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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 3471

02/15/2022

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The bill was read for the first time and referred to the Committee on Human Services Finance and Policy

1.1 A bill for an act

1.2 relating to human services; modifying human service provisions in community

1.3 supports; amending Minnesota Statutes 2020, sections 245D.12; 256.01, by adding

1.4 a subdivision; 256B.0659, subdivision 19; 256K.26, subdivisions 6, 7; 256Q.06,

1.5 by adding a subdivision; Minnesota Statutes 2021 Supplement, sections 62A.673,

1.6 subdivision 2; 148F.11, subdivision 1; 245.467, subdivisions 2, 3; 245.4871,

1.7 subdivision 21; 245.4876, subdivisions 2, 3; 245.735, subdivision 3; 245A.03,

1.8 subdivision 7; 245I.04, subdivision 4; 245I.05, subdivision 3; 245I.10, subdivisions

1.9 2, 6; 254B.05, subdivision 5; 256B.0622, subdivision 2; 256B.0625, subdivision

1.10 3b; 256B.0671, subdivision 6; 256B.0911, subdivision 3a; 256B.0946, subdivision

1.11 1; 256B.0947, subdivision 6; 256B.0949, subdivisions 2, 13; 256P.01, subdivision

1.12 6a; Laws 2020, First Special Session chapter 7, section 1, subdivision 1, as

1.13 amended; repealing Minnesota Statutes 2020, sections 254A.04; 254B.14,

1.14 subdivisions 1, 2, 3, 4, 6; Minnesota Statutes 2021 Supplement, section 254B.14,

1.15 subdivision 5.

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

1.17 Section 1. Minnesota Statutes 2021 Supplement, section 62A.673, subdivision 2, is

1.18 amended to read:

1.19 Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision

1.20 have the meanings given.

1.21 (b) "Distant site" means a site at which a health care provider is located while providing

1.22 health care services or consultations by means of telehealth.

1.23 (c) "Health care provider" means a health care professional who is licensed or registered

1.24 by the state to perform health care services within the provider's scope of practice and in

1.25 accordance with state law. A health care provider includes a mental health professional as

1.26 defined under section ~~245.462, subdivision 18, or 245.4871, subdivision 27~~ 245I.04,

1.27 subdivision 2; a mental health practitioner as defined under section ~~245.462, subdivision~~

2.1 ~~17, or 245.4871, subdivision 26~~ 245I.04, subdivision 4; a clinical trainee under section
2.2 245I.04, subdivision 6; a treatment coordinator under section 245G.11, subdivision 7; an
2.3 alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under
2.4 section 245G.11, subdivision 8.

2.5 (d) "Health carrier" has the meaning given in section 62A.011, subdivision 2.

2.6 (e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan
2.7 includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental
2.8 plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed
2.9 to pay benefits directly to the policy holder.

2.10 (f) "Originating site" means a site at which a patient is located at the time health care
2.11 services are provided to the patient by means of telehealth. For purposes of store-and-forward
2.12 technology, the originating site also means the location at which a health care provider
2.13 transfers or transmits information to the distant site.

2.14 (g) "Store-and-forward technology" means the asynchronous electronic transfer or
2.15 transmission of a patient's medical information or data from an originating site to a distant
2.16 site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

2.17 (h) "Telehealth" means the delivery of health care services or consultations through the
2.18 use of real time two-way interactive audio and visual communications to provide or support
2.19 health care delivery and facilitate the assessment, diagnosis, consultation, treatment,
2.20 education, and care management of a patient's health care. Telehealth includes the application
2.21 of secure video conferencing, store-and-forward technology, and synchronous interactions
2.22 between a patient located at an originating site and a health care provider located at a distant
2.23 site. Until July 1, 2023, telehealth also includes audio-only communication between a health
2.24 care provider and a patient in accordance with subdivision 6, paragraph (b). Telehealth does
2.25 not include communication between health care providers that consists solely of a telephone
2.26 conversation, e-mail, or facsimile transmission. Telehealth does not include communication
2.27 between a health care provider and a patient that consists solely of an e-mail or facsimile
2.28 transmission. Telehealth does not include telemonitoring services as defined in paragraph
2.29 (i).

2.30 (i) "Telemonitoring services" means the remote monitoring of clinical data related to
2.31 the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits
2.32 the data electronically to a health care provider for analysis. Telemonitoring is intended to
2.33 collect an enrollee's health-related data for the purpose of assisting a health care provider
2.34 in assessing and monitoring the enrollee's medical condition or status.

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

3.4 Sec. 2. Minnesota Statutes 2021 Supplement, section 148F.11, subdivision 1, is amended
3.5 to read:

3.6 Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of
3.7 other professions or occupations from performing functions for which they are qualified or
3.8 licensed. This exception includes, but is not limited to: licensed physicians; registered nurses;
3.9 licensed practical nurses; licensed psychologists and licensed psychological practitioners;
3.10 members of the clergy provided such services are provided within the scope of regular
3.11 ministries; American Indian medicine men and women; licensed attorneys; probation officers;
3.12 licensed marriage and family therapists; licensed social workers; social workers employed
3.13 by city, county, or state agencies; licensed professional counselors; licensed professional
3.14 clinical counselors; licensed school counselors; registered occupational therapists or
3.15 occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders
3.16 (UMICAD) certified counselors when providing services to Native American people; city,
3.17 county, or state employees when providing assessments or case management under Minnesota
3.18 Rules, chapter 9530; and ~~individuals defined in section 256B.0623, subdivision 5, clauses~~
3.19 ~~(4) to (6),~~ staff persons providing co-occurring substance use disorder treatment in adult
3.20 mental health rehabilitative programs certified or licensed by the Department of Human
3.21 Services under section 245I.23, 256B.0622, or 256B.0623.

3.22 (b) Nothing in this chapter prohibits technicians and resident managers in programs
3.23 licensed by the Department of Human Services from discharging their duties as provided
3.24 in Minnesota Rules, chapter 9530.

3.25 (c) Any person who is exempt from licensure under this section must not use a title
3.26 incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug
3.27 counselor" or otherwise hold himself or herself out to the public by any title or description
3.28 stating or implying that he or she is engaged in the practice of alcohol and drug counseling,
3.29 or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless
3.30 that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice
3.31 of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the
3.32 use of one of the titles in paragraph (a).

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

4.4 Sec. 3. Minnesota Statutes 2021 Supplement, section 245.467, subdivision 2, is amended
4.5 to read:

4.6 Subd. 2. **Diagnostic assessment.** ~~Providers~~ A provider of services governed by this
4.7 section must complete a diagnostic assessment of a client according to the standards of
4.8 section 245I.10, ~~subdivisions 4 to 6.~~

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

4.12 Sec. 4. Minnesota Statutes 2021 Supplement, section 245.467, subdivision 3, is amended
4.13 to read:

4.14 Subd. 3. **Individual treatment plans.** ~~Providers~~ A provider of services governed by
4.15 this section must complete an individual treatment plan for a client according to the standards
4.16 of section 245I.10, subdivisions 7 and 8.

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

4.20 Sec. 5. Minnesota Statutes 2021 Supplement, section 245.4871, subdivision 21, is amended
4.21 to read:

4.22 Subd. 21. **Individual treatment plan.** (a) "Individual treatment plan" means the
4.23 formulation of planned services that are responsive to the needs and goals of a client. An
4.24 individual treatment plan must be completed according to section 245I.10, subdivisions 7
4.25 and 8.

4.26 (b) A children's residential facility licensed under Minnesota Rules, chapter 2960, is
4.27 exempt from the requirements of section 245I.10, subdivisions 7 and 8. Instead, the individual
4.28 treatment plan must:

4.29 (1) include a written plan of intervention, treatment, and services for a child with an
4.30 emotional disturbance that the service provider develops under the clinical supervision of
4.31 a mental health professional on the basis of a diagnostic assessment;

5.1 (2) be developed in conjunction with the family unless clinically inappropriate; and
 5.2 (3) identify goals and objectives of treatment, treatment strategy, a schedule for
 5.3 accomplishing treatment goals and objectives, and the individuals responsible for providing
 5.4 treatment to the child with an emotional disturbance.

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

5.8 Sec. 6. Minnesota Statutes 2021 Supplement, section 245.4876, subdivision 2, is amended
 5.9 to read:

5.10 Subd. 2. **Diagnostic assessment.** ~~Providers~~ A provider of services governed by this
 5.11 section ~~shall~~ must complete a diagnostic assessment of a client according to the standards
 5.12 of section 245I.10, ~~subdivisions 4 to 6.~~ Notwithstanding the required timelines for completing
 5.13 a diagnostic assessment in section 245I.10, a children's residential facility licensed under
 5.14 Minnesota Rules, chapter 2960, that provides mental health services to children must, within
 5.15 ten days of the client's admission: (1) complete the client's diagnostic assessment; or (2)
 5.16 review and update the client's diagnostic assessment with a summary of the child's current
 5.17 mental health status and service needs if a diagnostic assessment is available that was
 5.18 completed within 180 days preceding admission and the client's mental health status has
 5.19 not changed markedly since the diagnostic assessment.

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

5.23 Sec. 7. Minnesota Statutes 2021 Supplement, section 245.4876, subdivision 3, is amended
 5.24 to read:

5.25 Subd. 3. **Individual treatment plans.** ~~Providers~~ A provider of services governed by
 5.26 this section ~~shall~~ must complete an individual treatment plan for a client according to the
 5.27 standards of section 245I.10, subdivisions 7 and 8. A children's residential facility licensed
 5.28 according to Minnesota Rules, chapter 2960, is exempt from the requirements in section
 5.29 245I.10, subdivisions 7 and 8. Instead, the facility must involve the child and the child's
 5.30 family in all phases of developing and implementing the individual treatment plan to the
 5.31 extent appropriate and must review the individual treatment plan every 90 days after intake.

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

6.4 Sec. 8. Minnesota Statutes 2021 Supplement, section 245.735, subdivision 3, is amended
6.5 to read:

6.6 Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall
6.7 establish a state certification process for certified community behavioral health clinics
6.8 (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this
6.9 section to be eligible for reimbursement under medical assistance, without service area
6.10 limits based on geographic area or region. The commissioner shall consult with CCBHC
6.11 stakeholders before establishing and implementing changes in the certification process and
6.12 requirements. Entities that choose to be CCBHCs must:

6.13 (1) comply with state licensing requirements and other requirements issued by the
6.14 commissioner;

6.15 (2) employ or contract for clinic staff who have backgrounds in diverse disciplines,
6.16 including licensed mental health professionals and licensed alcohol and drug counselors,
6.17 and staff who are culturally and linguistically trained to meet the needs of the population
6.18 the clinic serves;

6.19 (3) ensure that clinic services are available and accessible to individuals and families of
6.20 all ages and genders and that crisis management services are available 24 hours per day;

6.21 (4) establish fees for clinic services for individuals who are not enrolled in medical
6.22 assistance using a sliding fee scale that ensures that services to patients are not denied or
6.23 limited due to an individual's inability to pay for services;

6.24 (5) comply with quality assurance reporting requirements and other reporting
6.25 requirements, including any required reporting of encounter data, clinical outcomes data,
6.26 and quality data;

6.27 (6) provide crisis mental health and substance use services, withdrawal management
6.28 services, emergency crisis intervention services, and stabilization services through existing
6.29 mobile crisis services; screening, assessment, and diagnosis services, including risk
6.30 assessments and level of care determinations; person- and family-centered treatment planning;
6.31 outpatient mental health and substance use services; targeted case management; psychiatric
6.32 rehabilitation services; peer support and counselor services and family support services;
6.33 and intensive community-based mental health services, including mental health services

