuana and nonsynthetic tetrahydrocannabinols to Schedule II of controlled substances. (Substances in Schedule II are those with a high potential for abuse, with use potentially leading to severe psychological or physical dependence.) This section is effective August 1, 2021, and applicable to crimes committed on or after that date.
69	**Prescription requirements for Schedule II controlled substances.** Amends § 152.11, subd. 1a. Exempts medical cannabis from the requirement that a Schedule II controlled substance must be dispensed according to a prescription (health care practitioners do not prescribe medical cannabis under the medical cannabis program).
70	**Exception.** Adds subd. 5 to § 152.11. Provides that marijuana and tetrahydrocannabinols are not considered Schedule II controlled substances for purposes of a section establishing prescription requirements for controlled substances.
71	**Exception.** Adds subd. 6 to § 152.12. Provides that marijuana and tetrahydrocannabinols are not considered Schedule II controlled substances for purposes of a section governing the prescribing, dispensing, administration, and sale of controlled substances.

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72 **Limits on applicability.**

Amends § 152.125, subd. 3. Provides that a section governing the prescription and administration of controlled substances for intractable pain does not apply to medical cannabis.

73 **Hemp processor.**

Adds subd. 5c to § 152.22. Adds a definition of hemp processor to the medical cannabis statutes.

74 **Medical cannabis.**

Amends § 152.22, subd. 6. Amends the definition of medical cannabis for the medical cannabis program to allow delivery of medical cannabis via combustion of dried raw cannabis.

This section is effective the earlier of (1) March 1, 2022, or (2) a date by which rules on combustion of dried raw cannabis are in effect and independent laboratories are able to perform the required tests of dried raw cannabis.

75 **Registered designated caregiver.**

Amends § 152.22, subd. 11. Amends the definition of registered designated caregiver for the medical cannabis program to remove a requirement that a health care practitioner identify a patient as needing assistance in administering or obtaining medical cannabis due to a disability.

76 **Tribal medical cannabis program.**

Adds subd. 13a to § 152.22. Defines tribal medical cannabis program for the medical cannabis statutes.

77 **Limitations.**

Amends § 152.23. States that the medical cannabis statutes do not permit, or prevent the imposition of penalties for, combusting medical cannabis in any of the listed locations or where the smoke would be inhaled by a minor child.

78 **Tribal medical cannabis programs.**

Adds subd. 5 to § 152.25. Requires the commissioner to determine if tribal medical cannabis programs meet or exceed the standards in state law for the state medical cannabis program. If the commissioner determines a tribal medical cannabis program meets or exceeds the standards in state law, requires the commissioner to recognize the tribal program and post on the Department of Health website, the tribal programs that have been recognized.

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79 **Rulemaking.**

Amends § 152.26. Allows the commissioner to adopt or amend rules to implement the addition of dried raw cannabis as an allowable form of medical cannabis, allows the commissioner to adopt rules using the procedure to adopt exempt rules, and provides that the two-year limit on the effect of such rules does not apply to these rules.

This section is effective the day following final enactment.

80 **Patient application.**

Amends § 152.27, subd. 3. Removes a reference in the medical cannabis statutes to a health care practitioner determining, as part of the patient application, that the patient needs assistance in administering or obtaining medical cannabis due to a disability.

81 **Registered designated caregiver.**

Amends § 152.27, subd. 4. In the medical cannabis statutes governing registered designated caregivers, removes a requirement that a health care practitioner must certify that a patient is disabled and therefore needs assistance in administering or obtaining medical cannabis in order for the commissioner to register a designated caregiver for the patient. Allows a registered designated caregiver to be caregiver for up to six patients at once (rather than one patient as in current law), and counts patients who live in the same residence as one patient.

82 **Patient enrollment.**

Amends § 152.27, subd. 6. Under current law a patient enrolled in the registry program whose enrollment is revoked for violating specified patient duties or committing certain prohibited acts is permanently prohibited from enrollment in the medical cannabis program. This section strikes language making this conduct a ground for denying a patient's enrollment, and instead allows a patient to apply for reenrollment 12 months after the patient's enrollment was revoked. Also prohibits the commissioner from denying an application for registration or revoking enrollment solely because the patient is also enrolled in a tribal medical cannabis program.

83 **Health care practitioner duties.**

Amends § 152.28, subd. 1. Deletes from the list of health care practitioner duties under the medical cannabis statutes, the duty of determining whether a patient is disabled and needs assistance administering or obtaining medical cannabis due to that disability.

Section	Description - Article 3: Health Department

84 **Manufacturer; requirements.**

Amends § 152.29, subd. 1. Allows a medical cannabis manufacturer to acquire hemp products produced by a hemp processor licensed by the commissioner of agriculture under chapter 18K. (Under current law a manufacturer is authorized to acquire hemp from a hemp grower.) Allows a manufacturer to manufacture or process hemp products into an allowable form of medical cannabis, and makes hemp products subject to the quality control, security, testing, and other requirements that apply to medical cannabis. Requires a manufacturer's operating documents to include procedures for the delivery and transportation of hemp products between hemp processors and manufacturers, and requires a manufacturer to verify that a hemp processor is licensed under chapter 18K before acquiring hemp products from the processor.

85 **Manufacturer; distribution.**

Amends § 152.29, subd. 3. Modifies requirements for distribution of medical cannabis, to:

- allow pharmacist consultations to occur by telephone or other remote means, in addition to by videoconference as permitted under current law (consultations by telephone or other remote means are currently permitted by executive order during the peacetime emergency);
- eliminate a requirement that the pharmacist consultation occur when the patient is at the distribution facility;
- provide that a pharmacist consultation is not required when the manufacturer is distributing medical cannabis according to a patient-specific dosage plan and is not modifying the dosage or product; and
- specify that medical cannabis in dried raw cannabis form shall be distributed only patients age 21 or older or their caregivers.

Paragraph (e) is effective the earlier of (1) March 1, 2022, or (2) a date by which rules on combustion of dried raw cannabis are in effect and independent laboratories are able to perform the required tests of dried raw cannabis.

86 **Distribution to recipient in a motor vehicle.**

Adds subd. 3b to § 152.29. Allows a manufacturer to distribute medical cannabis to a patient, registered designated caregiver, or other caregiver who is at the distribution facility but remains in a motor vehicle, provided the requirements in the subdivision are met regarding the distribution of medical cannabis and payment. (Dispensing medical cannabis to patients and caregivers who remain in their vehicles is currently permitted by executive order during the peacetime emergency.)

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87	**Disposal of medical cannabis plant root balls.** Adds subd. 3c to § 152.29. An administrative rule currently requires medical cannabis manufacturers to render plant material waste unusable and unrecognizable by grinding the waste and incorporating it with other solid waste. This section exempts manufacturers from being required to grind medical cannabis plant root balls or to incorporate the root balls with other solid waste before transporting them to another location for disposal.
88	**Data practices.** Amends § 152.31. Allows the commissioner of health to execute data sharing arrangements with the commissioner of agriculture to verify licensing, inspection, and compliance information related to hemp processors (in addition to hemp growers as permitted under current law).
89	**Discrimination prohibited.** Amends § 152.32, subd. 3. Specifies that the protections in this subdivision also apply to persons enrolled in a tribal medical cannabis program.
90	**Identification card for homeless youth.** Adds subd. 3b to § 171.07. Authorizes a homeless youth to obtain a Minnesota identification card without paying transaction or filing fees. Sets documentation requirements that apply instead of administrative rules requiring proof of identity, Minnesota residency, and lawful presence in the United States. This section is effective the day following final enactment for identification card issuances starting January 1, 2022.
91	**Wrongfully obtaining assistance.** Amends § 256.98, subd. 1. In a subdivision making it a crime to wrongfully obtain certain public assistance, changes a term used related to WIC and makes a technical change.
92	**Lead risk assessments.** Amends § 256B.0625, subd. 52. Updates a cross-reference to conform with a paragraph relettering in section 144.9504, subdivision 2.
93	**Asbestos-related work.** Amends § 326.71, subd. 4. Amends a definition of asbestos-related work for sections governing asbestos abatement, to remove an exception to the asbestos abatement requirements for work on asbestos-containing floor tiles and sheeting, roofing

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materials, siding, and ceilings in single family homes and buildings with four or fewer dwelling units.

94 **Licensing fee.**

Amends § 326.75, subd. 1. Increases the licensing fee to perform asbestos-related work from $100 to $105.

95 **Certification fee.**

Amends § 326.75, subd. 2. Increases the fee for certification as an asbestos worker or asbestos site supervisor from $50 to $52.50. Establishes in statute a $105 fee for certification as an asbestos inspector, asbestos management planner, or asbestos project designer (current fees are established in Minnesota Rules, chapter 4620, and are $100 per certification), and removes authority for the commissioner to establish these certification fees by rule.

96 **Permit fee.**

Amends § 326.75, subd. 3. Increases the project permit fee that must be paid to the commissioner for asbestos-related work from one percent to two percent of the total costs of the asbestos-related work.

97 **Housing with services establishment registration; conversion to assisted living facility license.**

Amends Laws 2020, Seventh Special Session chapter 1, article 6, section 12, subd. 4. Corrects a cross-reference in a subdivision governing conversion of housing with services establishments from registration to assisted living facility licensure.

This section is effective retroactively from December 17, 2020.

98 **Additional member to COVID-19 vaccine allocation advisory group.**

Requires the commissioner of health to appoint an expert on vaccine disinformation to the state COVID-19 Vaccine Allocation Advisory Group no later than an unspecified date.

This section is effective the day following final enactment.

99 **Federal Schedule I exemption application for the medical use of cannabis.**

By September 1, 2021, requires the commissioner of health to apply to the Drug Enforcement Administration's Office of Diversion Control for an exception to federal controlled substances rules, and request formal acknowledgment that the listing of marijuana, marijuana extract, and tetrahydrocannabinols as controlled substances in federal Schedule I does not apply to the use of medical cannabis under the medical cannabis program.

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100 **Mental health cultural community continuing education grant program.**

Requires the commissioner of health to develop a grant program to provide the continuing education needed by social workers, marriage and family therapists, psychologists, and professional clinical counselors who are members of communities of color or underrepresented communities and who work for community mental health providers, to become supervisors.

101 **Recommendations; expanded access to data from all-payer claims database.**

Requires the commissioner of health to develop recommendations to expand access to data in the all-payer claims database to additional outside entities for public health or research purposes, and specifies what the commissioner must address in the recommendations. Requires the recommendations to be submitted by December 15, 2021, to the chairs and ranking minority members of certain legislative committees.

102 **Skin lightening products public awareness and education grant program.**

Requires the commissioner of health to establish a skin lightening products public awareness and education grant program, specifies organizations eligible for and prioritized for grants, and specifies how grant funds must be used.

Subd. 1. Establishment; purpose. Requires the commissioner of health to develop a grant program to increase public awareness and education on the dangers of using skin lightening creams and products that contain mercury.

Subd. 2. Grants authorized. Directs the commissioner to award grants using a request for proposal process to community-based, nonprofit organizations that focus on public health outreach to Black, Indigenous, and people of color communities on issues of chemical exposure from skin lightening products. Requires the commissioner to prioritize organizations that have historically served ethnic communities on this issue for the past three years.

Subd. 3. Grant allocation. Requires grant recipients to use grant funds for public awareness and education activities on the listed topics. Lists information a grant application must include.

103 **Trauma-informed gun violence reduction; pilot program.**

Requires the commissioner of health to establish a gun violence reduction pilot program, requires the commissioner to develop program protocols and guidelines, and requires the commissioner to submit a progress report to certain members of the legislature.

Subd. 1. Pilot program. Directs the commissioner of health to establish a pilot program to reduce trauma resulting from gun violence and to address the root causes of gun violence, by making the following resources available to health, law

Section **Description - Article 3: Health Department**

enforcement, and advocacy professionals likely to encounter individuals affected by or involved in gun violence: training, skills development, investments in community-based organizations to provide high-quality services to individuals in need, replication and expansion of effective gun violence prevention initiatives, and education campaigns and outreach materials.

Subd. 2. Program guidelines and protocols. Requires the commissioner, with advice from an advisory panel, to develop protocols and program guidelines for resources and training used by professionals likely to encounter individuals affected by or involved in gun violence. Specifies what the materials must address and what the protocols must include. Allows the commissioner to contract with community-based organizations to perform activities required by this section.

Subd. 3. Report. By November 15, 2021, requires the commissioner to submit a report on the progress of the pilot program to the chairs and ranking minority members of the committees with jurisdiction over health and public safety.

104 **Revisor instruction.**

Directs the revisor of statutes to modify the headnote for section 62J.63.

105 **Repealer.**

Repeals the following:

- section 62J.63, subd. 3 (requiring the commissioner of health to annually report to the legislature on the operations and impact of the Center for Health Care Purchasing Improvement; other sections in this article eliminate this center from statutes);
- section 144.0721, subd. 1 (an obsolete subdivision on assessing appropriateness and quality of care and services to private paying residents in nursing homes and certified boarding care homes);
- section 144.0722 (a section governing resident reimbursement classifications for residents of nursing homes and boarding care homes);
- section 144.0724, subd. 10 (a subdivision specifying the statute under which reconsideration requests for case mix classifications are determined); and
- section 144.693 (a section requiring reports from insurers providing health professional liability insurance to the commissioner of health on closed or filed malpractice claims, and requiring annual reports from the commissioner to the legislature on malpractice claims).

Article 4: Health-Related Licensing Boards

This article modifies mental health professional licensing board composition and continuing education requirements, allows emergency medical personnel certified by the Emergency Medical Services Regulatory Board to provide emergency medical care to a police dog wounded in the line of duty without a veterinary license, and requires the mental health professional licensing boards to develop recommendations related to licensing supervision.

Section	Description – Article 4: Health-Related Licensing Boards
1	**Members.** Amends § 148.90, subd. 2. For the Board of Psychology, requires that, at the time of their appointments, at least two members of the board reside outside of the 11-county metropolitan area, and at least two members are members of a community of color or underrepresented community.{Enter summary}
2	**Continuing education.** Amends § 148.911. Requires at least four of the required continuing education hours for licensed psychologists to be on increasing knowledge, understanding, self-awareness, and skills to competently address the needs of clients from diverse backgrounds. Lists topics for continuing education. Makes this section effective July 1, 2023.
3	**Creation.** Amends § 148B.30, subd. 1. For the Board of Marriage and Family Therapy, requires that, at the time of their appointments, at least two members of the board reside outside of the 11-county metropolitan area, and at least two members are members of a community of color or underrepresented community.
4	**Duties of the board.** Amends § 148B.31. Requires at least four of the required continuing education hours for licensed marriage and family therapists to be on increasing knowledge, understanding, self-awareness, and skills to serve clients from diverse backgrounds. Lists topics for continuing education. Makes this section effective July 1, 2023.
5	**Board of Behavioral Health and Therapy.** Amends § 148B.51. For the Board of Behavioral Health and Therapy, requires that, at the time of their appointments, at least three members of the board reside outside of the 11-county metropolitan area, and at least three members are members of a community of color or underrepresented community.

Section	Description – Article 4: Health-Related Licensing Boards
6	**Continuing education.** Requires at least four of the required continuing education hours for licensed professional counselors and licensed professional clinical counselors to be on increasing knowledge, understanding, self-awareness, and skills to serve clients from diverse backgrounds. Lists topics for continuing education. Makes this section effective July 1, 2023.
7	**Cultural responsiveness.** Amends § 148E.101 by adding subd. 7f. Defines "cultural responsiveness" for purposes of the Board of Social Work chapter.
8	**Total clock hours required.** Amends § 148E.130, subd. 1. Adds four hours of cultural responsiveness training to required clock hours for social work continuing education.
9	**New content clock hours required effective July 1, 2021.** Amends § 148E.130 by adding subd. 1b. Adds effective dates for social work continuing education requirements.
10	**Authorized activities.** Amends § 156.12, subd. 2. Allows emergency medical personnel certified by the Emergency Medical Services Regulatory Board to provide emergency medical care to a police dog wounded in the line of duty without being licensed by the Board of Veterinary Practice.
11	**Mental health professional licensing supervision.** Requires the mental health professional licensing boards to develop recommendations on: ▪ providing certification of individuals across multiple mental health professions to serve as supervisors; ▪ adopting a single, common supervision certificate for all mental health professional education programs; ▪ determining ways for internship hours to be counted toward licensure; and ▪ determining ways for practicum hours to count toward supervisory experience. Requires a report to the legislature on the recommendations by February 1, 2023.

Article 5: Prescription Drugs

This article contains provisions related to prescription drug costs, health carrier and pharmacy benefit manager requirements related to prescription drugs, drug temperature monitoring, and the drug repository program.

Section	Description - Article 5: Prescription Drugs

1 **Definitions.**

Adds § 62J.841. Defines the following terms: Consumer Price Index, generic or off-patent drug, manufacturer, prescription drug, wholesale acquisition cost, and wholesale distributor.

2 **Excessive price increases prohibited.**

Adds § 62J.842.

Subd. 1. Prohibition. Prohibits a manufacturer from imposing, or causing to be imposed, an excessive price increase, whether directly or through a wholesale distributor, pharmacy, or similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or delivered to consumers in the state.

Subd. 2. Excessive price increase. Provides that a price increase is excessive when:

3) the price increase, adjusted by the CPI, exceeds: (i) 15 percent of the WAC over the immediately preceding calendar year; or (ii) 40 percent of the WAC over the three immediately preceding calendar years; and
4) the price increase, adjusted by the CPI, exceeds $30 for a 30-day supply, or course of treatment lasting less than 30 days.

Subd. 3. Exemption. States that it is not a violation of this section for a wholesale distributor or pharmacy to increase the price of a generic or off-patent drug if the increase is directly attributable to additional costs imposed by the manufacturer.

3 **Registered agent and office within the state.**

Adds § 62J.843. Requires manufacturers of generic or off-patent drugs made available in the state to maintain a registered agent and office within the state.

4 **Enforcement.**

Adds § 62J.844.

Subd. 1. Notification. Requires the commissioner of management and budget and any other state agency that provides or purchases a pharmacy benefit except the Department of Human Services, and any entity under contract with a state agency to provide a pharmacy benefit, other than an entity under contract with

Section Description - Article 5: Prescription Drugs

the Department of Human Services, to notify the manufacturer of the drug, the attorney general, and the Board of Pharmacy of any price increase of a generic or off-patent drug that violates section 62J.842.

Subd. 2. Submission of drug cost statement and other information by manufacturer; investigation by attorney general. (a) Requires the manufacturer, within 45 days of receiving notice under subdivision 1, to submit a drug cost statement to the attorney general. Requires the statement to:

1) itemize the cost components related to drug production;
2) identify the circumstances and timing of any increase in materials or manufacturing costs that caused any price increase, in the preceding calendar year or preceding three calendar years as applicable; and
3) provide any other information the manufacturer believes to be relevant.

(b) Allows the attorney general to investigate whether a violation has occurred, is occurring, or is about to occur, in accordance with section 8.31, subdivision 2 (general investigative powers of the attorney general).

Subd. 3. Petition to court. (a) Allows a court, on petition of the attorney general, to issue an order:

1) compelling the manufacturer to provide the drug cost statement, and answer interrogatories, produce records or documents, or be examined under oath, as required by the attorney general;
2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including restoring drug prices to levels that comply with section 62J.842;
3) requiring the manufacturer to account for all revenues resulting from a violation of section 62J.842;
4) requiring the manufacturer to repay all consumers, including third-party payers, any money acquired as a result of a price increase that violates section 62J.842;
5) requiring that all revenues generated from a violation of section 62J.842 be remitted to the state and deposited into a special fund, to be used to reduce consumer drug costs, if the manufacturer is unable to determine the individual transactions necessary to make repayments under clause (4);
6) imposing a civil penalty of up to $10,000 per day for each violation of section 62J.842;
7) providing for the recovery of costs and disbursements incurred by the attorney general in bringing an action; and

Section	Description - Article 5: Prescription Drugs

8) providing any other appropriate relief, including any other equitable relief as determined by the court.

(b) Provides that for purposes of paragraph (a), clause (6), requires every individual transaction in violation of section 62J.842 to be considered a separate violation.

Subd. 4. Private right of action. States that any action brought by a person injured by a violation of this section is for the benefit of the public.

5 **Prohibition on withdrawal of generic or off-patent drugs for sale.**

Adds § 62J.845.

Subd. 1. Prohibition. Prohibits a manufacturer of a generic or off-patent drug from withdrawing that drug from sale or distribution in the state for purposes of avoiding the prohibition on excessive price increases.

Subd. 2. Notice to board and attorney general. Requires any manufacturer that intends to withdraw a generic or off-patent drug from sale or distribution in the state to provide 180 days' written notice of withdrawal to the Board of Pharmacy and the attorney general.

Subd. 3. Financial penalty. Requires the attorney general to assess a $500,000 penalty on any manufacturer that it determines has failed to comply with the requirements of this section.

6 **Severability.**

Adds § 62J.846. Provides that the provisions of sections 62J.841 to 62J.845 are severable.

7 **Prescription drug benefits.**

Amends § 62Q.81, by adding subd. 6.

(a) Requires that 25 percent of the individual health plans offered by an insurer apply a predeductible flat-dollar amount co-pay structure for prescription drugs.

(b) Requires that 25 percent of the small group health plans offered by an insurer apply a predeductible flat-dollar co-pay structure for prescription drugs.

(c) Limits the highest co-pay under this subdivision to 1/12 of the plan's out-of-pocket maximum.

Section **Description - Article 5: Prescription Drugs**

(d) Requires the co-pay structure for prescription drugs under this subdivision to be graduated and proportionate.

(e) Requires individual and small group health plans offered under this subdivision to be clearly named, marketed in the same way as other health plans, and offered for purchase to any individual or small group.

(f) Clarifies that this subdivision does not apply to catastrophic plans, grandfathered plans, large group health plans, health savings accounts (HSA), qualified high deductible health benefit plans, limited health benefit plans, or short-term limited-duration health insurance policies.

(g) Requires health plans to meet the requirements of this subdivision separately for plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

Effective date: This section is effective January 1, 2022, and applies to individual and small group health plans offered, issued, or renewed on or after that date.

8 **Prescription drug benefit transparency and management.**

Adds § 62Q.83.

Subd. 1. Definitions. Defines the following terms: drug, enrollee contract term, formulary, health plan company, pharmacy benefits management, and prescription. “Enrollee contract term” is defined as a 12-month term for health plan company products and a calendar quarter for managed care and county-based purchasing plans under MA and MinnesotaCare.

Subd. 2. Prescription drug benefit disclosure. (a) Requires a health plan company that provides drug coverage and uses a formulary to make its formulary and related benefit information available by electronic means, and upon request in writing, at least 30 days prior to annual renewal dates.

(b) Requires formularies to be organized and disclosed consistent with the most recent version of the United States Pharmacopeia’s Model Guidelines.

(c) Requires the specific enrollee benefit terms, including cost-sharing and out-of-pocket costs, to be identified for each item or category of items on the formulary.

Subd. 3. Formulary changes. (a) Allows a health plan company, at any time during a contract term, to expand the formulary, reduce copayments or coinsurance, or move a drug to a lower cost benefit category.

(b) Allows a health plan company to remove a brand name drug from the formulary or place the drug in a higher cost benefit category only if a generic or

Section	Description - Article 5: Prescription Drugs

multisource drug rated as therapeutically equivalent, or a biologic drug rated as interchangeable, that is at a lower cost to the enrollee, is added, with at least 60 days' notice.

(c) Allows a health plan company to change utilization review requirements or move drugs to a higher cost benefit category, that increases enrollee costs during a contract term, only with 60 days' notice, and provides that the changes do not apply to enrollees taking the drugs for the duration of the contract term.

(d) Allows a health plan company to remove drugs from its formulary that have been deemed unsafe by the Food and Drug Administration (FDA), been withdrawn by the FDA or manufacturer, or when an independent source of research, guidelines, or standards has issued drug-specific warnings or recommended changes in drug usage.

9 **Alternative biological products.**

Adds § 62W.0751.

Subd. 1. Definitions. Defines the following terms: biological product, biosimilar or biosimilar product, interchangeable biological product, and reference biological product.

Subd. 2. Pharmacy and provider choice related to dispensing reference biological products, interchangeable biological products, or biosimilar products. (a) Prohibits a PBM or health carrier from requiring or demonstrating a preference for a pharmacy or health care provider to prescribe or dispense a single biological product for which there is a U.S. Food and Drug Administration (FDA) approved biosimilar or interchangeable biological product, except as provided in paragraph (b).

(b) If a PBM or health carrier elects coverage of a product listed in paragraph (a), requires the PBM or health carrier to also elect equivalent coverage for at least three reference, biosimilar, or interchangeable biological products, or the total number of FDA approved products relative to the reference product if less than three, for which the wholesale acquisition cost (WAC) is less than the WAC of the product listed in paragraph (a).

(c) Prohibits a PBM or health carrier from imposing limits on access to a product required to be covered in paragraph (b) that are more restrictive than the limits imposed on a product listed in paragraph (a) or that have the effect of giving preferred status to the product listed in paragraph (a).

(d) Provides that the section does not apply to MA, MinnesotaCare, or SEGIP coverage.

Section	Description - Article 5: Prescription Drugs

Provides a January 1, 2022, effective date.

10 **Gag clause prohibition.**

Amends § 62W.11. Provides that a PBM or health carrier must not prohibit a pharmacist or pharmacy from discussing with patients the pharmacy's acquisition cost for a prescription drug and the amount the pharmacy is being reimbursed by the PBM or health carrier for the drug.

Also provides that a PBM must not prohibit a pharmacist or pharmacy from discussing with the health carrier the amount the pharmacy is being paid or reimbursed for a prescription drug by the PBM or the pharmacy's acquisition cost for a drug.

11 **Point of sale.**

Amends § 62W.12. Prohibits a PBM or health carrier from requiring an enrollee to pay at the point of sale of a prescription drug an amount greater than the net price of the prescription drug plus the dispensing fee. Defines "net price" as the PBM's or health carrier's cost for the drug, after any rebates or discounts received or accrued directly or indirectly. Provides an effective date of January 1, 2022.

12 **Biosimilar product.**

Amends § 151.01, by adding subd. 43. Defines "biosimilar" or "interchangeable biological product" as a biological product that the FDA has licensed and determined to be biosimilar.

Provides a January 1, 2022, effective date.

13 **Reference biological product.**

Amends § 151.01, by adding subd. 44. Defines "reference biological product" as the single biological product for which the FDA has approved an initial biological product license application, against which other biological products are evaluated for licensure as biosimilar or interchangeable. Provides a January 1, 2022, effective date.

14 **Forms of disciplinary action.**

Amends § 151.071, subd. 1. Allows the Board of Pharmacy to impose a civil penalty not exceeding $25,000 for each separate violation of section 62J.842.

15 **Grounds for disciplinary action.**

Amends § 151.071, subd. 2. Provides that a violation of section 62J.842 or section 62J.845 by a manufacturer is grounds for the Board of Pharmacy to take disciplinary action.

Section	Description - Article 5: Prescription Drugs
16	**Delivery through common carrier; compliance with temperature requirements.** Adds § 151.335. Requires mail order or specialty pharmacies that use the U.S. Postal Service or other common carrier to deliver a drug to a patient to ensure that the drug is delivered in compliance with manufacturer temperature requirements. Requires the pharmacy to develop policies and procedures consistent with the U.S. Pharmacopeia and with nationally recognized standards issued by entities recognized by the board through guidance. Requires the policies and procedures to be provided to the board upon request.
17	**Definitions.** Amends § 151.555, subd. 1. Includes over-the-counter medications in the definition of drugs that may be donated to the drug repository program. Provides an immediate effective date.
18	**Standards and procedures for inspecting and storing donated prescription drugs and supplies.** Amends § 151.555, subd. 7. The amendment to paragraph (b) eliminates the requirement that donated drugs and supplies that are not inspected immediately upon receipt be quarantined separately from dispensing stock until inspection. The amendment to paragraph (f) reduces from five to two years the time period during which a repository must maintain records of drugs and supplies that are destroyed because they are not dispensed, subject to recall, or not suitable for donation. Provides an immediate effective date.
19	**Forms and record-keeping requirements.** Amends § 151.555, subd. 11. Reduces from five to two years the time period during which a repository must maintain all records. Provides an immediate effective date.
20	**Cooperation.** Amends § 151.555, by adding subd. 14. Allows the central repository, with the approval of the Board of Pharmacy, to enter into an agreement with another state that has a drug repository or drug donation program that meets specified standards, to permit the central repository to offer inventory to another state program, and to accept inventory from another state program. Provides an immediate effective date.
21	**Service delivery.** Amends § 256B.69, subd. 6. Requires managed care plans and county-based purchasing plans under Medical Assistance to comply with § 62Q.83.
22	**Study of pharmacy and provider choice of biological products.** Requires the commissioner of health, within the limits of existing resources, to analyze the effect of section 62W.0751 on the net price for different payors of

Section	Description - Article 5: Prescription Drugs
	biological products, interchangeable biological products, and biosimilar products. Requires the commissioner to report to the legislature by December 15, 2023.
23	**Study of temperature monitoring.** Requires the Board of Pharmacy to study the appropriateness and feasibility of requiring mail order and specialty pharmacies to enclose in each medication's packaging a method for the patient to detect improper storage and temperature violations. Requires the board to report to the legislature by January 15, 2022.

Article 6: Health Insurance

This article makes changes to health insurance statutes. These changes include modifying provisions related to the Affordable Care Act in state statute and removing references to the Affordable Care Act; establishing requirements for timely provider credentialing; prohibiting lifetime and annual limits on screenings and urinalysis tests for opioids; and establishing requirements for coverage of contraceptives and contraceptive services.

Section	Description - Article 6: Health Insurance
1	**Required provisions.** Amends § 62A.04, subd. 2. Amends a subdivision specifying required provisions for health insurance policies, to delete a reference to qualified health plans and instead refer to individual and small group health plans, and to replace a reference to the ACA with a reference to section 62A.65, subd. 2a that governs a grace period for nonpayment of premiums. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.
2	**Prohibition on waiting periods that exceed 90 days.** Adds subd. 5 to § 62A.10. Prohibits a health carrier offering a group health plan from having an individual who is eligible to enroll in the plan wait to enroll for longer than 90 days. Makes an exception for employees for whom the employer takes time to determine the employee's eligibility, prohibits a cumulative hours of service requirement from exceeding 1,200 hours, allows an orientation period of one month or less to be added to the 90 days, and allows an employer to require a rehired employee to meet the employer's eligibility criteria and waiting period if doing so is reasonable.

Section	Description - Article 6: Health Insurance

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

3 **Mental health services.**

Adds subd. 3c to § 62A.15. Requires a group policy or subscriber contract that covers mental health treatment or services provided by a mental health professional to also cover treatment and services provided by a clinical trainee practicing in compliance with the medical assistance requirements for covering services provided by a clinical trainee.

This section is effective January 1, 2022 and applicable to policies and contracts offered, issued, or renewed on or after that date.

4 **Denial of benefits.**

Amends § 62A.15, subd. 4. Prohibits an insurance company or nonprofit health service plan corporation from denying benefits for services covered by a policy or contract of the services are performed by a mental health clinical trainee.

This section is effective January 1, 2022.

5 **Applicability.**

Amends § 62A.65, subd. 1. Removes an unnecessary cross-reference. Requires a health carrier to offer individual health plans on a guaranteed issue basis and at a premium rate that does not vary based on the health status of the individual.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

6 **Grace period for nonpayment of premium.**

Adds subd. 2a to § 62A.65. Allows an individual health plan to be canceled for nonpayment of premiums but requires a health carrier to provide a 3-month grace period. Allows an enrollee to stop a cancellation by paying all outstanding premiums before the end of the grace period. Provides that if a health plan is canceled under this subdivision, the final day of enrollment is the last day of the first month of the grace period.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Section	Description - Article 6: Health Insurance

7 **Co-payments.**

Amends § 62D.095, subd. 2. Removes a reference to the ACA and instead requires any co-payments and coinsurance imposed in a health maintenance contract to be consistent with state and federal law.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

8 **Deductibles.**

Amends § 62D.095, subd. 3. Removes a reference to the ACA and instead requires any deductibles imposed in a health maintenance contract to be consistent with state and federal law.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

9 **Annual out-of-pocket maximums.**

Amends § 62D.095, subd. 4. Removes a reference to the ACA and instead requires any annual out-of-pocket maximums imposed in a health maintenance contract to be consistent with section 62Q.677, subd. 6a.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

10 **Exceptions.**

Amends § 62D.095, subd. 5. Removes language prohibiting imposition of co-payments and deductibles on preventive health care services consistent with the ACA, and instead prohibits imposition of co-payments and deductibles on preventive items and services as defined in other state law.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

11 **Dependent child to the limiting age.**

Amends § 62Q.01, subd. 2a. Removes a reference to the ACA in a subdivision prohibiting a health plan company from denying health plan eligibility for a dependent child under age 26.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Section	Description - Article 6: Health Insurance

12 **Requirements for timely provider credentialing.**

Adds § 62Q.097. Establishes requirements governing the process of health care provider credentialing by health plan companies.

Subd. 1. Definitions. Defines terms for this section: clean application for provider credentialing or clean application; and provider credentialing.

Subd. 2. Time limit for credentialing determination. Requires a health plan company that receives an application for provider credentialing to do the following. If the application is a clean application and if the provider so requests, the health plan company must notify the provider that the application is clean and specify when the health plan company will make a determination on the application. If the application is not a clean application, the health plan company must notify the provider of the application's deficiencies within 3 business days after a determination that the application is not clean. A health plan company must make a determination on a clean application within 45 days after receipt and, upon notice to the provider, clinic, or facility, may take 30 additional days to investigate quality or safety concerns.

This section applies to applications for provider credentialing submitted on or after January 1, 2022.

13 **Preventive items and services.**

Amends § 62Q.46.

Subd. 1. Coverage for preventive items and services. Amends a definition for preventive items and services by removing a reference to the definition of that term in the ACA and instead adding a reference to subdivision 1a.

Subd. 1a. Preventive items and services. Requires the commissioner of commerce to provide health plan companies with information on which items and services must be categorized as preventive.

Subd. 3. Additional services not prohibited. Removes references to the ACA and instead refers to preventive items and services categorized as preventive under subdivision 1a.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

14 **Screening and testing for opioids.**

Adds § 62Q.472. Prohibits a health plan company from placing lifetime or annual limits on screenings and urinalysis testing for opioids for enrollees in SUD treatment programs, when ordered by a health care provider and performed by an accredited

Section **Description - Article 6: Health Insurance**

clinical laboratory. Allows a health plan company to perform medical necessity review for more than 24 screenings or urinalysis tests per 12 months. Specifies that this section does not apply to managed care plans and county-based purchasing plans covering MA or MinnesotaCare enrollees.

This section is effective January 1, 2022, and applies to health plans offered, issued, or renewed on or after that date.

15 **Coverage of contraceptives and contraceptive services.**

Adds § 62Q.521. Establishes requirements for coverage of contraceptives and contraceptive services.

Subd. 1. Definitions. Defines terms for this section: closely held for-profit entity, contraceptive, contraceptive service, eligible organization, medical necessity, religious employer, and therapeutic equivalent version.

Subd. 2. Required coverage; cost sharing prohibited. Paragraph (a) requires a health plan to cover prescription contraceptives and contraceptive services.

Paragraph (b) prohibits health plan companies from imposing cost-sharing on contraceptives or contraceptive services.