7.1 for members of the armed forces and veterans. CCBHCs must directly provide the majority
7.2 of these services to enrollees, but may coordinate some services with another entity through
7.3 a collaboration or agreement, pursuant to paragraph (b);

7.4 (7) provide coordination of care across settings and providers to ensure seamless
7.5 transitions for individuals being served across the full spectrum of health services, including
7.6 acute, chronic, and behavioral needs. Care coordination may be accomplished through
7.7 partnerships or formal contracts with:

7.8 (i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified
7.9 health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or
7.10 community-based mental health providers; and

7.11 (ii) other community services, supports, and providers, including schools, child welfare
7.12 agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally
7.13 licensed health care and mental health facilities, urban Indian health clinics, Department of
7.14 Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals,
7.15 and hospital outpatient clinics;

7.16 (8) be certified as a mental health ~~clinics~~ clinic under section ~~245.69, subdivision 2~~
7.17 245I.20;

7.18 (9) comply with standards established by the commissioner relating to CCBHC
7.19 screenings, assessments, and evaluations;

7.20 (10) be licensed to provide substance use disorder treatment under chapter 245G;

7.21 (11) be certified to provide children's therapeutic services and supports under section
7.22 256B.0943;

7.23 (12) be certified to provide adult rehabilitative mental health services under section
7.24 256B.0623;

7.25 (13) be enrolled to provide mental health crisis response services under ~~sections~~ section
7.26 256B.0624 and 256B.0944;

7.27 (14) be enrolled to provide mental health targeted case management under section
7.28 256B.0625, subdivision 20;

7.29 (15) comply with standards relating to mental health case management in Minnesota
7.30 Rules, parts 9520.0900 to 9520.0926;

7.31 (16) provide services that comply with the evidence-based practices described in
7.32 paragraph (e); and

8.1 (17) comply with standards relating to peer services under sections 256B.0615,
8.2 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer
8.3 services are provided.

8.4 (b) If a certified CCBHC is unable to provide one or more of the services listed in
8.5 paragraph (a), clauses (6) to (17), the CCBHC may contract with another entity that has the
8.6 required authority to provide that service and that meets the following criteria as a designated
8.7 collaborating organization:

8.8 (1) the entity has a formal agreement with the CCBHC to furnish one or more of the
8.9 services under paragraph (a), clause (6);

8.10 (2) the entity provides assurances that it will provide services according to CCBHC
8.11 service standards and provider requirements;

8.12 (3) the entity agrees that the CCBHC is responsible for coordinating care and has clinical
8.13 and financial responsibility for the services that the entity provides under the agreement;
8.14 and

8.15 (4) the entity meets any additional requirements issued by the commissioner.

8.16 (c) Notwithstanding any other law that requires a county contract or other form of county
8.17 approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets
8.18 CCBHC requirements may receive the prospective payment under section 256B.0625,
8.19 subdivision 5m, for those services without a county contract or county approval. As part of
8.20 the certification process in paragraph (a), the commissioner shall require a letter of support
8.21 from the CCBHC's host county confirming that the CCBHC and the county or counties it
8.22 serves have an ongoing relationship to facilitate access and continuity of care, especially
8.23 for individuals who are uninsured or who may go on and off medical assistance.

8.24 (d) When the standards listed in paragraph (a) or other applicable standards conflict or
8.25 address similar issues in duplicative or incompatible ways, the commissioner may grant
8.26 variances to state requirements if the variances do not conflict with federal requirements
8.27 for services reimbursed under medical assistance. If standards overlap, the commissioner
8.28 may substitute all or a part of a licensure or certification that is substantially the same as
8.29 another licensure or certification. The commissioner shall consult with stakeholders, as
8.30 described in subdivision 4, before granting variances under this provision. For the CCBHC
8.31 that is certified but not approved for prospective payment under section 256B.0625,
8.32 subdivision 5m, the commissioner may grant a variance under this paragraph if the variance
8.33 does not increase the state share of costs.

9.1 (e) The commissioner shall issue a list of required evidence-based practices to be
 9.2 delivered by CCBHCs, and may also provide a list of recommended evidence-based practices.
 9.3 The commissioner may update the list to reflect advances in outcomes research and medical
 9.4 services for persons living with mental illnesses or substance use disorders. The commissioner
 9.5 shall take into consideration the adequacy of evidence to support the efficacy of the practice,
 9.6 the quality of workforce available, and the current availability of the practice in the state.
 9.7 At least 30 days before issuing the initial list and any revisions, the commissioner shall
 9.8 provide stakeholders with an opportunity to comment.

9.9 (f) The commissioner shall recertify CCBHCs at least every three years. The
 9.10 commissioner shall establish a process for decertification and shall require corrective action,
 9.11 medical assistance repayment, or decertification of a CCBHC that no longer meets the
 9.12 requirements in this section or that fails to meet the standards provided by the commissioner
 9.13 in the application and certification process.

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

9.17 Sec. 9. Minnesota Statutes 2021 Supplement, section 245A.03, subdivision 7, is amended
 9.18 to read:

9.19 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
 9.20 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
 9.21 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
 9.22 for a physical location that will not be the primary residence of the license holder for the
 9.23 entire period of licensure. If a family child foster care home or family adult foster care home
 9.24 license is issued during this moratorium, and the license holder changes the license holder's
 9.25 primary residence away from the physical location of the foster care license, the
 9.26 commissioner shall revoke the license according to section 245A.07. The commissioner
 9.27 shall not issue an initial license for a community residential setting licensed under chapter
 9.28 245D. When approving an exception under this paragraph, the commissioner shall consider
 9.29 the resource need determination process in paragraph (h), the availability of foster care
 9.30 licensed beds in the geographic area in which the licensee seeks to operate, the results of a
 9.31 person's choices during their annual assessment and service plan review, and the
 9.32 recommendation of the local county board. The determination by the commissioner is final
 9.33 and not subject to appeal. Exceptions to the moratorium include:

10.1 (1) foster care settings where at least 80 percent of the residents are 55 years of age or
 10.2 older;

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

10.7 (3) new foster care licenses or community residential setting licenses determined to be
 10.8 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
 10.9 or regional treatment center; restructuring of state-operated services that limits the capacity
 10.10 of state-operated facilities; or allowing movement to the community for people who no
 10.11 longer require the level of care provided in state-operated facilities as provided under section
 10.12 256B.092, subdivision 13, or 256B.49, subdivision 24;

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

10.16 ~~(5) new foster care licenses or community residential setting licenses for people receiving~~
 10.17 ~~services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and~~
 10.18 ~~for which a license is required. This exception does not apply to people living in their own~~
 10.19 ~~home. For purposes of this clause, there is a presumption that a foster care or community~~
 10.20 ~~residential setting license is required for services provided to three or more people in a~~
 10.21 ~~dwelling unit when the setting is controlled by the provider. A license holder subject to this~~
 10.22 ~~exception may rebut the presumption that a license is required by seeking a reconsideration~~
 10.23 ~~of the commissioner's determination. The commissioner's disposition of a request for~~
 10.24 ~~reconsideration is final and not subject to appeal under chapter 14. The exception is available~~
 10.25 ~~until June 30, 2018. This exception is available when:~~

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

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

10.32 ~~(6)~~ (5) new foster care licenses or community residential setting licenses for people
 10.33 receiving customized living or 24-hour customized living services under the brain injury
 10.34 or community access for disability inclusion waiver plans under section 256B.49 and residing

11.1 in the customized living setting before July 1, 2022, for which a license is required. A
11.2 customized living service provider subject to this exception may rebut the presumption that
11.3 a license is required by seeking a reconsideration of the commissioner's determination. The
11.4 commissioner's disposition of a request for reconsideration is final and not subject to appeal
11.5 under chapter 14. The exception is available until June 30, 2023. This exception is available
11.6 when:

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

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

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

11.17 (b) The commissioner shall determine the need for newly licensed foster care homes or
11.18 community residential settings as defined under this subdivision. As part of the determination,
11.19 the commissioner shall consider the availability of foster care capacity in the area in which
11.20 the licensee seeks to operate, and the recommendation of the local county board. The
11.21 determination by the commissioner must be final. A determination of need is not required
11.22 for a change in ownership at the same address.

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

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

11.32 (e) A resource need determination process, managed at the state level, using the available
11.33 reports required by section 144A.351, and other data and information shall be used to
11.34 determine where the reduced capacity determined under section 256B.493 will be

12.1 implemented. The commissioner shall consult with the stakeholders described in section
12.2 144A.351, and employ a variety of methods to improve the state's capacity to meet the
12.3 informed decisions of those people who want to move out of corporate foster care or
12.4 community residential settings, long-term service needs within budgetary limits, including
12.5 seeking proposals from service providers or lead agencies to change service type, capacity,
12.6 or location to improve services, increase the independence of residents, and better meet
12.7 needs identified by the long-term services and supports reports and statewide data and
12.8 information.

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

12.17 (g) License holders of foster care homes identified under paragraph (f) that are not the
12.18 primary residence of the license holder and that also provide services in the foster care home
12.19 that are covered by a federally approved home and community-based services waiver, as
12.20 authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human
12.21 services licensing division that the license holder provides or intends to provide these
12.22 waiver-funded services.

12.23 (h) The commissioner may adjust capacity to address needs identified in section
12.24 144A.351. Under this authority, the commissioner may approve new licensed settings or
12.25 delicense existing settings. Delicensing of settings will be accomplished through a process
12.26 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
12.27 information and data on capacity of licensed long-term services and supports, actions taken
12.28 under the subdivision to manage statewide long-term services and supports resources, and
12.29 any recommendations for change to the legislative committees with jurisdiction over the
12.30 health and human services budget.

12.31 (i) The commissioner must notify a license holder when its corporate foster care or
12.32 community residential setting licensed beds are reduced under this section. The notice of
12.33 reduction of licensed beds must be in writing and delivered to the license holder by certified
12.34 mail or personal service. The notice must state why the licensed beds are reduced and must
12.35 inform the license holder of its right to request reconsideration by the commissioner. The

13.1 license holder's request for reconsideration must be in writing. If mailed, the request for
 13.2 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
 13.3 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
 13.4 reconsideration is made by personal service, it must be received by the commissioner within
 13.5 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

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

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

13.16 Sec. 10. Minnesota Statutes 2020, section 245D.12, is amended to read:

13.17 **245D.12 INTEGRATED COMMUNITY SUPPORTS; SETTING CAPACITY**
 13.18 **REPORT.**

13.19 (a) The license holder providing integrated community support, as defined in section
 13.20 245D.03, subdivision 1, paragraph (c), clause (8), must submit a setting capacity report to
 13.21 the commissioner to ensure the identified location of service delivery meets the criteria of
 13.22 the home and community-based service requirements as specified in section 256B.492.

13.23 (b) The license holder shall provide the setting capacity report on the forms and in the
 13.24 manner prescribed by the commissioner. The report must include:

13.25 (1) the address of the multifamily housing building where the license holder delivers
 13.26 integrated community supports and owns, leases, or has a direct or indirect financial
 13.27 relationship with the property owner;

13.28 (2) the total number of living units in the multifamily housing building described in
 13.29 clause (1) where integrated community supports are delivered;

13.30 (3) the total number of living units in the multifamily housing building described in
 13.31 clause (1), including the living units identified in clause (2); ~~and~~

14.1 (4) the total number of people who could reside in the living units in the multifamily
 14.2 housing building described in clause (2) and receive integrated community supports; and

14.3 ~~(4)~~ (5) the percentage of living units that are controlled by the license holder in the
 14.4 multifamily housing building by dividing clause (2) by clause (3).

14.5 (c) Only one license holder may deliver integrated community supports at the address
 14.6 of the multifamily housing building.