Paragraph (c) requires high-deductible health plans with a health savings account to include cost-sharing for contraceptives and contraceptive services at the minimum amount necessary for the enrollee to make tax-exempt contributions and withdrawals from the health savings account.

Paragraph (d) prohibits a health plan company from imposing referral requirements, restrictions, or delays for contraceptives or contraceptive services.

Paragraph (e) requires a health plan company to include at least one type of each FDA-approved contraceptive in its formulary. Clarifies that all therapeutic equivalent versions do not need to be included in the formulary.

Paragraph (f) requires health plan companies to list the contraceptives and contraceptive services that are covered without cost-sharing in an easily accessible manner. Requires the list to be promptly updated to reflect changes.

Paragraph (g) requires a health plan company to provide coverage without cost-sharing if an enrollee's health care provider recommends a particular contraceptive or contraceptive service for the enrollee based on medical necessity.

Subd. 3. Religious employers; exempt. Paragraph (a) allows a religious employer to not cover contraceptives or contraceptive services if the employer has

Section	Description - Article 6: Health Insurance

religious objections. Requires a religious employer to notify employees as part of the hiring process and all employees at least 30 days before enrollment in the health plan or the effective date of the health plan, whichever is first.

Paragraph (b) provides that if the religious employer covers some contraceptives or contraceptive services, the notice in para. (a) must include a list of what the employer does not cover.

Subd. 4. Accommodation for eligible organizations. Paragraph (a) allows an eligible organization to not cover contraceptives or contraceptive services if the eligible organization notifies the health plan company that it has a religious objection to coverage for all or some contraceptives or contraceptive services.

Paragraph (b) requires the notice from an eligible organization to include certain information.

Paragraph (c) requires an eligible organization to provide this notice to prospective employees as part of the hiring process and to all employees at least 30 days before enrollment in the health plan or at least 30 days before the effective date of the health plan, whichever is first.

Paragraph (d) requires a health plan company that receives notice from an eligible organization to either: (1) exclude coverage for some or all contraceptives or contraceptive services and provide separate payment for any contraceptive or service required to be covered under subdivision 2; or (2) arrange for another entity to provide payments for contraceptive services for plan participants and beneficiaries without imposing cost-sharing, premiums, or other charges on the eligible organization, health plan, participant, or enrollee.

Paragraph (e) prohibits a health plan company from imposing cost-sharing requirements, premiums, or other charges for contraceptives or contraceptive services to the eligible organization, health plan, or enrollee.

Paragraph (f) requires a health plan company to provide the commissioner of commerce with the number of eligible organization accommodations granted under this subdivision each year.

This section is effective January 1, 2022, and applies to coverage offered, sold, issued, or renewed on or after that date.

16 **Coverage for prescription contraceptives; supply requirements.**

Adds § 62Q.522. Requires health plans to cover a 12-month supply for a prescription contraceptive, with certain exceptions.

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Subd. 1. Scope of coverage. Requires health plans that provide prescription coverage to comply with this section, not including religious employers.

Subd. 2. Definition. Defines prescription contraceptive as a drug or device that requires a prescription and is approved by the FDA to prevent pregnancy. States that emergency contraceptives are not prescription contraceptives.

Subd. 3. Required coverage. Requires a health plan to cover a 12-month supply for a prescription contraceptive, and requires the prescribing provider to determine the appropriate number of months to prescribe the contraceptive, up to 12 months.

This section is effective January 1, 2022, and applies to coverage offered, sold, issued, or renewed on or after that date.

17 **Out-of-pocket annual maximum.**

Adds subd. 6a to § 62Q.677. By October of each year, requires the commissioner of commerce to determine the maximum annual out-of-pocket limits that apply to individual and small group health plans.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

18 **Essential health benefit package requirements.**

Amends § 62Q.81.

Subd. 1. Essential health benefits package. Removes cross-references to the ACA and inserts appropriate references to subdivisions in this section governing essential health benefits and metal levels for health plans.

Subd. 2. Cost-sharing; coverage for enrollees under the age of 21. Paragraph (a) specifies what is and is not included in cost-sharing.

Paragraph (b) limits cost-sharing per year for individual health plans to the amount allowed under the Internal Revenue Code plus a premium adjustment percentage.

Paragraph (c) limits cost-sharing per year for small group health plans to twice the amount allowed for individual health plans.

In paragraph (d) a reference to the ACA is stricken and a cross-reference is modified.

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Subd. 3. Levels of coverage; alternative compliance for catastrophic plans. Requires bronze, silver, gold, and platinum level health plans offered by health carriers to be actuarially equivalent to a certain percentage of the actuarial value of the benefits provided. Specifies circumstances under which catastrophic health plans may be sold and what those plans must include. Removes references to the ACA.

Subd. 4. Essential health benefits; definition. Paragraph (a) removes a reference to the ACA to define essential health benefits and instead defines that term as the services listed in that paragraph plus additional benefits included in a typical employer plan.

Paragraph (b) provides out-of-network providers of emergency services cannot impose more restrictive prior authorization requirements or coverage limitations than those required by in-network providers. Requires cost-sharing to be equivalent between in-network and out-of-network providers for these services.

Paragraph (c) requires the scope of essential health benefits to be equal to the scope of benefits provided under a typical employer plan.

Paragraph (d) lists requirements for essential health benefits.

Subd. 5. Exception. Removes a reference to the ACA and instead provides that this section does not apply to dental plans that are limited in scope and provide pediatric dental benefits.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

19 **Laboratory, x-ray, and opioid screening services.**

Amends § 256B.0625, subd. 10. Specifies that medical assistance covers screenings and urinalysis tests for opioids without lifetime or annual limits.

This section is effective January 1, 2022.

20 **Drugs.**

Amends § 256B.0625, subd. 13. Requires medical assistance coverage for a prescription contraceptive to provide a 12-month supply and requires the prescribing provider to determine the appropriate number of months to prescribe the prescription contraceptive, up to 12 months. Defines prescription contraceptive and specifies that prescription contraceptive does not include an emergency contraceptive.

Section	Description - Article 6: Health Insurance
	This section applies to MA and MinnesotaCare coverage effective January 1, 2022.
21	**Commissioner of commerce; determination of preventive items and services.** Directs the commissioner of commerce to determine the items and services that are preventive, and lists what must be included as preventive items and services.

Article 7: Telehealth

This article expands coverage of telehealth services and requires coverage of telemonitoring, for private sector insurance coverage and health care programs and services administered by the Department of Human Services.

Section	Description - Article 7: Telehealth
1	**Coverage of services provided through telehealth.** Adds § 62A.673. Establishes requirements for the coverage of telehealth by health carriers. This section incorporates language from telemedicine requirements in sections 62A.67 to 62A.672 (these sections are repealed in the bill) and provisions from Laws 2020, chapter 74, as well as new language.

Subd. 1. Citation. States that this section may be cited as the "Minnesota Telehealth Act."

Subd. 2. Definitions. Defines the following terms: distant site, health care provider, health carrier, health plan, originating site, store-and-forward transfer, and telehealth. These definitions are modifications of those in current law in § 62A.671. Major differences include:

- The definition of "health care provider" includes mental health practitioners (one of the groups added temporarily in chapter 74) and also treatment coordinators, alcohol and drug counselors, and recovery peers.
- The definition of "telehealth" is a revision of the definition of "telemedicine" in current law. The revised definition specifically includes "audio-only communication between a health care provider and a patient" if this is a scheduled appointment and the standard of care can be met; this is not explicit in current law.
- Provides a definition of "telemonitoring services;" this term is not defined in current law.

Section **Description - Article 7: Telehealth**

Subd. 3. Coverage of telehealth. (a) Requires health plans to cover benefits delivered through telehealth in the same manner as any other benefits, and to comply with this section. (Similar to language in § 62A.672.)

(b) Prohibits coverage of telehealth services from being limited on the basis of geography, location, or distance for travel. (New provision.)

(c) Prohibits a health carrier from creating a separate provider network or providing incentives for enrollees to use a separate provider network to deliver telehealth services, if this network does not include network providers who provide in-person care for the same service. (New provision.)

(d) Allows a health carrier to include cost-sharing for a service provided through telehealth, if this cost-sharing is not in addition to, and does not exceed, cost-sharing for the same service provided in-person. (Similar to language in § 62A.67.)

(e) States that nothing in this section shall be construed to: (1) require a health carrier to provide coverage for services that are not medically necessary or not covered under the enrollee's health plan; or (2) prohibit a health carrier from:

(i) establishing safety and efficacy criteria for a particular telehealth service for which other providers are not already reimbursed under telehealth;

(ii) establishing reasonable medical management techniques; or

(iii) requiring documentation or billing practices designed to prevent fraudulent claims.

(Item (ii) and the reference in clause (1) to services covered under a health plan are new; the other provisions in this paragraph are similar to language in § 62A.672.)

(f) States that nothing in this section shall be construed to require the use of telehealth when a provider determines this is not appropriate or the enrollee chooses not to receive a health care service through telehealth. (New provision.)

Subd. 4. Parity between telehealth and in-person services. (a) Prohibits a health carrier from restricting or denying coverage of a covered health care service solely: (1) because the service is not provided in-person; or (2) based on the communication technology or application used to deliver the service through telehealth, provided the technology or application complies with this section and is appropriate for the particular service. (Clause (1) is similar to language in § 62A.672; clause (2) is new.)

Section	Description - Article 7: Telehealth

(b) Allows prior authorization to be used for a telehealth service only if it is required when the same service is delivered in-person. (New provision.)

(c) Allows a health carrier to require utilization review for a service delivered through telehealth so long as it is conducted in the same manner and uses the same clinical review criteria as utilization review for the same service delivered in-person. (New provision.)

Subd. 5. Reimbursement for services delivered through telehealth. (a) Requires health carriers to reimburse providers for telehealth services on the same basis and at the same rate as would apply had the service been delivered in-person. (Similar to language in § 62A.672.)

(b) Prohibits a health carrier from denying or limiting reimbursement solely because the service was delivered though telehealth rather than in-person. (Similar to temporary language in chapter 74.)

(c) Prohibits a health carrier from denying or limiting reimbursement based solely on the technology and equipment used by the health care provider to deliver the service through telehealth, as long as the technology and equipment meets the requirements of this section and is appropriate for the particular service. (Similar to temporary language in chapter 74.)

Subd. 6. Telehealth equipment. (a) Prohibits a health carrier from requiring a provider to use specific telecommunications technology and equipment as a condition of coverage, as long as this technology and equipment complies with current industry interoperable standards and with federal Health Insurance Portability and Accountability Act (HIPAA) standards and regulations, unless authorized under this section.

(b) Requires a health carrier to cover services delivered through telehealth by audio-only telephone communication, if this communication is a result of a scheduled appointment and the standard of care for the particular service can be met through audio-only communication. (The provisions in this subdivision are new.)

Subd. 7. Telemonitoring services. Requires a health carrier to provide coverage for telemonitoring services if: (1) the services are medically appropriate for the enrollee; (2) the enrollee is capable of operating the monitoring device or equipment, or has a caregiver willing and able to assist; and (3) the enrollee resides in a setting suitable for telemonitoring and not in a setting with health care staff on site. (The provisions in this subdivision are new.)

Provides an effective date of January 1, 2022.

Section **Description - Article 7: Telehealth**

2 **Practice of telehealth.**

Amends § 147.033. Modifies telehealth provisions in the physician licensure statute.

Subd. 1. Definition. Changes terminology from "telemedicine" to "telehealth" and modifies definition to be consistent with the definition in § 62A.673.

Subd. 2. Physician-patient relationship. Modifies terminology from "telemedicine" to "telehealth."

Subd. 3. Standards of practice and conduct. Modifies terminology from "telemedicine" to "telehealth."

3 **Prescribing and filing.**

Amends § 151.37, subd. 2. Reorganizes provision relating to examination requirement for licensed practitioners prescribing certain drugs; specifies drugs for which an examination via telehealth meets the requirements.

Makes this section effective the day following final enactment.

4 **Face-to-face.**

Amends § 245G.01, subd. 13. Modifies definition of "face-to-face" in the substance use disorder treatment program licensing chapter, to clarify that services delivered via telehealth should prioritize using combined audio and visual communication. Requires meetings to prescribe high dose medications to treat opioid use disorder to be conducted by interactive video and visual communication.

States that this section is effective January 1, 2022, or upon federal approval, whichever is later.

5 **Telehealth.**

Amends § 245G.01, subd. 26. Modifies terminology to "telehealth" and definition for "telemedicine" in the substance use disorder treatment program licensing chapter.

6 **General.**

Amends § 245G.06, subd. 1. Allows an alcohol and drug counselor to document a client's approval of a treatment plan verbally or electronically, in lieu of a signature, if a client is receiving services or an assessment via telehealth.

7 **Assessment via telehealth.**

Amends § 254A.19, subd. 5. Adds cross-reference to definition of telehealth.

Section	Description - Article 7: Telehealth

States that this section is effective January 1, 2022, or upon federal approval, whichever is later.

8 **Rate requirements.**

Amends § 254B.05, subd. 5. Modifies paragraph (f) to clarify terminology and add cross-reference to definition of telehealth.

States that this section is effective January 1, 2022, or upon federal approval, whichever is later.

9 **Payment rates.**

Amends § 256B.0621, subd. 10. Strikes a reference to a provision related to targeted case management and interactive video that is repealed in this article. States that this section is effective upon federal approval.

10 **Telehealth services.**

Amends § 256B.0625, subd. 3b. Modifies MA coverage of telehealth services, to be consistent with changes made to telemedicine coverage requirements for health carriers that are reflected in § 62A.676. Under current law, MA coverage is generally consistent with § 62A.67 to 62A.672 (these sections are repealed in the bill and modified provisions are included in § 62A.676).

The amendment to paragraph (a) eliminates the three visit per enrollee per calendar week limit on the provision of telehealth services and makes conforming changes.

The amendment to paragraph (b) allows the commissioner to establish criteria that health care providers must attest to in order to demonstrate the safety or efficacy of a service delivered through telehealth (this is required of the commissioner under current law). Also makes conforming changes.

The amendment to paragraph (c) makes conforming changes.

The amendment to paragraph (d) replaces the definition of “telemedicine” with the definition of “telehealth.” (This is the same definition as provided in § 62A.673, except that audio-only communication between a provider and patient is not covered if interactive visual and audio communication is specifically required.) The amendment to paragraph (d) also makes conforming changes in terminology.

The amendment to paragraph (e) of current law incorporates the definition of “health care provider” used in § 62A.673 (this includes adding mental health practitioners), but expands the definition to also include other mental health and substance use disorder service providers. The amendment also incorporates the definitions of originating site, distant site, and store-and-forward transfer used in § 62A.673 into the MA statute. “Distant site” and “store-and-forward transfer” had not

Section **Description - Article 7: Telehealth**

previously been defined in this section. Community paramedics and community health workers are retained in the MA definition of "health care provider" (these providers are not included in the definition of health care provider used in § 62A.673).

The amendment to paragraph (f) of current law makes a conforming change to the elimination of the three visit per week limit on the provision of telehealth services.

States that the section is effective January 1, 2022, or upon federal approval, whichever is later.

11 **Telemonitoring services.**

Amends § 256B.0625, by adding subd. 3h.

(a) States that MA covers telemonitoring services if the recipient:

9) has been diagnosed with and is receiving services for at least one specified chronic condition;
10) requires monitoring at least five times per week to manage the condition;
11) has had two or more emergency room or inpatient hospital stays within the last 12 months due to the chronic condition, or the recipient's health care provider has identified that telemonitoring would likely prevent admission or readmission to a hospital, emergency room, or nursing facility;
12) is capable of operating the monitoring device or equipment, or has a caregiver willing and able to assist; and
13) resides in a setting suitable for telemonitoring and not in a setting with health care staff on site.

(b) Provides a definition of "telemonitoring services." The definition specifies the provider types that can assess and monitor the data transmitted by telemonitoring.

12 **Medication therapy management services.**

Amends §256B.0625, subd. 13h.

The amendment to paragraph (b) eliminates the requirement that a pharmacist practice in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process, in order to be eligible for MA reimbursement for medication therapy management services.

The amendment to paragraph (c) eliminates a reference to the commissioner establishing contact requirements between the pharmacist and recipient.

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The amendment to paragraph (d) states that medication therapy management services may be provided by telehealth and delivered in a patient's residence. Strikes current law which provides coverage for the service when provided through two-way interactive video if there are no pharmacists practicing within a reasonable geographic distance. Also strikes language limiting reimbursement to situations in which both the pharmacist and patient are located in an ambulatory care setting, and prohibiting services from being transmitted into the patient's residence.

Strikes paragraph (e), which specifies requirements for the delivery of medication therapy management services into a patient's residence through secure interactive video.

13 **Mental health case management.**

Amends § 256B.0625, subd. 20. Allows medical assistance and MinnesotaCare payment for mental health case management provided through contact by interactive video that meets statutory requirements. States that this section is effective upon federal approval.

14 **Targeted case management face-to-face contact through interactive video.**

Amends § 256B.0625, subd. 20b. Allows the face-to-face contact requirements for mental health targeted case management to be met using interactive video, if this is in the best interests of the person and deemed appropriate by the recipient or legal guardian and the case management provider. Makes various clarifying and conforming changes. Also prohibits interactive video from being used to meet face-to-face contact requirements for children who are in out-of-home placement or receiving case management services for child protection reasons. Provides a definition of interactive video. States that this section is effective upon federal approval.

15 **Mental health telehealth.**

Amends § 256B.0625, subd. 46. Clarifies terminology and adds a cross-reference to the definition of telehealth.

States that this section is effective January 1, 2022, or upon federal approval, whichever is later.

16 **Definitions.**

Amends § 256B.0911, subd. 1a. Modifies the definition of "long-term care consultation services" by removing language requiring long-term care consultation assessments to be face-to-face.