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

14.8 Sec. 11. Minnesota Statutes 2021 Supplement, section 245I.04, subdivision 4, is amended
 14.9 to read:

14.10 Subd. 4. **Mental health practitioner qualifications.** (a) An individual who is qualified
 14.11 in at least one of the ways described in paragraph (b) to (d) may serve as a mental health
 14.12 practitioner.

14.13 (b) An individual is qualified as a mental health practitioner through relevant coursework
 14.14 if the individual completes at least 30 semester hours or 45 quarter hours in behavioral
 14.15 sciences or related fields and:

14.16 (1) has at least 2,000 hours of experience providing services to individuals with:

14.17 (i) a mental illness or a substance use disorder; or

14.18 (ii) a traumatic brain injury or a developmental disability, and completes the additional
 14.19 training described in section 245I.05, subdivision 3, paragraph (c), before providing direct
 14.20 contact services to a client;

14.21 (2) is fluent in the non-English language of the ethnic group to which at least 50 percent
 14.22 of the individual's clients belong, and completes the additional training described in section
 14.23 245I.05, subdivision 3, paragraph (c), before providing direct contact services to a client;

14.24 (3) is working in a day treatment program under section 256B.0671, subdivision 3, or
 14.25 256B.0943; ~~or~~

14.26 (4) has completed a practicum or internship that (i) required direct interaction with adult
 14.27 clients or child clients, and (ii) was focused on behavioral sciences or related fields; or

14.28 (5) is in the process of completing a practicum or internship as part of a formal
 14.29 undergraduate or graduate training program in social work, psychology, or counseling.

14.30 (c) An individual is qualified as a mental health practitioner through work experience
 14.31 if the individual:

15.1 (1) has at least 4,000 hours of experience in the delivery of services to individuals with:

15.2 (i) a mental illness or a substance use disorder; or

15.3 (ii) a traumatic brain injury or a developmental disability, and completes the additional
15.4 training described in section 245I.05, subdivision 3, paragraph (c), before providing direct
15.5 contact services to clients; or

15.6 (2) receives treatment supervision at least once per week until meeting the requirement
15.7 in clause (1) of 4,000 hours of experience and has at least 2,000 hours of experience providing
15.8 services to individuals with:

15.9 (i) a mental illness or a substance use disorder; or

15.10 (ii) a traumatic brain injury or a developmental disability, and completes the additional
15.11 training described in section 245I.05, subdivision 3, paragraph (c), before providing direct
15.12 contact services to clients.

15.13 (d) An individual is qualified as a mental health practitioner if the individual has a
15.14 master's or other graduate degree in behavioral sciences or related fields.

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

15.18 Sec. 12. Minnesota Statutes 2021 Supplement, section 245I.05, subdivision 3, is amended
15.19 to read:

15.20 Subd. 3. **Initial training.** (a) A staff person must receive training about:

15.21 (1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and

15.22 (2) the maltreatment of minor reporting requirements and definitions in chapter 260E
15.23 within 72 hours of first providing direct contact services to a client.

15.24 (b) Before providing direct contact services to a client, a staff person must receive training
15.25 about:

15.26 (1) client rights and protections under section 245I.12;

15.27 (2) the Minnesota Health Records Act, including client confidentiality, family engagement
15.28 under section 144.294, and client privacy;

15.29 (3) emergency procedures that the staff person must follow when responding to a fire,
15.30 inclement weather, a report of a missing person, and a behavioral or medical emergency;

16.1 (4) specific activities and job functions for which the staff person is responsible, including
16.2 the license holder's program policies and procedures applicable to the staff person's position;

16.3 (5) professional boundaries that the staff person must maintain; and

16.4 (6) specific needs of each client to whom the staff person will be providing direct contact
16.5 services, including each client's developmental status, cognitive functioning, and physical
16.6 and mental abilities.

16.7 (c) Before providing direct contact services to a client, a mental health rehabilitation
16.8 worker, mental health behavioral aide, or mental health practitioner ~~qualified~~ required under
16.9 section 245I.04, subdivision 4, must receive 30 hours of training about:

16.10 (1) mental illnesses;

16.11 (2) client recovery and resiliency;

16.12 (3) mental health de-escalation techniques;

16.13 (4) co-occurring mental illness and substance use disorders; and

16.14 (5) psychotropic medications and medication side effects.

16.15 (d) Within 90 days of first providing direct contact services to an adult client, a clinical
16.16 trainee, mental health practitioner, mental health certified peer specialist, or mental health
16.17 rehabilitation worker must receive training about:

16.18 (1) trauma-informed care and secondary trauma;

16.19 (2) person-centered individual treatment plans, including seeking partnerships with
16.20 family and other natural supports;

16.21 (3) co-occurring substance use disorders; and

16.22 (4) culturally responsive treatment practices.

16.23 (e) Within 90 days of first providing direct contact services to a child client, a clinical
16.24 trainee, mental health practitioner, mental health certified family peer specialist, mental
16.25 health certified peer specialist, or mental health behavioral aide must receive training about
16.26 the topics in clauses (1) to (5). This training must address the developmental characteristics
16.27 of each child served by the license holder and address the needs of each child in the context
16.28 of the child's family, support system, and culture. Training topics must include:

16.29 (1) trauma-informed care and secondary trauma, including adverse childhood experiences
16.30 (ACEs);

- 17.1 (2) family-centered treatment plan development, including seeking partnership with a
17.2 child client's family and other natural supports;
- 17.3 (3) mental illness and co-occurring substance use disorders in family systems;
- 17.4 (4) culturally responsive treatment practices; and
- 17.5 (5) child development, including cognitive functioning, and physical and mental abilities.
- 17.6 (f) For a mental health behavioral aide, the training under paragraph (e) must include
17.7 parent team training using a curriculum approved by the commissioner.

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

17.11 Sec. 13. Minnesota Statutes 2021 Supplement, section 245I.10, subdivision 2, is amended
17.12 to read:

17.13 Subd. 2. **Generally.** (a) A license holder must use a client's diagnostic assessment or
17.14 crisis assessment to determine a client's eligibility for mental health services, except as
17.15 provided in this section.

17.16 (b) Prior to completing a client's initial diagnostic assessment, a license holder may
17.17 provide a client with the following services:

17.18 (1) an explanation of findings;

17.19 (2) neuropsychological testing, neuropsychological assessment, and psychological
17.20 testing;

17.21 (3) any combination of psychotherapy sessions, family psychotherapy sessions, and
17.22 family psychoeducation sessions not to exceed three sessions;

17.23 (4) crisis assessment services according to section 256B.0624; and

17.24 (5) ten days of intensive residential treatment services according to the assessment and
17.25 treatment planning standards in section ~~245.23~~ 245I.23, subdivision 7.

17.26 (c) Based on the client's needs that a crisis assessment identifies under section 256B.0624,
17.27 a license holder may provide a client with the following services:

17.28 (1) crisis intervention and stabilization services under section 245I.23 or 256B.0624;
17.29 and

18.1 (2) any combination of psychotherapy sessions, group psychotherapy sessions, family
18.2 psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions
18.3 within a 12-month period without prior authorization.

18.4 (d) Based on the client's needs in the client's brief diagnostic assessment, a license holder
18.5 may provide a client with any combination of psychotherapy sessions, group psychotherapy
18.6 sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed
18.7 ten sessions within a 12-month period without prior authorization for any new client or for
18.8 an existing client who the license holder projects will need fewer than ten sessions during
18.9 the next 12 months.

18.10 (e) Based on the client's needs that a hospital's medical history and presentation
18.11 examination identifies, a license holder may provide a client with:

18.12 (1) any combination of psychotherapy sessions, group psychotherapy sessions, family
18.13 psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions
18.14 within a 12-month period without prior authorization for any new client or for an existing
18.15 client who the license holder projects will need fewer than ten sessions during the next 12
18.16 months; and

18.17 (2) up to five days of day treatment services or partial hospitalization.

18.18 (f) A license holder must complete a new standard diagnostic assessment of a client:

18.19 (1) when the client requires services of a greater number or intensity than the services
18.20 that paragraphs (b) to (e) describe;

18.21 (2) at least annually following the client's initial diagnostic assessment if the client needs
18.22 additional mental health services and the client does not meet the criteria for a brief
18.23 assessment;

18.24 (3) when the client's mental health condition has changed markedly since the client's
18.25 most recent diagnostic assessment; or

18.26 (4) when the client's current mental health condition does not meet the criteria of the
18.27 client's current diagnosis.

18.28 (g) For an existing client, the license holder must ensure that a new standard diagnostic
18.29 assessment includes a written update containing all significant new or changed information
18.30 about the client, and an update regarding what information has not significantly changed,
18.31 including a discussion with the client about changes in the client's life situation, functioning,
18.32 presenting problems, and progress with achieving treatment goals since the client's last
18.33 diagnostic assessment was completed.

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

19.4 Sec. 14. Minnesota Statutes 2021 Supplement, section 245I.10, subdivision 6, is amended
19.5 to read:

19.6 Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health
19.7 professional or a clinical trainee may complete a standard diagnostic assessment of a client.
19.8 A standard diagnostic assessment of a client must include a face-to-face interview with a
19.9 client and a written evaluation of the client. The assessor must complete a client's standard
19.10 diagnostic assessment within the client's cultural context.

19.11 (b) When completing a standard diagnostic assessment of a client, the assessor must
19.12 gather and document information about the client's current life situation, including the
19.13 following information:

19.14 (1) the client's age;

19.15 (2) the client's current living situation, including the client's housing status and household
19.16 members;

19.17 (3) the status of the client's basic needs;

19.18 (4) the client's education level and employment status;

19.19 (5) the client's current medications;

19.20 (6) any immediate risks to the client's health and safety;

19.21 (7) the client's perceptions of the client's condition;

19.22 (8) the client's description of the client's symptoms, including the reason for the client's
19.23 referral;

19.24 (9) the client's history of mental health treatment; and

19.25 (10) cultural influences on the client.

19.26 (c) If the assessor cannot obtain the information that this ~~subdivision~~ paragraph requires
19.27 without retraumatizing the client or harming the client's willingness to engage in treatment,
19.28 the assessor must identify which topics will require further assessment during the course
19.29 of the client's treatment. The assessor must gather and document information related to the
19.30 following topics:

20.1 (1) the client's relationship with the client's family and other significant personal
20.2 relationships, including the client's evaluation of the quality of each relationship;

20.3 (2) the client's strengths and resources, including the extent and quality of the client's
20.4 social networks;

20.5 (3) important developmental incidents in the client's life;

20.6 (4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

20.7 (5) the client's history of or exposure to alcohol and drug usage and treatment; and

20.8 (6) the client's health history and the client's family health history, including the client's
20.9 physical, chemical, and mental health history.

20.10 (d) When completing a standard diagnostic assessment of a client, an assessor must use
20.11 a recognized diagnostic framework.

20.12 (1) When completing a standard diagnostic assessment of a client who is five years of
20.13 age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic
20.14 Classification of Mental Health and Development Disorders of Infancy and Early Childhood
20.15 published by Zero to Three.

20.16 (2) When completing a standard diagnostic assessment of a client who is six years of
20.17 age or older, the assessor must use the current edition of the Diagnostic and Statistical
20.18 Manual of Mental Disorders published by the American Psychiatric Association.

20.19 (3) When completing a standard diagnostic assessment of a client who is five years of
20.20 age or younger, an assessor must administer the Early Childhood Service Intensity Instrument
20.21 (ECSII) to the client and include the results in the client's assessment.

20.22 (4) When completing a standard diagnostic assessment of a client who is six to 17 years
20.23 of age, an assessor must administer the Child and Adolescent Service Intensity Instrument
20.24 (CASII) to the client and include the results in the client's assessment.