Section	Description - Article 7: Telehealth

17 **Assessment and support planning.**

Amends § 256B.0911, subd. 3a. Adds paragraph (q), which requires all long-term care consultation assessments to be face-to-face unless the assessment is a reassessment that meets specified requirements such as:

14) allowing remote reassessments to be conducted by interactive video or telephone for services provided under alternative care, the elderly waiver, the developmental disabilities waiver, the CADI waiver, and the BI waiver;
15) allowing remote assessments to substitute for two consecutive reassessments if followed by a face-to-face reassessment; and
16) allowing a remote assessment if the person being assessed, the person's legal representative, and the lead agency case manager all agree that a remote reassessment is appropriate.

Gives the person being reassessed, or the person's legal representative, the right to refuse a remote reassessment at any time. Requires a certified assessor to suspend a remote reassessment and schedule a face-to-face reassessment if the certified assessor determines that a remote reassessment is inappropriate. Applies all other requirements of a face-to-face reassessment to a remote reassessment.

Also makes technical and conforming changes.

18 **Long-term care reassessments and community support plan updates.**

Amends § 256B.0911, subd 3f. Makes conforming changes in the section of statutes governing long-term care consultation services.

19 **Preadmission screening of individuals under 65 years of age.**

Amends § 256B.0911, subd. 4d. Makes conforming changes in the section of statutes governing long-term care consultation services. Also specifies criteria for remote assessments. Gives the person being reassessed, or the person's legal representative, the right to refuse a remote assessment at any time.

20 **Payment for targeted case management.**

Amends § 256B.0924, subd. 6. Allows for medical assistance and MinnesotaCare payment for targeted management provided thought contact by interactive video that meets statutory requirements. States that this section is effective upon federal approval.

21 **Medical assistance reimbursement of case management services.**

Amends § 256B.094, subd. 6. Allows for case management face-to-face contacts for clients or children placed more than 60 miles from the county or tribal boundaries to

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occur via interactive video for up to two consecutive contacts following each in-person contact. States that this section is effective upon federal approval.

22 **Assessment and reassessment.**

Amends § 256B.49, subd. 14. Removes language requiring assessments to be face-to-face in the section of statutes governing home and community-based service waivers for persons with disabilities.

23 **Submitting application form.**

Amends § 256J.09, subd. 3. Modifies county agency duties related to the information the agency must provide to potential MFIP applicants by requiring the agency to inform a person that the application may be submitted by telephone or through Internet telepresence and the interview may be conducted by telephone. Makes technical and conforming changes.

24 **County agency to provide orientation.**

Amends § 256J.45, subd. 1. Removes the requirement that the MFIP orientation be provided face-to-face.

25 **Nursing facility level of care determination required.**

Amends § 256S.05, subd. 2. Makes a conforming change in the chapter of statutes governing the elderly waiver related to the changes in long-term care consultation assessments.

26 **Study of telehealth.**

(a) Requires the commissioner of health, in consultation with the commissioners of human services and commerce, to study the impact of telehealth payment methodologies and expansion under this act on the coverage and provision of health care services in public and private sector health coverage. Requires the study to review specified topics.

(b) Requires the commissioner to consult with stakeholders and communities, and allows the commissioner to use data from the all-payer claims database. Requires the commissioner to report to the legislature by February 15, 2023.

27 **Effective date.**

Provides that the sections in the article related to medical assistance and DHS substance use disorder treatment are effective January 1, 2022.

Section	Description - Article 7: Telehealth
28	**Expiration date.** Provides that the sections in the article related to medical assistance and DHS substance use disorder treatment expire July 1, 2023. Exempts the definition of "originating site" from expiration.
29	**Revisor instruction.** Directs the revisor to substitute the term "telehealth" for "telemedicine" in Minnesota Statutes and Minnesota Rules, and to substitute "section 62A.673" whenever references to sections 62A.67, 62A.671, and 62A.672 appear.
30	**Repealer.** (a) Repeals sections 62A.67, 62A.671, and 62A.672 (current law governing coverage of telemedicine services by health carriers). (b) Repeals sections 256B.0956 (county contracts for mental health case management) and 256B.0924, subd. 4a (targeted case management through interactive video), effective upon federal approval.

Article 8: Economic Supports

This article provides for economic cash assistance uniformity, clarifies public assistance statutes, provides for MFIP cost of living increases, increases the SNAP gross income limit, aligns the SNAP employment and training statute with federal policy, allows tribal governments to access the Minnesota food shelf program and the MFIP consolidated fund, requires a runaway and homeless youth report, and requires a long-term homelessness supportive services report.

Section	Description - Article 8: Economic Supports
1	**Income.** Amends § 119B.011, subd. 15. Modifies the definition of "income" in the chapter of statutes governing child care assistance programs by including nonrecurring income over $60 per quarter unless earmarked and used for the purpose for which it was intended. Makes technical changes. Provides a March 1, 2023, effective date.
2	**Changes in eligibility.** Amends § 119B.025, subd. 4. Clarifies a cross-reference.

Section	Description - Article 8: Economic Supports

Provides a March 1, 2023, effective date.

3 **Budgeting and reporting.**

Amends § 256D.03, by adding subd. 2b. Requires county agencies to determine eligibility and calculate benefit amounts for GA according to the chapter of statutes governing economic assistance program eligibility and verification.

Provides a March 1, 2023, effective date.

4 **SNAP employment and training.**

Amends § 256D.051, by adding subd. 20. Requires the commissioner to: (1) implement a SNAP employment and training program that meets federal SNAP employment and training participating requirements; and (2) operate a voluntary SNAP employment and training program. Requires nonexempt SNAP recipients who do not meet federal SNAP work requirements to participate in an employment and training program, unless residing in an area covered by a time-limited waiver. Allows the commissioner to contract with third-party providers for SNAP employment and training services.

Provides an August 1, 2021, effective date.

5 **County and tribal agency duties.**

Amends § 256D.051, by adding subd. 21. Requires county or tribal agencies that administer SNAP to inform adult SNAP recipients about employment and training services and providers in the recipient's area. Allows county or tribal agencies that administer SNAP to subcontract with a public or private entity approved by the commissioner to provide SNAP employment and training services.

Provides an August 1, 2021, effective date.

6 **Duties of commissioner.**

Amends § 256D.051, by adding subd. 22. Lists the commissioner's duties related to administering SNAP employment and training services.

Provides an August 1, 2021, effective date.

7 **Recipient duties.**

Amends § 256D.051, by adding subd. 23. Requires nonexempt SNAP recipients to meet federal SNAP work requirements to receive SNAP assistance beyond the time limit, unless residing in an area covered by a time-limited waiver.

Provides an August 1, 2021, effective date.

Section	Description - Article 8: Economic Supports
8	**Program funding.** Amends § 256D.051, by adding subd. 24. With certain exceptions, requires the commissioner to disburse money allocated for federal SNAP employment and training to counties and tribes that administer SNAP based on a formula determined by the commissioner. Requires the commissioner to disburse federal funds 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. Allows the commissioner to reallocate unexpended money to county, tribal, or contracted agencies that demonstrate a need for additional funds. Provides an August 1, 2021, effective date.
9	**Asset limitations for SNAP households.** Amends § 256D.0515. Increases the SNAP gross income limit from 165 percent of the federal poverty guidelines to 200 percent of the federal poverty guidelines.
10	**SNAP reporting requirements.** Amends § 256D.0516, subd. 2. Removes language exempting households receiving food benefits under the MFIP waiver from SNAP reporting requirements. Provides a March 1, 2023, effective date.
11	**Distribution of appropriation.** Amends § 256E.34, subd. 1. Allows food shelves affiliated with a federally recognized tribal nation to be eligible for food shelf grants.
12	**Prospective budgeting.** Amends § 256I.03, subd. 13. Modifies the definition of “prospective budgeting” under the chapter of statutes governing housing support by cross-referencing a new definition in the chapter of statutes governing economic assistance eligibility and verification. Provides a March 1, 2023, effective date.
13	**Reports.** Amends § 256I.06, subd. 6. Modifies requirements related to reporting changes in circumstances under the housing support program to conform to new reporting requirements under the chapter of statutes governing economic assistance eligibility and verification. Provides a March 1, 2023, effective date.

Section	Description - Article 8: Economic Supports
14	**Amount of housing support payment.** Amends § 256I.06, subd. 8. Makes a conforming change related to prospective budgeting. Provides a March 1, 2023, effective date.
15	**Countable income.** Amends § 256J.08, subd. 15. Modifies the definition of "countable income" under MFIP to be consistent with requirements under the chapter of statutes governing economic assistance eligibility and verification. Provides an August 1, 2021, effective date.
16	**Prospective budgeting.** Amends § 256J.08, subd. 71. Modifies the definition of "prospective budgeting" in the chapter of statutes governing MFIP by cross-referencing a new definition in the chapter of statutes governing economic assistance eligibility and verification. Provides a March 1, 2023, effective date.
17	**Recurring income.** Amends § 256J.08, subd. 79. Modifies the definition of "recurring income" under MFIP by removing a reference to retrospective budgeting. Provides a March 1, 2023, effective date.
18	**MFIP eligibility requirements.** Amends § 256J.10. Makes income limitations consistent with requirements in the chapter of statutes governing economic assistance eligibility and verification. Provides an August 1, 2021, effective date.
19	**Initial income test.** Amends § 256J.21, subd. 3. Makes changes to MFIP initial eligibility determinations to make the determinations consistent with requirements in the chapter of statutes governing economic assistance eligibility and verification. Removes the monthly income test and replaces it with prospective budgeting and specifies the income test is for a six month period. Provides an August 1, 2021, effective date, except for the changes related to the monthly income test, which are effective March 1, 2023.

Section	Description - Article 8: Economic Supports
20	**Income test and determination of assistance payment.** Amends § 256J.21, subd. 4. Makes conforming changes related to prospective budgeting under MFIP. Provides a March 1, 2023, effective date.
21	**Distribution of income.** Amends § 256J.21, subd. 5. Modifies MFIP distribution of income requirements to be consistent with the chapter of statutes governing economic assistance eligibility and verification. Provides an August 1, 2021, effective date.
22	**MFIP transitional standard.** Amends § 256J.24, subd. 5. Requires the commissioner of human services to adjust the cash portion of the MFIP grant for inflation based on the CPI-U for the prior calendar year on October 1 of each year beginning in fiscal year 2022.
23	**Late MFIP household report forms.** Amends § 256J.30, subd. 8. Requires the county agency to contact the MFIP caregiver by phone or in writing to acquire the necessary information to complete the MFIP household report form when the agency receives an incomplete form (under current law the county agency must return the incomplete form and clearly state what the caregiver must do to complete the form).
24	**Determination of eligibility.** Amends § 256J.33, subd. 1. Makes conforming changes related to prospective budgeting under MFIP. Makes income calculations consistent with requirements under the chapter of statutes governing economic assistance eligibility and verification. Specifies 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. Provides a March 1, 2023, effective date, with certain exceptions that are effective August 1, 2021.
25	**Prospective eligibility.** Amends § 256J.33, subd. 2. Makes conforming changes related to prospective budgeting under MFIP. Provides a March 1, 2023, effective date.

Section	Description - Article 8: Economic Supports
26	**Monthly income test.** Amends § 256J.33, subd. 4. Makes MFIP income calculations consistent with requirements under the chapter of statutes governing economic assistance eligibility and verification. Provides an August 1, 2021, effective date.
27	**Deemed income from ineligible assistance unit members.** Amends § 256J.37, subd. 1. Clarifies that SSI or MSA income from an ineligible household member must not be deemed to the household members who are eligible for MFIP. Provides an August 1, 2021, effective date.
28	**Deemed income from parents of minor caregivers.** Amends § 256J.37, subd. 1b. Clarifies that the income of a stepparent living with a minor caregiver must be counted in determining the minor caregiver's benefits. Removes a cross-reference that is being repealed. Provides an August 1, 2021, effective date.
29	**Earned income of wage, salary, and contractual employees.** Amends § 256J.37, subd. 3. Makes conforming changes. Provides a March 1, 2023, effective date.
30	**Rental subsidies; unearned income.** Amends § 256J.37, subd. 3a. Makes conforming changes related to prospective budgeting under MFIP. Provides a March 1, 2023, effective date.
31	**Consolidated fund.** Amends § 256J.626, subd. 1. Clarifies use of the MFIP consolidated fund by tribes. Provides a July 1, 2021, effective date.
32	**Property and income limitations.** Amends § 256J.95, subd. 9. Makes income calculations for DWP consistent with requirements under the chapter of statutes governing economic assistance eligibility and verification.

Section	Description - Article 8: Economic Supports
	Provides an August 1, 2021, effective date.
33	**Earned income.** Amends § 256P.01, subd. 3. Modifies the definition of "earned income" under the chapter of statutes governing economic assistance eligibility and verification. Provides an August 1, 2021, effective date.
34	**Prospective budgeting.** Amends § 256P.01, by adding subd. 9. Defines "prospective budgeting" in the chapter of statutes governing economic assistance eligibility and verification. Provides a March 1, 2023, effective date.
35	**Factors to be verified.** Amends § 256P.04, subd. 4. Removes from the list of items that must be verified the use of nonrecurring income. Makes conforming cross-reference changes. Provides a March 1, 2023, effective date, except the cross-reference changes are effective July 1, 2021.
36	**Recertification.** Amends § 256P.04, subd. 8. Removes the requirement for an interview during the recertification process under the chapter of statutes governing economic assistance eligibility and verification. Provides an immediate effective date.
37	**Exemptions.** Amends § 256P.02, subd. 2. Makes grammatical changes. For individuals who are members of a housing support and MFIP assistance unit, the assistance standard effective January 2020 for a household of one under MFIP shall be counted as income under housing support, and any subsequent increases to unearned income under MFIP are exempt.
38	**Income inclusions.** Amends § 256P.06, subd. 3. Clarifies the list of items that must be included in determining the income of an assistance unit and removes nonrecurring income from the list in the chapter of statutes governing economic assistance eligibility and verification.

Section	Description - Article 8: Economic Supports

Provides a March 1, 2023, effective date, except the provision related to unemployment insurance income is effective immediately and the provision related to workers' compensation is effective August 1, 2021.

39 **Reporting of changes.**

Amends § 256P.07. Clarifies language related to exempted programs. Adds language exempting participants who qualify for child care assistance programs (CCAP) from this section, except for the reporting requirements specifically related to CCAP. Requires applicants or assistance units to report certain changes during the application period or by the tenth of the month following the month that the change occurred. Modifies the list of changes that must be reported. Modifies MFIP-specific, CCAP-specific, and MSA-specific reporting requirements. Adds housing support-specific and GA-specific reporting requirements.

Provides a March 1, 2023, effective date.

40 **Prospective budgeting of benefits.**

Creates § 256P.09.

Subd. 1. Exempted programs. Exempts participants who qualify for CCAP, housing support, and MSA from prospective budgeting of benefits.

Subd. 2. Prospective budgeting of benefits. Requires agencies to use prospective budgeting to calculate an assistance payment amount.

Subd. 3. Income changes. Requires prospective budgeting to be used to determine the amount of the assistance unit's benefit for the following six-month period. Prohibits an increase in income from affecting an assistance unit's eligibility or benefit amount until the next case review. Specifies when decreases in income are effective.

Provides a March 1, 2023, effective date.

41 **Six-month reporting.**

Creates § 256P.10.

Subd. 1. Exempted programs. Exempts assistance units who qualify for CCAP, MSA, and certain housing support assistance units from six-month reporting.

Subd. 2. Reporting. Paragraph (a) subjects assistance units that qualify for MFIP, assistance units that qualify for GA with earned income of $100 per month or greater, and assistance units that qualify for housing support with earned income of $100 per month or greater to six month case reviews. Allows the initial

Section **Description - Article 8: Economic Supports**

reporting period to be shorter than six months in order to align with other program reporting periods.

Paragraph (b) requires assistance units that qualify for MFIP and GA to complete household report forms for redetermination of benefits.

Paragraph (c) requires assistance units that qualify for housing support to complete household report forms to provide information about earned income.

Paragraph (d) requires assistance units that qualify for housing support and also receive MFIP to be subject to the six-month reporting requirements for MFIP, but not for housing support.

Paragraph (e) requires assistance units to submit a household report form in compliance with the requirements of this chapter.

Paragraph (f) allows assistance units to choose to report changes under this section at any time.

Subd. 3. When to terminate assistance. Paragraph (a) requires an agency to terminate 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, requires benefits to be reinstated and made available retroactively for the full benefit month.

Paragraph (b) requires an agency to terminate assistance when an assistance unit is determined to be ineligible for assistance according to the chapters of statutes governing GA, housing support, or MFIP.

Provides a March 1, 2023, effective date.

42 **Waivers and modifications.**

Amends Laws 2020, First Special Session ch. 7, § 1, by adding subd. 5. Extends certain DHS program waivers and modifications related to the peacetime emergency declared by the governor in response to the COVID-19 outbreak until December 31, 2021.

43 **Direction to commissioner; long-term homeless supportive services report.**

Paragraph (a) requires the commissioner of human services to produce a report that shows the projects funded under the long-term homeless supportive services program and provide a copy of the report to the legislative committees with jurisdiction over services for persons experiencing homelessness by January 15, 2023.

Section	Description - Article 8: Economic Supports

Paragraph (b) requires the report to be updated annually for two additional years and the commissioner to provide copies of the updated reports to the legislative committees with jurisdiction over services for persons experiencing homelessness by January 15, 2024, and January 15, 2025.

44 **2022 Report to Legislature on Runaway and Homeless Youth.**

Subd. 1. Report development. Exempts the commissioner of human services from preparing the 2023 homeless youth report and instead requires the commissioner to update a 2007 legislative report on runaway and homeless youth using existing data, studies, and analysis provided by state, county, and other entities. Lists the data, studies, and analysis that must be included in the development of the report.