20.25 (5) When completing a standard diagnostic assessment of a client who is 18 years of
20.26 age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria
20.27 in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders
20.28 published by the American Psychiatric Association to screen and assess the client for a
20.29 substance use disorder.

20.30 (e) When completing a standard diagnostic assessment of a client, the assessor must
20.31 include and document the following components of the assessment:

20.32 (1) the client's mental status examination;

21.1 (2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources;
 21.2 vulnerabilities; safety needs, including client information that supports the assessor's findings
 21.3 after applying a recognized diagnostic framework from paragraph (d); and any differential
 21.4 diagnosis of the client;

21.5 (3) an explanation of: (i) how the assessor diagnosed the client using the information
 21.6 from the client's interview, assessment, psychological testing, and collateral information
 21.7 about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths;
 21.8 and (v) the client's responsivity factors.

21.9 (f) When completing a standard diagnostic assessment of a client, the assessor must
 21.10 consult the client and the client's family about which services that the client and the family
 21.11 prefer to treat the client. The assessor must make referrals for the client as to services required
 21.12 by law.

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

21.16 Sec. 15. Minnesota Statutes 2021 Supplement, section 254B.05, subdivision 5, is amended
 21.17 to read:

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

21.20 (b) Eligible substance use disorder treatment services include:

21.21 (1) outpatient treatment services that are licensed according to sections 245G.01 to
 21.22 245G.17, or applicable tribal license;

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

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

21.27 (4) peer recovery support services provided according to section 245G.07, subdivision
 21.28 2, clause (8);

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

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

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

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

22.6 (9) hospital-based treatment services that are licensed according to sections 245G.01 to
22.7 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to
22.8 144.56;

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

22.13 (11) high-intensity residential treatment services that are licensed according to sections
22.14 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of
22.15 clinical services each week provided by a state-operated vendor or to clients who have been
22.16 civilly committed to the commissioner, present the most complex and difficult care needs,
22.17 and are a potential threat to the community; and

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

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

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

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

22.23 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
22.24 9503; or

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

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

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

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

- 23.1 (2) culturally specific or culturally responsive programs as defined in section 254B.01,
23.2 subdivision 4a;
- 23.3 (3) disability responsive programs as defined in section 254B.01, subdivision 4b;
- 23.4 (4) programs that offer medical services delivered by appropriately credentialed health
23.5 care staff in an amount equal to two hours per client per week if the medical needs of the
23.6 client and the nature and provision of any medical services provided are documented in the
23.7 client file; or
- 23.8 (5) programs that offer services to individuals with co-occurring mental health and
23.9 chemical dependency problems if:
- 23.10 (i) the program meets the co-occurring requirements in section 245G.20;
- 23.11 (ii) 25 percent of the counseling staff are licensed mental health professionals, ~~as defined~~
23.12 ~~in section 245.462, subdivision 18, clauses (1) to (6)~~ under section 245I.04, subdivision 2,
23.13 or are students or licensing candidates under the supervision of a licensed alcohol and drug
23.14 counselor supervisor and ~~licensed~~ licensed mental health professional under section 245I.04,
23.15 subdivision 2, except that no more than 50 percent of the mental health staff may be students
23.16 or licensing candidates with time documented to be directly related to provisions of
23.17 co-occurring services;
- 23.18 (iii) clients scoring positive on a standardized mental health screen receive a mental
23.19 health diagnostic assessment within ten days of admission;
- 23.20 (iv) the program has standards for multidisciplinary case review that include a monthly
23.21 review for each client that, at a minimum, includes a licensed mental health professional
23.22 and licensed alcohol and drug counselor, and their involvement in the review is documented;
- 23.23 (v) family education is offered that addresses mental health and substance abuse disorders
23.24 and the interaction between the two; and
- 23.25 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
23.26 training annually.
- 23.27 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program
23.28 that provides arrangements for off-site child care must maintain current documentation at
23.29 the chemical dependency facility of the child care provider's current licensure to provide
23.30 child care services. Programs that provide child care according to paragraph (c), clause (1),
23.31 must be deemed in compliance with the licensing requirements in section 245G.19.

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

24.4 (f) Subject to federal approval, substance use disorder services that are otherwise covered
 24.5 as direct face-to-face services may be provided via telehealth as defined in section 256B.0625,
 24.6 subdivision 3b. The use of telehealth to deliver services must be medically appropriate to
 24.7 the condition and needs of the person being served. Reimbursement shall be at the same
 24.8 rates and under the same conditions that would otherwise apply to direct face-to-face services.

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

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

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

24.21 Sec. 16. Minnesota Statutes 2020, section 256.01, is amended by adding a subdivision to
 24.22 read:

24.23 Subd. 12b. **Department of Human Services systemic critical incident review team.** (a)
 24.24 The commissioner may establish a Department of Human Services systemic critical incident
 24.25 review team to review critical incidents reported as required under section 626.557 for
 24.26 which the Department of Human Services is responsible under section 626.5572, subdivision
 24.27 13; chapter 245D; or Minnesota Rules, chapter 9544. When reviewing a critical incident,
 24.28 the systemic critical incident review team shall identify systemic influences to the incident
 24.29 rather than determining the culpability of any actors involved in the incident. The systemic
 24.30 critical incident review may assess the entire critical incident process from the point of an
 24.31 entity reporting the critical incident through the ongoing case management process.
 24.32 Department staff shall lead and conduct the reviews and may utilize county staff as reviewers.
 24.33 The systemic critical incident review process may include but is not limited to:

25.1 (1) data collection about the incident and actors involved. Data may include the critical
25.2 incident report under review; previous incident reports pertaining to the person receiving
25.3 services; the service provider's policies and procedures applicable to the incident; the
25.4 coordinated service and support plan as defined in section 245D.02, subdivision 4b, for the
25.5 person receiving services; or an interview of an actor involved in the critical incident or the
25.6 review of the critical incident. Actors may include:

25.7 (i) staff of the provider agency;

25.8 (ii) lead agency staff administering home and community-based services delivered by
25.9 the provider;

25.10 (iii) Department of Human Services staff with oversight of home and community-based
25.11 services;

25.12 (iv) Department of Health staff with oversight of home and community-based services;

25.13 (v) members of the community including advocates, legal representatives, health care
25.14 providers, pharmacy staff, or others with knowledge of the incident or the actors in the
25.15 incident; and

25.16 (vi) staff from the office of the ombudsman for mental health and developmental
25.17 disabilities;

25.18 (2) systemic mapping of the critical incident. The team conducting the systemic mapping
25.19 of the incident may include any actors identified in clause (1), designated representatives
25.20 of other provider agencies, regional teams, and representatives of the local regional quality
25.21 council identified in section 256B.097; and

25.22 (3) analysis of the case for systemic influences.

25.23 Data collected by the critical incident review team shall be aggregated and provided to
25.24 regional teams, participating regional quality councils, and the commissioner. The regional
25.25 teams and quality councils shall analyze the data and make recommendations to the
25.26 commissioner regarding systemic changes that would decrease the number and severity of
25.27 critical incidents in the future or improve the quality of the home and community-based
25.28 service system.

25.29 (b) Cases selected for the systemic critical incident review process shall be selected by
25.30 a selection committee among the following critical incident categories:

25.31 (1) cases of caregiver neglect identified in section 626.5572, subdivision 17;

25.32 (2) cases involving financial exploitation identified in section 626.5572, subdivision 9;

26.1 (3) incidents identified in section 245D.02, subdivision 11;

26.2 (4) incidents identified in Minnesota Rules, part 9544.0110; and

26.3 (5) service terminations reported to the department in accordance with section 245D.10,
26.4 subdivision 3a.

26.5 (c) The systemic critical incident review under this section shall not replace the process
26.6 for screening or investigating cases of alleged maltreatment of an adult under section 626.557.
26.7 The department may select cases for systemic critical incident review, under the jurisdiction
26.8 of the commissioner, reported for suspected maltreatment and closed following initial or
26.9 final disposition.

26.10 (d) A member of the systemic critical incident review team shall not disclose what
26.11 transpired during the review, except to carry out the duties of the review. The proceedings
26.12 and records of the review team are protected nonpublic data as defined in section 13.02,
26.13 subdivision 13, and are not subject to discovery or introduction into evidence in a civil or
26.14 criminal action against a professional, the state, or a county agency arising out of the matters
26.15 that the team is reviewing. Information, documents, and records otherwise available from
26.16 other sources are not immune from discovery or use in a civil or criminal action solely
26.17 because the information, documents, and records were assessed or presented during
26.18 proceedings of the review team. A person who presented information before the systemic
26.19 critical incident review team or who is a member of the team shall not be prevented from
26.20 testifying about matters within the person's knowledge. In a civil or criminal proceeding, a
26.21 person shall not be questioned about the person's presentation of information to the review
26.22 team or opinions formed by the person as a result of the review.

26.23 Sec. 17. Minnesota Statutes 2021 Supplement, section 256B.0622, subdivision 2, is
26.24 amended to read:

26.25 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
26.26 meanings given them.

26.27 (b) "ACT team" means the group of interdisciplinary mental health staff who work as
26.28 a team to provide assertive community treatment.

26.29 (c) "Assertive community treatment" means intensive nonresidential treatment and
26.30 rehabilitative mental health services provided according to the assertive community treatment
26.31 model. Assertive community treatment provides a single, fixed point of responsibility for
26.32 treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per
26.33 day, seven days per week, in a community-based setting.

27.1 (d) "Individual treatment plan" means a plan described by section 245I.10, subdivisions
27.2 7 and 8.

27.3 (e) "Crisis assessment and intervention" means ~~mental health~~ mobile crisis response
27.4 services ~~as defined in~~ under section 256B.0624, ~~subdivision 2~~.

27.5 (f) "Individual treatment team" means a minimum of three members of the ACT team
27.6 who are responsible for consistently carrying out most of a client's assertive community
27.7 treatment services.

27.8 (g) "Primary team member" means the person who leads and coordinates the activities
27.9 of the individual treatment team and is the individual treatment team member who has
27.10 primary responsibility for establishing and maintaining a therapeutic relationship with the
27.11 client on a continuing basis.

27.12 (h) "Certified rehabilitation specialist" means a staff person who is qualified according
27.13 to section 245I.04, subdivision 8.

27.14 (i) "Clinical trainee" means a staff person who is qualified according to section 245I.04,
27.15 subdivision 6.

27.16 (j) "Mental health certified peer specialist" means a staff person who is qualified
27.17 according to section 245I.04, subdivision 10.

27.18 (k) "Mental health practitioner" means a staff person who is qualified according to section
27.19 245I.04, subdivision 4.

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

27.22 (m) "Mental health rehabilitation worker" means a staff person who is qualified according
27.23 to section 245I.04, subdivision 14.

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

27.27 Sec. 18. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 3b, is
27.28 amended to read:

27.29 Subd. 3b. **Telehealth services.** (a) Medical assistance covers medically necessary services
27.30 and consultations delivered by a health care provider through telehealth in the same manner
27.31 as if the service or consultation was delivered through in-person contact. Services or
27.32 consultations delivered through telehealth shall be paid at the full allowable rate.

28.1 (b) The commissioner may establish criteria that a health care provider must attest to in
28.2 order to demonstrate the safety or efficacy of delivering a particular service through
28.3 telehealth. The attestation may include that the health care provider:

28.4 (1) has identified the categories or types of services the health care provider will provide
28.5 through telehealth;

28.6 (2) has written policies and procedures specific to services delivered through telehealth
28.7 that are regularly reviewed and updated;

28.8 (3) has policies and procedures that adequately address patient safety before, during,
28.9 and after the service is delivered through telehealth;

28.10 (4) has established protocols addressing how and when to discontinue telehealth services;
28.11 and

28.12 (5) has an established quality assurance process related to delivering services through
28.13 telehealth.