Subd. 2. Key elements; due date. Paragraph (a) requires the report to include three key elements where significant learning has occurred since the 2007 report, including: (1) unique causes of youth homelessness; (2) targeted responses to youth homelessness; and (3) recommendations based on existing reports and analysis on what is needed to end youth homelessness. Paragraph (b) lists other data that must be included in the report. Paragraph (c) requires the commissioner to consult with community-based providers of homeless youth services and other stakeholders to complete the report and to submit the report to the legislative committees with jurisdiction over youth homelessness by December 15, 2022.

45 **Repealer.**

Paragraph (a) repeals Minn. Stat. §§ 256D.051, subds. 1 (SNAP employment and training program), 1a (notices and sanctions), 2 (county agency duties), 2a (duties of commissioner), 3 (participant duties), 3a (requirement to register work), 3b (orientation), 6b (federal reimbursement), 6c (program funding), 7 (registrant status), 8 (voluntary quit), 9 (subcontractors), and 18 (work experience placements); and 256D.052, subd. 3 (participant literacy transportation costs); and 256J.21, subds. 1 (income inclusions) and 2 (income exclusions), effective August 1, 2021.

Paragraph (b) repeals Minn. Stat. §§ 256J.08, subds. 10 (budget month), 53 (lump sum), 61 (monthly income test), 62 (nonrecurring income), 81 (retrospective budgeting), and 83 (significant change); 256J.30, subds. 5 (monthly MFIP household reports), 7 (due date of MFIP household report form), and 8 (late MFIP household report forms); 256J.33, subds. 3 (retrospective eligibility), 4 (monthly income test), and 5 (when to terminate assistance); 256J.34, subds. 1 (prospective budgeting), 2 (retrospective budgeting), 3 (additional uses of retrospective budgeting), and 4 (significant change in gross income); and 256J.37, subd. 10 (treatment of lump sums), effective March 1, 2023.

Article 9: Child Care Assistance

This article makes technical and policy changes to the child care assistance program, increases child care assistance rates for providers, and reprioritizes the waiting list for child care assistance.

Section	Description - Article 9: Child Care Assistance
1	**Funding priority.** Amends §119B.03, subd. 4. Modifies how families are prioritized on the basic sliding free program waiting list.
2	**Allocation formula.** Amends §119B.03, subd. 6. Modifies the formula for allocating money to counties for their basic sliding fee programs. This section is effective January 1, 2022, with the 2022 calendar year a phase-in year for the revised allocation formula.
3	**Eligibility; annual income; calculation.** Amends §119B.09, subd. 4. Changes how a family's income is calculated for child care assistance. This section is effective March 1, 2023.
4	**Recovery of overpayments.** Amends §119B.11, subd. 2a. Paragraph (b) allows the commissioner of human services to initiate efforts to recover child care assistance overpayments from families for child care assistance fraud investigations. Under current law, only county agencies are specified as being able to initiate recovery efforts. Adds a condition under which a family with an outstanding debt is eligible for child care assistance. Paragraph (c) allows the commissioner to initiate efforts to recover child care assistance overpayments from providers. Under current law, only county agencies are specified as being able to initiate recovery efforts. Adds a condition under which a provider with an outstanding debt is eligible to care for children receiving child care assistance. This section is effective August 1, 2021.
5	**Authorization.** Amends §119B.125, subd. 1. Prohibits county agencies from issuing provisional authorization and payment for child care assistance to providers while the agency is determining whether to give the provider final authorization for child care assistance.

Section	Description - Article 9: Child Care Assistance

This section is effective August 1, 2021.

6 **Subsidy restrictions.**

Amends §119B.13, subd. 1. Directs DHS to establish the maximum rate paid to child care providers for child care assistance. Dependent on federal funds and consistent with federal law, the maximum rate must be up to the 75th percentile of the most recent child care provider rate survey and it cannot be less than the 50th percentile of the most recent child care provider rate survey. Makes corresponding changes to the maximum registration fee for child care assistance.

This section is effective the day following enactment.

7 **Legal nonlicensed family child care provider rates.**

Amends §119B.13, subd. 1a. Increases the maximum rate for child care assistance paid to legal, nonlicensed family child care providers from 68 percent to 90 percent of the maximum hourly rate for licensed family child care providers.

This section is effective the day following enactment.

8 **Provider payments.**

Amends §119B.13, subd. 6. Paragraph (c) limits retroactive payments under the child care assistance program to three months, rather than the six months allowed under current law.

Paragraph (d) Adds certified, license-exempt child care providers to the list of providers that may have their child care assistance authorization refused or revoked or payments stopped or refused by a county agency or the commissioner of human services. Provides circumstances under which a child care provider must forfeit child care assistance payments to a county agency or the commissioner of human services.

Paragraph (g) provides circumstances under which a child care provider must forfeit child care assistance payments to a county agency or the commissioner of human services.

This section is effective August 1, 2021.

9 **Absent days.**

Amends §119B.13, subd. 7. Modifies the circumstances under which a family receiving child are assistance is assessed an overpayment for absent days.

This section is effective August 1, 2021.

Section	Description - Article 9: Child Care Assistance
10	**Financing program.** Amends §119B.25, subd. 3. Provides that a nonprofit that receives a grant under this section to plan, develop, and finance early care and education sites may use the money to provide business training and consultation to child care providers.
11	**Repealer.** Repeals §119B.04, which provides authority to the commissioner of human services that is duplicative of the authority provided under Minnesota Statutes, section 119B.06. Repeals §119B.125, subd. 5, which allows county agencies to issue provisional authorization and payment for child care assistance to providers while the county is determining whether to give the provider final authorization for child care assistance.

Article 10: Child Protection

This article modifies Northstar Care for Children payment agreement and offset requirements, adds sex trafficking language to various statutes relating to child protection and maltreatment reporting, makes clarifying changes, and adds a noncaregiver sex trafficking assessment to the possible local welfare agency responses to a report of child maltreatment alleging sex trafficking by someone who is not a child's caregiver.

Section	Description - Article 10: Child Protection
1	**Negotiation of agreement.** Amends § 256N.25, subd. 2. Removes language relating to offsets for Northstar kinship and adoption payments.
2	**Renegotiation of agreement.** Amends § 256N.25, subd. 3. Removes language relating to circumstances that require the renegotiation of Northstar kinship or adoption assistance agreements.
3	**Child income or income attributed to the child.** Amends § 256N.26, subd. 11. Removes language requiring consideration of income and resources attributable to the child during the negotiation process for Northstar kinship and adoption payment agreements.

Section	Description - Article 10: Child Protection
4	**Treatment of retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, and black lung benefits.** Amends § 256N.26, subd. 13. Removes language requiring benefits paid to a child to be considered as offsets to Northstar payment amounts, and removes related language detailing how certain benefit payments must be considered.
5	**Agency and court notice to tribes.** Amends § 260.761, subd. 2. Adds "noncaregiver sex trafficking assessment" to provision requiring local social services agency notification provided to an Indian child's tribe. Specifies that notification must be made within seven days of receiving information that the child may be an Indian child; makes clarifying changes.
6	**Egregious harm.** Amends § 260C.007, subd. 14. Amends the definition of "egregious harm" by making clarifying changes and adding sex trafficking to conduct that constitutes egregious harm.
7	**Policy.** Amends § 260E.01. Adds a noncaregiver sex trafficking assessment to the list of state child protection policies and carves out report alleging sex trafficking by a noncaregiver sex trafficker from sexual abuse or substantial child endangerment investigation requirement.
8	**Establishment of team.** Amends § 260E.02, subd. 1. Adds representatives of agencies providing specialized services or responding to youth who experience or are at risk of experiencing sex trafficking or sexual exploitation, to the multidisciplinary child protection team.
9	**Noncaregiver sex trafficker.** Amends § 260E.03 by adding subd. 15a. Defines "noncaregiver sex trafficker."
10	**Noncaregiver sex trafficking assessment.** Amends § 260E.03 by adding subd. 15b. Defines "noncaregiver sex trafficking assessment," and specifies when the local welfare agency must perform such an assessment.
11	**Substantial child endangerment.** Amends § 260E.03, subd. 22. Modifies definition of "substantial child endangerment" by adding sex trafficking and making clarifying changes.
12	**Sexual abuse.** Amends § 260E.14, subd. 2. Makes clarifying change.

Section	Description - Article 10: Child Protection
13	**Law enforcement.** Amends § 260E.14, subd. 5. Makes clarifying changes; adds a report alleging child sex trafficking to circumstances under which agencies must coordinate responses.
14	**Local welfare agency.** Amends § 260E.17, subd. 1. Adds noncaregiver sex trafficking assessment to the local welfare agency responses; makes clarifying changes. Requires the local welfare agency to conduct a noncaregiver sex trafficking assessment when a maltreatment report alleges sex trafficking by a noncaregiver; requires an immediate investigation if there is reason to believe a caregiver, parent, or household member engaged in child sex trafficking or other conduct warranting an investigation.
15	**Notice to child's tribe.** Amends § 260E.18. Makes clarifying change; adds noncaregiver sex trafficking assessment to tribal notice section.
16	**Face-to-face contact.** Amends § 260E.20, subd. 2. Makes clarifying changes; exempts noncaregiver sex trafficking assessments from requirements regarding face-to-face contact, informing or interviewing the alleged offender, and the alleged offender's opportunity to make a statement.
17	**Determination after family assessment or a noncaregiver sex trafficking assessment.** Amends § 260E.24, subd. 2. Adds noncaregiver sex trafficking assessment to subdivision regarding local welfare agency determinations after assessments.
18	**Notification at conclusion of family assessment or a noncaregiver sex trafficking assessment.** Amends § 260E.24, subd. 7. Adds noncaregiver sex trafficking assessment to subdivision regarding notification of a parent or guardian at the conclusion of an assessment.
19	**Following a family assessment or a noncaregiver sex trafficking assessment.** Amends § 260E.33, subd. 1. Specifies that administrative reconsideration does not apply to a noncaregiver sex trafficking assessment.
20	**Data retention.** Amends § 260E.35, subd. 6. Adds noncaregiver sex trafficking assessment cases to data retention requirements.

Article 11: Child Protection Policy

This article makes clarifying changes, adds definitions, and makes other changes related to compliance with the federal Family First Prevention Services Act, in chapters 260C, 260D, and 260E, regarding child placement in qualified residential treatment programs, voluntary foster care for treatment, and other residential settings. The article also adds definitions to the human services licensing chapter, adds a section governing certification of qualified residential treatment programs and other residential settings, and increases the age to 13 years old for children in need of protection or services who commit a juvenile petty offense or delinquent act. The article also expands who is mandated to report known or suspected child maltreatment, modifies face-to-face contact requirements, modifies reporting requirements for prenatal substance use, and adds a requirement for parents or legal guardians to be notified of and participate in contested case hearings related to appeals of child maltreatment determinations.

Section	Description - Article 11: Child Protection Policy
1	**Admission criteria.** Amends § 245.4885, subd. 1. Modifies terminology; clarifies that the validated tool used to determine a child's need for out-of-home care may be the tool approved for the child's assessment for placement in a qualified residential treatment program, if the juvenile screening team recommended such placement. Makes this section effective September 30, 2021.
2	**At risk of becoming a victim of sex trafficking or commercial sexual exploitation.** Amends § 245A.02 by adding subd. 3c. Adds definition of a youth who is "at risk of becoming a victim of sex trafficking or commercial sexual exploitation" to the human services licensing chapter. Makes this section effective the day following final enactment.
3	**Children's residential facility.** Amends § 245A.02 by adding subd. 4a. Adds definition of "children's residential facility" to human services licensing chapter. Makes this section effective the day following final enactment.
4	**Foster family setting.** Amends § 245A.02 by adding subd. 6d. Adds definition of "foster family setting" to human services licensing chapter. Makes this section effective the day following final enactment.

Section	Description - Article 11: Child Protection Policy
5	**Foster residence setting.** Amends § 245A.02 by adding subd. 6e. Adds definition of "foster residence setting" to human services licensing chapter. Makes this section effective the day following final enactment.
6	**Trauma.** Amends § 245A.02 by adding subd. 18a. Adds definition of "trauma" to human services licensing chapter. Makes this section effective the day following final enactment.
7	**Victim of sex trafficking or commercial sexual exploitation.** Amends § 245A.02 by adding subd. 23. Adds definition of "victim of sex trafficking or commercial sexual exploitation" to human services licensing chapter. Makes this section effective the day following final enactment.
8	**Youth.** Amends § 245A.02 by adding subd. 24. Adds definition of "youth" to human services licensing chapter. Makes this section effective the day following final enactment.
9	**First date of working in a facility or setting; documentation requirements.** Amends § 245A.041 by adding subd. 6. Adds requirements for children's residential facility and foster residence settings license holder documentation of the first date of work for a background study subject. Makes this section effective August 1, 2021.
10	**Residential program certifications for compliance with the Family First Prevention Services Act.** Proposes coding for § 245A.25. Adds section establishing certification requirements for children's residential facilities or child foster residence settings to receive federal Title IV-E funding; outlines the types of facilities and program certifications, certification requirements, trauma-informed care requirements, monitoring and inspection processes, decertification processes, and variances. Makes this section effective the day following final enactment.

Section	Description - Article 11: Child Protection Policy
11	**American Indian child welfare projects.** Amends § 256.01, subd. 14b. Adds tribal host contract language. Makes this section effective the day following final enactment.
12	**Contracting within and across county lines; lead county contracts; lead tribal contracts.** Amends § 256.0112, subd. 6. Makes clarifying changes; adds language relating to lead tribal contracts for initiative tribes. Makes this section effective the day following final enactment.
13	**Child in need of protection or services.** Amends § 260C.007, subd. 6. Amends definition to include children who commit a juvenile petty offense or delinquent act before becoming 13 years old, increased from 10 years old.
14	**Qualified individual.** Amends § 260C.007, subd. 26c. Clarifies who may be a “qualified individual” for purposes of completing a child’s assessment for placement in a qualified residential treatment program, when the Indian Child Welfare Act applies to a child.
15	**Sexually exploited youth.** Amends § 260C.007, subd. 31. Adds federal definition of commercial sexual exploitation to definition of “sexually exploited youth.” Makes this section effective September 30, 2021.
16	**Juvenile treatment screening team.** Amends § 260C.157, subd. 2. Clarifies sexual exploitation language and makes other clarifying changes; requires the responsible social services agency to obtain recommendations from the child’s tribe on which individuals to include on the team, if applicable. Makes this section effective September 30, 2021.
17	**Out-of-home placement plan update.** Amends § 260C.212, subd. 1a. Specifies that the responsible social services agency must file its report seeking the court's approval of the child's placement at a qualified residential treatment program; makes clarifying changes throughout. Makes this section effective September 30, 2021.

Section	Description - Article 11: Child Protection Policy

18 **Protecting missing and runaway children and youth at risk of sex trafficking or commercial sexual exploitation.**

Amends § 260C.212, subd. 13. Adds commercial sexual exploitation terminology; makes clarifying changes.

Makes this section effective September 30, 2021.

19 **Payment for residential placements.**

Amends § 260C.4412. Specifies that a lead county contract is not required to establish foster care maintenance payments for foster residence settings. Requires foster maintenance payments to be consistent with provisions in chapter 256N.

20 **Successful transition to adulthood.**

Amends § 260C.452.

Subd. 1. Scope and purpose. Defines "youth" for purposes of this section; makes clarifying changes. Adds clauses (4), (5), and (6) specifying circumstances that would make youth eligible for services under this section. Adds paragraph (c), specifying the purpose of the section. Adds paragraph (d) specifying that the responsible social services agency may provide case management and support until a youth is 23 years of age.

Subd. 1a. Case management services. Outlines what case management services include for successful transition to adulthood under this section.

Subd. 2. Independent living plan. Makes clarifying changes.

Subd. 3. Notification. Strikes subdivision.

Subd. 4. Administrative or court review of placements. Modifies terminology and references, makes clarifying changes.

Subd. 5. Notice of termination of social services. Modifies terminology and references; removes paragraphs relating to termination of foster care and court review of terminations. Adds paragraph relating to case management service termination, notice, and appeal rights.

Makes this section effective July 1, 2021.

21 **Requirements for the qualified individual's assessment of the child for placement in a qualified residential treatment program.**

Amends § 260C.704. Provides exception to requirement for an assessment prior to placement in a qualified residential treatment program for immediate placements in crisis situations; requires an assessment within 30 days of the child's placement.

Section **Description - Article 11: Child Protection Policy**

Requires that a level of care determination be shared with the qualified individual and the juvenile treatment screening team. Modifies requirements for distributing and filing completed qualified residential treatment facility placement assessments. Modifies placement and referral requirements based on qualified individual recommendations.

Makes this section effective September 30, 2021.

22 **Family and permanency team requirements.**

Amends § 260C.706. Modifies cross-reference and makes clarifying changes.

Makes this section effective September 30, 2021.

23 **Out-of-home placement plan for qualified residential treatment program placements.**

Amends § 260C.708. Modifies cross-reference and terminology; adds required content for a child's out-of-home placement plan when the responsible social services agency places a child in a qualified residential treatment program; adds placement preference requirements.

Makes this section effective September 30, 2021.

24 **Court approval requirements.**

Amends § 260C.71 by adding subdivisions 1, 2, 3, 4, and 5.

Subd. 1. Judicial review. Requires placement in a qualified residential treatment facility in specified circumstances. Requires responsible social services agency to obtain a court order within 60 days of placement, that finds that the placement is appropriate and meets the child's needs.

Subd. 2. Qualified residential treatment program; agency report to court. Requires a written report to be filed with the court within 35 days of the child's placement; specifies required contents of the written report. Requires the agency to inform a child who is 10 or older, and the child's parent, of the court review requirements and of their right to submit information to the court.

Subd. 3. Court hearing. Outlines when a court must hold a hearing and when the court has discretion to hold a hearing.

Subd. 4. Court findings and order. Adds clarifying language; adds requirements for when a court disapproves of a child's placement in a qualified residential treatment program.

Section	Description - Article 11: Child Protection Policy

Subd. 5. Court review and approval not required. Specifies circumstances under which a court hearing and order are not required. Under these circumstances, requires the responsible social services agency to make a plan for the child's placement and file the assessment determination with the court at the next required hearing.

Makes this section effective September 30, 2021.

25 **Ongoing reviews and permanency hearing requirements.**

Amends § 260C.712. Adds cross-references to 260D sections; adds requirement for the responsible social services agency to submit compelling reasons for placing a child in a qualified residential treatment program in another state, and reasons the child's needs cannot be met by an in-state placement.

Makes this section effective September 30, 2021.

26 **Review of extended qualified residential treatment program placements.**

Amends § 260C.714. Modifies reference.

Makes this section effective September 30, 2021.

27 **Child in voluntary foster care for treatment.**

Amends § 260D.01. Makes clarifying changes; adds paragraph specifying that chapter 260D includes requirements for child placement in a qualified residential treatment program. Adds paragraphs specifying that ongoing planning for a child includes engaging with the responsible social services agency to ensure that the family and permanency team makeup is appropriate, that the agency must consult with the child if over age 14, and the child's parent or legal guardian regarding members of the family and permanency team and engaging in a relative search.

Makes this section effective September 30, 2021.

28 **Administrative review of child in voluntary foster care for treatment.**

Amends § 260D.05. Adds reference to requirements under section 260C.712.

Makes this section effective September 30, 2021.

29 **Agency report to court; court review.**

Amends § 260D.06, subd. 2. Adds reference to requirements under section 260C.712.

Makes this section effective September 30, 2021.

Section	Description - Article 11: Child Protection Policy
30	**Required permanency review hearing.** Amends § 260D.07. Adds reference to requirements under section 260C.712. Makes this section effective September 30, 2021.
31	**Annual review.** Amends § 260D.08. Adds reference to requirements under section 260C.712. Makes this section effective September 30, 2021.
32	**Successful transition to adulthood for youth in voluntary placement.** Amends § 260D.14. Modifies terminology, makes clarifying and conforming changes. Lowers the age for review of transition to adulthood from 17 to 14. Makes this section effective September 30, 2021.
33	**Mandatory reporters.** Amends § 260E.06, subd. 1. Adds an owner, administrator, or employee who is 18 or older of a youth recreation program or other organization that provides services or activities requiring face-to-face contact with and supervision of children, to the list of persons who are required to report known or suspected maltreatment in the preceding three years.
34	**Face-to-face contact.** Amends § 260E.20, subd. 2. Allows for face-to-face contact in response to a report alleging sexual abuse or substantial child endangerment to be postponed for up to five calendar days, if the child is residing in a location that is confirmed to restrict contact with the alleged offender, or the local welfare agency is pursuing a court order for the child's caregiver to produce the child for an interview.
35	**Reports required.** Amends § 260E.31, subd. 1. Removes the requirement for health care and social services professionals to report a woman's use of a controlled substance for a nonmedical purpose or excessive consumption of alcohol during pregnancy to the local welfare agency, if the professional is providing or collaborating with other professionals to provide the woman with prenatal care, postpartum care, or other health care services, including care of the woman's infant. Adds a clause to reinstate the requirement if the woman does not continue to receive regular care.
36	**Notification of contested case hearing.** Amends § 260E.33 by adding subd. 6a. Specifies that, in a contested case hearing appealing a licensing sanction or disqualification related to a maltreatment

Section	Description - Article 11: Child Protection Policy
	determination, the administrative law judge must inform the maltreated child's parent, legal custodian, or guardian of the right to file a written statement and the right to attend and participate in the hearing. Specifies notice requirements, requirements for the written statement, and procedures for providing the address of a parent, legal custodian, or guardian.
37	**Sex trafficking and sexual exploitation training requirement.** Amends § 260E.36 by adding subd. 1b. Adds requirement for all child protection workers to complete training on sex trafficking and sexual exploitation of children and youth. Makes this section effective July 1, 2021.
38	**Direction to the commissioner; qualified residential treatment transition supports.** Directs the commissioner of human services to consult with stakeholders to develop policies related to aftercare supports for transitions from qualified residential treatment programs to reunification with a child's parent or guardian, by December 31, 2022.
39	**Revisor instruction.** Instructs the revisor to add a headnote in chapter 260C.

Article 12: Behavioral Health

This article includes provisions related to behavioral health provider workforce and cultural diversity requirements, and modifies provisions relating to children's residential treatment placement. The article also modifies and updates provisions relating to certified community behavioral health clinics (CCBHCs), substance use disorder (SUD) treatment enhanced rates, the Opiate Epidemic Response Advisory Council membership and funding, and mental health case management services. The article also creates an SUD community of practice, requires certain SUD programs to enroll in the federal demonstration project, and includes several directions to the commissioner, including directions to develop sober housing program recommendations, SUD treatment provider paperwork reduction, and a SUD treatment rate restructure analysis.

Section	Description – Article 12: Behavioral Health
1	**Mental health practitioner.** Amends § 245.462, subd. 17. Expands the definition of "mental health practitioner" to include a student who is completing a practicum or internship as part of a formal undergraduate or graduate social work, psychology, or counseling program.

Section	Description – Article 12: Behavioral Health
2	**Individual treatment plans.** Amends § 245.4876, subd. 3. Removes language establishing different administrative review requirements for individual treatment plans for children placed in residential facilities.
3	**Availability of residential treatment services.** Amends § 245.4882, subd. 1. Provides 90-day review for a child's length of stay in residential treatment.
4	**Transition to community.** Amends § 245.4882, subd. 3. Adds requirements for discharge planning content and timelines for children in residential treatment.
5	**Admission criteria.** Amends § 245.4885, subd. 1. Makes clarifying changes; specifies that the county board, rather than the responsible social services agency, will determine the appropriate level of care for a child when county funds are used to pay for the child's residential treatment; makes corresponding changes. Deletes references to treatment foster care settings and functional assessments; requires that the child and the child's family are invited to level of care determination or decision making meetings and allows them to invite others. Requires the level of care determination, placement decision, and service recommendations to be made available to the child's family, as appropriate. Makes this section effective September 30, 2021.
6	**Establishment and authority.** Amends § 245.4889, subd. 1. Expands services eligible for children's mental health grant funding to include, as part of mental health services for people from cultural and ethnic minorities, supervision of clinical trainees who are Black, indigenous, or people of color providing services in certain clinics. Also adds to list of eligible services mental health services based on traditional healing practices.
7	**Culturally Informed and Culturally Responsive Mental Health Task Force.** Proposes coding for § 245.4902. Establishes the Culturally Informed and Culturally Responsive Mental Health Task Force; lists membership, compensation, reimbursement, meeting, and report requirements; specifies a January 1, 2025 expiration date.
8	**Certified community behavioral health clinics.** Amends § 245.735, subd. 3. Updates CCBHC certification process language; requires the commissioner to consult with CCBHC stakeholders before making changes to the

Section	Description – Article 12: Behavioral Health

certification process. Specifies that CCBHCs must directly provide most of the listed services, but allows coordination with another entity to provide some services; establishes criteria for a CCBHC to contract with another entity to provide services.

9 **Information systems support.**

Amends § 245.735, subd. 5. Makes clarifying change.

10 **Demonstration entities.**

Amends § 245.735 by adding subd. 6. Allows the commissioner to continue to operate the CCBHC demonstration program if federal funding remains available. Requires the commissioner to align the demonstration program requirements with the requirements for CCBHCs receiving MA reimbursement. Prohibits a CCBHC from participating in both the demonstration and the CCBHC MA benefit.

11 **Culturally specific or culturally responsive program.**

Amends § 254B.01, subd. 4a. Modifies the definition of "culturally specific program" for purposes of chapter 254B, expanding it to include culturally responsive programs. Requires attestation that program requirements are satisfied and adds requirements that must be met for a program to qualify under the definition.

Makes this section effective January 1, 2022.

12 **Disability responsive program.**

Amends § 254B.01 by adding subd. 4b. Adds definition of "disability responsive program."

Makes this section effective January 1, 2022.

13 **Rate requirements.**

Amends § 254B.05, subd. 5. Removes language establishing higher rates for certain types of substance use disorder treatment services and providers. Adds "culturally responsive" terminology and disability responsive programs. Updates terminology and modifies telehealth requirements to align with requirements for medical assistance coverage of telehealth. Specifies that payment for outpatient services is limited to six hours per day, or 30 hours per week without prior authorization from the commissioner.

Makes this section effective January 1, 2022, or upon federal approval, whichever is later, except paragraph (e), which is effective July 1, 2021.

Section	Description – Article 12: Behavioral Health
14	**Culturally specific or culturally responsive program and disability responsive program provider rate increase.** Amends § 254B.12 by adding subd. 4. Provides a 5% rate increase for substance use disorder treatment services provided by culturally specific or culturally responsive programs, or disability responsive programs, on or after January 1, 2022. Makes this section effective January 1, 2022, or upon federal approval, whichever is later.
15	**Substance use disorder community of practice.** Proposes coding for § 254B.151. Establishes a substance use disorder of community of practice; specifies the purposes of the community of practice, required participants, meeting and compensation requirements, and duties of the community of practice.
16	**Membership.** Amends § 256.042, subd. 2. Increases the number of members on the Opiate Epidemic Response Advisory Council; increases the number of members representing Indian tribes and expands representation to each of Minnesota's tribal nations.
17	**Grants.** Amends § 256.042, subd. 4. Modifies the report on the Opiate Epidemic Response Advisory Council's proposed grants from the upcoming fiscal year to the upcoming calendar year; modifies month for the report; increases allowable grant amount percentage for administration from three to ten percent.
18	**Appropriations from fund.** Amends § 256.043, subd. 3. Specifies that grant funds and funds for county and tribal social services agencies from the opiate epidemic response fund will be distributed on a calendar year basis beginning in fiscal year 2022.
19	**Certified community behavioral health clinic services.** Amends § 256B.0625, subd. 5m. Updates language to require CCBHC reimbursement on a per-visit basis, and to include incentive payments; establishes requirements for the prospective payment system for CCBHC reimbursement, requires a phase-out of CCBHC wrap payments, and requires updates to rates. Establishes requirements for the CCBHC quality incentive payment program. Specifies process for claims to managed care plans for CCBHC services.

Section	Description – Article 12: Behavioral Health

20 **Mental health case management.**

Amends § 256B.0625, subd. 20. Modifies payment requirements for mental health case management provided by vendors who contract with counties and tribes.

21 **Provider participation.**

Amends § 256B.0759, subd. 2. Specifies that outpatient substance use disorder treatment providers may participate in the substance use disorder demonstration project. Requires licensed residential treatment programs, withdrawal management programs, and out-of-state residential treatment programs receiving payment under medical assistance to enroll as demonstration project providers by January 1, 2022. Provides a six-month extension for providers who demonstrate extraordinary circumstances; specifies that programs that do not meet the requirements by July 1, 2023 are ineligible for payment.

Allows tribally licensed programs to participate in the demonstration project and requires DHS to consult with tribal nations.

Specifies rate enhancement applicability and requirements and provides for recoupment by the commissioner.

Makes this section effective July 1, 2021, or upon federal approval, whichever is later; makes paragraphs (f) and (g) effective the day following final enactment.

22 **Provider payment rates.**

Amends § 256B.0759, subd. 4. Adds reference to provider standards and allows the commissioner to temporarily suspend payments if statutory requirements are not met. Increases payment rates for certain services.

Makes this section effective July 1, 2021, or upon federal approval, whichever is later; makes the rate increase changes effective January 1, 2022.

23 **Data and outcome measures; public posting.**

Amends § 256B.0759 by adding subd. 6. Requires that SUD demonstration project data and outcome measures from the previous calendar year be posted publicly on the DHS website.

Makes this section effective July 1, 2021.

24 **Federal approval; demonstration project extension.**

Amends § 256B.0759 by adding subd. 7. Requires the commissioner to seek a five-year extension of the SUD demonstration project and to receive enhanced federal participation.

Section	Description – Article 12: Behavioral Health

Makes this section effective July 1, 2021.

25 **Demonstration project evaluation work group.**

Amends § 256B.0759 by adding subd. 8. Requires the commissioner to assemble a work group of relevant stakeholders to evaluate the long-term sustainability of improvements to quality or access to SUD treatment services caused by participation in the demonstration project.

Makes this section effective July 1, 2021.

26 **Case management services.**

Proposes coding for § 256B.076. Outlines state policy for medical assistance coverage of targeted case management services, subject to federal approval. Requires DHS, tribes, counties, providers, and individuals served to propose further modifications to targeted case management services.

Requires the commissioner to develop and implement a statewide rate methodology for any county that subcontracts targeted case management services, paid by medical assistance, to a vendor. Lists what the commissioner must include when setting the rate methodology. Allows a county to request authorization of a rate based on a lower caseload size in certain circumstances; outlines what must be included in such a request.

Sets caseload size limits for county-subcontracted providers of targeted case management services.

27 **Payment for targeted case management.**

Amends § 256B.0924, subd. 6. Modifies payment provisions for targeted case management services provided by county-contracted vendors to reference requirements in the new section created in this bill. Removes negotiation provision.

28 **Medical assistance reimbursement of case management services.**

Amends § 256B.094, subd. 6. Modifies payment provisions for case management services provided by county-contracted vendors to reference requirements in the new section created in this bill. Requires payment for case management services provided by tribe-contracted vendors to be a monthly rate negotiated by the tribe. Removes negotiation language.

29 **Direction to the commissioner; adult mental health initiatives reform.**

Requires the commissioner of human services to ensure continued funding for certain regions when reforming the adult mental health initiative funding formula.

Section	Description – Article 12: Behavioral Health

Requires the commissioner to notify the legislature upon finalization of the adult mental health initiatives reform.

30 **Direction to the commissioner; alternative mental health professional licensing pathways work group.**

Requires the commissioners of health and human services to convene a work group to:

- identify barriers to licensure in mental health professions;
- collect data on the number of individuals graduating from educational programs but not passing licensing exams;
- evaluate the feasibility of alternative pathways for licensure in mental health professions; and
- consult with national behavioral health testing entities.

Provides for reimbursement for expenses for mental health providers participating in the work group. Requires a report to the legislature on the work group's recommendations by February 1, 2023.

31 **Direction to the commissioner; children's mental health residential treatment work group.**

Requires the commissioner of human services to organize a work group, in consultation with specified entities and individuals, to develop recommendations on funding room and board costs for children's mental health residential treatment and how to address systemic barriers in transitioning children into the community. Requires a report to the legislature with recommendations by February 15, 2022.

32 **Direction to the commissioner; culturally and linguistically appropriate services.**

Requires the commissioner of human services to develop a statewide implementation and transition plan for culturally and linguistically appropriate services (CLAS) national standards, in consultation with listed stakeholders. Requires the commissioner to consult with individuals who are Black, indigenous, people of color, and linguistically diverse in developing these plans.

33 **Direction to the commissioner; rate recommendations for opioid treatment programs.**

Directs the commissioner of human services to evaluate the rate structure for licensed opioid treatment programs, and report to the legislature on rate structure recommendations and proposed legislation by October 1, 2021.

Section	Description – Article 12: Behavioral Health
34	**Direction to the commissioner; sober housing program recommendations.** Requires the commissioner, in consultation with stakeholders, to develop recommendations on increasing access to sober housing programs, promoting person-centered practices and cultural responsiveness in these programs, possible oversight measures, and providing consumer protections for individuals in the programs. Lists stakeholders that must be involved in developing the recommendations and requires a report to the legislature by March 1, 2022.
35	**Direction to the commissioner; substance use disorder treatment paperwork reduction.** Directs the commissioner to consult with relevant stakeholders to develop, assess, and recommend systems improvements in order to minimize paperwork for licensed substance use disorder programs. Requires the commissioner of health to make necessary information available, and requires MN.IT to provide advance consultation and implementation of needed systems changes. Requires the commissioner to contract with a vendor to develop the improvements, to begin implementing the improvements by December 15, 2022, and to submit a report to the legislature.
36	**Substance use disorder treatment rate restructure analysis.** Requires the commissioner of human services to issue a request for proposals by January 1, 2022, for frameworks and modeling of substance use disorder rates. Requires a report to the legislature by January 15, 2023.
37	**Revisor instruction.** Instructs the revisor to modify a head note related to certified community behavioral health clinic services.
38	**Repealer.** Repeals sections related to mental health case management, the Excellence in Mental Health demonstration project, and the definition of "responsible social services agency" in the Children's Mental Health Act. Specifies effective dates for repealers.

Article 13: Direct Care and Treatment

This article adds language to specify that county payments for the cost of care at state-operated community-based behavioral health hospitals apply to care at such hospitals for both adults and children.

Article 14: Disability Services and Continuing Care for Older Adults

This article establishes acuity-based customized living rates and closes the corporate foster care licensing loophole, provides for phase II of the waiver reimagine project, establishes a customized living moratorium for the BI and CADI waivers, modifies the Disability Waiver Rate System (DWRS), includes tribes in the cost-neutral housing support allocation option, provides rate increases for the direct support services workforce, provides for nursing facility reassessment and consumer improvements, provides for the Governor's Council on an Age-Friendly Minnesota, and provides for PCA rate reform.