28.14 (c) As a condition of payment, a licensed health care provider must document each
28.15 occurrence of a health service delivered through telehealth to a medical assistance enrollee.
28.16 Health care service records for services delivered through telehealth must meet the
28.17 requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must
28.18 document:

28.19 (1) the type of service delivered through telehealth;

28.20 (2) the time the service began and the time the service ended, including an a.m. and p.m.
28.21 designation;

28.22 (3) the health care provider's basis for determining that telehealth is an appropriate and
28.23 effective means for delivering the service to the enrollee;

28.24 (4) the mode of transmission used to deliver the service through telehealth and records
28.25 evidencing that a particular mode of transmission was utilized;

28.26 (5) the location of the originating site and the distant site;

28.27 (6) if the claim for payment is based on a physician's consultation with another physician
28.28 through telehealth, the written opinion from the consulting physician providing the telehealth
28.29 consultation; and

28.30 (7) compliance with the criteria attested to by the health care provider in accordance
28.31 with paragraph (b).

29.1 (d) Telehealth visits, as described in this subdivision provided through audio and visual
 29.2 communication, or accessible video-based platforms may be used to satisfy the face-to-face
 29.3 requirement for reimbursement under the payment methods that apply to a federally qualified
 29.4 health center, rural health clinic, Indian health service, 638 tribal clinic, and certified
 29.5 community behavioral health clinic, if the service would have otherwise qualified for
 29.6 payment if performed in person. Beginning July 1, 2021, visits provided through telephone
 29.7 may satisfy the face-to-face requirement for reimbursement under these payment methods
 29.8 if the service would have otherwise qualified for payment if performed in person until the
 29.9 COVID-19 federal public health emergency ends or July 1, 2023, whichever is earlier.

29.10 ~~(e) For mental health services or assessments delivered through telehealth that are based~~
 29.11 ~~on an individual treatment plan, the provider may document the client's verbal approval or~~
 29.12 ~~electronic written approval of the treatment plan or change in the treatment plan in lieu of~~
 29.13 ~~the client's signature in accordance with Minnesota Rules, part 9505.0371.~~

29.14 ~~(f)~~ (e) For purposes of this subdivision, unless otherwise covered under this chapter:

29.15 (1) "telehealth" means the delivery of health care services or consultations through the
 29.16 use of real-time two-way interactive audio and visual communication to provide or support
 29.17 health care delivery and facilitate the assessment, diagnosis, consultation, treatment,
 29.18 education, and care management of a patient's health care. Telehealth includes the application
 29.19 of secure video conferencing, store-and-forward technology, and synchronous interactions
 29.20 between a patient located at an originating site and a health care provider located at a distant
 29.21 site. Telehealth does not include communication between health care providers, or between
 29.22 a health care provider and a patient that consists solely of an audio-only communication,
 29.23 e-mail, or facsimile transmission or as specified by law;

29.24 (2) "health care provider" means a health care provider as defined under section 62A.673,
 29.25 a community paramedic as defined under section 144E.001, subdivision 5f, a community
 29.26 health worker who meets the criteria under subdivision 49, paragraph (a), a mental health
 29.27 certified peer specialist under section ~~256B.0615~~, subdivision 5 245I.04, subdivision 10, a
 29.28 mental health certified family peer specialist under section ~~256B.0616~~, subdivision 5 245I.04,
 29.29 subdivision 12, a mental health rehabilitation worker under section ~~256B.0623~~, subdivision
 29.30 5, paragraph (a), clause (4), and paragraph (b) 245I.04, subdivision 14, a mental health
 29.31 behavioral aide under section ~~256B.0943~~, subdivision 7, paragraph (b), clause (3) 245I.04,
 29.32 subdivision 16, a treatment coordinator under section 245G.11, subdivision 7, an alcohol
 29.33 and drug counselor under section 245G.11, subdivision 5, a recovery peer under section
 29.34 245G.11, subdivision 8; and

30.1 (3) "originating site," "distant site," and "store-and-forward technology" have the
30.2 meanings given in section 62A.673, subdivision 2.

30.3 **EFFECTIVE DATE.** This section is effective July 1, 2022, or upon federal approval,
30.4 whichever is later, except that the amendment to paragraph (d) is effective retroactively
30.5 from July 1, 2021, and expires when the COVID-19 federal public health emergency ends
30.6 or July 1, 2023, whichever is earlier. The commissioner of human services shall notify the
30.7 revisor of statutes when federal approval is obtained and when the amendments to paragraph
30.8 (d) expire.

30.9 Sec. 19. Minnesota Statutes 2020, section 256B.0659, subdivision 19, is amended to read:

30.10 Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a) Under
30.11 personal care assistance choice, the recipient or responsible party shall:

30.12 (1) recruit, hire, schedule, and terminate personal care assistants according to the terms
30.13 of the written agreement required under subdivision 20, paragraph (a);

30.14 (2) develop a personal care assistance care plan based on the assessed needs and
30.15 addressing the health and safety of the recipient with the assistance of a qualified professional
30.16 as needed;

30.17 (3) orient and train the personal care assistant with assistance as needed from the qualified
30.18 professional;

30.19 (4) ~~effective January 1, 2010,~~ supervise and evaluate the personal care assistant with the
30.20 qualified professional, who is required to visit the recipient at least every 180 days;

30.21 (5) monitor and verify in writing and report to the personal care assistance choice agency
30.22 the number of hours worked by the personal care assistant and the qualified professional;

30.23 (6) engage in an annual ~~face-to-face~~ reassessment as required in subdivision 3a to
30.24 determine continuing eligibility and service authorization; and

30.25 (7) use the same personal care assistance choice provider agency if shared personal
30.26 assistance care is being used.

30.27 (b) The personal care assistance choice provider agency shall:

30.28 (1) meet all personal care assistance provider agency standards;

30.29 (2) enter into a written agreement with the recipient, responsible party, and personal
30.30 care assistants;

31.1 (3) not be related as a parent, child, sibling, or spouse to the recipient or the personal
31.2 care assistant; and

31.3 (4) ensure arm's-length transactions without undue influence or coercion with the recipient
31.4 and personal care assistant.

31.5 (c) The duties of the personal care assistance choice provider agency are to:

31.6 (1) be the employer of the personal care assistant and the qualified professional for
31.7 employment law and related regulations including, but not limited to, purchasing and
31.8 maintaining workers' compensation, unemployment insurance, surety and fidelity bonds,
31.9 and liability insurance, and submit any or all necessary documentation including, but not
31.10 limited to, workers' compensation, unemployment insurance, and labor market data required
31.11 under section 256B.4912, subdivision 1a;

31.12 (2) bill the medical assistance program for personal care assistance services and qualified
31.13 professional services;

31.14 (3) request and complete background studies that comply with the requirements for
31.15 personal care assistants and qualified professionals;

31.16 (4) pay the personal care assistant and qualified professional based on actual hours of
31.17 services provided;

31.18 (5) withhold and pay all applicable federal and state taxes;

31.19 (6) verify and keep records of hours worked by the personal care assistant and qualified
31.20 professional;

31.21 (7) make the arrangements and pay taxes and other benefits, if any, and comply with
31.22 any legal requirements for a Minnesota employer;

31.23 (8) enroll in the medical assistance program as a personal care assistance choice agency;
31.24 and

31.25 (9) enter into a written agreement as specified in subdivision 20 before services are
31.26 provided.

31.27 Sec. 20. Minnesota Statutes 2021 Supplement, section 256B.0671, subdivision 6, is
31.28 amended to read:

31.29 Subd. 6. **Dialectical behavior therapy.** (a) Subject to federal approval, medical assistance
31.30 covers intensive mental health outpatient treatment for dialectical behavior therapy for
31.31 adults. A dialectical behavior therapy provider must make reasonable and good faith efforts

32.1 to report individual client outcomes to the commissioner using instruments and protocols
 32.2 that are approved by the commissioner.

32.3 (b) "Dialectical behavior therapy" means an evidence-based treatment approach that a
 32.4 mental health professional or clinical trainee provides to a client or a group of clients in an
 32.5 intensive outpatient treatment program using a combination of individualized rehabilitative
 32.6 and psychotherapeutic interventions. A dialectical behavior therapy program involves:
 32.7 individual dialectical behavior therapy, group skills training, telephone coaching, and team
 32.8 consultation meetings.

32.9 (c) To be eligible for dialectical behavior therapy, a client must:

32.10 ~~(1)~~ be 18 years of age or older;

32.11 ~~(2)~~ (1) have mental health needs that available community-based services cannot meet
 32.12 or that the client must receive concurrently with other community-based services;

32.13 ~~(3)~~ (2) have either:

32.14 (i) a diagnosis of borderline personality disorder; or

32.15 (ii) multiple mental health diagnoses, exhibit behaviors characterized by impulsivity or
 32.16 intentional self-harm, and be at significant risk of death, morbidity, disability, or severe
 32.17 dysfunction in multiple areas of the client's life;

32.18 ~~(4)~~ (3) be cognitively capable of participating in dialectical behavior therapy as an
 32.19 intensive therapy program and be able and willing to follow program policies and rules to
 32.20 ensure the safety of the client and others; and

32.21 ~~(5)~~ (4) be at significant risk of one or more of the following if the client does not receive
 32.22 dialectical behavior therapy:

32.23 (i) having a mental health crisis;

32.24 (ii) requiring a more restrictive setting such as hospitalization;

32.25 (iii) decompensating; or

32.26 (iv) engaging in intentional self-harm behavior.

32.27 (d) Individual dialectical behavior therapy combines individualized rehabilitative and
 32.28 psychotherapeutic interventions to treat a client's suicidal and other dysfunctional behaviors
 32.29 and to reinforce a client's use of adaptive skillful behaviors. A mental health professional
 32.30 or clinical trainee must provide individual dialectical behavior therapy to a client. A mental
 32.31 health professional or clinical trainee providing dialectical behavior therapy to a client must:

- 33.1 (1) identify, prioritize, and sequence the client's behavioral targets;
- 33.2 (2) treat the client's behavioral targets;
- 33.3 (3) assist the client in applying dialectical behavior therapy skills to the client's natural
- 33.4 environment through telephone coaching outside of treatment sessions;
- 33.5 (4) measure the client's progress toward dialectical behavior therapy targets;
- 33.6 (5) help the client manage mental health crises and life-threatening behaviors; and
- 33.7 (6) help the client learn and apply effective behaviors when working with other treatment
- 33.8 providers.
- 33.9 (e) Group skills training combines individualized psychotherapeutic and psychiatric
- 33.10 rehabilitative interventions conducted in a group setting to reduce the client's suicidal and
- 33.11 other dysfunctional coping behaviors and restore function. Group skills training must teach
- 33.12 the client adaptive skills in the following areas: (1) mindfulness; (2) interpersonal
- 33.13 effectiveness; (3) emotional regulation; and (4) distress tolerance.
- 33.14 (f) Group skills training must be provided by two mental health professionals or by a
- 33.15 mental health professional co-facilitating with a clinical trainee or a mental health practitioner.
- 33.16 Individual skills training must be provided by a mental health professional, a clinical trainee,
- 33.17 or a mental health practitioner.
- 33.18 (g) Before a program provides dialectical behavior therapy to a client, the commissioner
- 33.19 must certify the program as a dialectical behavior therapy provider. To qualify for
- 33.20 certification as a dialectical behavior therapy provider, a provider must:
- 33.21 (1) allow the commissioner to inspect the provider's program;
- 33.22 (2) provide evidence to the commissioner that the program's policies, procedures, and
- 33.23 practices meet the requirements of this subdivision and chapter 245I;
- 33.24 (3) be enrolled as a MHCP provider; and
- 33.25 (4) have a manual that outlines the program's policies, procedures, and practices that
- 33.26 meet the requirements of this subdivision.
- 33.27 **EFFECTIVE DATE.** This section is effective July 1, 2022, or upon federal approval,
- 33.28 whichever is later. The commissioner of human services shall notify the revisor of statutes
- 33.29 when federal approval is obtained.