Section	Description - Article 14: Disability Services and Continuing Care for Older Adults
1	**Resident assessment schedule.** Amends § 144.0724, subd. 4. Modifies nursing facility resident assessments for purposes of establishing case mix classifications for MA reimbursement.
2	**Licensing moratorium.** Amends § 245A.03, subd. 7. Adds an exception to the corporate foster care licensing moratorium for new foster care licenses or community residential setting licenses for people receiving customized living or 24-hour customized living services under the BI or CADI waivers and residing in the customized living setting before July 1, 2022. Allows a customized living service provider to rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. Makes the commissioner's disposition of a request for reconsideration final and not subject to appeal. Makes this exception available until June 30, 2023. Specifies circumstances under which this exception is available. Provides a July 1, 2022, effective date.
3	**Assessment and support planning.** Amends § 256B.0911, subd. 3a. Modifies the statute governing long-term care assessment and support planning by adding language to allow a person who receives MA HCBS and temporarily enters certain health care facilities for 121 days or less to return to the community under the same waiver services without requiring an assessment or reassessment, unless the person's annual reassessment is otherwise due. Specifies nothing in this section changes annual long-term care consultation reassessment requirements, payment for institutional or treatment services, MA financial eligibility, or any other law. Makes this section effective upon federal approval and requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.
4	**Home and community-based services for developmental disabilities.** Amends § 256B.092, subd. 4. Removes language under the sections of statutes governing the MA developmental disabilities waiver requiring the commissioner to

Section	Description - Article 14: Disability Services and Continuing Care for Older Adults
	allocate MA waiver funds to county agencies and requiring county agencies to manage the funds. Provides a January 1, 2023, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.
5	**Federal waivers.** Amends § 256B.092, subd. 5. Requires the commissioner to seek approval to allow for the reconfiguration of the MA home and community-based waivers to implement a two-waiver program structure and to implement an individual resource allocation methodology. Provides a January 1, 2023, effective date, or 90 days after federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.
6	**Waiver services statewide priorities.** Amends § 256B.092, subd. 12. Makes conforming changes related to having the commissioner manage waiver funds rather than county agencies.
7	**Regional quality councils and systems improvement.** Amends § 256B.097, by adding subd. 7. Requires the commissioner to maintain the regional quality councils and lists duties of the regional quality councils.
8	**Membership and staff.** Amends § 256B.097, by adding subd. 8. Specifies membership of the regional quality councils and give each regional quality council the authority to hire staff.
9	**Duties.** Amends § 256B.097, by adding subd. 9. Lists the duties of each regional quality council and allows each regional quality council to engage in quality improvement initiatives.
10	**Compensation.** Amends § 256B.097, by adding subd. 10. Provides for compensation for certain regional quality council members and allows regional quality councils to charge fees for their services.

Section	Description - Article 14: Disability Services and Continuing Care for Older Adults
11	**Contact information for consumer surveys for nursing facilities and home and community-based services.** Amends § 256B.439, by adding subd. 3c. Allows the commissioner to request contact information of clients and associated key representatives for purposes of conducting consumer surveys for nursing facilities and home and community-based services. Requires providers to furnish contact information available to the provider. Provides an immediate effective date.
12	**Resident experience survey and family survey for assisted living facilities.** Amends § 256B.439, by adding subd. 3d. Requires the commissioner to develop and administer a resident experience survey for assisted living facility residents and a family survey for families of assisted living facility residents. Specifies money appropriated to the commissioner to administer the resident experience survey and family survey is available in either fiscal year of the biennium in which it is appropriated.
13	**Authority.** Amends § 256B.49, subd. 11. Makes clarifying changes. Requires the commissioner to seek approval to allow for the reconfiguration of MA home and community-based waivers to implement a two-waiver program structure and to implement an individual resource allocation methodology. Provides a January 1, 2023, effective date, or 90 days after federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.
14	**Waiver services statewide priorities.** Amends § 256B.49, subd. 11a. Makes conforming changes related to having the commissioner manage waiver funds rather than county agencies. Provides a January 1, 2023, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.
15	**Cost of services and supports.** Amends § 256B.49, subd. 17. Removes language requiring the commissioner to allocate MA waiver funds to counties. Removes obsolete language. Provides a January 1, 2023, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

Section	Description - Article 14: Disability Services and Continuing Care for Older Adults

16 **Customized living moratorium for brain injury and community access for disability inclusion waivers.**

Amends § 256B.49, by adding subd. 28. Paragraph (a) prohibits the commissioner from enrolling new customized living settings serving four or fewer people in a single-family home to deliver customized living services under the BI or CADI waiver plans to prevent new developments of customized living settings that otherwise meet the definition of "residential program."

Paragraph (b) lists exceptions to the moratorium the commissioner may approve.

Paragraph (c) considers customized living settings operational on or before June 30, 2021, as existing customized living settings.

Paragraph (d) makes the authorizing lead agency responsible for all HCBS payments to any new customized living settings operational on or after July 1, 2021, serving four or fewer people in a single-family home.

Paragraph (e) defines "operational" for purposes of this subdivision.

Provides a July 1, 2021, effective date. Specifies this section only applies to customized living services provided under the MA BI and CADI waivers.

17 **Base wage index and standard component values.**

Amends § 256B.4914, subd. 5. Removes language related to family foster care base wages and component values in the section of statutes governing DWRS. Establishes component values under the disability waiver rate system (DWRS) for day support services, prevocational services, unit-based services with programming, and unit-based services without programming, except for respite care, delivered remotely. Makes technical and conforming changes.

Provides a January 1, 2022, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

18 **Payments for residential support services.**

Amends § 256B.4914, subd. 6. Removes references to family residential services, corporate and family foster care services, and supportive living services. Requires the commissioner to establish acuity-based input limits, based on case mix, for customized living and 24-hour customized living rates determined under DWRS. Limits customized living and 24-hour customized living rates determined under DWRS to 24 hours of support in a daily unit.

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Provides a January 1, 2022, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

19 **Payments for day programs.**

Amends § 256B.4914, subd. 7. Specifies day programs may be provided in person or remotely. Makes conforming changes in the formula establishing rates under DWRS for day services.

Provides a January 1, 2022, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

20 **Payments for unit-based services with programming.**

Amends § 256B.4914, subd. 8. Specifies unit-based services with programming may be provided in person or remotely. Makes conforming changes in the formula establishing rates under DWRS for unit-based services with programming.

Provides a January 1, 2022, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

21 **Payments for unit-based services without programming.**

Amends § 256B.4914, subd. 9. Specifies unit-based services without programming may be provided in person or remotely. Makes conforming changes in the formula establishing rates under DWRS for unit-based services without programming.

Provides a January 1, 2022, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

22 **Payments for family residential services.**

Amends § 256B.4914, by adding subd. 18. Requires the commissioner to establish rates for family residential services based on a person's assessed needs.

Provides a January 1, 2022, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

23 **Managed care contracts.**

Amends § 256B.69, subd. 5a. By January 30 of each year that follows a PCA or CFSS rate increase, requires managed care plans to inform the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction

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over rates determined under the new payment rate system of the amount of the rate increase that is paid to each PCA provider agency with which the plan has a contract.

Provides a January 1, 2023, effective date.

24 **Definitions.**

Amends § 256B.85, subd. 2. Applies the definitions under the CFSS program to the new payment rate system that is established and makes a grammatical change.

Provides a January 1, 2023, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

25 **Community first services and supports; payment rates.**

Creates § 256B.851.

Subd. 1. Application. Applies the payment methodologies in this section to: (1) CFSS, extended CFSS, and enhanced rate CFSS; and (2) PCA services, extended PCA service, and enhanced rate PCA services. Specifies this section does not change existing PCA program or CFSS policies and procedures.

Subd. 2. Definitions. Defines the terms “commissioner,” “component value,” and “payment rate.”

Subd. 3. Payment rates; base wage index. Paragraph (a) establishes base wage component value calculations for the services covered under this section based on Bureau of Labor Statistics (BLS) standard occupational classifications.

Paragraph (b) requires the commissioner to update base wage component values based on wage data from the BLS available 30 months and a day prior to the scheduled update beginning on January 1, 2025, and every two years thereafter.

Paragraph (c) requires the commissioner to report to the legislature on framework component updates under paragraph (b) beginning on August 1, 2024, and every two years thereafter.

Subd. 4. Payment rates; total wage index. Paragraphs (a) to (c) establish the competitive workforce factor and total wage component value for the services covered under this rate methodology.

Paragraph (d) requires the commissioner to report to the legislature with an update of the competitive workforce factors beginning on August 1, 2024, and every two years thereafter. Requires the commissioner to calculate biennial adjustments to the competitive workforce factor after determining the base

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wage index updates, and specifies the manner in which the competitive workforce factor must be adjusted.

Paragraph (e) requires the commissioner to recommend an increase or decrease of the competitive workforce factor from its previous value by no more than three percent. Prohibits the competitive workforce factor from being less than zero.

Subd. 5. Payment rates; component values. Paragraph (a) establishes component values for the payment rate methodology.

Paragraph (b) establishes implementation components for the payment rate methodology.

Paragraph (c) provides for inflationary adjustments of the implementation components.

Paragraph (d) requires the commissioner to update certain component values for changes in the Consumer Price Index by the percentage change from the date of any previous update to the data available six months and one day prior to the scheduled update beginning on January 1, 2025, and every two years thereafter.

Paragraph (e) requires the commissioner to report to the legislature with an update on the component values beginning on August 1, 2024, and every two years thereafter.

Subd. 6. Payment rates; rate determination. Paragraph (a) lays out the payment rate calculation the commissioner must use to determine rates for PCA services, CFSS, extended PCA services, extended CFSS, enhanced rate PCA services, enhanced rate CFSS, qualified professional services, and CFSS worker training and development.

Paragraph (b) requires the commissioner to publish the total adjusted payment rates.

Subd. 7. Provider agency; required reporting and analysis of cost data. Paragraph (a) requires the commissioner to evaluate on an ongoing basis whether the base wage component values and component values appropriately address the cost to provide the service and to make recommendations to adjust the rate methodology as indicated by the evaluation. Requires agencies enrolled to provide services with rates determined under this section to submit requested cost data to the commissioner. Lists the data the commissioner may request.

Paragraph (b) requires providers to submit the required cost data for a fiscal year that ended not more than 18 months prior to the submission date at least once

Section **Description - Article 14: Disability Services and Continuing Care for Older Adults**

every three years. Requires the commissioner to provide each provider with a 90-day notice prior to its submission due date and with notices 30 and 60 days after the required submission date for providers who fail to submit required cost data. Allows the commissioner to temporarily suspend payments to a provider if the commissioner has not received the required cost data 90 days after the required submission date and to make withheld payments when the required cost data is received by the commissioner.

Paragraph (c) requires the commissioner to conduct a random validation of data submitted to ensure data accuracy, analyze cost documentation, and provide recommendations for adjustments to cost components.

Paragraph (d) requires the commissioner to analyze cost documentation and allows the commissioner to submit recommendations on component values, updated base wage component values, and competitive workforce factors to the legislature every two years beginning August 1, 2026. Requires the commissioner to release cost data in aggregate form and prohibits cost data from individual providers from being released except as provided for in current law.

Paragraph (e) requires the commissioner to develop and implement a process for providing training and technical assistance necessary to support provider submission of cost data.

Subd. 8. Payment rates; reports required. Paragraph (a) requires the commissioner to assess the component values and publish evaluation findings and recommended changes to the rate methodology in a report to the legislature by August 1, 2026.

Paragraph (b) requires the commissioner to: (1) assess the long-term impacts of the rate methodology implementation on staff providing services with rates determined under this section, including but not limited to measuring changes in wages, benefits provided, hours worked, and retention; and (2) publish evaluation findings in a report to the legislature by August 1, 2028, and once every two years thereafter.

Subd. 9. Payment rates; collective bargaining. Subjects the commissioner's authority to set payment rates, including wages and benefits, for individual providers to the state's obligation to meet and negotiate under the Public Employment Labor Relations Act, as modified and made applicable to individual providers, and to agreements with any exclusive representative of individual providers as authorized under the Public Employment Labor Relations Act, as modified and made applicable to individual providers.

Section	Description - Article 14: Disability Services and Continuing Care for Older Adults

Provides a January 1, 2023, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

26 **Moratorium on development of housing support beds.**

Amends § 256I.04, subd. 3. Modifies the housing support bed moratorium exceptions by expanding the exception for supportive housing units in the metro area for homeless adults with mental illness, a history of substance abuse, or HIV/AIDS to allow for more supportive housing units and to include additional counties (Carver, Scott, and Washington counties). Removes language requiring 70 percent of the supportive housing units to serve homeless adults who are about to be, or within the last six months, have been discharged from a regional treatment center, a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. Removes obsolete language. Adds paragraph (c), which requires the appropriation for the housing support bed moratorium exceptions to include administrative funding equal to the cost of two FTEs to process eligibility and requires the commissioner to disburse administrative funding to the fiscal agent for counties.

27 **Supplementary service rates.**

Amends § 256I.05, subd. 1a. Makes clarifying changes. Includes tribes in the cost-neutral housing support allocation option.

Provides an immediate effective date.

28 **Rate increases.**

Amends § 256I.05, subd. 1c. Makes the housing support room and board rate for an individual payable beyond an 18-calendar-day absence period, not to exceed 150 days in a calendar year, for purposes of maintaining housing while temporarily absent due to residential behavioral health treatment or health care treatment that requires admission to certain facilities.

29 **Transfer of emergency shelter funds.**

Amends § 256I.05, subd. 11. Includes tribes in the cost-neutral housing support allocation option.

Provides an immediate effective date.

30 **Monthly case mix budget cap exception.**

Amends § 256S.18, subd. 7. Modifies the monthly case mix budget cap exception under the elderly waiver program by making technical changes, requiring the commissioner to calculate the difference between PCA services and enhanced rate

Section	Description - Article 14: Disability Services and Continuing Care for Older Adults

PCA services, and prohibiting the additional budget amount approved under an exception from exceeding this difference.

Provides a July 1, 2021, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

31 **Customized living services provider requirements.**

Amends § 256S.20, subd. 1. Makes changes to customized living services provider requirements to conform to the assisted living licensure statutes.

32 **Temporary PCA compensation for services provided by a parent or spouse.**

Amends Laws 2020, Fifth Special Session ch. 3, art. 10, § 3. Modifies the expiration date of a provision allowing for temporary PCA compensation for services provided by a parent or spouse. This provision expired on February 7, 2021.

33 **Self-directed worker contract ratification.**

Ratifies the labor agreement between the state of Minnesota and SEIU Healthcare Minnesota that was submitted to the Legislative Coordinating Commission on March 1, 2021.

34 **Direction to the commissioner; customized living report.**

Paragraph (a) requires, by January 15, 2022, the commissioner of human services to submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance and specifies the information that must be included in the report.

Paragraph (b) requires the commissioner of health to provide the commissioner of human services with the required data to complete the report in paragraph (a) and implement the moratorium on HCBS customized living. Specifies the data that must be included.

35 **Governor's Council on an Age-Friendly Minnesota.**

Specifies duties of the Governor's Council on an Age-Friendly Minnesota and extends the council until October 1, 2022.

36 **Rate increase for direct support services workforce.**

Paragraph (a) requires the commissioner of human services to increase direct support services reimbursement rates, individual budgets, grants, or allocations by specified percentages effective October 1, 2021, or upon federal approval, whichever is later, if the labor agreement between the state and SEIU Healthcare Minnesota is approved.

Section	Description - Article 14: Disability Services and Continuing Care for Older Adults
	Paragraphs (b) and (c) list the programs to which the rate changes apply.
37	**Waiver reimagine phase II.** Paragraph (a) requires the commissioner of human services to implement a two-home and community-based services waiver program structure that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, hospital, neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities. Paragraph (b) requires the commissioner to implement an individualized budget methodology that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, hospital, neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities. Paragraph (c) allows the commissioner to seek all federal authority necessary to implement this section. Provides a September 1, 2024, effective date, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.
38	**Repealer.** Paragraph (a) repeals Minn. Stat. § 256B.097, subds. 1 to 6 (state quality assurance, quality improvement, and licensing system). Paragraph (b) repeals Minn. Stat. §§ 256B.0916, subds. 2 (distribution of funds; partnerships), 3 (failure to develop partnerships or submit a plan), 4 (allowed reserve), 5 (allocation of new diversions and priorities for reassignment of resources for developmental disabilities), 8 (financial and wait-list data reporting), 11 (excess spending), and 12 (use of waiver allocations); and 256B.49, subds. 26 (excess allocations) and 27 (use of waiver allocations), effective January 1, 2023, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

Article 15: Community Supports Policy

This article contains clarifications and updates to intensive nonresidential rehabilitative mental health services and community first services and supports (CFSS).

Section	Description - Article 15: Community Supports Policy
1	**Service standards.** Amends § 256B.0947, subd. 6. Makes clarifying change.
2	**Managed care contracts.** Amends § 256B.69, subd. 5a. Requires managed care plans to use processes, forms, documentation, data reporting, and other policies consistent with MA fee-for-service or DHS contract requirements for community first services and supports (CFSS), which are scheduled to replace PCA services beginning in October.
3	**Basis and scope.** Amends § 256B.85, subd. 1. Clarifies that supports purchased under CFSS are not considered home care services.
4	**Definitions.** Amends § 256B.85, subd. 2. Clarifies the definitions of “activities of daily living,” “complex health-related needs,” “CFSS service delivery plan,” “dependency,” “extended CFSS,” “medication assistance,” “participant’s representative,” and “shared services.”
5	**Eligibility.** Amends § 256B.85, subd. 3. Clarifies eligibility for CFSS.
6	**Eligibility for other services.** Amends § 256B.85, subd. 4. Makes technical changes.
7	**Assessment requirements.** Amends § 256B.85, subd. 5. Modifies assessment requirements under CFSS.
8	**CFSS service delivery plan.** Amends § 256B.85, subd. 6. Clarifies CFSS service delivery plans must meet the needs identified in the developmental disabilities waiver coordinated service and support plan. Requires the CFSS service delivery plan to describe the units or dollar amount available to the participant.
9	**CFSS; covered services.** Amends § 256B.85, subd. 7. Modifies prohibitions for CFSS support workers who are the parent, stepparent, or legal guardian of a participant under age 18, or who are a participant’s spouse.

Section	Description - Article 15: Community Supports Policy
10	**Determination of CFSS service authorization amount.** Amends § 256B.85, subd. 8. Clarifies the provision of additional service units for level I behaviors.
11	**Authorization; exceptions.** Amends § 256B.85, by adding subd. 8a. Provides for exceptions to CFSS service authorizations.
12	**Noncovered services.** Amends § 256B.85, subd. 9. Clarifies noncovered services in residential settings and for children under age 18 under CFSS.
13	**Agency provider and FMS provider qualifications and duties.** Amends § 256B.85, subd. 10. Requires agency providers to complete required training as determined by the commissioner. Clarifies general duties of agency providers and FMS providers under CFSS.
14	**Agency provider model.** Amends § 256B.85, subd. 11. Requires the agency to make a reasonable effort to fulfill the participant's request for the participant's preferred worker. Makes terminology consistent.
15	**Agency provider model; support worker competency.** Amends § 256B.11b. Clarifies support worker competency requirements under CFSS. Clarifies requirements when providing shared services.
16	**Requirements for enrollment of CFSS agency providers.** Amends § 256B.85, subd. 12. Clarifies requirements CFSS agency providers must meet at the time of enrollment, reenrollment, and revalidation as a CFSS agency provider.
17	**CFSS agency provider requirements; notice regarding termination of services.** Amends § 256B.85, subd. 12b. Extends the timeline for agency providers to provide a termination of services notice to a participant from ten calendar days to 30 calendar days before the proposed termination of service. Corrects spelling.
18	**Budget model.** Amends § 256B.85, subd. 13. Requires two or more participants who are using the budget model, living in the same household, and using the same worker to use the same FMS provider. If the FMS provider advises that there is a joint employer in the

Section	Description - Article 15: Community Supports Policy

budget model, requires all participants associated with that joint employer to use the same FMS provider.

19 **Financial management services.**

Amends § 256B.85, subd. 13a. Expands FMS provider requirements to include providing written notice to the participant or the participant's representative at least 30 calendar days before a proposed service termination becomes effective. Removes unnecessary language.

20 **Participant's representative responsibilities.**

Amends § 256B.85, by adding subd. 14a. Paragraph (a) requires a participant to use a participant's representative to receive CFSS services if the participant is unable to direct the participant's own care. Lists circumstances under which a participant's representative is required.

Paragraph (b) lists requirements a participant's representative must meet.

Paragraph (c) lists certain persons who are prohibited from being a participant's representative.

Paragraph (d) allows a licensed family foster parent to be the participant's representative under certain circumstances.

Paragraph (e) allows for two persons to be designated as the participant's representative.

Paragraph (f) requires the participant or the participant's legal representative to appoint a participant's representative.

Paragraph (g) requires a participant's representative to enter into a written agreement with an agency provider or FMS provider and lists the items that must be included in the agreement.

Paragraph (h) allows a participant's representative to temporarily delegate responsibility to another adult and lists duties a participant's representative must meet in delegating responsibility.

Paragraph (i) specifies the length of time the designation of a participant's representative remains in place.

Paragraph (j) allows a lead agency to disqualify a participant's representative who engages in conduct that creates an imminent risk of harm to the participant, the support worker, or other staff. Requires a participant's representative who fails to

Section	Description - Article 15: Community Supports Policy
	provide support required by the participant to be referred to the common entry point.
21	**Documentation of support services provided; time sheets.** Amends § 256B.85, subd. 15. Clarifies support workers must submit time sheets at least once per month. Makes technical changes.
22	**Consultation services provider qualifications and requirements.** Amends § 256B.85, subd. 17a. Expands the list of qualifications and requirements consultation services providers must meet under CFSS to include proof of surety bond coverage and reporting of maltreatment of minors and vulnerable adults.
23	**Worker training and development services.** Amends § 256B.85, subd. 18a. Requires worker training and development services to be delivered by an individual competent to perform, teach, or assign the tasks, including health-related tasks, identified in the plan through education, training, and work experience. Modifies the list of items worker training and development services do not include.
24	**Service-related rights under an agency provider.** Amends § 256B.85, subd. 20b. Clarifies participant's service-related rights under an agency provider related to shared services.
25	**Commissioner's access.** Amends § 256B.85, subd. 23. Makes technical and clarifying changes.
26	**Sanctions; information for participants upon termination of services.** Amends § 256B.85, subd. 23a. Clarifies consultation services providers must also provide a participant with notice of service termination and support the participant in transitioning to another provider. Allows the commissioner to inform the ombudsman for long-term care and the lead agencies for all participants with active service agreements with a consultation services provider whose enrollment has been suspended or terminated.

Article 16: Miscellaneous

This article establishes in statute a grant program that incentivizes early care and education providers to remain in the workforce, makes changes to a grant program that provides scholarships to individuals in the early care and education workforce, and makes several

clarifying and policy changes to the Cultural and Ethnic Communities Leadership Council. The article also establishes a grant program to expand access to child care for children with disabilities, establishes a grant program to test strategies for sharing services among family child care providers, and directs DHS to report on foster children's participation in early care and education programs.

Section	Description – Article 16: Miscellaneous
1	**Retaining early educators through attaining incentives now (REETAIN) grant program.** Creates § 119B.195. Establishes in statute the REETAIN grant program to provide competitive grants to eligible child care providers to incentivize them to remain in the early care and education field. Directs the commissioner of human services to allocate the funding for the REETAIN grant program to a nonprofit organization. The nonprofit organization must annually award grant money to eligible child care providers in an amount determined by the commissioner. By January 1 of each year, the commissioner must report to the legislature on the number of grants awarded and program outcomes.
2	**Program components.** Amends § 136A.128, subd. 2. Increases the tuition scholarships available under the TEACH grant program from $5,000 per year to $10,000 per year and increases the minimum education incentives from $100 to $250 for participants in the tuition scholarship program if they complete a year of working in the early care and education field. Adds that applicants may be employed by a public prekindergarten program, modifies the amount scholarship recipients must contribute from 10 percent to at least 10 percent of the total scholarship, and decreases the amount their employer must contribute from 10 percent to at least 5 percent of the total scholarship.
3	**Administration.** Amends § 136A.128, subd. 4. Increases the amount a nonprofit organization that receives a TEACH grant may use to administer the program from 5 percent to 10 percent of the grant amount.
4	**Cultural and ethnic communities leadership council.** Amends § 256.041. Makes clarifying and policy changes related to the Cultural and Ethnic Communities Leadership Council, including: ▪ specifying broad membership groups; ▪ requiring the Commissioner of Human Services to accept council recommendations when appointing a chair; ▪ removing language regarding initial appointees' terms;

Section	Description – Article 16: Miscellaneous

- modifying the timeline for replacing members;
- requiring the commissioner to actively engage with the council;
- modifying language to ensure equitable and culturally responsive models of program implementation;
- requiring the department to advise on progress and accountability measures for addressing inequities;
- adding more duties for the commissioner;
- adding council duty to advance legislative proposals to improve racial and health equity outcomes, with community input;
- modifying council legislative report requirements;
- specifying that council members may not be absent from meetings more than three times per year;
- adding council member duty to participate in work groups;
- removing current June 30, 2022, expiration date; and
- providing compensation, under Minnesota Statutes, section 15.059, subdivision 3.

5 **Children with disabilities inclusive child care access expansion grant program.**

Directs DHS to establish a competitive grant program to expand access to child care for children with disabilities. DHS must award grants to counties or tribes, and grant money must be used to enable child care providers to develop inclusive child care settings to offer care to both children with disabilities and children without disabilities.

6 **Direction to commissioner of human services; family child care shared services innovation grants.**

Directs DHS to establish a grant program to test strategies that family child care providers can use to share services. DHS must report the results of the grant program to the legislature.

7 **Report on participation in early childhood programs by children in foster care.**

Directs DHS to issue a report on participation in early care and education programs by children under the age of six who have experienced foster care.

8 **Revisor instruction.**

Directs the revisor to renumber Minnesota Statutes, section 136A.128 (the TEACH grant program) as a section in Minnesota Statutes, section 119B.

Article 17: Mental Health Uniform Service Standards

This article moves various statutes and rules related to mental health service standards into a new chapter, 245I, and updates, aligns, and streamlines definitions and standards for providing a range of mental health services.

Section	Description - Article 17: Mental Health Uniform Service Standards

1 **Purpose and citation.**

Proposes coding for § 245I.01. Provides a citation for the act; states the purpose of creating a unified, comprehensive, and accountable system of mental health care; states public policy.

2 **Applicability.**

Proposes coding for § 245I.011.

Subd. 1. License requirements. Specifies other sections of statute and rules with which licensees must comply.

Subd. 2. Variances. Allows the commissioner to grant variances in certain circumstances, if the license holder, applicant, or certification holder meets listed conditions. Allows the commissioner to grant a permanent variance under certain circumstances; specifies that a variance decision is final and not subject to appeal.

Subd. 3. Certification required. Allows for mental health clinic certification; codifies standards for certification of mental health clinics.

Subd. 4. License required. Requires licensure for intensive residential treatment services (IRTS) or residential crisis stabilization.

Subd. 5. Programs certified under chapter 256B. Specifies that programs that are currently certified must comply with all license holder responsibilities.

Makes this section effective upon federal approval or July 1, 2022, whichever is later.

3 **Definitions.**

Proposes coding for § 245I.02. Defines the following terms for purposes of chapter 245I:

- Approval
- Behavioral sciences or related fields
- Business day
- Case manager
- Certified rehabilitation specialist

Section	Description - Article 17: Mental Health Uniform Service Standards

- Child
- Client
- Clinical trainee
- Commissioner
- Co-occurring substance use disorder treatment
- Crisis plan
- Critical incident
- Diagnostic assessment
- Direct contact
- Family and other natural supports
- Functional assessment
- Individual abuse prevention plan
- Level of care assessment
- License
- License holder
- Licensed prescriber
- Mental health behavioral aide
- Mental health certified family peer specialist
- Mental health practitioner
- Mental health professional
- Mental health rehabilitation worker
- Mental illness
- Organization
- Personnel file
- Registered nurse
- Rehabilitative mental health services
- Residential program
- Signature
- Staff person
- Strengths
- Trauma
- Treatment plan
- Treatment supervision
- Volunteer

4 **Required policies and procedures.**

Proposes coding for § 245I.03. Outlines standards for license holders to establish, enforce, and maintain policies and procedures to comply with the requirements of

Section	Description - Article 17: Mental Health Uniform Service Standards
	this chapter and additional relevant statutes and rules. Outlines additional requirements for policies and procedures; requires policies and procedures to address: health and safety; client rights; behavioral emergencies; health services and medications; reporting maltreatment; critical incidents; personnel; volunteers; and data privacy.
5	**Provider qualifications and scope of practice.** Proposes coding for § 245I.04. Modifies, centralizes, and clarifies mental health provider qualifications and scopes of practice; distinguishes between clinical trainees and mental health practitioners.
6	**Training required.** Proposes coding for § 245I.05. Aligns training standards for mental health staff; requires a license holder to develop a training plan and document training provided to staff. Specifies what must be included in initial training and ongoing training; requires additional training for medication administration.
7	**Treatment supervision.** Proposes coding for § 245I.06. Requires a license holder to ensure that a mental health professional or certified rehabilitation specialist provides treatment supervision to staff who are not mental health professionals or certified rehabilitation specialists. Outlines treatment supervision requirements and responsibilities; requires treatment supervision planning. Allows for greater flexibility in supervision. Requires direct observation of mental health behavioral aides or rehabilitation workers.
8	**Personnel files.** Proposes coding for § 245I.07. Aligns standards for maintaining personnel files; lists what a personnel file must include; requires personnel files to be readily accessible for the commissioner's review.
9	**Documentation standards.** Proposes coding for § 245I.08. Aligns standards for documenting treatment supervisor approval, services provided, and medication administered.
10	**Client files.** Proposes coding for § 245I.09. Aligns standards for maintaining and retaining client files; specifies what client files must include.
11	**Assessment and treatment planning.** Proposes coding for § 245I.10.

Section	Description - Article 17: Mental Health Uniform Service Standards
	Subd. 1. Definitions. Defines "diagnostic formulation" and "responsivity factors."
	Subd. 2. Generally. Outlines new requirements for diagnostic and crisis assessments and services that may be provided prior to those assessments. Allows specified services based on a client's needs identified in a hospital's medical history and presentation examination.
	Subd. 3. Continuity of services. Specifies that a diagnostic assessment conducted before the effective date of this section is valid for one year after it was completed. Specifies that an individual treatment plan is valid until the treatment plan's expiration date. Provides a July 1, 2023, expiration date for this subdivision.
	Subd. 4. Diagnostic assessment. Specifies required findings for a diagnostic assessment.
	Subd. 5. Brief diagnostic assessment; required elements. Outlines requirements for a brief diagnostic assessment.
	Subd. 6. Standard diagnostic assessment; required elements. Outlines requirements for a standard diagnostic assessment.
	Subd. 7. Individual treatment plan. Requires a license holder to follow each client's written individual treatment plan when providing services; lists exceptions.
	Subd. 8. Individual treatment plan; required elements. Outlines requirements for an individual treatment plan.
	Subd. 9. Functional assessment; required elements. Outlines requirements for a functional assessment.
12	**Health services and medications.** Proposes coding for § 245I.11. Establishes standards for health services, ordering, storing, and accounting for medications, and administering medications, for residential programs, license holders that store or administer client medications, or license holders that observe clients self-administer medication.
13	**Client rights and protections.** Proposes coding for § 245I.12. Outlines requirements for client rights and protections, aligning with the Health Care Bill of Rights and other relevant statutory provisions.

Section	Description - Article 17: Mental Health Uniform Service Standards
14	**Critical incidents.** Proposes coding for § 245I.13. Requires residential program license holders to report all critical incidents to the commissioner within 10 days of learning of the incident. Requires records to be kept in a central location, readily accessible to the commissioner for review.
15	**Mental health clinic.** Proposes coding for § 245I.20. Updates and increases flexibility for mental health clinic certification standards; moves standards from rule to statutes. Modifies staffing requirements, provides satellite location flexibility, and eliminates certain prescriptive requirements and replaces with requirement to implement a quality assurance and improvement plan.
16	**Intensive residential treatment services and residential crisis stabilization.** Proposes coding for § 245I.23. Outlines and aligns licensing standards for IRTS and residential crisis stabilization programs. Updates include allowing additional time for certain initial documentation and assessment requirements, reducing required assessment frequency, and modifying discharge standards.
17	**Covered mental health services.** Proposes coding for § 256B.0671. Standardizes terminology, using definitions established in chapter 245I. Provides for continued medical assistance coverage of mental health services defined in section 256B.0625 or rule 9505.0372, including: adult day treatment services; family psychoeducation services; dialectical behavior therapy; mental health clinical care consultation; neuropsychological assessment; neuropsychological testing; psychological testing; psychotherapy; partial hospitalization; and diagnostic assessments.
18	**Direction to commissioner; single comprehensive license structure.** Requires the commissioner, in consultation with stakeholders, to make recommendations to develop a single comprehensive licensing structure for mental health services programs. Lists required priorities for the recommendations developed under this section.
19	**Effective date.** Makes this article effective July 1, 2022, or upon federal approval, whichever is later.

Article 18: Crisis Response Services

This article modifies provisions related to crisis response services for adults and children by unifying service, eligibility, provider, and staff requirements, making clarifying changes, adding clinical trainees, adding language to include family members and other third parties, and aligning definitions and other provisions with the mental health uniform service standards established in chapter 245I.

Section	Description - Article 18: Crisis Response Services
1	**Availability of emergency services.** Amends § 245.469, subd. 1. Modifies Adult Mental Health Act language to include services and requirements currently provided under children's crisis services provisions; adds language to include family members and other third parties.
2	**Specific requirements.** Amends § 245.469, subd. 2. Modifies Adult Mental Health Act language to include clinical trainees; makes clarifying changes.
3	**Availability of emergency services.** Amends § 245.4879, subd. 1. Modifies Children's Mental Health Act crisis language by inserting cross-reference to provisions added in the above two sections.
4	**Crisis response services covered.** Amends § 256B.0624. Unifies service, eligibility, provider, and staff standards and qualifications for crisis services for adults and children; clarifies and merges definitions and references uniform service standard definitions (chapter 245I); distinguishes mobile crisis teams and residential crisis stabilization providers; adds subdivisions to clarify screening, initial assessment, and intervention processes.
5	**Effective date.** Makes this article effective July 1, 2022, or upon federal approval, whichever is later.

Article 19: Uniform Service Standards: Conforming Changes

This article makes conforming changes related to the establishment of the mental health uniform service standards in Article 9 and crisis response services in article 10, and includes a repealer of statutes and rules related to the newly-aligned and clarified standards.

Article 20: Forecast Adjustments

This article adjusts appropriations to the commissioner of human services in fiscal year 2021 for forecasted programs administered by the commissioner of human services.

Article 21: Appropriations

This article appropriates money for fiscal years 2022 and 2023 from the specified funds to the commissioner of human services, the commissioner of health, the health-related licensing boards, the Emergency Medical Services Regulatory Board, the Council on Disability, the ombudsman for mental health and developmental disabilities, the ombudspersons for families, and the attorney general. It also:

- reduces fiscal year 2021 appropriations from the state government special revenue fund to the commissioner of health;
- transfers an appropriation to the commissioner of health from fiscal year 2021 to fiscal year 2022;
- appropriates money in fiscal year 2021 to the commissioner of human services for an MFIP supplemental payment;
- refinances certain fiscal year 2020 emergency child care grants with money from the coronavirus relief federal fund;
- directs the commissioner of human services to allocate certain amounts from the child care and development block grant for specified purposes;
- appropriates to the commissioner of health, federal funds made available to the commissioner for vaccine activities;
- replaces expenditures authorized in this article with federal funds from the American Rescue Plan Act if the commissioner of management and budget determines those funds can be used for expenditures authorized in this article; and
- repeals a subdivision requiring the commissioner of management and budget to transfer excess funds from the health care access fund to the general fund each June 30, effective June 30, 2025.