34.1 Sec. 21. Minnesota Statutes 2021 Supplement, section 256B.0911, subdivision 3a, is
34.2 amended to read:

34.3 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
34.4 planning, or other assistance intended to support community-based living, including persons
34.5 who need assessment ~~in order~~ to determine waiver or alternative care program eligibility,
34.6 must be visited by a long-term care consultation team within 20 calendar days after the date
34.7 on which an assessment was requested or recommended. Upon statewide implementation
34.8 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
34.9 requesting personal care assistance services. The commissioner shall provide at least a
34.10 90-day notice to lead agencies prior to the effective date of this requirement. Assessments
34.11 must be conducted according to paragraphs (b) to (r).

34.12 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
34.13 assessors to conduct the assessment. For a person with complex health care needs, a public
34.14 health or registered nurse from the team must be consulted.

34.15 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
34.16 be used to complete a comprehensive, conversation-based, person-centered assessment.
34.17 The assessment must include the health, psychological, functional, environmental, and
34.18 social needs of the individual necessary to develop a person-centered community support
34.19 plan that meets the individual's needs and preferences.

34.20 (d) Except as provided in paragraph (r), the assessment must be conducted by a certified
34.21 assessor in a face-to-face conversational interview with the person being assessed. The
34.22 person's legal representative must provide input during the assessment process and may do
34.23 so remotely if requested. At the request of the person, other individuals may participate in
34.24 the assessment to provide information on the needs, strengths, and preferences of the person
34.25 necessary to develop a community support plan that ensures the person's health and safety.
34.26 Except for legal representatives or family members invited by the person, persons
34.27 participating in the assessment may not be a provider of service or have any financial interest
34.28 in the provision of services. For persons who are to be assessed for elderly waiver customized
34.29 living or adult day services under chapter 256S, with the permission of the person being
34.30 assessed or the person's designated or legal representative, the client's current or proposed
34.31 provider of services may submit a copy of the provider's nursing assessment or written
34.32 report outlining its recommendations regarding the client's care needs. The person conducting
34.33 the assessment must notify the provider of the date by which this information is to be
34.34 submitted. This information shall be provided to the person conducting the assessment prior
34.35 to the assessment. For a person who is to be assessed for waiver services under section

35.1 256B.092 or 256B.49, with the permission of the person being assessed or the person's
35.2 designated legal representative, the person's current provider of services may submit a
35.3 written report outlining recommendations regarding the person's care needs the person
35.4 completed in consultation with someone who is known to the person and has interaction
35.5 with the person on a regular basis. The provider must submit the report at least 60 days
35.6 before the end of the person's current service agreement. The certified assessor must consider
35.7 the content of the submitted report prior to finalizing the person's assessment or reassessment.

35.8 (e) The certified assessor and the individual responsible for developing the coordinated
35.9 service and support plan must complete the community support plan and the coordinated
35.10 service and support plan no more than 60 calendar days from the assessment visit. The
35.11 person or the person's legal representative must be provided with a written community
35.12 support plan within the timelines established by the commissioner, regardless of whether
35.13 the person is eligible for Minnesota health care programs.

35.14 (f) For a person being assessed for elderly waiver services under chapter 256S, a provider
35.15 who submitted information under paragraph (d) shall receive the final written community
35.16 support plan when available and the Residential Services Workbook.

35.17 (g) The written community support plan must include:

35.18 (1) a summary of assessed needs as defined in paragraphs (c) and (d);

35.19 (2) the individual's options and choices to meet identified needs, including:

35.20 (i) all available options for case management services and providers;

35.21 (ii) all available options for employment services, settings, and providers;

35.22 (iii) all available options for living arrangements;

35.23 (iv) all available options for self-directed services and supports, including self-directed
35.24 budget options; and

35.25 (v) service provided in a non-disability-specific setting;

35.26 (3) identification of health and safety risks and how those risks will be addressed,
35.27 including personal risk management strategies;

35.28 (4) referral information; and

35.29 (5) informal caregiver supports, if applicable.

36.1 For a person determined eligible for state plan home care under subdivision 1a, paragraph
36.2 (b), clause (1), the person or person's representative must also receive a copy of the home
36.3 care service plan developed by the certified assessor.

36.4 (h) A person may request assistance in identifying community supports without
36.5 participating in a complete assessment. Upon a request for assistance identifying community
36.6 support, the person must be transferred or referred to long-term care options counseling
36.7 services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for
36.8 telephone assistance and follow up.

36.9 (i) The person has the right to make the final decision:

36.10 (1) between institutional placement and community placement after the recommendations
36.11 have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

36.12 (2) between community placement in a setting controlled by a provider and living
36.13 independently in a setting not controlled by a provider;

36.14 (3) between day services and employment services; and

36.15 (4) regarding available options for self-directed services and supports, including
36.16 self-directed funding options.

36.17 (j) The lead agency must give the person receiving long-term care consultation services
36.18 or the person's legal representative, materials, and forms supplied by the commissioner
36.19 containing the following information:

36.20 (1) written recommendations for community-based services and consumer-directed
36.21 options;

36.22 (2) documentation that the most cost-effective alternatives available were offered to the
36.23 individual. For purposes of this clause, "cost-effective" means community services and
36.24 living arrangements that cost the same as or less than institutional care. For an individual
36.25 found to meet eligibility criteria for home and community-based service programs under
36.26 chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally
36.27 approved waiver plan for each program;

36.28 (3) the need for and purpose of preadmission screening conducted by long-term care
36.29 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
36.30 nursing facility placement. If the individual selects nursing facility placement, the lead
36.31 agency shall forward information needed to complete the level of care determinations and
36.32 screening for developmental disability and mental illness collected during the assessment
36.33 to the long-term care options counselor using forms provided by the commissioner;

37.1 (4) the role of long-term care consultation assessment and support planning in eligibility
37.2 determination for waiver and alternative care programs, and state plan home care, case
37.3 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
37.4 and (b);

37.5 (5) information about Minnesota health care programs;

37.6 (6) the person's freedom to accept or reject the recommendations of the team;

37.7 (7) the person's right to confidentiality under the Minnesota Government Data Practices
37.8 Act, chapter 13;

37.9 (8) the certified assessor's decision regarding the person's need for institutional level of
37.10 care as determined under criteria established in subdivision 4e and the certified assessor's
37.11 decision regarding eligibility for all services and programs as defined in subdivision 1a,
37.12 paragraphs (a), clause (6), and (b);

37.13 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
37.14 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
37.15 (8), and (b), and incorporating the decision regarding the need for institutional level of care
37.16 or the lead agency's final decisions regarding public programs eligibility according to section
37.17 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
37.18 to the person and must visually point out where in the document the right to appeal is stated;
37.19 and

37.20 (10) documentation that available options for employment services, independent living,
37.21 and self-directed services and supports were described to the individual.

37.22 (k) An assessment that is completed as part of an eligibility determination for multiple
37.23 programs for the alternative care, elderly waiver, developmental disabilities, community
37.24 access for disability inclusion, community alternative care, and brain injury waiver programs
37.25 under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish
37.26 service eligibility for no more than 60 calendar days after the date of the assessment.

37.27 (l) The effective eligibility start date for programs in paragraph (k) can never be prior
37.28 to the date of assessment. If an assessment was completed more than 60 days before the
37.29 effective waiver or alternative care program eligibility start date, assessment and support
37.30 plan information must be updated and documented in the department's Medicaid Management
37.31 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
37.32 state plan services, the effective date of eligibility for programs included in paragraph (k)
37.33 cannot be prior to the date the most recent updated assessment is completed.

38.1 (m) If an eligibility update is completed within 90 days of the previous assessment and
38.2 documented in the department's Medicaid Management Information System (MMIS), the
38.3 effective date of eligibility for programs included in paragraph (k) is the date of the previous
38.4 face-to-face assessment when all other eligibility requirements are met.

38.5 (n) If a person who receives home and community-based waiver services under section
38.6 256B.0913, 256B.092, or 256B.49 or chapter 256S temporarily enters for 121 days or fewer
38.7 a hospital, institution of mental disease, nursing facility, intensive residential treatment
38.8 services program, transitional care unit, or inpatient substance use disorder treatment setting,
38.9 the person may return to the community with home and community-based waiver services
38.10 under the same waiver, without requiring an assessment or reassessment under this section,
38.11 unless the person's annual reassessment is otherwise due. Nothing in this paragraph shall
38.12 change annual long-term care consultation reassessment requirements, payment for
38.13 institutional or treatment services, medical assistance financial eligibility, or any other law.

38.14 (o) At the time of reassessment, the certified assessor shall assess each person receiving
38.15 waiver residential supports and services currently residing in a community residential setting,
38.16 licensed adult foster care home that is either not the primary residence of the license holder
38.17 or in which the license holder is not the primary caregiver, family adult foster care residence,
38.18 customized living setting, or supervised living facility to determine if that person would
38.19 prefer to be served in a community-living setting as defined in section 256B.49, subdivision
38.20 23, in a setting not controlled by a provider, or to receive integrated community supports
38.21 as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified
38.22 assessor shall offer the person, through a person-centered planning process, the option to
38.23 receive alternative housing and service options.

38.24 (p) At the time of reassessment, the certified assessor shall assess each person receiving
38.25 waiver day services to determine if that person would prefer to receive employment services
38.26 as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified
38.27 assessor shall describe to the person through a person-centered planning process the option
38.28 to receive employment services.

38.29 (q) At the time of reassessment, the certified assessor shall assess each person receiving
38.30 non-self-directed waiver services to determine if that person would prefer an available
38.31 service and setting option that would permit self-directed services and supports. The certified
38.32 assessor shall describe to the person through a person-centered planning process the option
38.33 to receive self-directed services and supports.

39.1 (r) All assessments performed according to this subdivision must be face-to-face unless
 39.2 the assessment is a reassessment meeting the requirements of this paragraph. Remote
 39.3 reassessments conducted by interactive video or telephone may substitute for face-to-face
 39.4 reassessments. For services provided by the developmental disabilities waiver under section
 39.5 256B.092, and the community access for disability inclusion, community alternative care,
 39.6 and brain injury waiver programs under section 256B.49, remote reassessments may be
 39.7 substituted for two consecutive reassessments if followed by a face-to-face reassessment.
 39.8 For services provided by alternative care under section 256B.0913, essential community
 39.9 supports under section 256B.0922, and the elderly waiver under chapter 256S, remote
 39.10 reassessments may be substituted for one reassessment if followed by a face-to-face
 39.11 reassessment. A remote reassessment is permitted only if the person being reassessed, ~~or~~
 39.12 ~~the person's legal representative, and the lead agency case manager both agree that there is~~
 39.13 ~~no change in the person's condition, there is no need for a change in service, and that a~~
 39.14 ~~remote reassessment is appropriate~~ and the person's legal representative provide informed
 39.15 choice for a remote assessment. The person being reassessed, or the person's legal
 39.16 representative, has the right to refuse a remote reassessment at any time. During a remote
 39.17 reassessment, if the certified assessor determines a face-to-face reassessment is necessary
 39.18 ~~in order~~ to complete the assessment, the lead agency shall schedule a face-to-face
 39.19 reassessment. All other requirements of a face-to-face reassessment shall apply to a remote
 39.20 reassessment, including updates to a person's support plan.

39.21 Sec. 22. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 1, is
 39.22 amended to read:

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

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

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

39.33 (2) crisis planning;

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

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

40.5 (5) individual treatment plan development as defined in ~~Minnesota Rules, part 9505.0371,~~
40.6 ~~subpart 7~~ section 245I.10, subdivisions 7 and 8; and

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

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

40.11 Sec. 23. Minnesota Statutes 2021 Supplement, section 256B.0947, subdivision 6, is
40.12 amended to read:

40.13 Subd. 6. **Service standards.** The standards in this subdivision apply to intensive
40.14 nonresidential rehabilitative mental health services.

40.15 (a) The treatment team must use team treatment, not an individual treatment model.

40.16 (b) Services must be available at times that meet client needs.

40.17 (c) Services must be age-appropriate and meet the specific needs of the client.

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

40.22 (e) The treatment team must complete an individual treatment plan for each client,
40.23 according to section 245I.10, subdivisions 7 and 8, and the individual treatment plan must:

40.24 (1) be completed in consultation with the client's current therapist and key providers and
40.25 provide for ongoing consultation with the client's current therapist to ensure therapeutic
40.26 continuity and to facilitate the client's return to the community. For clients under the age of
40.27 18, the treatment team must consult with parents and guardians in developing the treatment
40.28 plan;

40.29 (2) if a need for substance use disorder treatment is indicated by validated assessment:

40.30 (i) identify goals, objectives, and strategies of substance use disorder treatment;

41.1 (ii) develop a schedule for accomplishing substance use disorder treatment goals and
41.2 objectives; and

41.3 (iii) identify the individuals responsible for providing substance use disorder treatment
41.4 services and supports; and

41.5 (3) provide for the client's transition out of intensive nonresidential rehabilitative mental
41.6 health services by defining the team's actions to assist the client and subsequent providers
41.7 in the transition to less intensive or "stepped down" services; and.

41.8 ~~(4) notwithstanding section 245I.10, subdivision 8, be reviewed at least every 90 days~~
41.9 ~~and revised to document treatment progress or, if progress is not documented, to document~~
41.10 ~~changes in treatment.~~

41.11 (f) The treatment team shall actively and assertively engage the client's family members
41.12 and significant others by establishing communication and collaboration with the family and
41.13 significant others and educating the family and significant others about the client's mental
41.14 illness, symptom management, and the family's role in treatment, unless the team knows or
41.15 has reason to suspect that the client has suffered or faces a threat of suffering any physical
41.16 or mental injury, abuse, or neglect from a family member or significant other.

41.17 (g) For a client age 18 or older, the treatment team may disclose to a family member,
41.18 other relative, or a close personal friend of the client, or other person identified by the client,
41.19 the protected health information directly relevant to such person's involvement with the
41.20 client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the
41.21 client is present, the treatment team shall obtain the client's agreement, provide the client
41.22 with an opportunity to object, or reasonably infer from the circumstances, based on the
41.23 exercise of professional judgment, that the client does not object. If the client is not present
41.24 or is unable, by incapacity or emergency circumstances, to agree or object, the treatment
41.25 team may, in the exercise of professional judgment, determine whether the disclosure is in
41.26 the best interests of the client and, if so, disclose only the protected health information that
41.27 is directly relevant to the family member's, relative's, friend's, or client-identified person's
41.28 involvement with the client's health care. The client may orally agree or object to the
41.29 disclosure and may prohibit or restrict disclosure to specific individuals.

41.30 (h) The treatment team shall provide interventions to promote positive interpersonal
41.31 relationships.

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

42.1 Sec. 24. Minnesota Statutes 2021 Supplement, section 256B.0949, subdivision 2, is
42.2 amended to read:

42.3 Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this
42.4 subdivision.

42.5 (b) "Agency" means the legal entity that is enrolled with Minnesota health care programs
42.6 as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide
42.7 EIDBI services and that has the legal responsibility to ensure that its employees or contractors
42.8 carry out the responsibilities defined in this section. Agency includes a licensed individual
42.9 professional who practices independently and acts as an agency.

42.10 (c) "Autism spectrum disorder or a related condition" or "ASD or a related condition"
42.11 means either autism spectrum disorder (ASD) as defined in the current version of the
42.12 Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found
42.13 to be closely related to ASD, as identified under the current version of the DSM, and meets
42.14 all of the following criteria:

42.15 (1) is severe and chronic;

42.16 (2) results in impairment of adaptive behavior and function similar to that of a person
42.17 with ASD;

42.18 (3) requires treatment or services similar to those required for a person with ASD; and

42.19 (4) results in substantial functional limitations in three core developmental deficits of
42.20 ASD: social or interpersonal interaction; functional communication, including nonverbal
42.21 or social communication; and restrictive or repetitive behaviors or hyperreactivity or
42.22 hyporeactivity to sensory input; and may include deficits or a high level of support in one
42.23 or more of the following domains:

42.24 (i) behavioral challenges and self-regulation;

42.25 (ii) cognition;

42.26 (iii) learning and play;

42.27 (iv) self-care; or

42.28 (v) safety.

42.29 (d) "Person" means a person under 21 years of age.

42.30 (e) "Clinical supervision" means the overall responsibility for the control and direction
42.31 of EIDBI service delivery, including individual treatment planning, staff supervision,

43.1 individual treatment plan progress monitoring, and treatment review for each person. Clinical
43.2 supervision is provided by a qualified supervising professional (QSP) who takes full
43.3 professional responsibility for the service provided by each supervisee.

43.4 (f) "Commissioner" means the commissioner of human services, unless otherwise
43.5 specified.

43.6 (g) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive
43.7 evaluation of a person to determine medical necessity for EIDBI services based on the
43.8 requirements in subdivision 5.

43.9 (h) "Department" means the Department of Human Services, unless otherwise specified.

43.10 (i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI
43.11 benefit" means a variety of individualized, intensive treatment modalities approved and
43.12 published by the commissioner that are based in behavioral and developmental science
43.13 consistent with best practices on effectiveness.

43.14 (j) "Generalizable goals" means results or gains that are observed during a variety of
43.15 activities over time with different people, such as providers, family members, other adults,
43.16 and people, and in different environments including, but not limited to, clinics, homes,
43.17 schools, and the community.

43.18 (k) "Incident" means when any of the following occur:

43.19 (1) an illness, accident, or injury that requires first aid treatment;

43.20 (2) a bump or blow to the head; or

43.21 (3) an unusual or unexpected event that jeopardizes the safety of a person or staff,
43.22 including a person leaving the agency unattended.

43.23 (l) "Individual treatment plan" or "ITP" means the person-centered, individualized written
43.24 plan of care that integrates and coordinates person and family information from the CMDE
43.25 for a person who meets medical necessity for the EIDBI benefit. An individual treatment
43.26 plan must meet the standards in subdivision 6.

43.27 (m) "Legal representative" means the parent of a child who is under 18 years of age, a
43.28 court-appointed guardian, or other representative with legal authority to make decisions
43.29 about service for a person. For the purpose of this subdivision, "other representative with
43.30 legal authority to make decisions" includes a health care agent or an attorney-in-fact
43.31 authorized through a health care directive or power of attorney.

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

44.3 (o) "Person-centered" means a service that both responds to the identified needs, interests,
44.4 values, preferences, and desired outcomes of the person or the person's legal representative
44.5 and respects the person's history, dignity, and cultural background and allows inclusion and
44.6 participation in the person's community.

44.7 (p) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or
44.8 level III treatment provider.

44.9 (q) "Advanced certification" means a person who has completed advanced certification
44.10 in an approved modality under subdivision 13, paragraph (b).

44.11 Sec. 25. Minnesota Statutes 2021 Supplement, section 256B.0949, subdivision 13, is
44.12 amended to read:

44.13 Subd. 13. **Covered services.** (a) The services described in paragraphs (b) to (l) are
44.14 eligible for reimbursement by medical assistance under this section. Services must be
44.15 provided by a qualified EIDBI provider and supervised by a QSP. An EIDBI service must
44.16 address the person's medically necessary treatment goals and must be targeted to develop,
44.17 enhance, or maintain the individual developmental skills of a person with ASD or a related
44.18 condition to improve functional communication, including nonverbal or social
44.19 communication, social or interpersonal interaction, restrictive or repetitive behaviors,
44.20 hyperreactivity or hyporeactivity to sensory input, behavioral challenges and self-regulation,
44.21 cognition, learning and play, self-care, and safety.

44.22 (b) EIDBI treatment must be delivered consistent with the standards of an approved
44.23 modality, as published by the commissioner. EIDBI modalities include:

44.24 (1) applied behavior analysis (ABA);

44.25 (2) developmental individual-difference relationship-based model (DIR/Floortime);

44.26 (3) early start Denver model (ESDM);

44.27 (4) PLAY project;

44.28 (5) relationship development intervention (RDI); or

44.29 (6) additional modalities not listed in clauses (1) to (5) upon approval by the
44.30 commissioner.

45.1 (c) An EIDBI provider may use one or more of the EIDBI modalities in paragraph (b),
45.2 clauses (1) to (5), as the primary modality for treatment as a covered service, or several
45.3 EIDBI modalities in combination as the primary modality of treatment, as approved by the
45.4 commissioner. An EIDBI provider that identifies and provides assurance of qualifications
45.5 for a single specific treatment modality, including an EIDBI provider with advanced
45.6 certification overseeing implementation, must document the required qualifications to meet
45.7 fidelity to the specific model in a manner determined by the commissioner.

45.8 (d) Each qualified EIDBI provider must identify and provide assurance of qualifications
45.9 for professional licensure certification, or training in evidence-based treatment methods,
45.10 and must document the required qualifications outlined in subdivision 15 in a manner
45.11 determined by the commissioner.

45.12 (e) CMDE is a comprehensive evaluation of the person's developmental status to
45.13 determine medical necessity for EIDBI services and meets the requirements of subdivision
45.14 5. The services must be provided by a qualified CMDE provider.

45.15 (f) EIDBI intervention observation and direction is the clinical direction and oversight
45.16 of EIDBI services by the QSP, level I treatment provider, or level II treatment provider,
45.17 including developmental and behavioral techniques, progress measurement, data collection,
45.18 function of behaviors, and generalization of acquired skills for the direct benefit of a person.
45.19 EIDBI intervention observation and direction informs any modification of the current
45.20 treatment protocol to support the outcomes outlined in the ITP.

45.21 (g) Intervention is medically necessary direct treatment provided to a person with ASD
45.22 or a related condition as outlined in their ITP. All intervention services must be provided
45.23 under the direction of a QSP. Intervention may take place across multiple settings. The
45.24 frequency and intensity of intervention services are provided based on the number of
45.25 treatment goals, person and family or caregiver preferences, and other factors. Intervention
45.26 services may be provided individually or in a group. Intervention with a higher provider
45.27 ratio may occur when deemed medically necessary through the person's ITP.

45.28 (1) Individual intervention is treatment by protocol administered by a single qualified
45.29 EIDBI provider delivered to one person.

45.30 (2) Group intervention is treatment by protocol provided by one or more qualified EIDBI
45.31 providers, delivered to at least two people who receive EIDBI services.

45.32 (3) Higher provider ratio intervention is treatment with protocol modification provided
45.33 by two or more qualified EIDBI providers delivered to one person in an environment that
45.34 meets the person's needs and under the direction of the QSP or level I provider.

46.1 (h) ITP development and ITP progress monitoring is development of the initial, annual,
 46.2 and progress monitoring of an ITP. ITP development and ITP progress monitoring documents
 46.3 provide oversight and ongoing evaluation of a person's treatment and progress on targeted
 46.4 goals and objectives and integrate and coordinate the person's and the person's legal
 46.5 representative's information from the CMDE and ITP progress monitoring. This service
 46.6 must be reviewed and completed by the QSP, and may include input from a level I provider
 46.7 or a level II provider.

46.8 (i) Family caregiver training and counseling is specialized training and education for a
 46.9 family or primary caregiver to understand the person's developmental status and help with
 46.10 the person's needs and development. This service must be provided by the QSP, level I
 46.11 provider, or level II provider.

46.12 (j) A coordinated care conference is a voluntary meeting with the person and the person's
 46.13 family to review the CMDE or ITP progress monitoring and to integrate and coordinate
 46.14 services across providers and service-delivery systems to develop the ITP. This service
 46.15 ~~must be provided by the QSP and~~ may include the CMDE provider ~~or~~, QSP, a level I
 46.16 provider, or a level II provider.

46.17 (k) Travel time is allowable billing for traveling to and from the person's home, school,
 46.18 a community setting, or place of service outside of an EIDBI center, clinic, or office from
 46.19 a specified location to provide in-person EIDBI intervention, observation and direction, or
 46.20 family caregiver training and counseling. The person's ITP must specify the reasons the
 46.21 provider must travel to the person.

46.22 (l) Medical assistance covers medically necessary EIDBI services and consultations
 46.23 ~~delivered by a licensed health care provider~~ via telehealth, as defined under section
 46.24 256B.0625, subdivision 3b, in the same manner as if the service or consultation was delivered
 46.25 in person.

46.26 Sec. 26. Minnesota Statutes 2020, section 256K.26, subdivision 6, is amended to read:

46.27 Subd. 6. **Outcomes.** Projects will be selected to further the following outcomes:

46.28 (1) reduce the number of Minnesota individuals and families that experience long-term
 46.29 homelessness;

46.30 (2) increase the number of housing opportunities with supportive services;

46.31 (3) develop integrated, cost-effective service models that address the multiple barriers
 46.32 to obtaining housing stability faced by people experiencing long-term homelessness,

47.1 including abuse, neglect, chemical dependency, disability, chronic health problems, or other
47.2 factors including ethnicity and race that may result in poor outcomes or service disparities;

47.3 (4) encourage partnerships among counties, Tribes, community agencies, schools, and
47.4 other providers so that the service delivery system is seamless for people experiencing
47.5 long-term homelessness;

47.6 (5) increase employability, self-sufficiency, and other social outcomes for individuals
47.7 and families experiencing long-term homelessness; and

47.8 (6) reduce inappropriate use of emergency health care, shelter, ~~chemical dependency~~
47.9 substance use disorder treatment, foster care, child protection, corrections, and similar
47.10 services used by people experiencing long-term homelessness.

47.11 Sec. 27. Minnesota Statutes 2020, section 256K.26, subdivision 7, is amended to read:

47.12 Subd. 7. **Eligible services.** Services eligible for funding under this section are all services
47.13 needed to maintain households in permanent supportive housing, as determined by the
47.14 ~~county or counties~~ or Tribes administering the project or projects.

47.15 Sec. 28. Minnesota Statutes 2021 Supplement, section 256P.01, subdivision 6a, is amended
47.16 to read:

47.17 Subd. 6a. **Qualified professional.** (a) For illness, injury, or incapacity, a "qualified
47.18 professional" means a licensed physician, physician assistant, advanced practice registered
47.19 nurse, physical therapist, occupational therapist, or licensed chiropractor, according to their
47.20 scope of practice.

47.21 (b) For developmental disability, learning disability, and intelligence testing, a "qualified
47.22 professional" means a licensed physician, physician assistant, advanced practice registered
47.23 nurse, licensed independent clinical social worker, licensed psychologist, certified school
47.24 psychologist, or certified psychometrist working under the supervision of a licensed
47.25 psychologist.

47.26 (c) For mental health, a "qualified professional" means a licensed physician, advanced
47.27 practice registered nurse, or qualified mental health professional under section 245I.04,
47.28 subdivision 2.

47.29 (d) For substance use disorder, a "qualified professional" means a licensed physician, a
47.30 qualified mental health professional under section ~~245.462, subdivision 18, clauses (1) to~~
47.31 ~~(6)~~ 245I.04, subdivision 2, or an individual as defined in section 245G.11, subdivision 3,
47.32 4, or 5.

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

48.4 Sec. 29. Minnesota Statutes 2020, section 256Q.06, is amended by adding a subdivision
48.5 to read:

48.6 Subd. 6. **Account creation.** If an eligible individual is unable to establish the eligible
48.7 individual's own ABLE account, an ABLE account may be established on behalf of the
48.8 eligible individual by the eligible individual's agent under a power of attorney or, if none,
48.9 by the eligible individual's conservator or legal guardian, spouse, parent, sibling, or
48.10 grandparent or a representative payee appointed for the eligible individual by the Social
48.11 Security Administration, in that order.

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

48.13 Sec. 30. Laws 2020, First Special Session chapter 7, section 1, subdivision 1, as amended
48.14 by Laws 2021, First Special Session chapter 7, article 2, section 71, is amended to read:

48.15 Subdivision 1. **Waivers and modifications; federal funding extension.** When the
48.16 peacetime emergency declared by the governor in response to the COVID-19 outbreak
48.17 expires, is terminated, or is rescinded by the proper authority, the following waivers and
48.18 modifications to human services programs issued by the commissioner of human services
48.19 pursuant to Executive Orders 20-11 and 20-12 ~~that are required to comply with federal law~~
48.20 may remain in effect for the time period set out in applicable federal law or for the time
48.21 period set out in any applicable federally approved waiver or state plan amendment,
48.22 whichever is later:

48.23 (1) CV15: allowing telephone or video visits for waiver programs;

48.24 (2) CV17: preserving health care coverage for Medical Assistance and MinnesotaCare;

48.25 (3) CV18: implementation of federal changes to the Supplemental Nutrition Assistance
48.26 Program;

48.27 (4) CV20: eliminating cost-sharing for COVID-19 diagnosis and treatment;

48.28 (5) CV24: allowing telephone or video use for targeted case management visits;

48.29 (6) CV30: expanding telemedicine in health care, mental health, and substance use
48.30 disorder settings;

49.1 (7) CV37: implementation of federal changes to the Supplemental Nutrition Assistance
49.2 Program;

49.3 (8) CV39: implementation of federal changes to the Supplemental Nutrition Assistance
49.4 Program;

49.5 (9) CV42: implementation of federal changes to the Supplemental Nutrition Assistance
49.6 Program;

49.7 (10) CV43: expanding remote home and community-based waiver services;

49.8 (11) CV44: allowing remote delivery of adult day services;

49.9 (12) CV59: modifying eligibility period for the federally funded Refugee Cash Assistance
49.10 Program;

49.11 (13) CV60: modifying eligibility period for the federally funded Refugee Social Services
49.12 Program; and

49.13 (14) CV109: providing 15 percent increase for Minnesota Food Assistance Program and
49.14 Minnesota Family Investment Program maximum food benefits.

49.15 Sec. 31. **REVISOR INSTRUCTION.**

49.16 In Minnesota Statutes, chapters 245G, 253B, 254A, and 254B, the revisor of statutes
49.17 shall change the term "chemical dependency" or similar terms to "substance use disorder."
49.18 The revisor may make grammatical changes related to the term change.

49.19 Sec. 32. **REPEALER.**

49.20 (a) Minnesota Statutes 2020, sections 254A.04; and 254B.14, subdivisions 1, 2, 3, 4,
49.21 and 6, are repealed.

49.22 (b) Minnesota Statutes 2021 Supplement, section 254B.14, subdivision 5, is repealed.

254A.04 CITIZENS ADVISORY COUNCIL.

There is hereby created an Alcohol and Other Drug Abuse Advisory Council to advise the Department of Human Services concerning the problems of substance misuse and substance use disorder, composed of ten members. Five members shall be individuals whose interests or training are in the field of alcohol-specific substance use disorder and alcohol misuse; and five members whose interests or training are in the field of substance use disorder and misuse of substances other than alcohol. The terms, compensation and removal of members shall be as provided in section 15.059. The council expires June 30, 2018. The commissioner of human services shall appoint members whose terms end in even-numbered years. The commissioner of health shall appoint members whose terms end in odd-numbered years.

254B.14 CONTINUUM OF CARE PILOT PROJECTS; CHEMICAL HEALTH CARE.

Subdivision 1. **Authorization for continuum of care pilot projects.** The commissioner shall establish chemical dependency continuum of care pilot projects to begin implementing the measures developed with stakeholder input and identified in the report completed pursuant to Laws 2012, chapter 247, article 5, section 8. The pilot projects are intended to improve the effectiveness and efficiency of the service continuum for chemically dependent individuals in Minnesota while reducing duplication of efforts and promoting scientifically supported practices.

Subd. 2. **Program implementation.** (a) The commissioner, in coordination with representatives of the Minnesota Association of County Social Service Administrators and the Minnesota Inter-County Association, shall develop a process for identifying and selecting interested counties and providers for participation in the continuum of care pilot projects. There shall be three pilot projects: one representing the northern region, one for the metro region, and one for the southern region. The selection process of counties and providers must include consideration of population size, geographic distribution, cultural and racial demographics, and provider accessibility. The commissioner shall identify counties and providers that are selected for participation in the continuum of care pilot projects no later than September 30, 2013.

(b) The commissioner and entities participating in the continuum of care pilot projects shall enter into agreements governing the operation of the continuum of care pilot projects. The agreements shall identify pilot project outcomes and include timelines for implementation and beginning operation of the pilot projects.

(c) Entities that are currently participating in the navigator pilot project are eligible to participate in the continuum of care pilot project subsequent to or instead of participating in the navigator pilot project.

(d) The commissioner may waive administrative rule requirements that are incompatible with implementation of the continuum of care pilot projects.

(e) Notwithstanding section 254A.19, the commissioner may designate noncounty entities to complete chemical use assessments and placement authorizations required under section 254A.19 and Minnesota Rules, parts 9530.6600 to 9530.6655. Section 254A.19, subdivision 3, is applicable to the continuum of care pilot projects at the discretion of the commissioner.

Subd. 3. **Program design.** (a) The operation of the pilot projects shall include:

- (1) new services that are responsive to the chronic nature of substance use disorder;
- (2) telehealth services, when appropriate to address barriers to services;
- (3) services that assure integration with the mental health delivery system when appropriate;
- (4) services that address the needs of diverse populations; and
- (5) an assessment and access process that permits clients to present directly to a service provider for a substance use disorder assessment and authorization of services.

(b) Prior to implementation of the continuum of care pilot projects, a utilization review process must be developed and agreed to by the commissioner, participating counties, and providers. The utilization review process shall be described in the agreements governing operation of the continuum of care pilot projects.

Subd. 4. **Notice of project discontinuation.** Each entity's participation in the continuum of care pilot project may be discontinued for any reason by the county or the commissioner after 30 days' written notice to the entity.

APPENDIX
Repealed Minnesota Statutes: 22-06071

Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in this chapter, the commissioner may authorize the behavioral health fund to pay for nontreatment services arranged by continuum of care pilot projects. Individuals who are currently accessing Rule 31 treatment services are eligible for concurrent participation in the continuum of care pilot projects.

(b) County expenditures for continuum of care pilot project services shall not be greater than their expected share of forecasted expenditures in the absence of the continuum of care pilot projects.

Subd. 6. **Managed care.** An individual who is eligible for the continuum of care pilot project is excluded from mandatory enrollment in managed care unless these services are included in the health plan's benefit set.